



COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

C. Ray Davenport
COMMISSIONER

Main Street Centre
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DRAFT AGENDA

SAFETY AND HEALTH CODES BOARD MEETING

Tuesday January 12, 2021 Electronic meeting

9:15 a.m.

******Refer to the Second and Third Page of the Agenda for Instructions on Registering to Make Public Comment and Meeting Access Information******

1. **Call to Order**
2. **Approval of Agenda**
3. **Opportunity for the Public to Address the Board**
4. **New Business**
 - a) Review and consider for adoption a final standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16 VAC 25-220, for all employees and employers under the jurisdiction of the Virginia Occupational Safety and Health (VOSH) program.

Presenter – Jay Withrow
 - b) *(If requested by the Board)* Closed Meeting for the Purpose of Consultation with Legal Counsel Regarding Specific Legal Matters Pursuant to § 2.2-3711.A.8 of the Code of Virginia.
5. **Opportunity for Board Member discussion on any final items regarding Permanent Standard before Agency final recommendation**
6. **Items of Interest from the Department of Labor and Industry**
7. **Items of Interest from Members of the Board**
8. **Meeting Adjournment**

PUBLIC PARTICIPATION

Members of the public may listen to the meeting via the Cisco WebEx platform by using the weblink, access code, and password below, or audio conference only by using the telephone numbers and access code below.

Participation capacity is limited and is on a first come, first served basis due to the capacity of CISCO WebEx technology.

Event address for attendee:

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=e3f38b16a060298487a9188bc8ee16342>

Event number (access code): 178 486 8723

Event password: DOLI2020

To join the audio conference only:

Call this number: 1-517-466-2023 **or US Toll Free** 1-866-692-4530

Enter this Access Code: 178 486 8723

If you wish to make an Oral Public Comment during the “Opportunity for the Public to Address the Board” period of this meeting, you must follow the instructions below:

- Oral public comment will be received from those persons who have submitted an email to **Princy.Doss@doli.virginia.gov** no later than **5:00 PM** on **January 8, 2021** indicating that they wish to offer oral comment. Comments may be offered by these individuals when their name is announced by Ms. Doss. Oral comments will be restricted to 5 minutes each.
- When logging onto WebEx each person **must provide their full name** during the registration process upon entering the meeting. Do not use the default username as it is imperative that the meeting organizer be able to determine who is in attendance based on their registration name. Failure to follow these specific registration instructions will restrict your ability to participate with oral remarks.
- If you wish to make an oral comment and will be utilizing the “audio conference only” option to witness the hearing, you must provide the phone number you will be calling in from in your email to Ms. Doss so that the administrator will know whom to unmute at the appropriate time.
- Other important information:

- All parties will be muted until Ms. Doss announces the name of the person who is next to provide an oral comment.
- All public participation connections will be muted following the public comment periods.
- Please login from a location without background noise.
- Individuals participating in the Virtual meeting on January 12, 2021 are encouraged to submit a written version of any comments by email to **Princy.Doss@doli.virginia.gov** no later than **5:00 PM** on **January 13, 2021**.

Should any interruption of the broadcast of this meeting occur, please call 804-371-2318 or email **Brian.Jaffe@doli.virginia.gov** to notify the agency. Any interruption in the broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

FOIA Council Electronic Meetings Public Comment form for submitting feedback on this electronic meeting may be accessed at:

<http://foiacouncil.dls.virginia.gov/sample%20letters/welcome.htm>



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ITEMS HIGHLIGHTED
IN **YELLOW**
INDICATE SUBJECT TO CHANGE

DRAFT: January 4, 2021

VIRGINIA SAFETY AND HEALTH CODES BOARD

BRIEFING PACKAGE FOR

January 12, 2021

Final Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19, §16 VAC 25-220

I. Action Requested.

The VOSH Program requests the Safety and Health Codes Board adopt a final standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19, §16 VAC 25-220, applicable to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program as described in §§16 VAC 25-60-20 and 16 VAC 25-60-30. Va. Code §40.1-22(6a).

A. Attachments.

ATTACHMENT A:
INDUSTRY SPECIFIC INFORMATION

ATTACHMENT B:
CURRENT LAWS AND REGULATIONS
RECOGNIZED MITIGATION STRATEGIES FOR COVID-19 NOT COVERED
BY VOSH REGULATIONS OR STANDARDS
VA. CODE §40.1-51(A), THE “GENERAL DUTY CLAUSE”

ATTACHMENT C:
OTHER STATE COVID-19 LAWS, STANDARDS AND REGULATIONS

ATTACHMENT D:
FINDING OF “GRAVE DANGER” TO SUPPORT THE ADOPTION OF THE EMERGENCY TEMPORARY STANDARD (ETS) FOR INFECTION DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19, 16VAC25-220, EFFECTIVE JULY 27, 2020

ATTACHMENT E:
OSHA RECORDKEEPING GUIDELINES FOR RECORDING COVID-19 OCCUPATIONALLY RELATED CASES.

ATTACHMENT F:
VOSH INVESTIGATION AND INSPECTION PROCEDURES

ATTACHMENT G:
DETERMINING CAUSE OF DEATH (CDC)

ATTACHMENT H:
VOSH Violations Issued in COVID-19 Cases Opened From February 1, 2020 to December 30, 2020

B. Situation Summary.¹

- On February 7, 2020, the Commissioner of the Virginia Department of Health (VDH) issued a Declaration of Public Emergency.²
- On March 7, the first case of COVID-19 in Virginia was confirmed.³
- On March 11, the World Health Organization characterized COVID-19 as a pandemic.⁴
- On March 12, Governor Ralph S. Northam issued Executive Order 51, Declaration of a State of Emergency Due To Novel Coronavirus (Covid-19) in the Commonwealth of Virginia.⁵

¹ <https://www.vdh.virginia.gov/coronavirus/> - Situation Summary Taken in Part from the Virginia Department of Health Website

² <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf>

³ <https://www.vdh.virginia.gov/news/2020-news-releases/first-virginia-case-of-covid-19-confirmed-at-fort-belvoir/>

⁴ <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>

⁵ [https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/eo/EO-51-Declaration-of-a-State-of-Emergency-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/eo/EO-51-Declaration-of-a-State-of-Emergency-Due-to-Novel-Coronavirus-(COVID-19).pdf)

- On March 13, 2020, President Donald J. Trump declared a national emergency in response to the COVID-19 pandemic.⁶
- On March 17, Governor Northam and State Health Commissioner M. Norman Oliver, MD, MA issued a Declaration of Public Health Emergency.⁷
- On March 23, Governor Northam issued Executive Order 53⁸ that orders the closure of certain non-essential businesses, bans all gatherings of more than 10 people, and closes all K-12 schools for the remainder of the academic year. Governor Northam also urged all Virginians to avoid non-essential travel outside the home, if and when possible. Food establishments are mandated to offer curbside takeout and delivery service only, or close to the public.
- On March 25, Governor Northam and State Health Commissioner M. Norman Oliver, MD, MA directed all hospitals to stop performing elective surgeries or procedures to help conserve supplies of personal protective equipment (PPE). Order of Public Health Emergency Two.⁹
- On March 30, Governor Northam issued Executive Order 55¹⁰, a statewide Temporary Stay at Home order. The executive order took effect immediately and will remain in place until June 10, 2020. The order directed all Virginians to stay home except in extremely limited circumstances. Individuals may leave their residence for allowable travel, including to seek medical attention, work, care for family or household members, obtain goods and services like groceries, prescriptions, and others as outlined in Executive Order Fifty-Three, and engage in outdoor activity with strict social distancing requirements.
- On May 8, Governor Northam issued Executive Order 61 and Order of Public Health Emergency Three, Phase One Easing of Certain Temporary Restrictions Due to Novel Coronavirus (COVID-19).¹¹
- On May 12, Governor Northam issued Executive Order 62 and Order of Public Health Emergency Four, Jurisdictions Temporarily Delayed from Entering Phase

⁶ <https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/>

⁷ <https://www.governor.virginia.gov/media/governorviriniagov/governor-of-virginia/pdf/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf>

⁸ [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-53-Temporary-Restrictions-Due-To-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-53-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf)

⁹ <https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/Order-of-Public-Health-Emergency-Two---Order-of-The-Governor-and-State-Health-Commissioner.pdf>

¹⁰ [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-55-Temporary-Stay-at-Home-Order-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-55-Temporary-Stay-at-Home-Order-Due-to-Novel-Coronavirus-(COVID-19).pdf)

¹¹ [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf)

One in Executive Order 61 and Permitted to Remain in Phase Zero Northern Virginia Region.¹²

- On May 14, Governor Northam issued Amended Executive Order 62 and Amended Order of Public Health Emergency Four, Jurisdictions Temporarily Delayed from Entering Phase One in Executive Order 61 and Permitted to Remain in Phase Zero, Phase Zero Jurisdictions.¹³
- On May 26, Governor Northam issued a revised Executive Order 63¹⁴ (EO 63), “Order of Public Health Emergency Five, Requirement to Wear Face Covering While Inside Buildings.” EO 63 also directed the Commissioner of the Virginia Department of Labor and Industry [and Virginia Safety and Health Codes Board] to promulgate emergency regulations and standards to control, prevent, and mitigate the spread of COVID-19 in the workplace.

II. Summary of Rulemaking Process.

A. Petition Concerning Poultry and Meat Processing.

On April 23, 2020, the Commissioner of Labor and Industry received a petition from the Virginia Legal Aid Justice Center (LAJC), Community Organizing, and Community Solidarity with the Poultry Workers organizations to enact an emergency regulation to address COVID-19 related workplace hazards in the poultry processing and meatpacking industries. On April 29, 2020, Commissioner C. Ray Davenport provided an initial response to the April 23rd petition letter.

On May 6, 2020, the Commissioner received a follow-up letter from the same petitioners. On May 14, 2020, Commissioner C. Ray Davenport provided a follow-up response to the April 23rd and May 6th petition letters indicating that the petition would be submitted to the Virginia Safety and Health Codes Board for consideration.

B. Virginia Executive Order 63, issued May 26, 2020.

On May 26, 2020, Governor Northam issued a revised Executive Order 63¹⁵ (EO 63), “Order of Public Health Emergency Five, Requirement to Wear Face Covering While Inside Buildings” that provides in part:

“E. Department of Labor and Industry
Except for paragraph B above, this Order does not apply to employees, employers, subcontractors, or other independent contractors in the workplace.
The Commissioner of the Virginia Department of Labor and Industry shall

¹² <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-62-and-Order-of-Public-Health-Emergency-Four---Jurisdictions-Temporarily-Delayed-From-Entering-Phase-One-in-Executive-Order-61-and-Permitted-to-Remain-in-Phase-Zero-Northern-Virginia-Region.pdf>

¹³ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-62-and-Order-of-Public-Health-Emergency-Four-AMENDED.pdf>

¹⁴ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf>

¹⁵ *Id.*

promulgate emergency regulations and standards to control, prevent, and mitigate the spread of COVID-19 in the workplace. The regulations and standards adopted in accordance with §§ 40.1-22(6a) or 2.2-4011 of the Code of Virginia shall apply to every employer, employee, and place of employment within the jurisdiction of the Virginia Occupational Safety and Health program as described in 16 Va. Admin. Code § 25-60-20 and Va. Admin. Code § 25-60-30. These regulations and standards must address personal protective equipment, respiratory protective equipment, and sanitation, access to employee exposure and medical records and hazard communication. Further, these regulations and standards may not conflict with requirements and guidelines applicable to businesses set out and incorporated into Amended Executive Order 61 and Amended Order of Public Health Emergency Three.”¹⁶ (Emphasis added).

Although EO 63 does not mention the Safety and Health Codes Board, Governor Northam issued a news release which says in part:

“The Governor is also directing the Commissioner of the Department of Labor and Industry to develop emergency temporary standards for occupational safety that will protect employees from the spread of COVID-19 in their workplaces. These occupational safety standards will require the approval by vote of the Virginia Safety and Health Codes Board and must address personal protective equipment, sanitation, record-keeping of incidents, and hazard communication. Upon approval, the Department of Labor and Industry will be able to enforce the standards through civil penalties and business closures.”¹⁷ (Emphasis added).

C. Emergency Meeting of Safety and Health Codes Board.

1. Emergency Temporary Standard.

On June 12, 2020 the Department posted a Notice of Meeting for a June 24, 2020 emergency meeting¹⁸ of the Safety and Health Codes Board to consider for adoption an Emergency Temporary Standard/Emergency Regulation (“ETS/ER”), Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, applicable to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program as described in §§16VAC 25-60-20 and 16 VAC 25-60-30.

On June 12, 2020 the Department also opened a 10 day Comment Forum¹⁹ to provide the public the opportunity to submit written comments on the Department’s request to consider for adoption an ETS/ER Infectious Disease Prevention, SARS-CoV-2 Virus that Causes COVID-19. The comment period closed on June 22, 2020, and the

¹⁶ [https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-61-and-Order-Of-Public-Health-Emergency-Three-AMENDED---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-61-and-Order-Of-Public-Health-Emergency-Three-AMENDED---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf)

¹⁷ <https://www.governor.virginia.gov/newsroom/all-releases/2020/may/headline-857020-en.html>

¹⁸ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31004>

¹⁹ <https://townhall.virginia.gov/L/comments.cfm?GeneralNoticeid=1118>

comments were reviewed with the Board at its meeting on June 24, 2020.

On June 24, 2020, the Board decided to proceed with the adoption of an ETS under Va. Code §40.1-22(6a) and further provided that once the ETS was adopted, the Board would proceed with the consideration of adopting a permanent replacement standard for the ETS.

The Board continued its meeting of June 24th on June 29, 2020,²⁰ July 7, 2020²¹ and July 15, 2020.²² On July 15, 2020, the Virginia Safety and Health Codes Board adopted §16 VAC 25-220, Emergency Temporary Standard, Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19.

The ETS was published in the Richmond Times Dispatch on July 27, 2020 and took immediate effect.²³ The ETS expires on January 26, 2021.

2. Proposed Permanent Standard.

Pursuant to Va. Code §40.1-22(6a), publication of the COVID-19 ETS in the Richmond Times Dispatch constituted notice that the Board intends to adopt a permanent standard within a period of six months.

Although not required to under Va. Code §40.1-22(6a), the Board opted to engage in the following notice and comment process that would mirror, to the extent possible within the compressed six month timeline for adoption, Virginia Administrative Process Act (APA) procedures:

- The Board held a 60 day written comment period for the proposed permanent standard running from August 27, 2020 to September 25, 2020.²⁴
- The Board held a public hearing on the proposed permanent standard on September 30, 2020.²⁵

The Department received 993 written comments through the Virginia Regulatory Townhall for the 60 day written comment period from August 27, 2020 to September 25, 2020. There were 33 written comments sent directly to the Department during the 60 day written comment period, although a number of those were also posted by the Commenters on the Virginia Regulatory Townhall. There were 29 oral comments received during the public hearing on September 30, 2020.

The Board was briefed on the Department's response to the public comments at its regular meeting on November 12, 2020.

²⁰ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31037>

²¹ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31057>

²² <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31089>

²³ http://register.dls.virginia.gov/emergency_regs.shtml

²⁴ <https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1137>

²⁵ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31418>

- In response to the public comments received, the Department developed recommended revisions to the proposed permanent standard and published them on December 10, 2020 with a 30 day written comment period ending January 9, 2021.²⁶
- A public hearing is scheduled for January 5, 2021.²⁷
- An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04²⁸ will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.²⁹

[TO BE PROVIDED ON OR BEFORE JANUARY 11, 2021]

3. Final Standard.

- A meeting of the Board to consider adoption of a final standard is scheduled for January 12, 2021.³⁰ If necessary, continued meeting dates of January 13, 2021³¹ and January 19, 2021³² have been scheduled.

D. Review of Comments Submitted: Initial 60 day Written Comment Period from August 27, 2020 to September 25, 2020; and Public Hearing of September 30, 2020.

The Department received 993 written comments through the Virginia Regulatory Townhall for the 60 day written comment period from August 27, 2020 to September 25, 2020.³³

There were 33 written comments sent directly to the Department during the 60 day written comment period, although a number of those were also posted by the Commenter on the Virginia Regulatory Townhall.³⁴

There were 29 oral comments received during the public hearing on September 30, 2020.³⁵

E. Review of Comments Submitted: Follow-up 30 day Written Comment Period from December 10, 2020 to January 9, 2021; and Public Hearing of January 5, 2021.

[TO BE PROVIDED ON JANUARY 11, 2021]

²⁶ <https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1177>

²⁷ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31985>

²⁸ <https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/>

²⁹ <http://www.chmuraecon.com/>

³⁰ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31986>

³¹ <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31987>

³² <https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31989>

³³ https://townhall.virginia.gov/L/GetFile.cfm?File=meeting\92\31594\Agenda_DOLI_31594_v6.pdf

³⁴ *Id.*

³⁵ <https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1162>

F. Summary DOLI Recommended Changes From Revised Proposed Standard to Final Standard in Response to Comments Received During the 60 Day Written Comment Period, September 30, 2020 Public Hearing, and 30 Day Written Comment Period (as of January 3, 2021).

16VAC25-220-10. Purpose, scope, and applicability.

Language added to 16VAC25-220-10.C:

Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.³⁶

16VAC25-220-20. Effective dates.

Language added as 16VAC25-220-20.A:

A. Adoption Process.

1. This standard shall take effect upon review by the Governor, and if no revisions are requested, filing with the Registrar of Regulations, and publication in a newspaper of general circulation, published in the City of Richmond, Virginia.
2. If the Governor's review results in one or more requested revisions to the standard, the Safety and Health Codes Board shall reconvene to approve, amend, or reject the requested revisions.
3. If the Safety and Health Codes Board approves the requested revisions to the standard as submitted, the standard shall take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.
4. Should the Governor fail to review the standard under subsection 1 within thirty (30) days of its approval by the Safety and Health Codes Board, the Board will not need to reconvene to take further action, and the standard shall take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

³⁶ DOLI interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms."

DOLI will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

Language added as 16VAC25-220-20.B:

- B. The requirements for 16VAC25-220-70 [Infection disease preparedness and response plan] shall take effect on March 26, 2021.³⁷ The training requirements in 16VAC25-220-80 shall take effect on March 26, 2021.³⁸

Language added as 16VAC25-220-20.C:

- C. Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.³⁹

16VAC25-220-30. Definitions.

Definition of “Face covering” revised:

“Face covering” means an item made of two or more layers of washable, breathable fabric that fits snugly against the sides of the face without any gaps, completely covering the nose and mouth and fitting securely under the chin. Neck gaiters made of two or more layers of washable, breathable fabric, or folded to make two such layers are considered acceptable face coverings. Face coverings shall not have exhalation valves or vents, which allow virus particles to escape, and shall not be made of material that makes it hard to breathe, such as vinyl.⁴⁰ A face covering is not a surgical/medical procedure mask or respirator....

New definition for “Minimal occupational contact” is provided:

“Minimal occupational contact” means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others

³⁷ This date assumes the permanent standard has an effective date of January 27, 2021.

³⁸ This date assumes the permanent standard has an effective date of January 27, 2021.

³⁹ The new language in 16VAC25-220.C requires the Board to make a “determination” of whether there is continued need for the standard. The Department has identified three “determination” options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

With regard to the phrase “notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to,” the intent of the language is to give the Board the maximum amount of flexibility to “notice” the Board meeting within 14 days even if the Board may not actually meet within 14 days.

⁴⁰ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>

inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet); healthcare employees providing only telemedicine services; a long distance truck driver.⁴¹

New definition of “Severely immunocompromised” is provided:

“Severely immunocompromised” means being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days.”⁴² The degree of immunocompromise is determined by the treating provider, and preventive actions are tailored to each individual and situation.

16VAC25-220-40. Mandatory requirements for all employers.

16VAC25-220-40.B.8.d [notification to VDH of positive cases] is changed to:

d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp; (Emphasis added).

16VAC25-220.C.1.a is changed to reflect a symptoms based strategy for return to work:

1. Employers shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work.
 - a. Symptomatic employees known or suspected to be infected with the SARS-CoV-2 virus are excluded from returning to work until all three of the following have been met:
 - (i) The employee is fever-free (less than 100.0° F) for at least 24 hours,

⁴¹ <https://www.osha.gov/SLTC/covid-19/hazardrecognition.html>

⁴² Footnote 1, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

without the use of fever-reducing medications,

(ii) Respiratory symptoms, such as cough and shortness of breath have improved, and

(iii) At least 10 days have passed since symptoms first appeared.

However, a limited number of employees with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset.

Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

16VAC25-220-40.F [multiple employees occupying a vehicle] and -40.G [where physical distancing cannot be maintained], the following language was added:

Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons.

16VAC25-220-40.H, the following language is added:

H. When it is necessary for employees solely exposed to lower risk hazards or job tasks to have brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet), a face covering is required.

16VAC25-220-40.J.1, the following language is added:

1. Although face shields are not considered a substitute for face coverings as a method of source control and not used as a replacement for face coverings among people without medical contraindications, face shields may provide some level of protection against contact with respiratory droplets. In situations where a face covering cannot be worn due to medical contraindications, employers shall provide and employees shall wear either:

a. A face shield that wraps around the sides of the wearer's face and extends below the chin, or

b. A hooded face shield; and

c. To the extent feasible, employees wearing face shields in accordance with this subsection shall observe physical distancing requirements in this standard.

2. Face shield wearers shall wash their hands before and after removing the face shield and avoid touching their eyes, nose and mouth when removing it.

3. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.

4. Reusable face shields shall be cleaned and disinfected after each use

according to manufacturer instructions.

16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk.

16VA25-220-50.B.1 [air handling systems] is changed by deleting references to ASHRAE and ANSI standards,⁴³ and adding the following:

b. Where feasible and within the design parameters of the system, are utilized as follows:

- i. Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open);
- ii. In ground transportation settings, use natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of inside air when environmental conditions and transportation safety and health requirements allow;
- iii. Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;
- iv. Increase air filtration to as high as possible in a manner that will still enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;
- v. Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;
- vi. Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);
- vii. Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied.
- viii. If the system's design can accommodate such an adjustment and is allowed by the air handler manufacturer's installation instructions and listing, improve central air filtration to MERV-13 and seal edges of the filter to limit bypass; and
- ix. Check filters to ensure they are within service life and appropriately installed.

c. Comply with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards.

16VA25-220-60.B.6, the following language is added:

Diagnostic laboratories that conduct routine medical testing and environmental specimen testing for COVID-19 are not required to operate at BSL-3.

⁴³ American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a).

16VAC25-220-60.C.6, the following language from the ETS was accidentally deleted from the Revised Proposed Standard posted on December 10, 2020 during the .pdf conversion process and is added back in:

6. To the extent feasible, employers shall ensure that psychological and behavioral support is available to address employee stress at no cost to the employee.

16VAC25-220-60. Requirements for hazards or job tasks classified at medium exposure risk.

16VA25-220-60.B.1 [air handling systems] is changed in the same manner as 16VA25-220-50.B.1 above.

16VAC25-220-70. Infectious disease preparedness and response plan.

16VAC25-220-70.C.3.a.iv, new language is added:

- C.The plan shall:
 3. Consider and address the level of SARS-CoV-2 virus and COVID-19 disease risk associated with various places of employment, the hazards employees are exposed to at those sites, and job tasks employees perform at those sites. Such considerations shall include:
....
 - iv. Situations where employees work during higher risk activities involving potentially large numbers of people or enclosed work areas such as at large social gatherings, weddings, funerals, parties, restaurants, bars, hotels, sporting events, concerts, parades, movie theaters, rest stops, airports, bus stations, train stations, cruise ships, river boats, airplanes, etc.⁴⁴

16VAC25-220-80. Training.

16VAC25-220-80.C.2 [written certification of training], new language is added:

2. A physical or electronic signature is not necessary if other documentation of training completion can be provided (e.g., electronic certification through a training system; security precautions that enable the employer to demonstrate that training was accessed by passwords and usernames unique to each employee, etc.).

III. Summary of the Final Standard.

10 Purpose, scope, and applicability.

- The final standard is designed to establish requirements for employers to control, prevent, and mitigate the spread of coronavirus disease 2019 (COVID-19) to and among employees

⁴⁴ <https://www.vdh.virginia.gov/coronavirus/coronavirus/travel-to-areas-with-widespread-ongoing-community-spread/>
<https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>

and employers, and would apply to all Virginia employees and employers under VOSH's jurisdiction.

NOTE: VOSH is required by the OSH Act of 1970⁴⁵ and OSHA regulations⁴⁶ to be "at least as effective as" federal OSHA; and standards and regulations adopted by VOSH must be "as stringent as" those adopted by federal OSHA in accordance with Va. Code §40.1-22(5). VOSH generally follows OSHA interpretations of federal identical standards and regulations.

- Application of the standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., "very high", "high", "medium", and "lower").
- It is recognized that various hazards or job tasks at the same place of employment can be designated as "very high", "high", "medium", or "lower" as presenting potential exposure risk for purposes of application of the requirements of this standard.
- Provides factors to be considered in determining exposure risk level.
- No enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.

NOTE: DOLI interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms."

DOLI will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

- In lieu of specific provisions of the final standard, employers are permitted to comply with CDC guidelines, both mandatory and non-mandatory, provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of the final standard.

NOTE: The intent of the above section is to give employers the option to either comply with the requirements of the final standard or demonstrate that as an alternative that they have complied with requirements in a CDC publication addressing the same hazard, issue, etc.

⁴⁵ https://www.osha.gov/laws-regs/oshact/section_18

⁴⁶ <https://www.osha.gov/laws-regs/regulations/standardnumber/1902/1902.4>

In order for an employer to take advantage of the provision, it would have to demonstrate that it was complying with language in CDC publications that could be considered both “mandatory” (e.g., “shall”, “will”, etc.) and “non-mandatory” (“it is recommended that”, “should”, “may”, etc.). In other words, an employer would have to comply with a CDC “recommended” practice even if the CDC publication doesn't “require” it.

VOSH’s interpretation of the above section and language in CDC publications will otherwise follow normal rules of regulatory/statutory construction. For instance, if the CDC publication language offers options for an employer to address a hazard, issue, etc., that is also addressed by the final standard (e.g., the employer “should” do “this”, or “that”, or “the other”), then employer is required to implement at least one of the options in order for the above section to apply.

The final standard does not require employers to comply with any CDC publication language that is solely directed at assuring the safety and health of the general public.

- Similar to the CDC provision referenced above, a public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and who operate in compliance with the public school division’s or private school’s submitted plans shall be considered in compliance with this standard.
- A public or private institution of higher education that has received certification from the State Council of Higher Education of Virginia that the institution’s re-opening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor’s Office in conjunction with the Virginia Department of Health shall be considered in compliance with this standard, provided the institution operates in compliance with its certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard.

20 Dates.

- Provides a process for gubernatorial review of the final standard prior to its becoming effective.
- Requirements for training and development of infectious disease prevention and response plans take effect March 26, 2021.⁴⁷
- Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.⁴⁸

⁴⁷ This date assumes an effective date for the final standard of January 27, 2021.

⁴⁸ NOTE 1: The intent of the language is to give the Board the maximum amount of flexibility to “notice” the Board meeting within 14 days even if the Board may not actually meet within 14 days.

30 Definitions.

- Definitions are provided for the following terms: Administrative Control, Airborne infection isolation room (AIIR), Asymptomatic, Building/facility owner, Cleaning, Community transmission, COVID-19, Disinfecting, Duration and frequency of employee exposure, Economic feasibility, Elimination, Employee, Engineering control, Exposure Risk Level (“Very high,” “High,” “Medium,” and “Lower”), Face covering, Face shield, Feasible, Filtering facepiece, Hand sanitizer, HIPAA, Known to be infected with SARS-CoV-2 virus, May be infected with SARS-CoV-2 virus, Minimal occupational contact, Occupational exposure, Personal protective equipment, Physical distancing, Respirator, Respirator user, SARS-CoV-2, Severely immunocompromised, Signs of COVID-19, Surgical/Medical procedure mask, Suspected to be infected with SARS-CoV-2 virus, Symptomatic, Technical feasibility, USBC, VDH, VOSH, and Work practice control.

40 Mandatory requirements for employers in all exposure risk levels.

- Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.
- Serologic test issues are addressed.
- Employers shall develop and implement policies and procedures for employees to report when they are experiencing signs and/or symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees shall not report to or be allowed to remain at work or on a job site until cleared for return to work.
- Employers shall not permit employees known to be infected with SARS-CoV-2 to report to or be allowed to remain at work or on a job site until cleared for return to work. Employers shall discuss with subcontractors, and companies that provide contract or temporary employees about the importance of suspected COVID-19 and known COVID-19 subcontractor, contract, or temporary employees staying home and encourage them to develop non-punitive sick leave policies. Known COVID-19 and suspected COVID-19 subcontractor, contract, or temporary employees shall not report to or be allowed to remain at work or on a job site until cleared for return to work.
- Employers shall notify employees at the place of employment, other employers, and the building/facility owner if an employer is notified of a COVID-19 positive test for one of its own employees, a subcontractor employee, or other person who was present at the

NOTE 2: The new language in 16VAC25-220.C requires the Board to make a “determination” of whether there is continued need for the standard. The Department has identified three “determination” options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

place of employment within 2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test).

- Employers must also notify VDH and DOLI in certain situations.
- Employer shall develop and implement policies and procedures for employee return to work.
- Unless otherwise provided in this standard, employers shall establish and implement policies and procedures that ensure employees observe physical distancing while on the job and during paid breaks on the employer's property, including policies and procedures for verbal announcements, signage or visual cues to promote social distancing; and implement procedures to decrease worksite density.
- Access to common areas, break or lunchrooms shall be closed or controlled.
- Employers shall implement procedures when multiple employees are occupying a vehicle for work purposes.
- Employers shall comply with applicable respiratory protection, personal protective equipment regulations and ensure compliance with mandatory requirements of any applicable executive order or order of public health emergency.
- A medical exemption is provided from use of a respirator, surgical/medical procedure mask, or face covering by any employee.
- Procedures for use of a face shield are provided when face coverings cannot be worn due to medical contraindications.
- Employers must implement sanitation and disinfecting procedures, and assure compliance with the VOSH hazard communication standard.

50 Requirements for hazards or job tasks classified at very high or high exposure risk.

- Engineering controls (including installed air handling systems),⁴⁹ administrative and work practice controls, and personal protective equipment requirements are listed.
- Employers shall use special precautions associated with Biosafety Level 3 (BSL-3), as defined by the U.S. Department of Health and Human Services Publication No. (CDC) 21-1112 Biosafety in Microbiological and Biomedical Laboratories (Dec. 2009), which is hereby incorporated by reference, when handling specimens from patients or persons known or suspected to be infected with the SARS-CoV-2 virus. Diagnostic laboratories that conduct routine medical testing and environmental specimen testing for COVID-19 are not required to operate at BSL-3.⁵⁰
- For those employers with hazards or job tasks classified at very high or high exposure risk not already covered by 1910.132(d), that section is included to require employers to conduct a written assessment of the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). Employers shall provide for employee and employee representative involvement in the assessment process.

NOTE: An employer's "assessment of the workplace" may take into account the jobsite characteristics that could impact its decision making (e.g., the differences between the "linear" aspects of a highway construction workplace versus the "vertical" aspects of a building construction worksite).

⁴⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>

⁵⁰ See Frequently Asked Question (FAQ) §50, FAQ 3, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

- Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., Parts 1926, 1928, 1915, 1917, or 1918), the requirements of §§1910.132 (General requirements) and 1910.134 (Respiratory protection) shall apply to all employers for that purpose.

60 Requirements for hazards or job tasks classified at medium exposure risk.

- Engineering controls (including installed air handling systems),⁵¹ administrative and work practice controls, and personal protective equipment requirements are listed.
- For those employers with hazards or job tasks classified at very high or high exposure risk not already covered by 1910.132(d), that section is included to require employers to conduct a written assessment of the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). Employers shall provide for employee and employee representative involvement in the assessment process.

NOTE: An employer’s “assessment of the workplace” may take into account the jobsite characteristics that could impact its decision making (e.g., the differences between the “linear” aspects of a highway construction workplace versus the “vertical” aspects of a building construction worksite).

- Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., Parts 1926, 1928, 1915, 1917, or 1918), the requirements of §§1910.132 (General requirements) and 1910.134 (Respiratory protection) shall apply to all employers for that purpose.
- Employers shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.
- Employers shall provide and require employees in customer or other person facing jobs to wear face coverings.

70 Infectious disease preparedness and response plan.

- Employers with hazards or job tasks classified as:
 - “Very high,” and “high,” shall develop and implement a written Infectious Disease Preparedness and Response Plan;
 - “Medium” with eleven (11) or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.
- The plan and training requirements tied to the plan shall only apply to those employees classified as very high, high, and medium covered by this section. Provide for employee involvement in development and implementation of the plan.

⁵¹ *Id.*

- The plan shall consider and address the level(s) of risk associated with various places of employment, the hazards employee are exposed to and job tasks employees perform at those sites.
- The plan shall consider contingency plans for situations that may arise as a result of outbreaks that impact employee safety and health.
- The plan shall identify basic infection prevention measures to be implemented.
- The plan shall provide for the prompt identification and isolation of sick persons away from work, including procedures for employees to report when they are sick or experiencing symptoms of COVID-19.
- The plan shall address infectious disease preparedness and response with outside businesses.
- The plan shall identify the mandatory and non-mandatory recommendations in any CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard, as provided for in 16VAC25-220-10.

80 Training.

- Employers with hazards or job tasks classified at “very high” or “high” exposure risk shall provide training to all employee(s) regardless of employee risk classification.
- Employees shall be trained on the requirements of this standard, the employer’s Infectious Disease Preparedness and Response Plan, where applicable, the characteristics and methods of spread of the SARS-CoV-2 virus, the symptoms of the COVID-19 disease as well as the asymptomatic reactions of some persons to the SARS-CoV-2 virus, safe work practices, including but not limited to, disinfection procedures, disinfecting frequency, noncontact methods of greeting, and PPE.
- When the employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required, the employer shall retrain each such employee.

NOTE: Construction employers, regardless of risk category, will be required to provide SARS-COV-2 and COVID-19 related training, and training on the ETS/ER in accordance with the federal identical OSHA/VOSH regulation at 1926.21(b)(2), which provides:

“The employer shall instruct each employee in the recognition and avoidance of unsafe conditions and the regulations applicable to his work environment to control or eliminate any hazards or other exposure to illness or injury.”
(Emphasis added).

90 Discrimination against an employee for exercising rights under this emergency temporary standard/emergency regulation is prohibited.

- No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including but not limited to a respirator, face shield, gown, or gloves, , provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering,

provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees.

- No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer’s agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

NOTE: HIPAA does not apply to apply to VOSH or OSHA.⁵²

IV. **Basis, Purpose and Impact of the Final Standard.**

A. Basis.

1. Applicable Statutes.

The Safety and Health Codes Board is authorized by Title 40.1-22(5)⁵³ to:

“... adopt, alter, amend, or repeal rules and regulations to further, protect and promote the safety and health of employees in places of employment over which it has jurisdiction and to effect compliance with the federal OSH Act of 1970...as may be necessary to carry out its functions established under this title....All such rules and regulations shall be designed to protect and promote the safety and health of such employees. In making such rules and regulations to protect the occupational safety and health of employees, the Board shall adopt the standard which most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity. However, such standards shall be at least as stringent as the standards promulgated by the Federal Occupational Safety and Health Act of 1970 (P.L. 91-596). In addition to the attainment of the highest degree of health and safety protection for the employee, other considerations shall be the latest available scientific data in the field, the feasibility of the standards, and experience gained under this and other health and safety laws. Whenever practicable, the standard promulgated shall be expressed in terms of objective criteria and of the performance desired. Such standards when applicable to products which are distributed in interstate commerce shall be the same as federal standards unless deviations are required by compelling local conditions and do not unduly burden interstate commerce.”

Va. Code §40.1-22(6a)⁵⁴ provides that:

....

(6a) The Board shall provide, without regard to the requirements of Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2, for an emergency temporary standard to

⁵² <https://www.osha.gov/Publications/OSHA-factsheet-HIPPA-whistle.pdf>

⁵³ <https://law.lis.virginia.gov/vacode/40.1-22/>

⁵⁴ *Id.*

take immediate effect upon publication in a newspaper of general circulation, published in the City of Richmond, Virginia, if it determines that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and that such emergency standard is necessary to protect employees from such danger. The publication mentioned herein shall constitute notice that the Board intends to adopt such standard within a period of six months. The Board by similar publication shall prior to the expiration of six months give notice of the time and date of, and conduct a hearing on, the adoption of a permanent standard. The emergency temporary standard shall expire within six months or when superseded by a permanent standard, whichever occurs first, or when repealed by the Board. (Emphasis added).

The Department consulted with the OAG concerning the meaning and proper application of Va. Code §40.1-22(6a) and received the following response:

Our interpretation of Va. Code Section 40.1-22(6a) is that the APA does not apply to the Board's power to issue emergency temporary/permanent standards if the Board determines that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards and that such standard is necessary to protect employees from such danger. The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA. The emergency standard takes effect almost immediately, and then the Board can go through (6a)'s hearing process to adopt a permanent standard – instead of the normal APA process required by 40.1-22(6) for non-emergency rules and regulations issued by the Board [Title 2.2, which includes the Administrative Process Act]. This creates a separate procedure for emergency temporary/permanent standards – deliberately outside of the APA. And it is incumbent on the Board to make findings and a record sufficient to support those findings of a grave danger and the necessity of the standard to protect employees from that grave danger.

....

As this is an issue of first impression – and as with any litigation – there are corresponding risks that a Court may interpret that statute differently and apply the APA to 40.1-22(6a). (Emphasis added).

2. Requirements More Restrictive than Federal.⁵⁵

Federal OSHA does not have a specific regulation or standard that addresses the SARS-CoV-2 virus that causes COVID-19.

⁵⁵ Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect. Based on Townhall Agency Background Document, From TH-02.

3. Agencies, Localities, and Other Entities Particularly Affected.⁵⁶

The Department is not aware of any agency, locality or entity that is likely to bear a disproportionate material impact which would not be experienced by other agencies, localities, or entities.

4. Alternatives to Standard.⁵⁷

See ATTACHMENT B, CURRENT LAWS AND REGULATIONS RECOGNIZED MITIGATION STRATEGIES FOR COVID-19 NOT COVERED BY VOSH REGULATIONS OR STANDARDS.

OSHA does not have a regulation specific to SARS-CoV-2 or COVID-19 or infectious diseases generally. VOSH has the ETS which expires on January 26, 2021.

Certain VOSH regulations (identical to OSHA counterparts unless otherwise noted) can be used to address some SARS-CoV-2 or COVID-19 hazards (see ATTACHMENT B), but other hazards and mitigation efforts cannot be so addressed (see list below).

There are no VOSH or OSHA regulations or standards that would require:

Physical distancing of at least six feet where feasible (also known as Social Distancing)

Disinfection of work areas where known or suspected COVID-19 employees or other persons accessed or worked

Employers to develop policies and procedures for employees to report when they are sick or experiencing symptoms consistent with COVID-19

Employers to, prior to the commencement of each work shift, prescreen of employees and other persons to verify each employee or person is not COVID-19 symptomatic

Employers to prohibit known and suspected COVID-19 employees and other persons from reporting to or being allowed to remain at work or on a job site until cleared for return

⁵⁶ Identify any other state agencies, localities, or other entities particularly affected by the regulatory change. “Particularly affected” are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. “Locality” can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect. Based on Townhall Agency Background Document, From TH-02.

⁵⁷ Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses of achieving the purpose of the regulatory change. Based on Townhall Agency Background Document, From TH-02.

Employers to develop and implement policies and procedures for known COVID-19 or suspected COVID-19 employees to return to work using either a symptom-based or test-based strategy depending on local healthcare and testing circumstances

Employers to prohibit COVID-19 positive employees from reporting to or being allowed to remain at work or on a job site until cleared for return to work

Employers to provide employees assigned to work stations and in frequent contact with other persons inside six feet with alcohol based hand sanitizers at their workstations

Employers with hazards or job tasks classified at very high, high, or medium exposure risk to develop a written Infectious Disease Preparedness and Response Plan

Employee training on SARS-CoV-2 and COVID-19 hazards, with the exception of 1926.21(b)(2) referenced above for the Construction Industry

Va. Code §40.1-51(a), otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)⁵⁸ of the OSH Act of 1970), can be used to address some SARS-CoV-2 or COVID-19 hazards, but other hazards and mitigation efforts cannot be so addressed (see below). Va. Code §40.1-51(a) provides that:

“It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees....”

While Congress intended that the primary method of compliance and enforcement under the OSH Act of 1970 would be through the adoption of occupational safety and health standards⁵⁹, it also provided the general duty clause as an enforcement tool that could be used in the absence of an OSHA (or VOSH) regulation.

As is evident from the wording of the general duty statute, it does not directly address the issue of SARS-CoV-2 or COVID-19 related hazards. While preferable to no enforcement tool at all, the general duty clause does not provide either the regulated community, employees, or the VOSH Program with substantive and consistent requirements on how to reduce or eliminate SARS-CoV-2 or COVID-19 related hazards.

Federal case law has established that the general duty clause can only be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer’s requirements, requirements of the Centers for Disease Control

⁵⁸ [https://www.osha.gov/laws-regs/oshact/section_5,29_U.S.C. § 654\(a\)\(1\).](https://www.osha.gov/laws-regs/oshact/section_5,29_U.S.C._%20%24654(a)(1).)

⁵⁹ *The Law of Occupational Safety and Health*, Nothstein, 1981, page 259.

(CDC), or an employer's safety and health rules. Other than serious hazards cannot be addressed by the general duty clause.

One limitation on the use of the general duty clause can result in unfortunate outcomes worksites with multiple employers. For instance, a general duty clause violation can only be issued to an employer whose own employees were exposed to the alleged hazard.⁶⁰ In the context of a COVID-19 situation, consider a subcontractor ("subcontractor one") who sends one employee to a multi-employer worksite who is COVID-19 positive and knowingly allows that employee to work around disease free employees of another subcontractor ("subcontractor two"), which results in the transmission of the disease to one or more of the second contractors' employees.

In such a situation, because no uninfected employees of subcontractor one were exposed to the disease at the worksite, the contractor who created the hazard could not be issued a general duty violation or accompanying monetary penalty.

Finally, in the context of the COVID-19 pandemic, the primary problem with the use of the general duty clause is the inability to use it to enforce any national consensus standard, manufacturer's requirements, CDC recommendations, or employer safety and health rules which use "should," "may," "it is recommended," and similar non-mandatory language.⁶¹

5. Regulatory Flexibility Analysis.⁶²

The standard contains alternative regulatory methods in the form of options for employers to reduce the burden of compliance:

- At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus that causes COVID-19. It is designed to provide basic protections for all employees and employers within the jurisdiction of the VOSH program.
- It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks

⁶⁰

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf, VOSH Field Operations Manual (FOM), Chapter 10, page 18)

⁶¹“ Courts and the [Occupational Safety and Health Review] Commission have held that OSHA must define an alleged hazard in such a way as to give the employer fair notice of its obligations under the OSH Act. In *Ruhlin Co.* [*Ruhlin Co.*, 21 OSH Cases 1779], the Commission held that the employer ‘lacked fair notice that it could have an obligation under section 5(a)(1) to require its employees to wear high visibility vests.’ The Commission found that a May 2004 interpretive letter by OSHA refers to a provision of the Federal Highway Administration manual which contained optional, not mandatory language.”

⁶² Describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change. Based on Townhall Agency Background Document, From TH-02.

centered around mitigation of hazards. The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

- Employers with hazards and job tasks classified as very high, high and medium were provided 30 days to train employees and 60 days to develop and implement an Infectious disease preparedness and response plan. Employers with hazards and job tasks classified as lower risk were exempted from training and plan requirements. Small employers with 10 or fewer employees were exempted from the Infectious disease preparedness and response plan requirements.
- The standard provides flexibility to businesses through 16VAC25-220-10.E which provides that: “To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.”
- The standard provides flexibility to higher education through 16VAC25-220-10.F which provides that: “Public and private institutions of higher education that have received certification from the State Council of Higher Education of Virginia that the institution's re-opening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor's Office in conjunction with the Virginia Department of Health, shall be considered in compliance with this standard, provided the institution operates in compliance with their certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard.”
- The standard provides flexibility to public and private schools through 16VAC25-220-10.G.2: “A public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and who operate in compliance with the public school division's or private school's submitted plans shall be considered in compliance with this standard. An institution's actual compliance with recommendations contained in CDC guidelines or the Virginia Department of Education guidance, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.”
- The standard provides flexibility to employer purchase of PPE in 16VAC25-220-10.C: “Notwithstanding anything to the contrary in this standard, no

enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.”

B. Purpose.

The purpose of the standard is to reduce/eliminate employee injuries, illnesses, and fatalities through the adoption of a comprehensive final standard to address the exposure of similarly situated employees to SARS-CoV-2 and COVID-19 related hazards and job tasks in all industries under the jurisdiction of the Virginia State Plan.

Application of the proposed standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., “very high”, “high”, “medium”, and “lower”).

C. Background.

1. SARS-CoV-2 Virus That Causes the COVID-19 Disease.

SARS-CoV-2 is a betacoronavirus, like MERS-CoV (Middle East Respiratory Syndrome Coronavirus) and SARS-CoV (Severe Acute Respiratory Syndrome Coronavirus). Coronaviruses are named for crown-like spikes on their surface. SARS-CoV-2 causes the Coronavirus Disease 2019 (COVID-19).

The Virginia Safety and Health Codes Board ETS addressing the virus lapses on January 26, 2021. SARS-CoV-2 is easily transmitted through the air from person-to-person through respiratory droplets, aerosols, and other forms of airborne transmission, and the virus can settle and deposit on environmental surfaces where it can remain viable for days.

"Signs of COVID-19" are abnormalities that can be objectively observed, and may include fever, trouble breathing or shortness of breath, cough, vomiting, new confusion, bluish lips or face, etc.

“Symptoms of COVID-19” are abnormalities that are subjective to the person and not observable to others, and may include chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, congestion or runny nose, diarrhea, etc.

COVID-19 Medical Complications.

“Although most people with COVID-19 have mild to moderate symptoms, the disease

can cause severe medical complications and lead to death in some people. Older adults or people with existing chronic medical conditions are at greater risk of becoming seriously ill with COVID-19.”⁶³:

“Younger adults are also being hospitalized in the U.S. Adults 20–44 account for 20% of hospitalizations, 12% of ICU admissions.”⁶⁴

“Complications can include:

- Pneumonia and trouble breathing
- Organ failure in several organs
- Heart problems
- A severe lung condition that causes a low amount of oxygen to go through your bloodstream to your organs (acute respiratory distress syndrome)
- Blood clots
- Acute kidney injury
- Additional viral and bacterial infections”⁶⁵

“Illness Severity [CDC]

The largest cohort of >44,000 persons with COVID-19 from China showed that illness severity can range from mild to critical:

- Mild to moderate (mild symptoms up to mild pneumonia): 81%
- Severe (dyspnea, hypoxia, or >50% lung involvement on imaging): 14%
- Critical (respiratory failure, shock, or multi-organ system dysfunction): 5%

In this study, all deaths occurred among patients with critical illness and the overall case fatality rate was 2.3%. The case fatality rate among patients with critical disease was 49%. Among children in China, illness severity was lower with 94% having asymptomatic, mild or moderate disease, 5% having severe disease, and <1% having critical disease.

Among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%. The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.⁶⁶ (Emphasis added).

Long-term Effects of COVID-19

“People with moderate to severe asthma may be at higher risk of getting very sick from COVID-19. COVID-19 can affect your respiratory tract (nose, throat, lungs), cause an asthma attack, and possibly lead to pneumonia and acute respiratory disease.

⁶³ <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>

⁶⁴

https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19_SA_RS_CoV_2

⁶⁵ *Id.*

⁶⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

....

There is currently no specific treatment for or vaccine to prevent COVID-19. The best way to prevent illness is to avoid being exposed to this virus.”⁶⁷

‘Patients with acute respiratory distress syndrome (ARDS), seen often in severe COVID-19 illness, sometimes develop permanent lung damage or fibrosis as well,’ Dr. Andrew Martin, chair, pulmonary medicine at Deborah Heart and Lung Center in Browns Mills, New Jersey, told Healthline.

....

‘Viral respiratory infections can lead to anything from a simple cough that lasts for a few weeks or months to full-blown chronic wheezing or asthma,’ Martin said. He added that when a respiratory infection is severe, recovery can be prolonged with a general increase in shortness of breath — even after lung function returns to normal.

Also, patients with COVID-19 who developed ARDS, a potentially life threatening lung injury that could require treatment in an intensive care unit (ICU), have a greater risk of long-term health issues.

....

Those most at risk are ‘people 65 years and older, people who live in a nursing home or long-term care facility, people with chronic lung, heart, kidney and liver disease,’ said Dr. Gary Weinstein, pulmonologist/critical care medicine specialist at Texas Health Presbyterian Hospital Dallas (Texas Health Dallas). Additionally, he said others who could be at risk are those with compromised immune systems and people with morbid obesity or diabetes.

Weinstein added that there are particular health issues that patients with severe COVID-19 illness may face. He said some patients will need to recover from pneumonia or acute ARDS and that many may require oxygen. Additionally, depending on the duration of the illness, many will be severely debilitated, deconditioned, weak, and could require aggressive rehabilitation.

‘Finally, when patients have lung failure, they frequently have failure or dysfunction of their other organs, such as the kidney, heart, and brain,’ emphasized Weinstein. However, ‘Patients with mild symptoms will recover faster and be less likely to need oxygen but will likely have weakness and fatigue.’⁶⁸ (Emphasis added).

A CDC report on “Characteristics and Clinical Outcomes of Adult Patients Hospitalized with COVID-19 — Georgia, March 2020”:⁶⁹

“In a cohort of 305 hospitalized adults with COVID-19 in Georgia (primarily metropolitan Atlanta)...One in four hospitalized patients had no recognized risk factors for severe COVID-19.

....

Although a larger proportion of older patients had worse outcomes (IMV

⁶⁷ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/asthma.html>

⁶⁸ <https://www.healthline.com/health-news/what-we-know-about-the-long-term-effects-of-covid-19#COVID-19-might-affect-the-brain-stem>

⁶⁹ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e1.htm>

[invasive mechanical ventilation] or death), a considerable proportion of patients aged 18–64 years who lacked high-risk conditions received ICU-level care and died (23% and 5%, respectively). Estimated case fatality among patients who received ICU care was high (37%–49%) but comparable with that observed in a smaller case series of COVID-19 patients in the state of Washington. Among hospitalized patients, 26% lacked high-risk factors for severe COVID-19, and few patients (7%) lived in institutional settings before admission, suggesting that SARS-CoV-2 infection can cause significant morbidity in relatively young persons without severe underlying medical conditions. Community mitigation recommendations (e.g., social distancing) should be widely instituted, not only to protect older adults and those with underlying medical conditions, but also to prevent the spread of SARS-CoV-2 among persons in the general population who might not consider themselves to be at risk for severe illness.

Report on “What factors did people who died with COVID-19 have in common?”⁷⁰

“A team of investigators hailing from eight institutions in China and the United States — including the Chinese People’s Liberation Army General Hospital in Beijing, and the University of California – Davis — recently looked at the data of 85 patients who died of multiple organ failure after having received care for severe COVID-19.

....

‘The greatest number of deaths in our cohort were in males over 50 with noncommunicable chronic diseases,’ the investigators note.

‘We hope that this study conveys the seriousness of COVID-19 and emphasizes the risk groups of males over 50 with chronic comorbid conditions, including hypertension (high blood pressure), coronary heart disease, and diabetes,’ they have commented.

The team also notes that, among the 85 patients whose records they analyzed, the most common COVID-19 symptoms were fever, shortness of breath, and fatigue.

....

Among the complications that the patients experienced while hospitalized with COVID-19, some of the most common were respiratory failure, shock, acute respiratory distress syndrome, and cardiac arrhythmia, or irregular heartbeat.

....

‘Perhaps our most significant observation is that while respiratory symptoms may not develop until a week after presentation, once they do there can be a rapid decline, as indicated by the short duration between time of admission and death (6.35 days on average) in our study,’ they write.”

⁷⁰ <https://www.medicalnewstoday.com/articles/what-factors-did-people-who-died-with-covid-19-have-in-common#The-majority-were-older-males>

Report on “Irish Study: Blood Clotting a Significant Cause of Death in Patients With COVID-19.”

“A study led by clinician scientists at RCSI University of Medicine and Health Sciences has found that Irish patients admitted to hospital with severe COVID-19 infection are experiencing abnormal blood clotting that contributes to death in some patients.

The study, carried out by the Irish Centre for Vascular Biology, RCSI and St James' Hospital, Dublin, is published in current edition of the British Journal of Hematology.

The authors found that abnormal blood clotting occurs in Irish patients with severe COVID-19 infection, causing micro-clots within the lungs. They also found that Irish patients with higher levels of blood clotting activity had a significantly worse prognosis and were more likely to require ICU admission.

‘Our novel findings demonstrate that COVID-19 is associated with a unique type of blood clotting disorder that is primarily focused within the lungs and which undoubtedly contributes to the high levels of mortality being seen in patients with COVID-19,’ said Professor James O'Donnell, Director of the Irish Centre for Vascular Biology, RCSI and Consultant Hematologist in the National Coagulation Centre in St James's Hospital, Dublin.

‘In addition to pneumonia affecting the small air sacs within the lungs, we are also finding hundreds of small blood clots throughout the lungs. This scenario is not seen with other types of lung infection, and explains why blood oxygen levels fall dramatically in severe COVID-19 infection.’”⁷¹

2. National and State COVID-19 Case, Death and Hospitalization Statistics.

Centers for Disease Control (CDC): U.S. and Virginia Statistics

As of June 21, 2020, there were 1,248,029 total cases (32,411 new cases compared to June 20, 2020) of COVID-19 and 119,615 deaths (560 new deaths compared to June 20, 2020).⁷² Confirmed COVID-19 cases in Virginia totaled 57,994 with 1,611 deaths.

As of December 26, 2020, there were 18,730,806 total cases (146,512 new cases compared to December 25, 2020) and 329,592 deaths (1,692 new deaths compared to December 25, 2020). Confirmed COVID-19 cases in Virginia totaled 333,576 with 4,854 deaths.⁷³

⁷¹ <https://www.invasivecardiology.com/news/irish-study-blood-clotting-significant-cause-death-patients-covid-19>

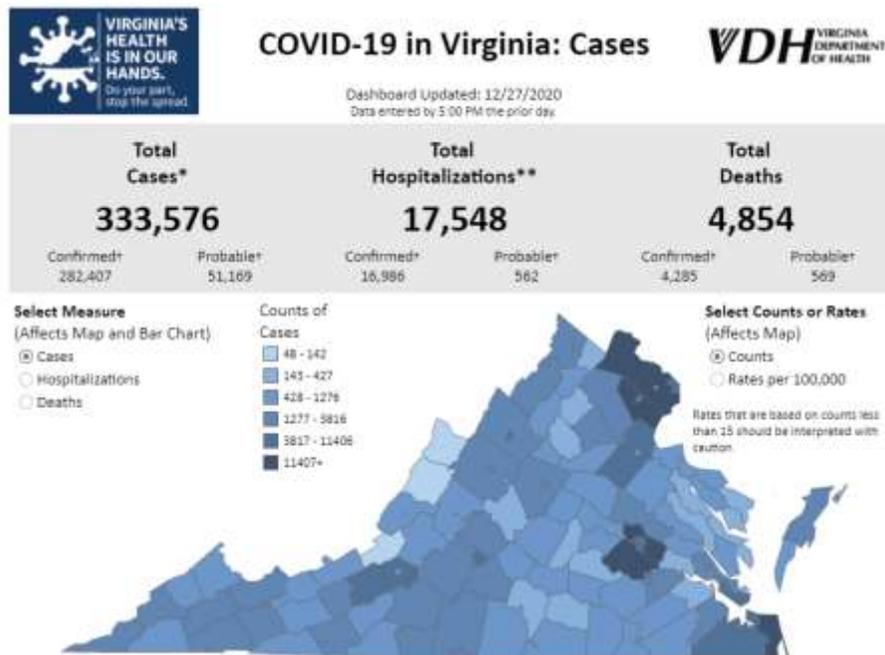
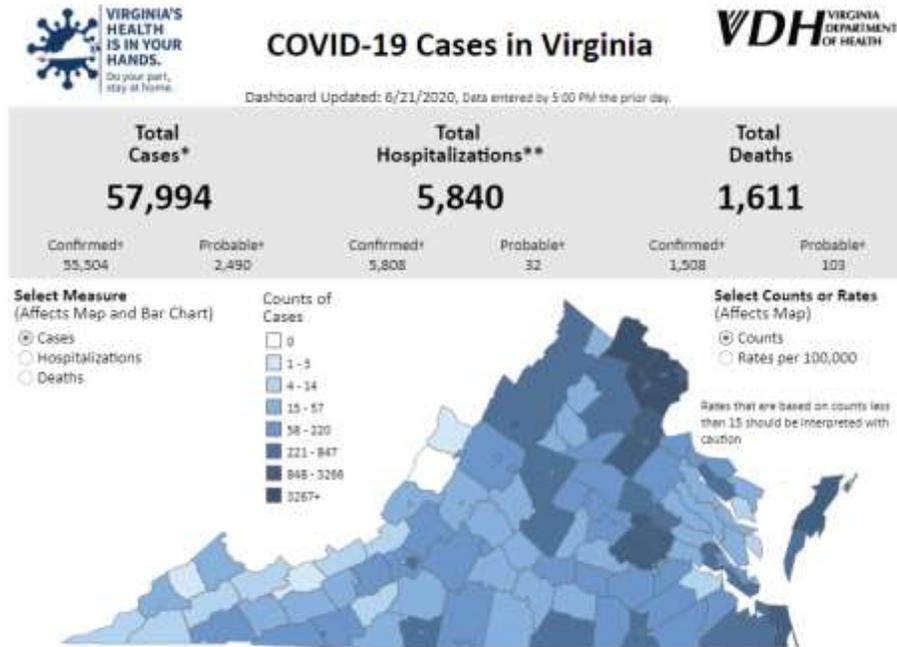
⁷² <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

⁷³ <https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/>

National and Virginia Charts

Virginia Cases by County as of June 21, 2020 and December 26, 2020.⁷⁴

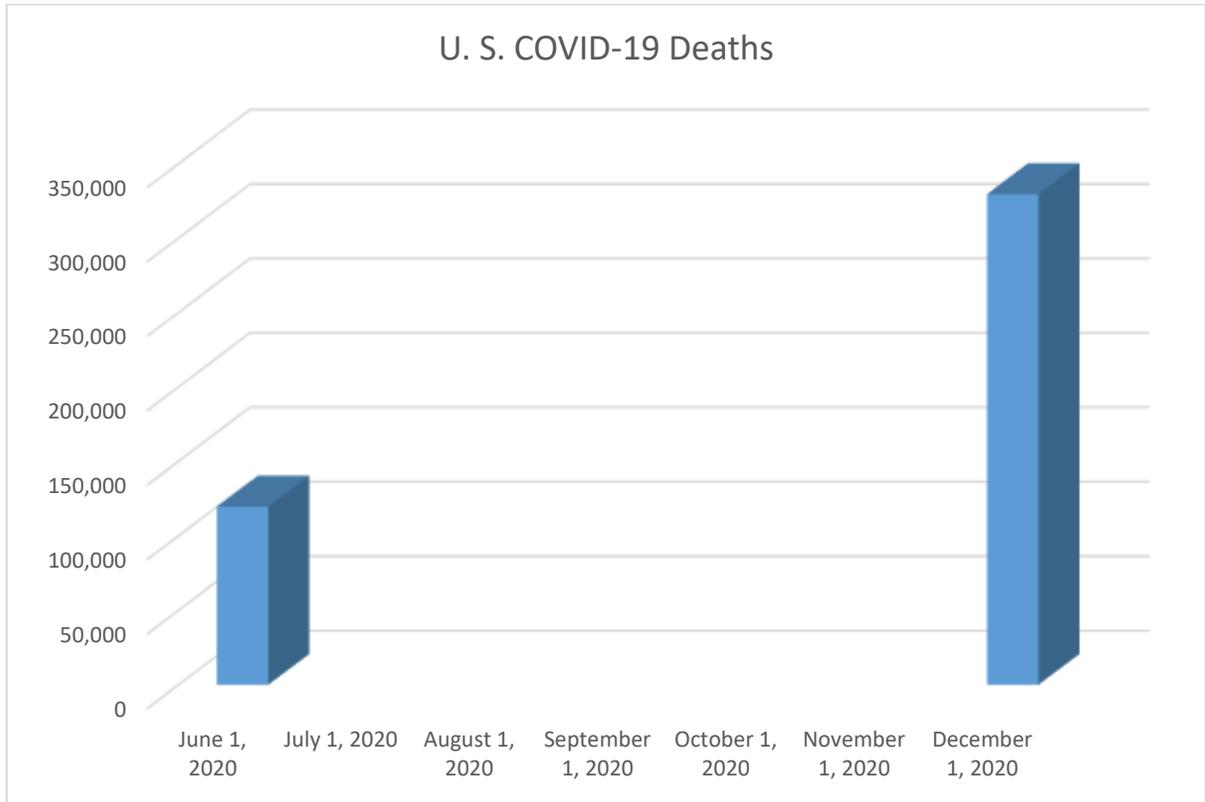
As is evident from the below county by county chart, community transmission of the virus remains widespread in Virginia. “Community spread [or transmission] means spread of an illness for which the source of infection is unknown.”⁷⁵



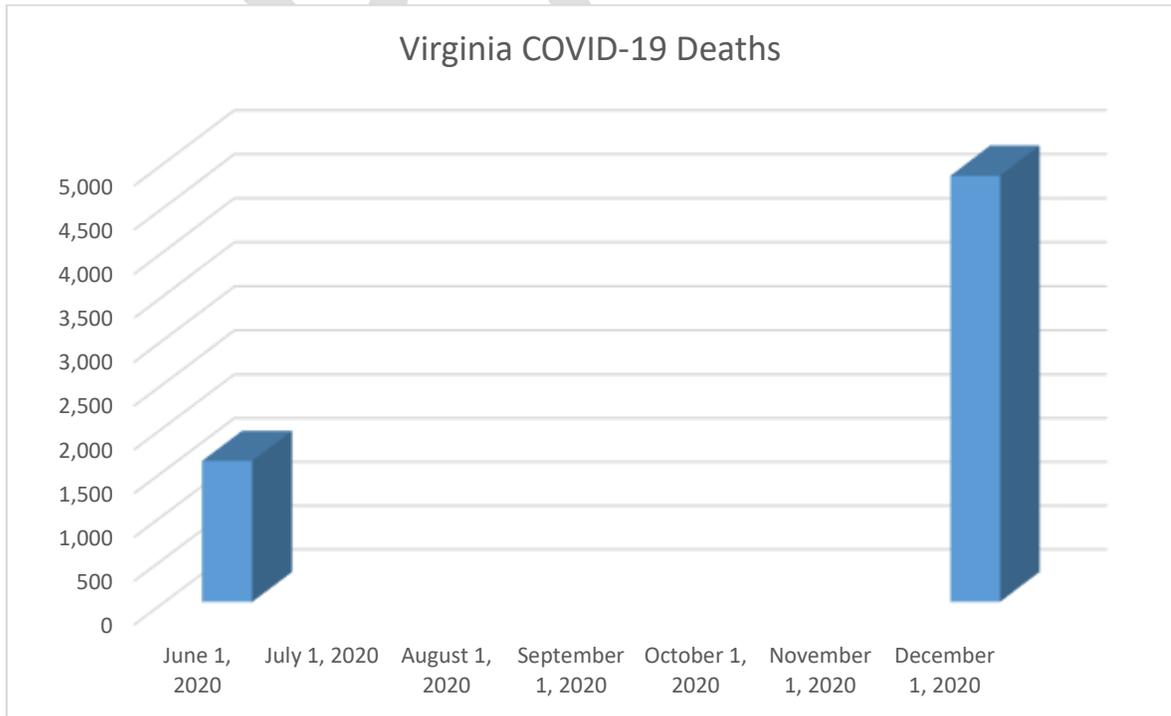
⁷⁴ <https://www.vdh.virginia.gov/coronavirus/>

⁷⁵ <https://www.cdc.gov/media/releases/2020/s0226-Covid-19-spread.html>

Comparison of U. S. Deaths as of June 21, 2020 versus as of December 26, 2020



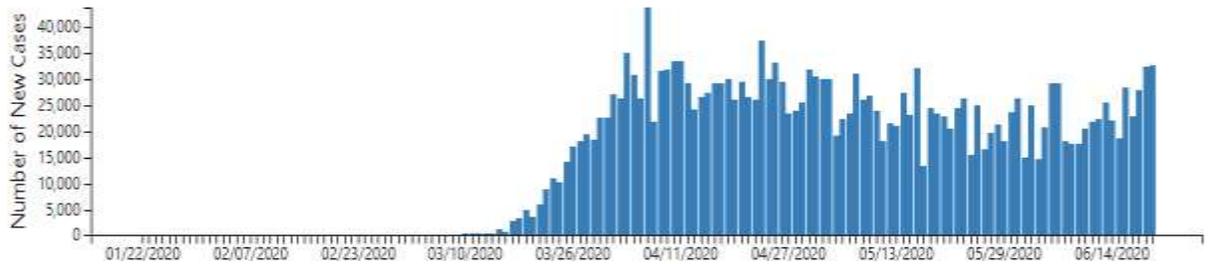
Comparison of Virginia Deaths as of June 21, 2020 versus as of December 26, 2020



National COVID-19 Cases as of June 21, 2020⁷⁶

New Cases by Day

The following chart shows the number of new COVID-19 cases reported each day in the U.S. since the beginning of the outbreak. Hover over the bars to see the number of new cases by day.



National COVID-19 Cases as of December 26, 2020.⁷⁷

Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory

Reported to the CDC by State or Territory



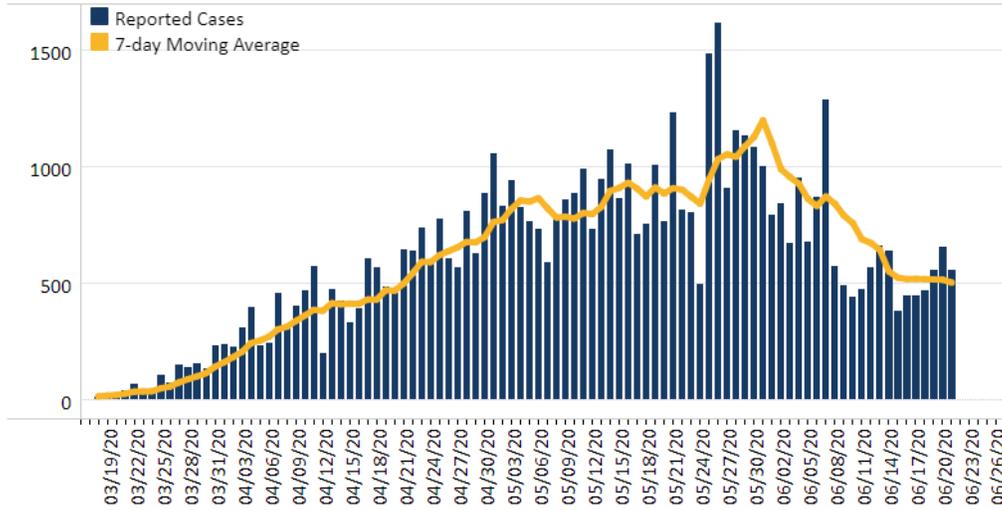
⁷⁶ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

⁷⁷ *Id.*

Virginia Cases as of June 21, 2020.⁷⁸

Total Cases by Date Reported

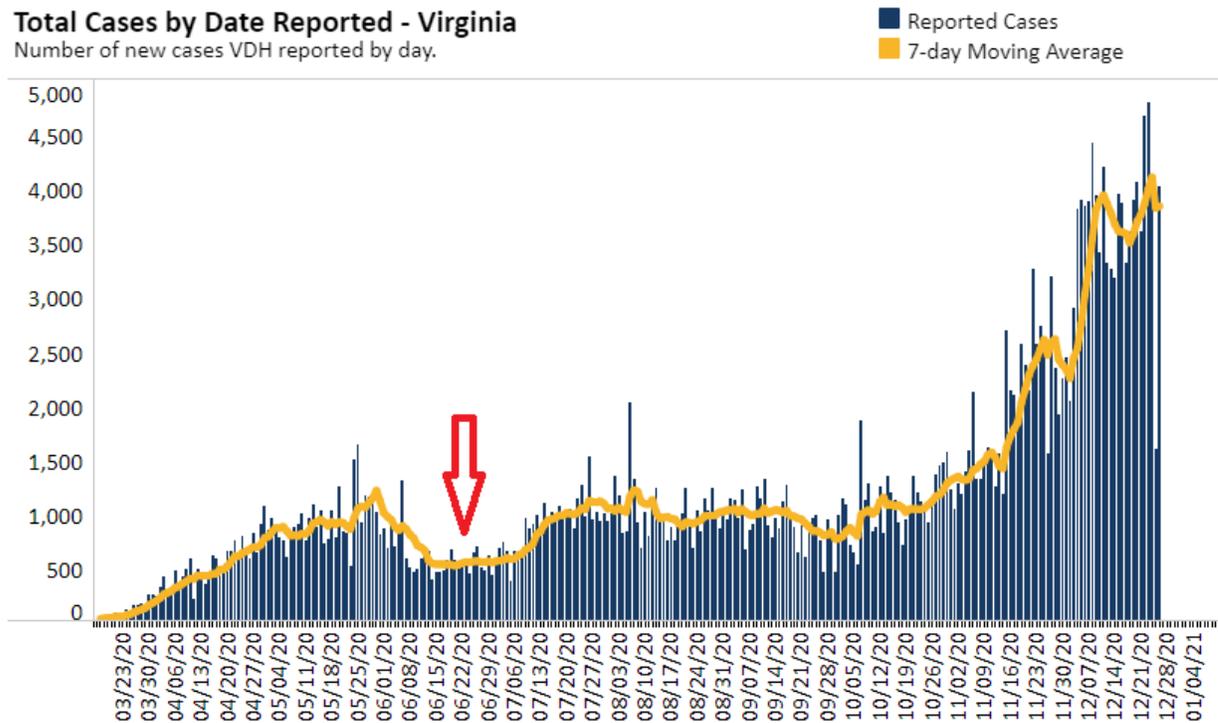
Number of new cases VDH reported by day.



Virginia Cases as of December 26, 2020.⁷⁹

Total Cases by Date Reported - Virginia

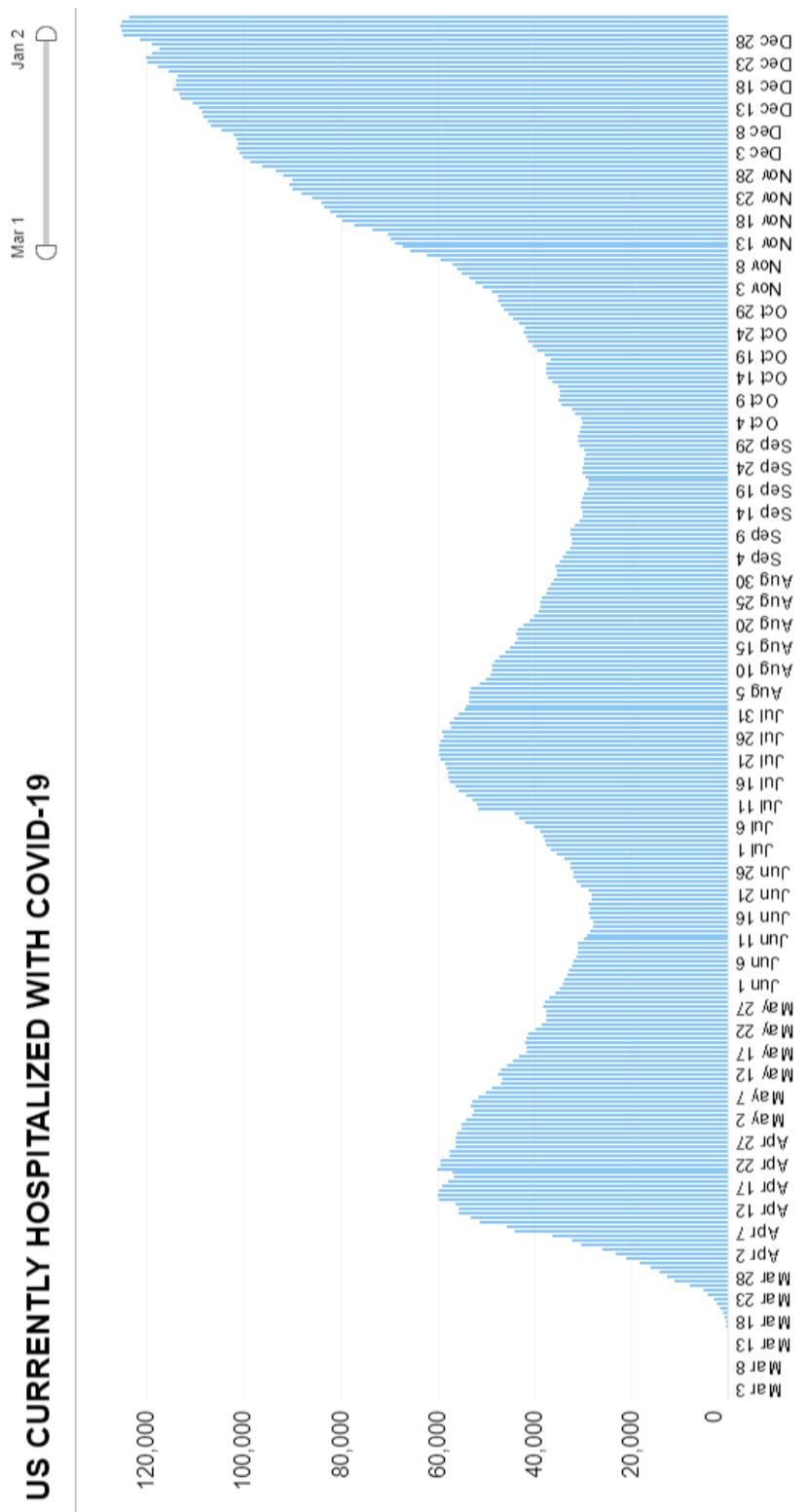
Number of new cases VDH reported by day.



⁷⁸ <https://www.vdh.virginia.gov/coronavirus/key-measures/>

⁷⁹ *Id.*

Current hospitalizations remain the most reliable statistic. Hospitalizations are a much better reflection of reality than the other metrics through the holiday reporting bumpiness.⁸⁰



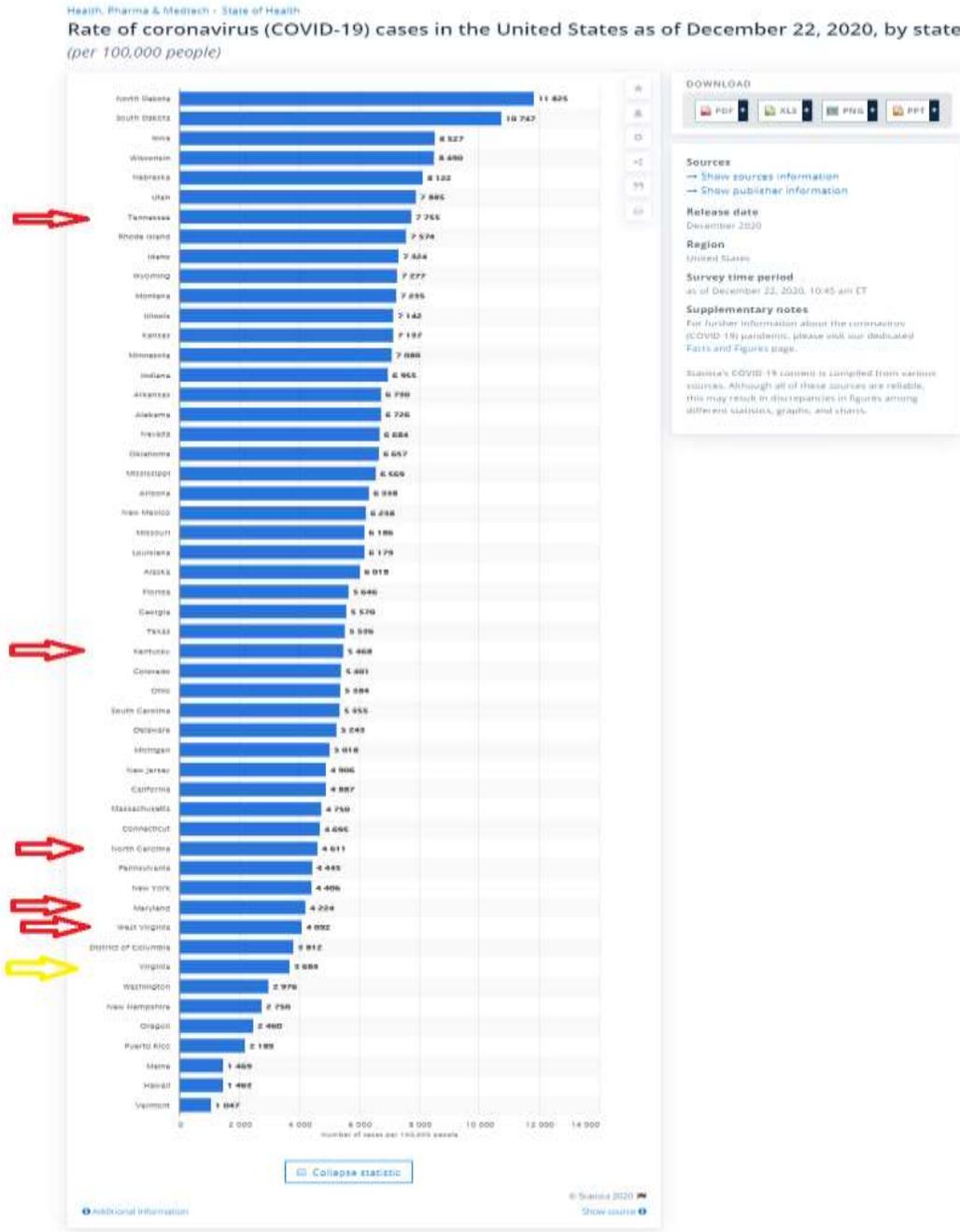
Note: Florida began reporting this figure on July 10.



⁸⁰ <https://covidtracking.com/data/charts/us-currently-hospitalized>

COVID-19 State Rankings: Total Cases per 100K as of December 22, 2020 ⁸¹

- 7 - Tennessee
- 29 - Kentucky
- 39 - North Carolina
- 42 - Maryland
- 43 - West Virginia
- 45 - Virginia



⁸¹ <https://www.statista.com/statistics/1109004/coronavirus-covid19-cases-rate-us-americans-by-state/>

COVID-19 State Rankings: Average Daily Cases per 100K in Last 7 Days as of December 26, 2020. ⁸²

- 1 - Tennessee
- 6 - West Virginia
- 19 - North Carolina
- 25 - Kentucky
- 30 - Virginia**
- 39 - Maryland

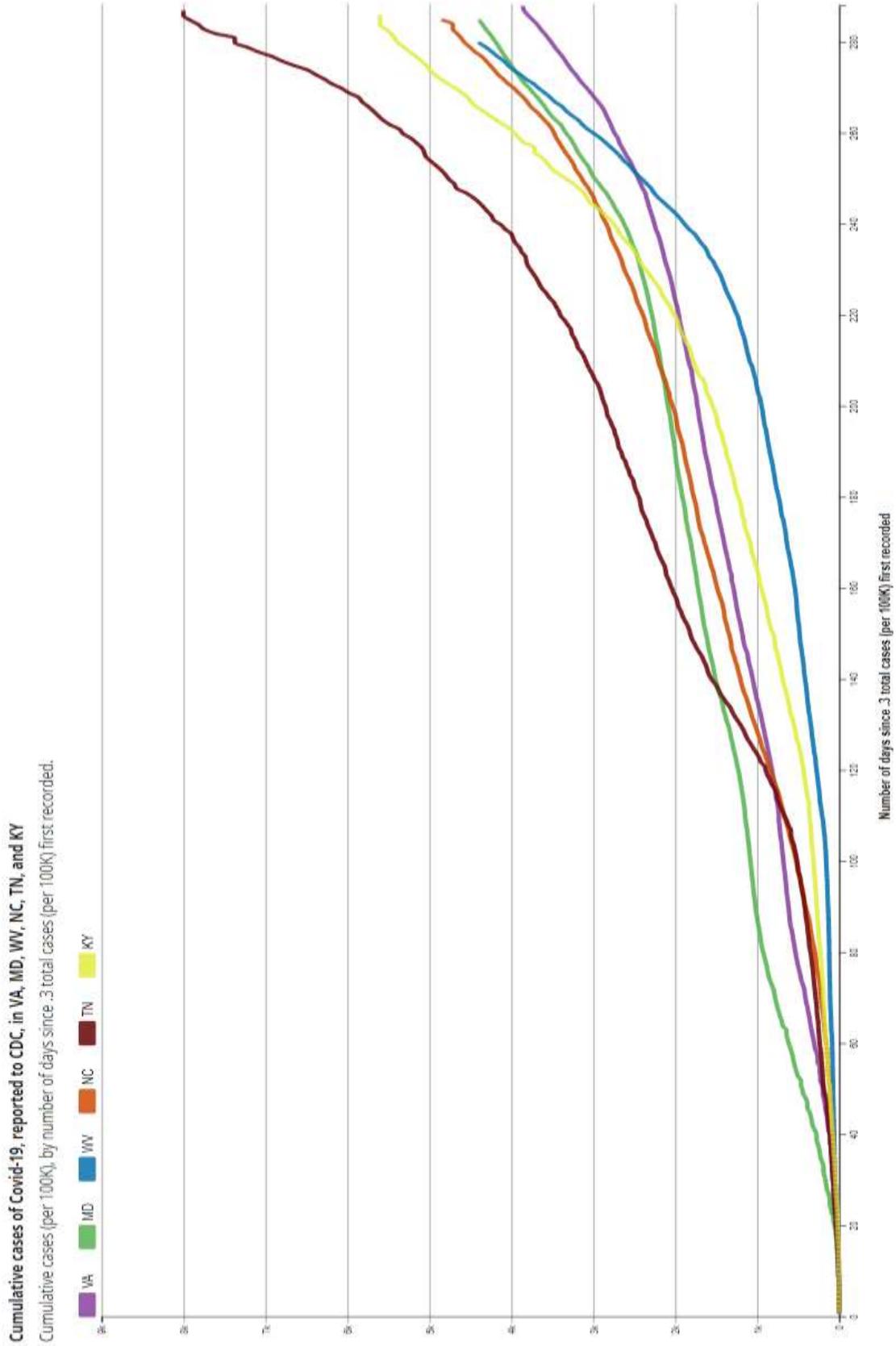
Data Table for Average Daily Cases per 100k in Last 7 Days

CDC | Updated Dec 27 2020 2:05PM

State/Territory #	Average Daily Cases per 100k in Last 7 Days #
Tennessee	118.7
California	95.7
Arizona	88
Oklahoma	88.2
Indiana	72.5
West Virginia	75.4
Alabama	68.8
Utah	67.3
Arkansas	65.6
Nevada	64
Delaware	63.6
New York*	63.6
Pennsylvania	63.2
Georgia	62.8
Ohio	61.4
Massachusetts	59.7
Mississippi	57.9
Rhode Island	57.4
North Carolina	56.8
New Mexico	56.5
Idaho	53.7
South Carolina	50.9
New Jersey	50.6
New York City*	50.5
Kentucky	48
Florida	46.4
Kansas	45.4
New Hampshire	45.4
Illinois	44.8
Virginia	44.7
Nebraska	43.7
Louisiana	43.2
Texas	42.7
South Dakota	42.4
Colorado	42.2
Wyoming	40.9
Missouri	40.8
Connecticut	39.9
Maryland	38.7
Wisconsin	37.7
Montana	37.6
Iowa	37
Alaska	34.3
Maine	31.2
Minnesota	30.2
Michigan	29
District of Columbia	27.7
North Dakota	26.7
Washington	26.5
Oregon	22.1
Puerto Rico	21.4
Vermont	14.3
Virgin Islands	9.1
Hawaii	8.5
Guam	6.3
Northern Mariana Islands	1.8
American Samoa	0
Federated States of Micronesia	0
Palau	0
Republic of Marshall Islands	0

⁸² https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

Comparison of trends in COVID-19 cases by state:⁸³



⁸³ https://covid.cdc.gov/covid-data-tracker/#compare-trends_newcases

D. SARS-CoV-2 and COVID-19, General Information, Studies, and Statistics.

1. General Information On Pandemics.⁸⁴

“Viruses are constantly mutating. Those that trigger pandemics have enough novelty that the human immune system does not quickly recognize them as dangerous invaders. They force the body to create a brand-new defense, involving new antibodies and other immune system components that can react to and attack the foe. Large numbers of people get sick in the short term, and social factors such as crowding and the unavailability of medicine can drive those numbers even higher. Ultimately, in most cases, antibodies developed by the immune system to fight off the invader linger in enough of the affected population to confer longer-term immunity and limit person-to-person viral transmission. But that can take several years, and before it happens, havoc reigns.

....

Containment. The severe acute respiratory syndrome (SARS) epidemic of 2003 was caused not by an influenza virus but by a coronavirus, SARS-CoV, that is closely related to the cause of the current affliction, SARS-CoV-2. Of the seven known human coronaviruses, four circulate widely, causing up to a third of common colds. The one that caused the SARS outbreak was far more virulent. Thanks to aggressive epidemiological tactics such as isolating the sick, quarantining their contacts and implementing social controls, bad outbreaks were limited to a few locations such as Hong Kong and Toronto.

This containment was possible because sickness followed infection very quickly and obviously: almost all people with the virus had serious symptoms such as fever and trouble breathing. And they transmitted the virus after getting quite sick, not before. “Most patients with SARS were not that contagious until maybe a week after symptoms appeared,” says epidemiologist Benjamin Cowling of the University of Hong Kong. “If they could be identified within that week and put into isolation with good infection control, there wouldn’t be onward spread.” Containment worked so well there were only 8,098 SARS cases globally and 774 deaths. The world has not seen a case since 2004.

Vaccine power. When a new H1N1 influenza virus, known as swine flu, caused a pandemic in 2009, “there was an alarm bell because this was a brand-new H1N1,” Cowling says, and it was very similar to the 1918 killer. Swine flu proved less severe than feared. In part, Krammer says, “we were lucky because the pathogenicity of the virus wasn’t very high.” But another important reason was that six months after the virus appeared, scientists developed a vaccine for it.

Unlike measles or smallpox vaccines, which can confer long-term immunity, **flu vaccines offer only a few years of protection. Influenza viruses are slippery, mutating rapidly to escape immunity. As a result, the vaccines must be updated every year and given regularly.** But during a pandemic, even a short-term vaccine is a boon. The 2009 vaccine helped to temper a second wave of cases in

⁸⁴ <https://www.scientificamerican.com/article/how-the-covid-19-pandemic-could-end1/>

the winter. As a result, the virus much more rapidly went the way of the 1918 virus, becoming a widely circulating seasonal flu, from which many people are now protected either by flu shots or by antibodies from a previous infection.

Projections about how COVID-19 will play out are speculative, but the end game will most likely involve a mix of everything that checked past pandemics: Continued social-control measures to buy time, new antiviral medications to ease symptoms, and a vaccine. The exact formula—how long control measures such as social distancing must stay in place, for instance—depends in large part on how strictly people obey restrictions and how effectively governments respond. For example, containment measures that worked for COVID-19 in places such as Hong Kong and South Korea came far too late in Europe and the U.S. “The question of how the pandemic plays out is at least 50 percent social and political,” Cobey says.

....

It will take a vaccine to stop transmission. That will take time—probably a year from now. Still, there is reason to think a vaccine could work effectively. Compared with flu viruses, coronaviruses don’t have as many ways to interact with host cells.

“If that interaction goes away, [the virus] can’t replicate anymore,” Krammer says. “That’s the advantage we have here.” It is not clear whether a vaccine will confer long-term immunity as with measles or short-term immunity as with flu shots. But “any vaccine at all would be helpful at this point,” says epidemiologist Aubree Gordon of the University of Michigan.

Unless a vaccine is administered to all of the world’s eight billion inhabitants who are not currently sick or recovered, COVID-19 is likely to become endemic. It will circulate and make people sick seasonally—sometimes very sick. But if the virus stays in the human population long enough, it will start to infect children when they are young.” (Emphasis added).

2. Transmission.

Modes of Transmission

“Infections with respiratory viruses are principally transmitted through three modes: contact, droplet, and airborne.

- Contact transmission is infection spread through direct contact with an infectious person (e.g., touching during a handshake) or with an article or surface that has become contaminated. The latter is sometimes referred to as “fomite transmission.”
- Droplet transmission is infection spread through exposure to virus-containing respiratory droplets (i.e., larger and smaller droplets and particles) exhaled by an infectious person. Transmission is most likely to occur when someone is close to the infectious person, generally within about 6 feet.

- Airborne transmission is infection spread through exposure to those virus-containing respiratory droplets comprised of smaller droplets and particles that can remain suspended in the air over long distances (usually greater than 6 feet) and time (typically hours).⁸⁵

“The virus that causes COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. Spread is more likely when people are in close contact with one another (within about 6 feet). COVID-19 seems to be spreading easily and sustainably in the community (“community spread”) in many affected geographic areas.”⁸⁶

“It may also be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes. This is not thought to be the main way the virus spreads; however, we are still learning more about this virus.”⁸⁷

Asymptomatic and Pre-symptomatic Transmission

“Increasing numbers of epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period. Studies using RT-PCR detection have reported low cycle thresholds, indicating larger quantities of viral RNA, among people with asymptomatic and pre-symptomatic SARS-CoV-2 infection. Likewise in viral culture, viral growth has been observed in specimens obtained from patients with asymptomatic and pre-symptomatic infection. The proportion of SARS-CoV-2 transmission due to asymptomatic or pre-symptomatic infection compared with symptomatic infection is not entirely clear; however, recent studies do suggest that people who are not showing symptoms may transmit the virus.”⁸⁸

A meta-analysis estimated that the initial median R_0 [the basic reproduction number for the virus] for COVID-19 is 2.79 (meaning that one infected person will on average infect 2.79 others), although current estimates might be biased because of insufficient data.⁸⁹ The current best estimate of the CDC based on data through August 1, 2020 is an R_0 value of 2.5.⁹⁰

Around one in five people are traditionally thought to be super-spreaders. These are people who seem to transmit a given infectious disease significantly more widely than most.⁹¹

The incubation period for COVID-19 is thought to extend to 14 days, with a median

⁸⁵ <https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-sars-cov-2.html>

⁸⁶ <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads>

⁸⁷ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html>

⁸⁸ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

⁸⁹ https://wwwnc.cdc.gov/eid/article/26/6/20-0495_article

⁹⁰ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

⁹¹ <https://newatlas.com/health-wellbeing/covid19-case-studies-coronavirus-superspreader-clusters-cdc-report/>

time of 4-5 days from exposure to symptoms onset.⁹²

Available data indicate that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset. Persons with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset.⁹³

The CDC's current best estimate of the percentage of persons with positive COVID-19 infections that are asymptomatic is 40%.⁹⁴

The CDC's current best estimate of the percentage of COVID-19 disease transmission occurring prior to symptom onset is 50%.⁹⁵

“It is not yet known whether weather and temperature affect the spread of COVID-19. Some other viruses, like those that cause the common cold and flu, spread more during cold weather months but that does not mean it is impossible to become sick with these viruses during other months. There is much more to learn about the transmissibility, severity, and other features associated with COVID-19 and investigations are ongoing.”⁹⁶ (Emphasis added).

Viral Shedding

“Viral shedding by asymptomatic people may represent 40–50% of total infections though some uncertainty remains regarding how much they contribute to totals. Viral shedding may antedate symptoms by up to 3+ days.”⁹⁷

“Viral shedding⁹⁸...occurs when a virus is released from an infected host. Studying viral shedding is helpful in understanding how infectious diseases like COVID-19 spread.

Researchers often define the term across a spectrum, using modifiers like “low” and “high” to describe levels of viral shedding. Assessing levels of viral shedding helps researchers determine at what point individuals are most infectious.

For example, a recently published study⁹⁹ of 94 patients with COVID-19 suggests that those infected with the new strain of coronavirus have the highest levels of viral shedding right before showing symptoms. Other studies have shown that some individuals may continue shedding the virus even after their symptoms resolve, or

⁹² <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

⁹³ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

⁹⁴ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

⁹⁵ *Id.*

⁹⁶ <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Coronavirus-Disease-2019-Basics>

⁹⁷

https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19_SA_RS_CoV_2_

⁹⁸ <https://achi.net/newsroom/defining-covid-19-terms-viral-shedding/>

⁹⁹ <https://www.nature.com/articles/s41591-020-0869-5>

subside; one study¹⁰⁰ found that individuals with mild cases of the virus may continue viral shedding up to eight days after symptom resolution.

From a public health perspective, understanding viral shedding of COVID-19 is necessary to determine appropriate actions for virus mitigation. If viral shedding is indeed highest right before a person starts showing symptoms, robust contact tracing efforts to identify potential exposures is necessary to slow the further spread of COVID-19 in communities. Information about viral spread after symptom resolution also allows public health officials to determine appropriate measures for those who have recovered from COVID-19, including guidance on extended quarantine.” (Emphasis added).

Infectious Dose and Viral Load

“Infectious respiratory diseases spread when a healthy person comes in contact with virus particles expelled by someone who is sick — usually through a cough or sneeze. The amount of particles a person is exposed to can affect how likely they are to become infected and, once infected, how severe the symptoms become.

The amount of virus necessary to make a person sick is called the infectious dose. Viruses with low infectious doses are especially contagious in populations without significant immunity. The minimum infectious dose of SARS-CoV-2, the virus that causes COVID-19, is unknown so far, but researchers suspect it is low. “The virus is spread through very, very casual interpersonal contact,” W. David Hardy, a professor of infectious disease at Johns Hopkins University School of Medicine, told STAT.¹⁰¹

A high infectious dose may lead to a higher viral load, which can impact the severity of COVID-19 symptoms. Viral load is a measure of virus particles. It is the amount of virus present once a person has been infected and the virus has had time to replicate in their cells. With most viruses, higher viral loads are associated with worse outcomes.

One study¹⁰² of COVID-19 patients in China found that those with more severe symptoms tended to have higher viral loads. ‘It’s not proven, but it would make sense that higher inoculating doses will lead to higher viral loads, and higher viral loads would translate into more pathogenic clinical courses,’ said Dan Barouch, director of the Center for Virology and Vaccine Research at Beth Israel Deaconess Medical Center.”¹⁰³ (Emphasis added).

3. Cross Border Transmission.

According to the Director-General of the World Health Organization, “This [SARS-

¹⁰⁰ <https://www.healio.com/pulmonology/practice-management/news/online/%7B071c6a27-2c50-458f-9558-19b9f501df05%7D/patients-with-covid-19-may-shed-virus-after-symptom-resolution>

¹⁰¹ <https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/>

¹⁰² [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30196-1/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30196-1/fulltext)

¹⁰³ <https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/>

CoV-2] virus does not respect borders.”¹⁰⁴ While “stay at home” orders were still in place in 17 states and the District of Columbia as of May 25, 2020, states began reopening over the summer, only to reinstate restrictions as case rates increased dramatically in the fall and early winter.¹⁰⁵

Particularly in the construction industry, but in other mobile work crew industries as well, contractors from the states of Maryland, North Carolina, West Virginia, Tennessee, the District of Columbia, Georgia, Pennsylvania, and other states regularly work in Virginia, increasing the chance of virus spread across borders.¹⁰⁶ For instance, during calendar year 2019, contractors from the following states were inspected by VOSH:

Alabama (5)	Missouri (5)
California (2)	Nebraska (3)
Delaware (3)	New Hampshire (1)
<u>District of Columbia (11)</u>	New Jersey (1)
Florida (9)	New York (1)
<u>Georgia (13)</u>	<u>North Carolina (96)</u>
Illinois (4)	Ohio (5)
Indiana (4)	Oklahoma (1)
Iowa (1)	<u>Pennsylvania (11)</u>
Kentucky (2)	South Carolina (5)
<u>Maryland (66)</u>	<u>Tennessee (22)</u>
Michigan (2)	Texas (6)
Minnesota (3)	<u>West Virginia (11)</u>
Mississippi (1)	Wisconsin (2).

WLS.com, Roanoke, VA, May 5, 2020, “25 COVID-19 cases connected to Cave Spring High School construction work”

“ROANOKE, Va. – More than two dozen coronavirus cases are connected to construction work at a local high school, according to Roanoke County Public Schools officials.

The president of Avis Construction, Troy Smith, spoke to the Roanoke County school board on Tuesday and reported as many as 25 cases of COVID-19 that are related to construction work at Cave Spring High School.

Smith told school board members that not all 25 cases are construction workers, but rather, some are family members of workers.

School officials told 10 News that most cases are in workers from different out-of-state subcontractors.

¹⁰⁴ <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19--27-february-2020>

¹⁰⁵ <https://www.aarp.org/politics-society/government-elections/info-2020/coronavirus-state-restrictions.html>

¹⁰⁶ <https://www.kayak.com/travel-restrictions/united-states/>

All work was halted at the Cave Spring High School construction site on Monday, per recommendation from the health department.”¹⁰⁷ (Emphasis added).

4. Infection Fatality Rate.

Though there are limitations on the availability and accuracy of COVID-19 data around the country, researchers are conducting studies to determine a likely range of the “infection mortality rate” (IFR) of COVID-19. The infection fatality rate is the ratio of deaths divided by the number of actual infections with SARS-CoV-2.

A study by the University of Washington using data through April 20, 2020 calculated the U.S. “infection mortality rate” among symptomatic cases (IFR-S) to be 1.3%.¹⁰⁸ Another study calculated a global IFR of 1.04%.¹⁰⁹

A study by the London School of Hygiene and Tropical Medicine estimated the infection fatality rate on the Diamond Princess Cruise Ship to be 1.2%.¹¹⁰ Nearly the entire cruise ships 3,711 passengers and crew were tested.

A study¹¹¹ published in the International Journal of Infectious Diseases in December 2020, concluded: “Based on a systematic review and meta-analysis of published evidence on COVID-19 until July 2020, the IFR of the disease across populations is 0.68% (0.53%–0.82%). However, due to very high heterogeneity in the meta-analysis, it is difficult to know if this represents a completely unbiased point estimate. It is likely that, due to age and perhaps underlying comorbidities in the population, different places will experience different IFRs due to the disease. Given issues with mortality recording, it is also likely that this represents an underestimate of the true IFR figure.”

¹⁰⁷ <https://www.wsls.com/news/local/2020/05/06/25-covid-19-cases-connected-to-cave-spring-high-school-construction-work/>

¹⁰⁸ <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00455>; Study assumptions: We make three assumptions for our analysis: (1) Errors in the numerator and the denominator lead to underreporting of true COVID-19 deaths and cases, respectively; error is smaller for deaths than for cases. (2) Both the errors are declining over time. (3) The errors in the denominator are declining at a faster rate than the error in the numerator.

Assumption #1 is self-evident; both the deaths and the actual cases are undercounted during the initial phase of the epidemic. Because deaths are much more visible events than infections, which, in the case of COVID-19, can go asymptomatic during the first few days of infection, we posit that, at any point in time, the errors in the denominator are larger than the errors in the numerator. Hence, this assumption leads to CFR estimates being larger than the IFR-S, which is typically believed to be true based on observed data.

Assumption #2 is our central assumption, which states that under some stationary processes of care delivery, health care supply, and reporting, which are all believed to be improving over time, the errors in both the numerator and the denominator are declining. It implies that we are improving in the measurement of both the numerator and denominator over time, albeit at different rates in different jurisdictions.

Assumption #3 posits that the error in the denominator is declining faster than the error in the numerator. This assumption indicates that the CFR rates, based on the number of cumulative COVID-19 deaths and the cumulative reported COVID-19 cases, are declining over time and are confirmed based on our observed data (described in detail below).

¹⁰⁹ <https://www.medrxiv.org/content/10.1101/2020.05.11.20098780v1>

¹¹⁰ <https://www.medrxiv.org/content/10.1101/2020.03.05.20031773v2>

¹¹¹ *A systematic review and meta-analysis of published research data on COVID-19 infection fatality rates,* <https://www.sciencedirect.com/science/article/pii/S1201971220321809?via%3Dihub>

More research looking at age-stratified IFR is urgently needed to inform policymaking on this front.”

The generally accepted approximate IFR-S of seasonal influenza is 0.1%.¹¹²

5. COVID-19 Comparisons to Seasonal Influenza.

Seasonal Influenza

“While seasonal influenza (flu) viruses are detected year-round in the United States, flu viruses are most common during the fall and winter. The exact timing and duration of flu seasons can vary, but influenza activity often begins to increase in October. Most of the time flu activity peaks between December and February, although activity can last as late as May.”¹¹³

“Influenza activity in the United States during the 2018–2019 season began to increase in November and remained at high levels for several weeks during January–February. Influenza A viruses were the predominant circulating viruses last year. While influenza A (H1N1pdm09) viruses predominated from October 2018 – mid February 2019, influenza A (H3N2) viruses were more commonly reported starting in late February 2019. Influenza B viruses were not commonly reported among circulating viruses during the 2018–2019 season. The season had moderate severity based on levels of outpatient influenza-like illness, hospitalizations rates, and proportions of pneumonia and influenza-associated deaths.

CDC estimates that the burden of illness during the 2018–2019 season included an estimated 35.5 million people getting sick with influenza, 16.5 million people going to a health care provider for their illness, 490,600 hospitalizations, and 34,200 deaths from influenza (Table 1). The number of influenza-associated illnesses that occurred last season was similar to the estimated number of influenza-associated illnesses during the 2012–2013 influenza season when an estimated 34 million people had symptomatic influenza illness.” (Emphasis added).

The effectiveness of the 2018-2019 influenza vaccine for all vaccine types against influenza A or B viruses was estimated by the CDC to be 29%.¹¹⁴

The mortality rate or death rate of the seasonal influenza in 2018 was approximately 0.1%.¹¹⁵

“According to the CDC, counted deaths during the peak week of the influenza seasons from 2013-2014 to 2019-2020 ranged from 351 (2015-2016, week 11 of 2016) to 1,626 (2017-2018, week 3 of 2018).”¹¹⁶

¹¹² *Id.* referencing <https://www.cdc.gov/flu/about/burden/2018-2019.html>

¹¹³ <https://www.cdc.gov/flu/about/season/flu-season.htm>

¹¹⁴ <https://www.cdc.gov/flu/vaccines-work/2018-2019.html>

¹¹⁵

https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00455?utm_campaign=covid19fasttrack&utm_medium=press&utm_content=basu&utm_source=mediaadvisory& citing <https://www.cdc.gov/flu/about/burden/2018-2019.html>

¹¹⁶ <https://www.thedenverchannel.com/news/coronavirus/study-covid-19-10-to-40-times-deadlier-than-seasonal-flu>

COVID-19

“The Centers for Disease Control and Prevention (CDC) today confirmed the first case of 2019 Novel Coronavirus (2019-nCoV) in the United States in the state of Washington. The patient recently returned from Wuhan, China, where an outbreak of pneumonia caused by this novel coronavirus has been ongoing since December 2019.... The patient from Washington with confirmed 2019-nCoV infection returned to the United States from Wuhan on January 15, 2020.”¹¹⁷ (Emphasis added).

“Officials in Santa Clara County, California, announced last night that at least two deaths in early February can now be attributed to COVID-19. Until now, the first US fatality from the pandemic coronavirus was assumed to be in the Seattle area on Feb 28, but postmortem testing on deaths from Feb 6 [2020] and Feb 17 now confirm that COVID-19 was spreading in the San Francisco Bay area weeks earlier than previously thought.”¹¹⁸

“[As of May 20, 2020] The CDC's current "best guess" is that — in a scenario without any further social distancing or other efforts to control the spread of the virus — roughly 4 million patients would be hospitalized in the U.S. with COVID-19 and 500,000 would die over the course of the pandemic. That's according to the agency's new parameters that the Center for Public Integrity plugged into a simple epidemiological model.

....

The CDC document outlines five possible scenarios¹¹⁹ for the future of the pandemic, one "best guess" and two better-case and two worse-case versions. All of them are "unmitigated," meaning they do not account for future social distancing, widespread mask usage or other efforts to contain the coronavirus.

State and local officials can use the scenarios as a baseline model against which to weigh different responses.”¹²⁰ (Emphasis added).

“[As of December 23, 2020] This week’s national ensemble forecast predicts that the number of newly reported COVID-19 deaths will likely increase over the next 4 weeks, with 16,400 to 27,600 new deaths likely to be reported in the week ending January 16, 2021. The national ensemble predicts that a total of 378,000 to 419,000 COVID-19 deaths will be reported by this date.”¹²¹

“During the week ending April 21, 2020, 15,455 coronavirus-related deaths [occurred], which made the coronavirus' peak death rate 10 to 40 times higher than the one-week peak of the flu.”¹²² (Emphasis added).

Early studies indicate that COVID-19 “infection fatality rate” may be substantially

¹¹⁷ <https://www.cdc.gov/media/releases/2020/p0121-novel-coronavirus-travel-case.html>

¹¹⁸ <https://www.cidrap.umn.edu/news-perspective/2020/04/coroner-first-us-covid-19-death-occurred-early-february>

¹¹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

¹²⁰ <https://www.npr.org/sections/health-shots/2020/05/22/860981956/scientists-say-new-lower-cdc-estimates-for-severity-of-covid-19-are-optimistic>

¹²¹ <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html>

¹²² <https://www.thedenverchannel.com/news/coronavirus/study-covid-19-10-to-40-times-deadlier-than-seasonal-flu>

higher than the seasonal influenza. A study by the University of Washington using data through April 20, 2020 calculated the U.S. “infection mortality rate” among symptomatic cases (IFR-S) to be 1.3%¹²³ [13 times the seasonal influenza rate]. Another study calculated a global IFR of 1.04%¹²⁴ [10.4 times the seasonal influenza rate]. A study by the London School of Hygiene and Tropical Medicine estimated the infection fatality rate on the Diamond Princess Cruise Ship to be 1.2%¹²⁵ [12 times the seasonal influenza rate] Nearly the entire cruise ships 3,711 passengers and crew were tested.

A study¹²⁶ published in the International Journal of Infectious Diseases in December 2020, concluded: “Based on a systematic review and meta-analysis of published evidence on COVID-19 until July 2020, the IFR of the disease across populations is 0.68% (0.53%–0.82%). However, due to very high heterogeneity in the meta-analysis, it is difficult to know if this represents a completely unbiased point estimate. It is likely that, due to age and perhaps underlying comorbidities in the population, different places will experience different IFRs due to the disease. Given issues with mortality recording, it is also likely that this represents an underestimate of the true IFR figure. More research looking at age-stratified IFR is urgently needed to inform policymaking on this front.”

6. Superspreader Cases.

“Superspreader Event”: High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice — Skagit County, Washington, March, 2020¹²⁷

¹²³ <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00455>; Study assumptions: We make three assumptions for our analysis: (1) Errors in the numerator and the denominator lead to underreporting of true COVID-19 deaths and cases, respectively; error is smaller for deaths than for cases. (2) Both the errors are declining over time. (3) The errors in the denominator are declining at a faster rate than the error in the numerator.

Assumption #1 is self-evident; both the deaths and the actual cases are undercounted during the initial phase of the epidemic. Because deaths are much more visible events than infections, which, in the case of COVID-19, can go asymptomatic during the first few days of infection, we posit that, at any point in time, the errors in the denominator are larger than the errors in the numerator. Hence, this assumption leads to CFR estimates being larger than the IFR-S, which is typically believed to be true based on observed data.

Assumption #2 is our central assumption, which states that under some stationary processes of care delivery, health care supply, and reporting, which are all believed to be improving over time, the errors in both the numerator and the denominator are declining. It implies that we are improving in the measurement of both the numerator and denominator over time, albeit at different rates in different jurisdictions.

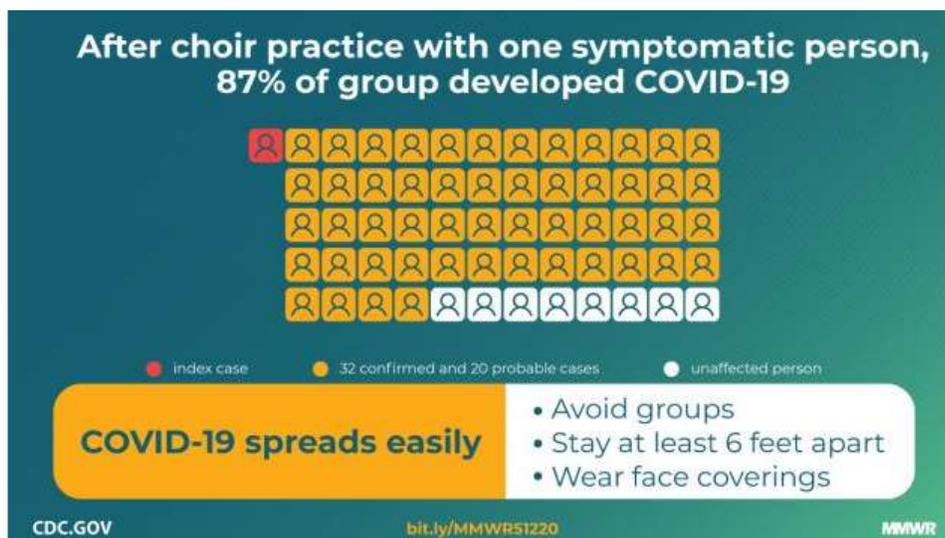
Assumption #3 posits that the error in the denominator is declining faster than the error in the numerator. This assumption indicates that the CFR rates, based on the number of cumulative COVID-19 deaths and the cumulative reported COVID-19 cases, are declining over time and are confirmed based on our observed data (described in detail below).

¹²⁴ <https://www.medrxiv.org/content/10.1101/2020.05.11.20098780v1>

¹²⁵ <https://www.medrxiv.org/content/10.1101/2020.03.05.20031773v2>

¹²⁶ *A systematic review and meta-analysis of published research data on COVID-19 infection fatality rates,* <https://www.sciencedirect.com/science/article/pii/S1201971220321809?via%3Dihub>

¹²⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm>



“Following a 2.5-hour choir practice on March 10, 2020 attended by 61 persons, including a symptomatic index patient, 32 confirmed and 20 probable secondary COVID-19 cases occurred (an attack virus rate of from 53.3% to 86.7%)¹²⁸; three patients were hospitalized, and two died. Transmission was likely facilitated by close proximity (within 6 feet) during practice and augmented by the act of singing.

....

No choir member reported having had symptoms at the March 3 practice. One person at the March 10 practice had cold-like symptoms beginning March 7. This person, who had also attended the March 3 practice, had a positive laboratory result for SARS-CoV-2 by reverse transcription–polymerase chain reaction (RT-PCR) testing.

....

Aerosol emission during speech has been correlated with loudness of vocalization, and certain persons, who release an order of magnitude more particles than their peers, have been referred to as superemitters and have been hypothesized to contribute to superspreading events.¹²⁹

....

The 2.5-hour singing practice provided several opportunities for droplet and fomite transmission, including members sitting close to one another, sharing snacks, and stacking chairs at the end of the practice. The act of singing, itself, might have contributed to transmission through emission of aerosols, which is affected by loudness of vocalization.

....

Certain persons, known as superemitters, who release more aerosol particles during speech than do their peers, might have contributed to this and previously reported COVID-19 superspreading events (2–5). These data demonstrate the high

¹²⁸ “The findings in this report are subject to at least two limitations. First, the seating chart was not reported because of concerns about patient privacy. However, with attack rates of 53.3% and 86.7% among confirmed and all cases, respectively, and one hour of the practice occurring outside of the seating arrangement, the seating chart does not add substantive additional information. Second, the 19 choir members classified as having probable cases did not seek testing to confirm their illness. One person classified as having probable COVID-19 did seek testing 10 days after symptom onset and received a negative test result. It is possible that persons designated as having probable cases had another illness.” *Id.*

¹²⁹ *Id.*

transmissibility of SARS-CoV-2 and the possibility of superemitters contributing to broad transmission in certain unique activities and circumstances.

....

It is recommended that persons avoid face-to-face contact with others, not gather in groups, avoid crowded places, maintain physical distancing of at least 6 feet to reduce transmission, and wear cloth face coverings in public settings where other social distancing measures are difficult to maintain.”¹³⁰

High COVID-19 Attack Rate Among Attendees at Events at a Church — Arkansas, March 2020¹³¹

On March 16, 2020, the day that national social distancing guidelines were released (1), the Arkansas Department of Health (ADH) was notified of two cases of coronavirus disease 2019 (COVID-19) from a rural county of approximately 25,000 persons; these cases were the first identified in this county. The two cases occurred in a husband and wife; the husband is the pastor at a local church.

During March 6–8, the church hosted a 3-day children’s event which consisted of two separate 1.5-hour indoor sessions (one on March 6 and one on March 7) and two, 1-hour indoor sessions during normal church services on March 8. This event was led by two guests from another state. During each session, children participated in competitions to collect offerings by hand from adults, resulting in brief close contact among nearly all children and attending adults.

On March 7, food prepared by church members was served buffet-style. A separate Bible study event was held March 11; the pastor reported most attendees sat apart from one another in a large room at this event. Most children and some adults participated in singing during the children’s event; no singing occurred during the March 11 Bible study. Among all 94 persons who might have attended any of the events, 19 (20%) attended both the children’s event and Bible study.

During the investigation, two church participants who attended the March 6–8 children’s event were found to have had onset of symptoms on March 6 and 7; these represent the primary cases and likely were the source of infection of other church attendees. The two out-of-state guests developed respiratory symptoms during March 9–10 and later received diagnoses of laboratory-confirmed COVID-19, suggesting that exposure to the primary cases resulted in their infections. The two primary cases were not linked except through the church; the persons lived locally and reported no travel and had no known contact with a traveler or anyone with confirmed COVID-

¹³⁰ *Id.*

¹³¹ https://www.cdc.gov/mmwr/volumes/69/wr/mm6920e2.htm?s_cid=mm6920e2_w

The findings in this report are subject to at least four limitations. First, some infected persons might have been missed because they did not seek testing, were ineligible for testing based on criteria at the time, or were unable to access testing. Second, although no previous cases had been reported from this county, undetected low-level community transmission was likely, and some patients in this cluster might have had exposures outside the church. Third, risk of exposure likely varied among attendees but could not be characterized because data regarding individual behaviors (e.g., shaking hands or hugging) were not collected. Finally, the number of cases beyond the cohort of church attendees likely is undercounted because tracking out-of-state transmission was not possible, and patients might not have identified church members as their source of exposure.

19. Patient interviews revealed no additional common exposures among church attendees.

The husband and wife were the first to be recognized by ADH among the 35 patients with laboratory-confirmed COVID-19 associated with church attendance identified through April 22; their illnesses represent the index cases. During the investigation, two persons who were symptomatic (not the husband and wife) during March 6–8 were identified; these are considered the primary cases because they likely initiated the chain of transmission among church attendees.

The estimated attack rate ranged from 38% (35 cases among all 92 church event attendees) to 78% (35 cases among 45 church event attendees who were tested for SARS-CoV-2).

During contact tracing, at least 26 additional persons with confirmed COVID-19 cases were identified among community members who reported contact with the church attendees and likely were infected by them; one of the additional persons was hospitalized and subsequently died.

Community Transmission of SARS-CoV-2 at Two Family Gatherings — Chicago, Illinois, February–March 2020¹³²

Most early reports of person-to-person SARS-CoV-2 transmission have been among household contacts, where the secondary attack rate has been estimated to exceed 10% (1), in health care facilities (2), and in congregate settings (3). However, widespread community transmission, as is currently being observed in the United States, requires more expansive transmission events between non-household contacts.

This report describes the cluster of 16 cases¹³³ of confirmed or probable COVID-19, including three deaths, likely resulting from transmission of SARS-CoV-2 at two family gatherings (a funeral and a birthday party).

The median interval from last contact with a patient with confirmed or probable COVID-19 to first symptom onset was 4 days. Within 3 weeks after mild respiratory symptoms were noted in the index patient, 15 other persons were likely infected with SARS-CoV-2, including three who died. Patient A1.1, the index patient, was apparently able to transmit infection to 10 other persons, despite having no household

¹³² *Id.*

¹³³ The findings in this investigation are subject to at least three limitations. First, lack of laboratory testing for probable cases means some probable COVID-19 patients might have instead experienced unrelated illnesses, although influenza-like illness was declining in Chicago at the time. Second, phylogenetic data, which could confirm presumed epidemiologic linkages, were unavailable. For example, patient B3.1 experienced exposure to two patients with confirmed COVID-19 in this cluster, and the causative exposure was presumed based on expected incubation periods. Patient D3.1 was a health care professional, and, despite not seeing any patients with known COVID-19, might have acquired SARS-CoV-2 during clinical practice rather than through contact with members of this cluster. Similarly, other members of the cluster might have experienced community exposures to SARS-CoV-2, although these transmission events occurred before widespread community transmission of SARS-CoV-2 in Chicago. Finally, despite intensive epidemiologic investigation, not every confirmed or probable case related to this cluster might have been detected. Persons who did not display symptoms were not evaluated for COVID-19, which, given increasing evidence of substantial asymptomatic infection (9), means the size of this cluster might be underestimated. *Id.*

contacts and experiencing only mild symptoms for which medical care was not sought (patient A1.1 was only tested later as part of this epidemiologic investigation).

Identifying and Interrupting Superspreading Events—Implications for Control of Severe Acute Respiratory Syndrome Coronavirus 2¹³⁴

Severe acute respiratory syndrome (SARS) coronavirus 2 (SARS-CoV-2) continues to spread (1). Although we still have limited information on the epidemiology of coronavirus disease (COVID-19), there have been multiple reports of superspreading events (SSEs)

SSEs highlight a major limitation of the concept of R_0 . The basic reproductive number R_0 , when presented as a mean or median value, does not capture the heterogeneity of transmission among infected persons (16); 2 pathogens with identical R_0 estimates may have markedly different patterns of transmission. Furthermore, the goal of a public health response is to drive the reproductive number to a value <1 , something that might not be possible in some situations without better prevention, recognition, and response to SSEs.

7. COVID-19 Pandemic Planning.

Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios.¹³⁵

The scenarios are intended to advance public health preparedness and planning. They are not predictions or estimates of the expected impact of COVID-19.

Scenario 5: Parameter values for disease severity, viral transmissibility, and pre-symptomatic and asymptomatic disease transmission that represent the best estimate, based on the latest surveillance data and scientific knowledge. Parameter values are based on data received by CDC through August 8, 2020.

Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
R_0^*	2.0		4.0		2.5
Infection Fatality Ratio†	0-19 years: 0.00002 20-49 years: 0.00007 50-69 years: 0.0025 70+ years: 0.028		0-19 years: 0.0001 20-49 years: 0.0003 50-69 years: 0.010 70+ years: 0.093		0-19 years: 0.00003 20-49 years: 0.0002 50-69 years: 0.005 70+ years: 0.054

¹³⁴ https://wwwnc.cdc.gov/eid/article/26/6/20-0495_article

¹³⁵ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
Percent of infections that are asymptomatic^s	10%	70%	10%	70%	40%
Infectiousness of asymptomatic individuals relative to symptomatic[†]	25%	100%	25%	100%	75%
Percentage of transmission occurring prior to symptom onset	30%	70%	30%	70%	50%

*The best estimate representative of the point estimates of R_0 from the following sources:

From Table 2: CDC Parameter Values Common to the Five COVID-19 Pandemic Planning Scenarios.¹³⁶

The parameter values are likely to change as we obtain additional data about disease severity and viral transmissibility of COVID-19.

Parameter values are based on data received by CDC through August 8, 2020, including COVID-19 Case Surveillance Public Use Data (<https://data.cdc.gov/Case-Surveillance/COVID-19-Case-Surveillance-Public-Use-Data/vbim-akqf>); data from the Hospitalization Surveillance Network ([COVID-NET](#)) (through August 1); and data from Data Collation and Integration for Public Health Event Response (*DCIPHER*).

Pre-existing immunity Assumption, ASPR and CDC	No pre-existing immunity before the pandemic began in 2019. It is assumed that all members of the U.S. population were susceptible to infection prior to the pandemic.
Time from exposure to symptom onset[*]	~6 days (mean)
Time from symptom onset in an individual and symptom onset of a second person infected by that individual[†]	~6 days (mean)
Mean ratio of estimated infections to reported case counts, Overall (range)[§]	11 (6, 24)

Parameter Values Related to Healthcare Usage

¹³⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

Median number of days from symptom onset to SARS-CoV-2 test among SARS-CoV-2 positive patients (interquartile range)[†]	Overall: 3 (1, 6) days
Median number of days from symptom onset to hospitalization (interquartile range)^{**}	18-49 years: 6 (3, 10) days 50-64 years: 6 (2, 10) days ≥65 years: 4 (1, 9) days
Median number of days of hospitalization among those not admitted to ICU (interquartile range)^{††}	18-49 years: 3 (2, 5) days 50-64 years: 4 (2, 7) days ≥65 years: 6 (3, 10) days
Median number of days of hospitalization among those admitted to ICU (interquartile range)^{††,§§}	18-49 years: 11 (6, 20) days 50-64 years: 14 (8, 25) days ≥65 years: 12 (6, 20) days
Percent admitted to ICU among those hospitalized^{††}	18-49 years: 23.8% 50-64 years: 36.1% ≥65 years: 35.3%
Percent on mechanical ventilation among those hospitalized. Includes both non-ICU and ICU admissions^{††}	18-49 years: 12.0% 50-64 years: 22.1% ≥65 years: 21.1%
Percent that die among those hospitalized. Includes both non-ICU and ICU admissions^{††}	18-49 years: 2.4% 50-64 years: 10.0% ≥65 years: 26.6%
Median number of days of mechanical ventilation (interquartile range)^{**}	Overall: 6 (2, 12) days
Median number of days from symptom onset to death (interquartile range)^{**}	18-49 years: 15 (9, 25) days 50-64 years: 17 (10, 26) days ≥65 years: 13 (8, 21) days
Median number of days from death to reporting (interquartile range)^{†††}	18-49 years: 19 (5, 45) days 50-64 years: 21 (6, 46) days ≥65 years: 19 (5, 44) days

8. Community or “Herd” Immunity.

“Community immunity [or herd immunity]: A situation in which a sufficient proportion of a population is immune to an infectious disease (through vaccination and/or prior illness) to make its spread from person to person unlikely. Even individuals not vaccinated (such as newborns and those with chronic illnesses) are offered some protection because the disease has little opportunity to spread within the community....”¹³⁷

“Although more than 2.5 million confirmed cases of COVID-19 have been reported worldwide, studies suggest that (as of early April 2020) no more than 2-4% of any country’s population has been infected with SARS-CoV-2 (the coronavirus that causes COVID-19). Even in hotspots like New York City that have been hit hardest by the pandemic, initial studies suggest that perhaps 15-21% of people have been exposed so far. In getting to that level of exposure, more than 17,500 of the 8.4 million people in New York City (about 1 in every 500 [480] New Yorkers) have died, with the overall death rate in the city suggesting deaths may be undercounted and mortality may be even higher. [more recent data indicate that as of May 24, 2020, New York City has suffered 16,469 confirmed COVID-19 deaths (i.e., positive laboratory test) and another 4,747 probable deaths (i.e., cause of death reported as “COVID-19” or equivalent, but no positive laboratory test) for a total of 21,216 deaths, about 1 in every 395 New Yorkers].¹³⁸

....

To reach herd immunity for COVID-19, likely 70% or more of the population would need to be immune. Without a vaccine, over 200 million Americans would have to get infected before we reach this threshold. Put another way, even if the current pace of the COVID-19 pandemic continues in the United States – with over 25,000 confirmed cases a day – it will be well into 2021 before we reach herd immunity.”¹³⁹ (Emphasis added).

Nypost.com, Dr. Fauci says COVID-19 herd immunity may take 90%¹⁴⁰ to be infected or vaccinated:

“Dr. Anthony Fauci now says as much as 90 percent of the population may need to get vaccinated or infected to achieve herd immunity against COVID-19 — admitting in a new interview that he has been intentionally raising the bar based, in part, on what he thinks the country is ready to hear.

“We really don’t know what the real number is,” the nation’s top infectious disease expert told the New York Times.

“I think the real range is somewhere between 70 to 90 percent. But, I’m not going to say 90 percent.”

¹³⁷ <https://www.cdc.gov/vaccines/terms/glossary.html#commimmunity>

¹³⁸ <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>

¹³⁹ <https://coronavirus.jhu.edu/from-our-experts/early-herd-immunity-against-covid-19-a-dangerous-misconception>

¹⁴⁰ <https://nypost.com/2020/12/24/fauci-covid-herd-immunity-requires-90-to-be-infected-or-vaccinated/>

The director of the National Institute of Allergy and Infectious Diseases acknowledged that he's been intentionally upping that number as science's understanding of the virus has changed — and as Americans have become more confident in coronavirus vaccines.

....

He said he's comfortable drawing the line at 90 percent herd immunity because he doesn't believe the virus is more infectious than the measles, which falls in that range.

"I'd bet my house that COVID isn't as contagious as measles," he said.

Around 46 percent of Americans plan to take the vaccine at the earliest available opportunity, while 32 percent are willing to wait for others to get the shot first, according to a recent USA Today-Suffolk University survey."

Latimes.com, December 26, 2020. Can COVID-19 vaccines get us to herd immunity? 'The jury is definitely still out':¹⁴¹

The aim of the vaccination campaign against COVID-19 is herd immunity — the point at which so few people are susceptible to infection that the virus runs out of places to go.

In the early days of the pandemic, epidemiologists estimated that would require inoculating about two-thirds of the U.S. population.

Now many of those same experts say that figure is almost certainly too low.

'If you really want true herd immunity, where you get a blanket of protection over the country ... you want about 75 to 85% of the country to get vaccinated,' Dr. Anthony Fauci, the nation's top infectious-disease official, told a reporter last week. 'I would say even closer to 85%.'

The shift reflects a deeper understanding of how the virus spreads — that it jumps from one person to another more easily than once thought.

The question of how many people must be vaccinated is of crucial importance as the world embarks on the biggest inoculation campaign in decades.

The goal of vaccination isn't just to protect the individual who receives it but also to drape a fire blanket over a large enough portion of the population that the fire begins running out of fuel.

If too few people are vaccinated, the virus will keep finding enough new hosts to propagate itself — and continue to stress the healthcare system, delay economic recovery, necessitate social distancing and potentially surge again if vaccines lose effectiveness over time.

¹⁴¹ <https://www.yahoo.com/now/covid-19-vaccines-us-herd-110023026.html>

Whatever the threshold for herd immunity, public health officials face a substantial challenge.

An early December poll from the Associated Press-NORC Center for Public Affairs Research found that 46% of American adults planned to get vaccinated while 26% would decline and 27% were still undecided.

One group of researchers found that anti-vaccination messaging on social media has tripled since the start of the pandemic.

A particular obstacle could be vaccinating children and teenagers, a group that has not been hit especially hard by the pandemic and for which vaccines are still being tested. But at 22% of the U.S. population, they are important to any effort to achieve herd immunity and return to normal life.

When epidemiologists first aimed to model how many people would need to be vaccinated in order to drive the coronavirus toward extinction, they compared early transmission trends to those of other recent flu pandemics.

They noted how the coronavirus had a longer incubation period, more asymptomatic spread and higher contagion — estimating that the pandemic would probably drag on for 18 to 24 months.

“It likely won’t be halted until 60% to 70% of the population is immune,” said a report published by infectious-disease experts in April.

There are two paths to immunity: becoming infected with the virus and recovering, or getting vaccinated. Neither is a guarantee.

Based on data from clinical trials showing that the efficacy of the two authorized vaccines — from Pfizer and Moderna — is excellent but still imperfect, the threshold for herd immunity rises to around 74%.

But experts say even that calculation is still too simple.

“Those numbers are useful for thought experiments, but they don’t represent what’s likely to be the way we control the virus or its impacts,” said Harvard epidemiologist Marc Lipsitch. “Offering a kind of magic number requires some very strong assumptions about these vaccines.”

Many factors can come into play. If the virus becomes even more transmissible, the threshold for herd immunity would increase.

The targets could vary by location. In sparsely populated places where people adhere to social distancing guidelines, fewer people would have to be vaccinated to burn out the virus.

‘It’s going to be the sort of thing that we’re studying for a very long time to come,’ said William Hanage, an epidemiologist at the Center for

Communicable Disease Dynamics at Harvard.

Then there are the vaccines themselves.

They were authorized based on rapid-fire clinical trials that showed recipients were highly unlikely to develop symptoms of COVID-19 — but did not determine whether the vaccines actually prevent people from becoming infected with the virus or transmitting it.

The degree to which the vaccines prevent transmission matters greatly in the equation for calculating herd immunity. In a bad-case scenario, the vaccines do so little to stop transmissions that herd immunity simply can't be achieved through vaccination alone.

“At the moment, the jury is definitely still out,” Lipsitch said. “If I had to guess, there will be a component of herd immunity — I just don't know how dramatic it will be.”

It could turn out that reaching herd immunity depends not only on how many people are vaccinated but also which people. Inoculating those most likely to spread it — people who live or work in close quarters, for example — may do much more to contain the pandemic than vaccinating people who live in relative seclusion.

Given all these unknowns, Fauci brought his estimate to 85% — and has said it could be even higher.

The costs of not achieving herd immunity are substantial. If the virus continues to circulate broadly, even some people who are vaccinated will develop COVID-19. Hospitals will continue to confront surges of the virus, depleting their resources and compromising their ability to treat heart attacks, strokes and other emergencies.

Meanwhile, overall quality of life would continue to suffer. Schools, offices and restaurants would remain closed even for people who have been vaccinated.

Experts say that until the virus is circulating at extraordinarily low levels — such that the risk of becoming infected is close to zero — social distancing and mask-wearing are here to stay.

The final answer to the question of how many people need to be vaccinated won't be known until herd immunity is actually achieved. When epidemiologists start to see the test positivity rate falling to extremely low numbers, that's how they'll know the campaign is working.

But with the exception of smallpox, no virus that afflicts humans has ever been wiped out completely. Experts have been struggling with polio for decades, lately in conflict regions where vaccination campaigns have been disrupted.

They emphasize that in the age of globalization, herd immunity must eventually take into account almost every corner of the earth — a pathogen anywhere remains a threat everywhere.

‘I think it’s extremely unlikely that we would be able to eradicate this virus,’ Hanage said. ‘In reality, we have to accept that.’

‘However, we should be able to get to a point where we are going to be able to live without it markedly damaging our lives, without leading to surges that damage our healthcare, or large excessive mortality — and that is what we are seeking to achieve.’” (Emphasis added).

As of December 29, 2020, the CDC says:

“Experts do not know what percentage of people would need to get vaccinated to achieve herd immunity to COVID-19. Herd immunity is a term used to describe when enough people have protection—either from previous infection or vaccination—that it is unlikely a virus or bacteria can spread and cause disease. As a result, everyone within the community is protected even if some people don’t have any protection themselves. The percentage of people who need to have protection in order to achieve herd immunity varies by disease.”¹⁴²

9. COVID-19 Virus Mutations.

Depending on the level of contagiousness of COVID-19 expressed in the R_0 ¹⁴³ value, “the threshold for combined [COVID-19] vaccine efficacy and herd immunity needed for disease extinction” is estimated between 55% and 82% “(i.e., >82% of the population has to be immune, through either vaccination or prior infection, to achieve herd immunity to stop transmission).¹⁴⁴

“The new [SARS-CoV-2] coronavirus is an RNA virus: a collection of genetic material packed inside a protein shell. Once an RNA virus makes contact with a host, it starts to make new copies of itself that can go on to infect other cells.

RNA viruses, like the flu and measles, are more prone to changes and mutations compared with DNA viruses, such as herpes, smallpox, and human papillomavirus

¹⁴² <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

¹⁴³ “The basic reproduction number (R_0), pronounced “R naught,” is intended to be an indicator of the contagiousness or transmissibility of infectious and parasitic agents.... R_0 has been described as being one of the fundamental and most often used metrics for the study of infectious disease dynamics (7–12). An R_0 for an infectious disease event is generally reported as a single numeric value or low–high range, and the interpretation is typically presented as straightforward; an outbreak is expected to continue if R_0 has a value >1 and to end if R_0 is <1 (13). The potential size of an outbreak or epidemic often is based on the magnitude of the R_0 value for that event (10), and R_0 can be used to estimate the proportion of the population that must be vaccinated to eliminate an infection from that population (14,15). R_0 values have been published for measles, polio, influenza, Ebola virus disease, HIV disease, a diversity of vectorborne infectious diseases, and many other communicable diseases (14,16–18).

https://wwwnc.cdc.gov/eid/article/25/1/17-1901_article

¹⁴⁴ https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article#suggestedcitation

(HPV).

‘In the world of RNA viruses, change is the norm. We expect RNA viruses to change frequently. That’s just their nature,’ said Dr. Mark Schleiss, a pediatric infectious disease specialist and investigator with the Institute for Molecular Virology at the University of Minnesota.

SARS-CoV-2 is no exception, and over the past few months it has been mutating. But the virus has mutated at a very slow pace. And when it does mutate, the new copies aren’t far off from the original virus.

‘The sequences of the original isolates from China are very close to those in viruses circulating in the U.S. and the rest of the world,’ said Dr. John Rose, a senior research scientist in the department of pathology at Yale Medicine who’s helping develop a COVID-19 vaccine.

....

Early research from scientists at Los Alamos National Laboratory¹⁴⁵ shows that SARS-CoV-2 has mutated into a new form that may be more contagious.

The new strain is responsible for the vast majority of infections reported around the world since mid-March, according to the new study published in the preprint research website BioRxiv Thursday.

In total, the researchers identified 14 strains of COVID-19 and released their findings to help those working on vaccines and treatments.

That being said, the new dominant strain identified does seem to be more infectious in laboratory settings.

But scientists are now trying to understand how the variation behaves in the body — which may be very different from lab settings. Additionally, the study is in preprint, which means it hasn’t yet been fully peer-reviewed.

It’s also unclear whether the new mutation infects and sickens people differently. At this time, the illness and hospitalization rates caused by the new variation seems to be similar.”¹⁴⁶

Forbes.com, December 29, 2020. First U.S. Case Of New Covid Mutation¹⁴⁷ Discovered In Colorado:

“A new, highly contagious coronavirus variant that was first identified in Britain has reached the United States, officials in Colorado confirmed Tuesday, reporting the first known U.S. case of the strain more than two weeks after it was discovered — a worrying development as Covid-19 infections and

¹⁴⁵ <https://www.biorxiv.org/content/10.1101/2020.04.29.069054v1>

¹⁴⁶ <https://www.healthline.com/health-news/what-to-know-about-mutation-and-covid-19#The-new-coronavirus-is-mutating,-but-very-slowly>

¹⁴⁷ <https://www.forbes.com/sites/joewalsh/2021/12/29/first-us-case-of-new-covid-mutation-discovered-in-colorado/?sh=5560175e1d79>

deaths climb nationwide.

The variant was discovered in a man in his 20s who lives in Elbert County, a rural area near Denver, Gov. Jared Polis (D-Colo.) said in a tweet Tuesday afternoon.

The man has no travel history, Polis said, placing him at odds with many other patients in Europe who appeared to contract the variant while traveling in the United Kingdom.

....

Researchers believe this new coronavirus variant — which U.K. officials disclosed earlier this month — is about 56% more contagious than other versions of the virus, an alarming figure even though it doesn't appear to lead to deadlier infections. As of last week, the variant was already responsible for the majority of London's Covid-19 infections, and officials have partly blamed it for a recent spike in U.K. Covid-19 cases that has forced much of the country back into strict lockdowns. Dozens of countries have banned or restricted travel from the United Kingdom in response, including the United States, which began requiring all U.K. travelers to show a negative coronavirus test before flying to the U.S. this week.

....

Most infectious disease experts aren't surprised to see the new variant arrive in the United States. Last week, Dr. Anthony Fauci told ABC News it's "certainly possible" the mutation was already present in the country. But experts fear a more transmissible form of Covid-19 could make controlling the virus' spread even more difficult, adding to an already-dire surge in cases throughout the United States." (Emphasis added).

10. COVID-19 Vaccine Development and Deployment.

How COVID-19 Vaccines Work¹⁴⁸

"COVID-19 vaccines help our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness. Different types of vaccines work in different ways to offer protection, but with all types of vaccines, the body is left with a supply of "memory" T-lymphocytes as well as B-lymphocytes that will remember how to fight that virus in the future.

It typically takes a few weeks for the body to produce T-lymphocytes and B-lymphocytes after vaccination. Therefore, it is possible that a person could be infected with the virus that causes COVID-19 just before or just after vaccination and then get sick because the vaccine did not have enough time to provide protection.

Sometimes after vaccination, the process of building immunity can cause symptoms, such as fever. These symptoms are normal and are a sign that the body is building

¹⁴⁸ https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/how-they-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fvaccines%2Fabout-vaccines%2Fhow-they-work.html

immunity.”

Authorized Vaccines

Currently, two vaccines are authorized and recommended to prevent COVID-19.¹⁴⁹

- Pfizer-BioNTech COVID-19 vaccine¹⁵⁰

“Based on evidence from clinical trials, the Pfizer-BioNTech vaccine was 95% effective at preventing laboratory-confirmed COVID-19 illness in people without evidence of previous infection.”

- Moderna’s COVID-19 vaccine¹⁵¹

“Based on evidence from clinical trials, the Moderna vaccine was 94.1% effective at preventing laboratory-confirmed COVID-19 illness in people who received two doses who had no evidence of being previously infected.”

As of December 28, 2020, large-scale (Phase 3) clinical trials are in progress or being planned for three COVID-19 vaccines in the United States:

- AstraZeneca’s COVID-19 vaccine
- Janssen’s COVID-19 vaccine
- Novavax’s COVID-19 vaccine

Cost is not an obstacle to getting vaccinated against COVID-19

Vaccine doses purchased with U.S. taxpayer dollars will be given to the American people at no cost. However, vaccination providers may be able to charge administration fees for giving the shot. Vaccination providers can get this fee reimbursed by the patient’s public or private insurance company or, for uninsured patients, by the Health Resources and Services Administration’s Provider Relief Fund.¹⁵²

Previously infected people and access to a COVID-19 vaccine

COVID-19 vaccination should be offered to previously infected persons. No antibody test is needed. “However, anyone currently infected with COVID-19 should wait to get vaccinated until after their illness has resolved and after they have met the criteria to discontinue isolation.

Additionally, current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection. Therefore, people with a recent infection may delay vaccination until the end of that 90-day period if

¹⁴⁹ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html>

¹⁵⁰ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Pfizer-BioNTech.html>

¹⁵¹ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Moderna.html>

¹⁵² <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/8-things.html>

desired.”¹⁵³

How long does immunity last

“The protection someone gains from having an infection (called natural immunity) varies depending on the disease, and it varies from person to person. Since this virus is new, we don’t know how long natural immunity might last. Current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection.

Regarding vaccination, we won’t know how long immunity lasts until we have a vaccine and more data on how well it works.

Both natural immunity and vaccine-induced immunity are important aspects of COVID-19 that experts are trying to learn more about, and CDC will keep the public informed as new evidence becomes available.”¹⁵⁴

Continued need to wear face covering and practice physical distancing after vaccination

As of December 29, 2020, the CDC says:

“While experts learn more about the protection that COVID-19 vaccines provide under real-life conditions, it will be important for everyone to continue using all the tools available to us to help stop this pandemic, like covering your mouth and nose with a mask, washing hands often, and staying at least 6 feet away from others. Together, COVID-19 vaccination and following CDC’s recommendations for how to protect yourself and others will offer the best protection from getting and spreading COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before deciding to change recommendations on steps everyone should take to slow the spread of the virus that causes COVID-19. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.

....

There is not enough information currently available to say if or when CDC will stop recommending that people wear masks and avoid close contact with others to help prevent the spread of the virus that causes COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before making that decision. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.”¹⁵⁵ (Emphasis added).

Vaccine rollout and timeline

ABC News, December 30, 2020.

¹⁵³ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

¹⁵⁴ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

¹⁵⁵ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

“The U.S. COVID-19 vaccine rollout moved slower than expected this month,...

vaccine experts and public health officials warned the bigger test will come next year when inventory finally expands and the broader public raises their hands for a shot.

‘It's really difficult to administer every dose when you are prioritizing it and trying to avoid waste,’ said Claire Hannan, executive director of the Association of Immunization Managers.

‘But when we get into a position of mass clinics and everyone has access, we'll be much more efficient in getting it out,’ she said.

[The federal government] initially pledged 300 million doses by January 2021 when announcing Operation Warp Speed, then later this fall dropped the estimate to 100 million. After Pfizer adjusted its production estimates, Health Secretary Alex Azar promised 40 million doses on hand and 20 million vaccinations by the end of the year.

Instead, the administration was on track to ship those 20 million doses by the first week of January -- enough for first doses in the two-dose vaccine -- with only 2.6 million vaccinations recorded by the federal government.

....

Vaccine experts and public health officials said they aren't ready to sound the alarms just yet, but they are citing numerous smaller logistical challenges that have complicated the rollout: a vaccine that has specific handling requirements, and hospitals that must stagger injections for front-line hospital employees based on the latest shipment numbers.

Holidays and snowstorms haven't helped, and a federally run partnership with major pharmacies to deliver vaccines in nursing homes only just got started. Also, states participating in that program were required to hold some doses in reserve.

‘Receiving, preparing and administering vaccines takes time,’ said Kris Ehresmann, director of the infectious disease division at the Minnesota Department of Health.

‘I really do expect next week, when the holidays are over, for those numbers to rapidly jump as jurisdictions move ahead quickly to protect their health care personnel, and also long-term care facility residents,’ said Dr. Nancy Messonnier, director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention.

Blaire Bryant, associate legislative director for health at the National Association of Counties, agreed that the slower-than-expected rollout isn't a problem yet. But counties are concerned about whether there's enough money to see it through a nationwide rollout in spring, she said.

The federal government in recent months has sent \$340 million to the states, but that money has been slow to trickle down as cash-strapped states sort through competing priorities, creating what Bryant called a "barrier" that could be addressed with direct, flexible cash grants. On Sunday, Trump signed a \$900 billion COVID relief bill that included more than \$8 billion for vaccine distribution.

Bryant said many overwhelmed local communities also could use help to support public messaging on the vaccine, as well as more details on what to expect in coming weeks. Initial allotment was based on each state's adult population. It's not known whether federal officials could change that formula to account for outbreaks, or whether a community could get to pick the vaccine of their choice.

....

Hannan, from the Association of Immunization Managers, agreed that expanding the vaccine rollout behind health care personnel was her biggest concern. By the time hospitals and nursing homes are covered and people over the age of 65 and essential workers are invited to get a shot, there will be less concern about fair allocation. But the government will need to have enrolled enough providers to roll it out nationwide next spring.

That means enlisting primary care physicians, local pharmacies and others to jump on board with federal requirements that show they can store, handle and administer the vaccines properly.”

U.S. Population

There are over 329,000,000 people living in the United States.¹⁵⁶

Vaccine deployment

Successful deployment of a COVID-19 vaccine will depend on the willingness of the U. S. population to actually take the vaccine. In a Reuters’ survey¹⁵⁷ of 4,428 U.S. adults taken between May 13 and May 19:

“Fourteen percent of respondents said they were not at all interested in taking a vaccine, and 10% said they were not very interested. Another 11% were unsure.

....

Overall, 84% of respondents said vaccines for diseases such as measles are safe for both adults and children, suggesting that people hesitant to take a coronavirus vaccine might reconsider, depending on safety assurances they receive. For example, among those who said they were “not very” interested in taking the vaccine, 29% said they would be more interested if the FDA

¹⁵⁶ <https://www.census.gov/popclock/>

¹⁵⁷ <https://www.reuters.com/article/us-health-coronavirus-vaccine-poll-exclu/exclusive-a-quarter-of-americans-are-hesitant-about-a-coronavirus-vaccine-reuters-ipsos-poll-idUSKBN22X19G>

approved it.

....

In addition, misinformation about vaccines has grown more prevalent on social media during the pandemic, according to academic researchers.

‘It’s not surprising a significant percentage of Americans are not going to take the vaccine because of the terrible messaging we’ve had, the absence of a communication plan around the vaccine and this very aggressive anti-vaccine movement,’ said Peter Hotez, dean of the National School of Tropical Medicine at Baylor College of Medicine, where he is developing a vaccine.

....

The Reuters/Ipsos poll was conducted online, in English, throughout the United States and had a credibility interval, a measure of precision, of plus or minus 2 percentage points.”¹⁵⁸

VCU.edu, December 14, 2020. Study¹⁵⁹ finds more than half of respondents are unlikely to get COVID-19 vaccine under emergency use authorization:

“A new study led by a Virginia Commonwealth University professor is among the first to examine the psychological and social predictors of U.S. adults’ willingness to get a future COVID-19 vaccine and whether these predictors differ under an emergency use authorization release of the vaccine.

The study, “Willingness to Get the COVID-19 Vaccine with and without Emergency Use Authorization,” will be published in the American Journal of Infection Control. It involved a survey of 788 U.S. adults, and found that 59.9% of respondents were definitely or probably planning to receive a future coronavirus vaccine, while 18.8% were neutral and 21.3% were probably or definitely not planning to get it.

When asked if they would get the vaccine under an emergency use authorization, 46.9% of respondents said they were definitely, likely, or somewhat willing to do so; while 53.1% said they were definitely, likely, or somewhat unwilling to do so.

“The biggest issue coming out of this study is that participants seemed worried about receiving the COVID-19 vaccine under emergency use authorization,” said lead author Jeanine Guidry, Ph.D., an assistant professor in the Richard T. Robertson School of Media and Culture in the College of Humanities and Sciences and director of the Media+Health Lab at VCU.

The study found that concerns about side effects were a significant barrier, Guidry noted.

¹⁵⁸ *Id.*

¹⁵⁹ https://news.vcu.edu/article/Study_finds_more_than_half_of_respondents_are_unlikely_to_get

“[Such concerns are] not unusual,” she said, “but we now also know that two of the vaccines — Pfizer and Moderna — may have some expected side effects ... [and that] may make people hesitate to get the vaccine.”

The study also found troubling disparities among demographic groups. For example, younger respondents were more likely than older respondents to express a willingness to get the vaccine. And it found that white respondents were more likely than Black respondents to be willing to get the vaccine, either under emergency use authorization or regular Food and Drug Administration approval.

“That is something researchers have found in other previous vaccine studies as well, but it is more worrying with COVID-19 because we know that Black Americans are infected with COVID-19 significantly more frequently than white Americans, and they are also more likely to die from the virus,” Guidry said.

“Unfortunately, there is history of medical mistreatment of African Americans and individuals from low-income communities in the U.S.,” said co-author Bernard Fuemmeler, Ph.D., a professor in the Department of Health Behavior and Policy in the VCU School of Medicine.

“Against this backdrop it is understandable that mistrust among certain communities will be an issue to contend with as we hope to make progress in delivering the vaccine to those most in need,” Fuemmeler said. “It starts with recognizing this history and providing people with the information they desire to alleviate their justifiable wariness about the vaccine.”

The researchers found that significant predictors of a willingness to get the coronavirus vaccine included education level and having health insurance, as well as a high-perceived susceptibility to COVID-19. Predictors of a willingness to get the vaccine under an emergency use authorization included age and race/ethnicity.” (Emphasis added).

NPR.org, December 15, 2020. Poll:¹⁶⁰ Americans Are Growing Less Reluctant To Take COVID-19 Vaccine:

“Now that federal regulators have authorized one COVID-19 vaccine for emergency use in the U.S. — and appear close to authorizing another — it seems Americans are growing less reluctant about receiving an inoculation themselves. The Kaiser Family Foundation, or KFF, released a poll Tuesday showing a significant leap in the number of people saying they definitely or probably would get vaccinated.

About 71% of respondents to the late November and early December survey said they would get a vaccine, up from 63% in an August/September poll.

¹⁶⁰ <https://www.npr.org/sections/coronavirus-live-updates/2020/12/15/946761737/poll-americans-are-growing-less-reluctant-to-take-covid-19-vaccine>

KFF says the increase was evident across all racial and ethnic groups surveyed, as well as both Democrats and Republicans.

Of course, since the previous poll, there have been important advances in the development of a vaccine for COVID-19, which has cost more than 300,000 lives in the U.S.”

E. Virginia VWCC and VOSH Statistics.

1. Virginia Workers Compensation Statistics as of May 31, 2020.¹⁶¹

Since February, 2020, the Virginia Workers’ Compensation Commission received 3,154 COVID-19 related claims as of May 31, 2020 in a wide variety of occupational settings, representing a nearly 44.5% increase in claims over a 20 day period since May 11, 2020 (2,182 claims).

NOTE 1: Individual private self-insurers are not included in these statistics.

NOTE 2: Most but not all claims are assigned a NAICS code (North American Industrial Classification Code). As of May 31, 2020, 18.4 % (581 claims) of claims were not assigned a NAICS code. A cursory review of the non-NAICS claims revealed that a significant number were in healthcare or long term care environments.

NOTE 3: Workers classified as independent contractors are not included in these statistics. There is a practice known as “misclassification”¹⁶² of employees as independent contractors that has been found to be prevalent in certain industries¹⁶³ in Virginia that impacts the ability to obtain accurate workers’ compensation data.

The following industries had 10 or more claims filed as of May 31, 2020:

¹⁶¹ Virginia Department of Human Resources Workers’ Compensation Statistics as of May 31, 2020.

As of May 31, 2020, the Virginia Department of Human Resource Management (DHRM) Workers’ Compensation Division has received 42 claims involving COVID-19 exposure. Agencies involved included: Library of Virginia, State Corporation Commission, Virginia Alcoholic Beverage Control Authority, Virginia Commonwealth University, Virginia Department of Agriculture and Consumer Services, Virginia Department of Behavioral Health and Developmental Services, Virginia Department of Corrections, Virginia Department of Forestry, Virginia Department of Game and Inland Fisheries, Virginia Department of Health, Virginia Department of Juvenile Justice, Virginia Department of Military Affairs, Virginia Department of Motor Vehicles, and Virginia State Police.

¹⁶² <https://www.doli.virginia.gov/vosh-programs/misclassification-in-the-workplace/>

¹⁶³ [http://www.dpor.virginia.gov/uploadedFiles/MainSite/Content/Licensees/JLARC_Employee%20Misclassification%20Report%20\(2012\).pdf](http://www.dpor.virginia.gov/uploadedFiles/MainSite/Content/Licensees/JLARC_Employee%20Misclassification%20Report%20(2012).pdf)

<u>NAICS</u> ¹⁶⁴	<u>Industry</u>
No NAICS	Restaurant: Fast Food (70)
322299	All Other Converted Paper Product Manufacturing (25)
445110	Supermarkets and Other Grocery (except Convenience) Stores (14)
452990	All Other General Merchandise Stores (11)
488119	Other Airport Operations (13)
531	Real Estate (33)
54151	Computer Programming (541511) and Design (541512) (13)
561320	Temporary Help Services (12)
561720	Janitorial Services (25)
621111	Offices of Physicians (except Mental Health Specialists) (97)
621498	All Other Outpatient Care Centers (33)
621511	Medical Laboratories (17)
621512	Diagnostic Imaging Centers (16)
621610	Home Health Care Services (12)
621999	All Other Miscellaneous Ambulatory Health Care Services (29)
622110	General Medical and Surgical Hospitals (457)
6223	Specialty (except Psychiatric and Substance Abuse) Hospitals (40)
623311	Continuing Care Retirement Communities (79) (See NOTE 2 above)
721110	Hotels (except Casino Hotels) and Motels (18)
722310	Food Service Contractors (13)
921190	Other General Government Support (317)
922120	Police Protection (106)
922160	Fire Protection (125)
922190	Other Justice, Public Order, and Safety Activities (941)

2. Virginia Workers Compensation Statistics as of November 30, 2020.

Since February, 2020, the Virginia Workers' Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020.

¹⁶⁴ North American Industrial Classification System, <https://www.census.gov/eos/www/naics/>

VWCC Reports Nineteen (19) Employee Deaths as of November 30, 2020

Date of Injury	Manual Classification Code	Year Of Birth	Date Death	Industry Code	Industry Code Description
3/23/2020	HOTEL: ALL OTHER EMPLOYEES & SALESPERSONS, DRIVERS	1963	4/3/2020	721110	Hotels (except Casino Hotels) and Motels
3/28/2020	CONVALESCENT OR NURSING HOME-ALL EMPLOYEES	1951	4/7/2020	621610	Home Health Care Services
3/20/2020	HOTEL: ALL OTHER EMPLOYEES & SALESPERSONS, DRIVERS	1969	4/9/2020	721110	Hotels (except Casino Hotels) and Motels
4/8/2020	RETIREMENT LIVING CENTERS: FOOD SERVICE EMPLOYEES	1946	4/12/2020	623311	Continuing Care Retirement Communities
4/13/2020	NOT AVAILABLE	1979	4/20/2020	237990	Other Heavy and Civil Engineering Construction
4/24/2020	NOT AVAILABLE	1963	5/5/2020	621112	Offices of Physicians, Mental Health Specialists)
3/31/2020	NOT AVAILABLE	1966	5/11/2020	453998	All Other Miscellaneous Store Retailers (except Tobacco Stores)
5/3/2020	NOT AVAILABLE	1958	5/19/2020	621610	Home Health Care Services
5/22/2020	CARPENTRY NOC	1975	5/22/2020	561110	Office Administrative Services
4/1/2020	STORE: MEAT, GROCERY AND PROVISION STORES COMBINED-RETAIL NOC	1961	5/24/2020	445110	Supermarkets and Other Grocery (except Convenience) Stores
6/2/2020	JANITORIAL SERVICES BY CONTRACTORS - NO WINDOW CLEANING ABOVE GROUND LEVEL & DRIVERS	1963	6/8/2020	722310	Food Service Contractors
5/28/2020	HOSPITAL: PROFESSIONAL EMPLOYEES	1969	7/14/2020	622210	Psychiatric and Substance Abuse Hospitals
5/11/2020	PHYSICIAN & CLERICAL	1959	7/19/2020	621111	Offices of Physicians (except Mental Health Specialists)
8/7/2020	NOT AVAILABLE	1945	8/13/2020	325613	Surface Active Agent Manufacturing
7/16/2020	MUNICIPAL, TOWNSHIP, COUNTY OR STATE EMPLOYEE NOC	1945	8/16/2020	922190	Other Justice, Public Order, and Safety Activities

9/10/2020	PLASTICS MANUFACTURING: MOLDED PRODUCTS NOC	1957	9/11/2020	325212	Synthetic Rubber Manufacturing
9/24/2020	COLLEGE: ALL OTHER EMPLOYEES	1950	10/4/2020	722310	Food Service Contractors
9/25/2020	RENDERING WORKS NOC & DRIVERS	1951	11/3/2020	311613	Rendering and Meat Byproduct Processing
11/29/2020	FIREFIGHTERS & DRIVERS	1960	11/29/2020	922190	Other Justice, Public Order, and Safety Activities

3. Deaths, Hospitalizations, and Employee Complaints reported to the Virginia Department of Labor and Industry.

Pursuant to Va. Code §40.1-51.1.D,¹⁶⁵ employers must report employee deaths and hospitalizations to DOLI.

NOTE: The VOSH Program has investigated an average of 37 annual work-related¹⁶⁶ employee deaths over the last five calendar years. The 30 COVID-19 death notifications so far in 2020 would represent 81% of the deaths investigated by VOSH in an average year.

Fatalities through December 25, 2020:

Fatalities - Calendar Year	2019	2020	%
Total	38	53	15
COVID-19	0	30	57%
Fall		7	13%
Struck-By		10	19%
Caught-in		5	9%
Electrocution		1	2%

¹⁶⁵ <https://law.lis.virginia.gov/vacode/40.1-51.1/>

¹⁶⁶ NOTE: The VOSH Program will ultimately make a determination as to whether an employee's death due to COVID-19 was work-related or not. An infectious disease such as COVID-19 presents additional difficulties to investigators when it comes to determining work-relatedness.

SUMMARY VOSH COVID-19 RESPONSE												
	Dates											
	11/20/20	11/27/20	12/4/20	12/11/20	12/18/20	12/25/20						Total
Phone Calls												
Total Phone Calls	195	110	150	171	204	121						10032
UPAs Complaints OIS Statewide	35	24	31	41	39	15						1509 *
# Inspections <i>Complaints, Referrals, Hospitalizations & Fatalities</i>	5	3	2	3	2	2						101 **
# Hospitalizations	2	0	1	0	0	0						60 ***
	<i>Inspection</i>											
	0	0	0	0	0	0						20
	<i>RRR</i>											
	2	0	1	0	0	0						30
Fatalities/Workplace deaths	0	1	0	1	0	0						30
# of Emails forwarded to Regional/Field Offices from MF <i>COVID-19 positive Cases Reports (ETS) Complaints (does not include reports submitted by phone in the Regional Offices).</i>	20	20	10	11	10	5						559
# REDCAP Notifications (Launched 09/28/20)	1219	980	1685	1718	1470	1201						11923
# REDCAP Notifications (3 or more cases reported)	245	228	365	428	354	331						2823 ****
* Time Range: 01/01/2020 to 12/25/2020 UPA numbers may change as Regions update the system.												
**Inspections opened (Total: 101 - Draft + Final)												
***There are Employers submitting multiple notifications. Some of the hospitalizations reported to VOSH later resulted in fatalities.												

<u>331 of the 1201 notifications were reports of more than 3 cases.</u>												
Top 3 Health Districts Reporting Cases												
Fairfax County Loudoun County Richmond City												

NOTE: “UPA” means unprogrammed activity (complaints, referrals, fatalities, hospitalizations).
“MF” means Occupational Safety Compliance Director Marta Fernandes

4. VOSH Inspection and Citation History.

NOTE: See ATTACHMENT F for VOSH Investigation and Inspection Procedures.

See ATTACHMENT H for a list of VOSH Violations Issued in COVID-19 Cases Opened from February 1, 2020 to December 30, 2020.

Through December 30, 2020, VOSH has conducted 94 COVID-19 inspections:

Inspections in Progress	43
[Citations pending HQ/Legal Review: 10]	
[Employee deaths: 8]	
Inspections Closed with No Violations	25
[Employee deaths: 7]	
Inspections with Violations	26
[Inspections with Violations Settled: 15]	
[Inspections with Violations Contested: 7]	
[Employee deaths: 6]	
Total Inspections	94

Violation Types	
Serious	29 (50.0%)
Other-than-serious	29 (50.0%)
Willful	0
Repeat	0
Total Violations	58

a. Pre-ETS Inspection Statistics – Cases Opened Prior to July 27, 2020.

Inspections in Progress	0
Inspections Closed with No Violations	18
Inspections with Violations	17
Total Inspections	35

Violation Types	
Serious	18 (48.6%)
Other-than-serious	19 (51.4%)
Willful	0
Repeat	0
Total Violations	37

b. Post-ETS Inspection Statistics – Cases Opened on or After July 27, 2020.

Inspections in Progress	43
[Citations pending HQ/Legal Review: 10]	
Inspections Closed with No Violations	7
Inspections with Violations	9
Total Inspections	59
Violation Types	
Serious	11 (52.4%)
Other-than-serious	10 (47.6%)
Willful	0
Repeat	0
Total Violations	21

c. Inspection Statistics for Very High and High Risk.¹⁶⁷

Inspections in Progress	9
Inspections Closed with No Violations	9
Inspections with Violations	15
Total Inspections	33
Violation Types	
Serious	19 (52.8%)
Other-than-serious	17 (47.2%)
Willful	0
Repeat	0
Total Violations	36

d. Inspection Statistics for Medium Risk.¹⁶⁸

Inspections in Progress	34
Inspections Closed with No Violations	15
Inspections with Violations	11
Total Inspections	60

¹⁶⁷ Classification of risk for these inspections was based solely on NAICS and the relative likelihood that the employer's hazards and job tasks fell within the definitions for the various risk categories (very high, high, medium and lower).

It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons. 16VAC25-220-10.

¹⁶⁸ *Id.*

Violation Types	
Serious	10 (45.5%)
Other-than-serious	12 (54.5%)
Willful	0
Repeat	0
Total Violations	22

f. Inspection Statistics for Lower Risk.¹⁶⁹

Inspections in Progress	0
Inspections Closed with No Violations	1
Inspections with Violations	0
Total Inspections	1

Violation Types	
Serious	0
Other-than-serious	0
Willful	0
Repeat	0
Total Violations	1

g. Inspection Statistics by NAICS.¹⁷⁰

11: Agriculture, Forestry, Fishing and Hunting	4
21-23: Mining, Quarrying, and Oil and Gas Extraction; Utilities; Construction	2
31-33: Manufacturing	15
42: Wholesale Trade	2
44-45: Retail Trade	8
48-49: Transportation and Warehousing	5
51: Information	1
53: Real Estate and Rental and Leasing	3
54: Professional, Scientific, and Technical Services	8
62: Health Care and Social Assistance	31
72: Accommodation and Food Services	6
81: Other Services (except Public Administration)	3
92: Public Administration	6

Virginia Occupational Safety and Health (VOSH)

¹⁶⁹ *Id.*

¹⁷⁰ North America Industrial Classification System.

COVID-19 Inspections Conducted From January 1, 2020 to December 30, 2020

Site NAICS	NAICS Description	Insp With Viols Issued	No Citations Issued	Insp In Progress	Insp Closed	Very High or High	Medium	Lower	Employee Death	Entry Date
	NAICS Sector 11: Agriculture, Forestry, Fishing and Hunting									
111998	All Other Miscellaneous Crop Farming			1			1			09/18/2020
111421	Nursery and Tree Production			1			1			09/18/2020
114111	Finfish Fishing			1			1			10/30/2020
115114	Postharvest Crop Activities (except Cotton Ginning)			1			1			09/01/2020
	NAICS Sector 21-23: Mining, Quarrying, and Oil and Gas Extraction; Utilities; Construction									
221310	Water Supply and Irrigation Systems		1		1		1		1	06/02/2020
236118	Residential Remodelers		1		1		1			11/12/2020
	NAICS Sector 31-33: Manufacturing									
311612	Meat Processed from Carcasses		1		1		1			05/20/2020
311612	Meat Processed from Carcasses			1			1			09/22/2020
311613	Rendering and Meat Byproduct Processing			1			1			10/30/2020
311615	Poultry Processing		1		1		1		1	04/28/2020
311812	Commercial Bakeries		1		1		1			06/24/2020
311821	Cookie and Cracker Manufacturing			1			1			09/01/2020
314110	Carpet and Rug Mills			1			1			08/07/2020
321212	Softwood Veneer and Plywood Manufacturing			1			1		1	10/23/2020
321999	All Other Miscellaneous Wood Product Manufacturing			1			1			11/24/2020
326291	Rubber Product Manufacturing for Mechanical Use			1			1			10/29/2020
327390	Other Concrete Product Manufacturing		1		1		1		1	07/15/2020
333414	Heating Equipment (except Warm Air Furnaces) Manufacturing			1			1			10/07/2020
333991	Power-Driven Handtool Manufacturing			1			1			09/30/2020
336211	Motor Vehicle Body Manufacturing			1			1			10/20/2020
337110	Wood Kitchen Cabinet and Countertop Manufacturing			1			1			12/22/2020
	NAICS Sector 42: Wholesale Trade									

423910	Sporting and Recreational Goods and Supplies Merchant Wholesalers			1					11/16/2020
424410	General Line Grocery Merchant Wholesalers	1			1		1		07/31/2020
NAICS Sector 44-45: Retail Trade									
444110	Home Centers			1			1		10/19/2020
441120	Used Car Dealers		1		1		1	1	06/18/2020
441222	Boat Dealers			1			1		08/28/2020
441228	Motorcycle, ATV, and All Other Motor Vehicle Dealers		1		1		1		11/23/2020
441310	Automotive Parts and Accessories Stores			1			1		11/18/2020
442110	Furniture Stores			1			1	1	08/11/2020
453910	Pet and Pet Supplies Stores	1					1		11/02/2020
453998	All Other Miscellaneous Store Retailers (except Tobacco Stores)			1			1		12/14/2020
NAICS Sector 48-49: Transportation and Warehousing									
485113	Bus and Other Motor Vehicle Transit Systems		1		1		1		06/08/2020
485310	Taxi Service	1			1		1		06/29/2020
488119	Other Airport Operations		1		1		1	1	04/29/2020
492110	Couriers and Express Delivery Services		1		1		1		10/30/2020
492110	Couriers and Express Delivery Services	1					1		10/30/2020
NAICS Sector 51: Information									
519120	Libraries and Archives			1			1		09/14/2020
NAICS Sector 53: Real Estate and Rental and Leasing									
531110	Lessors of Residential Buildings and Dwellings		1		1		1	1	05/26/2020
541350	Building Inspection Services		1		1		1		07/10/2020
541519	Other Computer Related Services		1		1		1		04/29/2020
NAICS Sector 54: Professional, Scientific, and Technical Services									
561110	Office Administrative Services	1			1			1	08/12/2020
561422	Telemarketing Bureaus and Other Contact Centers	1					1	1	05/13/2020
561612	Security Guards and Patrol Services			1			1		10/30/2020
561612	Security Guards and Patrol Services			1		1		1	09/10/2020
561720	Janitorial Services			1		1			11/09/2020

561720	Janitorial Services	1			1	1			06/26/2020
561720	Janitorial Services		1		1	1			07/16/2020
562910	Remediation Services			1			1		10/02/2020
	NAICS Sector 62: Health Care and Social Assistance								
621210	Offices of Dentists	1			1	1			09/25/2020
621310	Offices of Chiropractors			1			1		10/28/2020
621310	Offices of Chiropractors			1			1		12/10/2020
621330	Offices of Mental Health Practitioners (except Physicians)			1					10/15/2020
622110	General Medical and Surgical Hospitals	1			1	1			05/29/2020
622110	General Medical and Surgical Hospitals			1		1			08/12/2020
621420	Outpatient Mental Health and Substance Abuse Centers		1		1				11/19/2020
621491	HMO Medical Centers	1			1	1			05/20/2020
621498	All Other Outpatient Care Centers	1			1	1			06/16/2020
621610	Home Health Care Services		1		1	1			05/13/2020
621610	Home Health Care Services	1				1		1	05/20/2020
622110	General Medical and Surgical Hospitals		1		1	1			08/11/2020
622110	General Medical and Surgical Hospitals			1		1			10/30/2020
622110	General Medical and Surgical Hospitals	1			1	1			05/08/2020
622210	Psychiatric and Substance Abuse Hospitals			1				1	09/06/2020
622310	Nursing Care Facilities (Skilled Nursing Facilities)		1		1				08/13/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1							08/04/2020
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	1				1			07/02/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)			1				1	11/24/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1			07/02/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)			1				1	07/27/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1			1	1			07/06/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)			1					12/11/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1			07/02/2020

623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1		1	06/23/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1		1	04/30/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1			06/08/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1			05/06/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1		1	05/05/2020
623311	Continuing Care Retirement Communities	1				1		1	04/27/2020
623312	Assisted Living Facilities for the Elderly	1			1	1			08/07/2020
NAICS 72: Accommodation and Food Services									
721110	Hotels (except Casino Hotels) and Motels	1			1		1	1	06/01/2020
722310	Food Service Contractors		1		1	1			07/06/2020
722511	Full-Service Restaurants			1			1		10/27/2020
722511	Full-Service Restaurants			1			1		10/08/2020
722511	Full-Service Restaurants			1			1		08/20/2020
722515	Snack and Nonalcoholic Beverage Bars		1		1		1		09/22/2020
NAICS 81: Other Services (except Public Administration)									
811192	Car Washes	1			1		1		07/17/2020
812112	Beauty Salons	1			1		1		10/28/2020
812199	Other Personal Care Services	1					1		12/03/2020
NAICS Sector 92: Public Administration									
921190	Other General Government Support			1			1	1	08/25/2020
922120	Police Protection	1			1		1		06/30/2020
922140	Correctional Institutions			1			1	1	09/09/2020
922160	Fire Protection			1		1			11/19/2020
923120	Administration of Public Health Programs			1			1		08/25/2020
923120	Administration of Public Health Programs			1			1		08/25/2020
Total Inspections: 94		26	25	43	40	33	60	1	21
		27.7%	26.6%	45.7%					

SOURCE:

OSHA Information System Scan Detail Report: Time run: 12/30/2020 8:08:38 AM

V. Economic and Workplace Impacts.

A. Economic Impact Analysis.

An economic impact analysis (EIA) meeting the requirements of Va. Code §2.2-4007.04¹⁷¹ will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.¹⁷²

[TO BE PROVIDED ON OR BEFORE JANUARY 11, 2021]

B. Impact on Employers.

Employers will have to familiarize themselves with the differences between the final standard and the ETS that was in effect from July 27, 2020 to January 26, 2021. Certain employers will have to train employees on the requirements of the standard based on the risk levels for its employees (see IV. Summary of Final Standard and attached text of final standard).

The Department will significantly supplement its COVID-19 webpage with education, training, and outreach materials that will assist employers and employees in complying with the final standard.

Employers should benefit from reductions in injuries, illnesses, and fatalities associated with employee exposure to SARS-CoV-2 and COVID-19 related hazards which would be addressed by any comprehensive regulation.

In addition, there may be an ancillary benefit to those employers whose establishments are frequented by the general public who may take some level of confidence in the safety and health of the physical establishment because of the requirements of this emergency temporary standard/emergency regulation.

C. Impact on Employees.

1. Vulnerabilities of Virginia's Workforce to SARS-CoV-2 and COVID-19 Hazards.

Those employees at high-risk for severe illness from COVID-19 are¹⁷³:

Older adults:

¹⁷¹ <https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/>

¹⁷² <http://www.chmuraecon.com/>

¹⁷³ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html>

Compared to younger adults, older adults are more likely to require hospitalization if they get COVID-19

	Hospitalization ¹	Death ²
18-29 years	Comparison Group	Comparison Group
30-39 years	2x higher	4x higher
40-49 years	3x higher	10x higher
50-64 years	4x higher	30x higher
65-74 years	5x higher	90x higher
75-84 years	8x higher	220x higher
85+ years	13x higher	630x higher

Adults of any age with certain underlying medical conditions are at increased risk for severe illness from the virus that causes COVID-19. Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death.

Adults of any age with the following conditions are at increased risk of severe illness from the virus that causes COVID-19:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Down Syndrome
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 kg/m² or higher but < 40 kg/m²)
- Severe Obesity (BMI ≥ 40 kg/m²)
- Pregnancy
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

COVID-19 is a new disease. Currently there are limited data and information about the impact of many underlying medical conditions on the risk for severe illness from COVID-19. Based on what we know at this time, adults of any age with the following conditions might be at an increased risk for severe illness from the virus that causes COVID-19:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Overweight (BMI > 25 kg/m², but < 30 kg/m²)
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus¹⁷⁴

2. National and Virginia Statistics.

Based on U. S. Census figures, “In 1998, adults ages 55 and older represented 12 percent of the American workforce. Twenty years later, this group represents 23 percent of the workforce, the largest labor force share of any age group. By 2028, nearly one in three people between the ages of 65 and 74 are expected to remain in the labor force, and more than 12 percent of people 75 and older will still be working, roughly tripling the rate at which the oldest Americans were working two decades ago.”¹⁷⁵

NOTE: In 2008, the labor force participation rate for employees 65 and older in Virginia was 16%.¹⁷⁶ In 2017 the U.S. Senate’s Special Committee on Aging noted that the average labor force participation rate of employees 65 years and older in the South Atlantic states, including Virginia, was 17.9%.¹⁷⁷

The U.S. Census estimates that Virginia’s population as of July 1, 2019 was 8,535,519, and that 15.4% (1,314,469) of Virginia’s population was 65 years or older.¹⁷⁸

A labor force participation rate for those 65 and older in Virginia of 17.9% would equate to 235,289 elderly employees.

¹⁷⁴ https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html

¹⁷⁵ <https://www.seniorliving.org/research/senior-employment-outlook-covid/>

¹⁷⁶ [http://sfc.virginia.gov/pdf/health/2008%20Session/August%2020%20mtg/HHR%20-%20Perrone%20-%20UVA%20-%208.20.08%20\(B&W\).pdf](http://sfc.virginia.gov/pdf/health/2008%20Session/August%2020%20mtg/HHR%20-%20Perrone%20-%20UVA%20-%208.20.08%20(B&W).pdf)

¹⁷⁷ <https://www.aging.senate.gov/imo/media/doc/Aging%20Workforce%20Report%20FINAL.pdf>, p. 12.

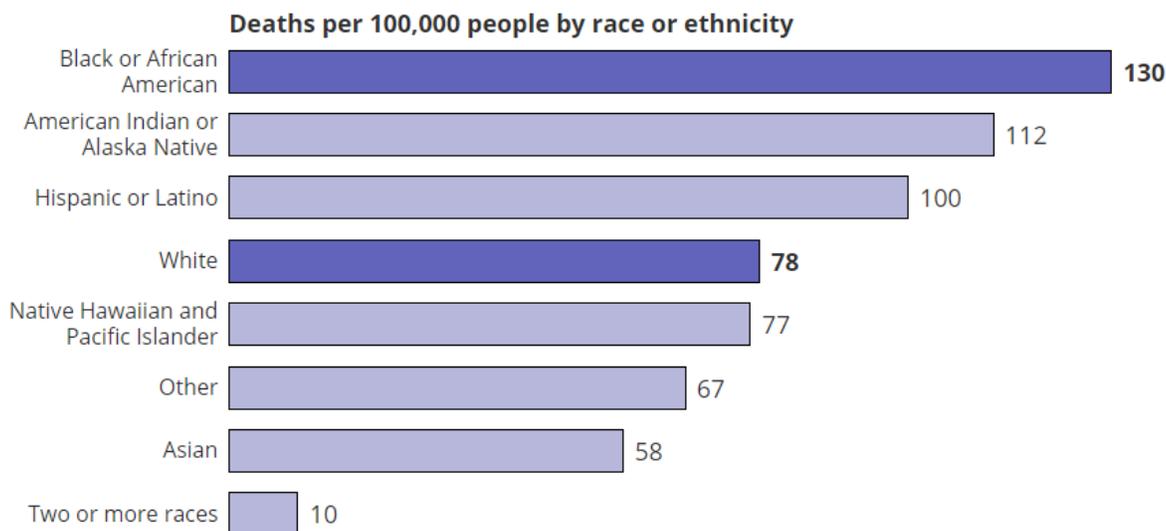
¹⁷⁸ <https://www.census.gov/quickfacts/fact/table/VA#>

A study by SeniorLiving.Org looked “at the jobs that are most common for seniors, how have their labor force participation rates changed over time, and what impacts might arise from the COVID-19 crisis.” Key findings include:

- In all 50 states and the District of Columbia, at least 20 percent of adults ages 65 to 74 are in the workforce. In seven states, more than 30 percent are working.
- Since 2013, 46 of 51 had seen increases in workforce participation of 75-and-older residents. Seven states posted 20 percent gains, including Vermont, West Virginia, Maine, Georgia, Michigan, Rhode Island and Connecticut.
- Seniors represent significant portions of the workforce for many professions that require close contact with others, including bus drivers, ushers, ticket takers, taxi drivers, street vendors, chiropractors, dentists, barbers, etc.

Additionally, current data suggest a disproportionate burden of illness and death among racial and ethnic minority groups.¹⁷⁹

Nationwide, Black people are dying at 1.7 times the rate of white people.



The CDC postulates that part of the reason for this disparity is that some racial and ethnic minority groups are disproportionately represented in essential work settings such as healthcare facilities, farms, factories, grocery stores, and public transportation.

Other factors postulated include the disproportionate lack of access to healthcare and health insurance, language barriers, discrimination, financial status, serious underlying health conditions, stigmatization, and other systemic inequalities.¹⁸⁰

¹⁷⁹ <https://covidtracking.com/race>

¹⁸⁰ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

Almost 40% of the population of Virginia are from a racial minority.¹⁸¹

The Bureau of Labor Statistics (BLS) conducted an analysis of employment statistics entitled “How many workers are employed in sectors directly affected by COVID-19 shutdowns, where do they work, and how much do they earn?”¹⁸² The report looked at “six of the most directly exposed sectors include: Restaurants and Bars, Travel and Transportation, Entertainment (e.g., casinos and amusement parks), Personal Services (e.g., dentists, daycare providers, barbers), other sensitive Retail (e.g., department stores and car dealers), and sensitive Manufacturing (e.g., aircraft and car manufacturing).”

In all, 20.4 percent of all workers are employed in industries most immediately affected by the COVID-19 shutdowns”¹⁸³:

Table 1. Industry statistics, by firm size class

Firm size (number of employees)	Total	All other	Most exposed sectors						
			Restaurants and bars	Travel and transportation	Entertainment	Personal services	Other sensitive retail	Sensitive manufacturing	Most exposed sectors combined
Employment levels in June 2019 (thousands)									
10 or less	14,139.9	10,813.4	1,124.6	140.1	209.2	845.7	779.8	227.1	3,326.5
11 to 50	22,257.7	14,994.6	4,022.0	545.2	541.1	743.5	961.4	449.9	7,263.1
51 to 100	10,572.4	7,644.2	1,533.8	198.5	294.7	100.9	556.5	243.8	2,928.2
101 to 500	25,483.5	20,893.5	1,668.0	558.9	642.0	146.2	830.9	744.0	4,590.0
More than 500	77,528.8	65,076.8	3,925.1	2,050.6	957.0	249.9	3,419.9	1,849.5	12,452.0
Total	149,982.3	119,422.5	12,273.5	3,493.3	2,644.0	2,086.2	6,548.5	3,514.3	30,559.8
Total wages paid in second quarter 2019 (billions of dollars)									
10 or less	\$144.894	\$120.886	\$5.183	\$0.926	\$1.951	\$7.731	\$5.844	\$2.373	\$24.008
11 to 50	242.971	194.789	19.428	3.350	2.581	7.412	9.954	5.457	48.182
51 to 100	132.246	108.932	8.192	1.674	1.649	1.010	7.550	3.239	23.314
101 to 500	358.286	314.502	8.519	5.413	5.783	1.453	12.052	10.564	43.784

¹⁸¹ <https://www.census.gov/quickfacts/VA>

¹⁸² <https://www.bls.gov/opub/mlr/2020/article/covid-19-shutdowns.htm>

¹⁸³ *Id.*

Table 1. Industry statistics, by firm size class

Firm size (number of employees)	Total	All other	Most exposed sectors						
			Restaurants and bars	Travel and transportation	Entertainment	Personal services	Other sensitive retail	Sensitive manufacturing	Most exposed sectors combined
More than 500	1,240.032	1,121.793	20.876	27.118	8.879	2.259	24.403	34.704	118.239
Total	2,118.429	1,860.902	62.198	38.481	20.843	19.865	59.803	56.337	257.527

Note: Firms are identified by Employer Identification Number.

Source: Authors' calculations based on U.S. Bureau of Labor Statistics Quarterly Census of Employment and Wages data for June and second quarter 2019. The North American Industry Classification System codes used to define the most exposed sectors can be found in Joseph S. Vavra, "Shutdown sectors represent large share of all U.S. employment" (Chicago, IL: Becker Friedman Institute for Economics at the University of Chicago, March 31, 2020), <https://bfi.uchicago.edu/insight/blog/key-economic-facts-about-covid-19/>.

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“Older adults make up a large percentage of many of the jobs in these industries. For example, nearly half of bus drivers are older than 55, while almost 1 in 5 ticket takers and ushers are 65 or older. And although the BLS didn’t specifically call them out, farmers have also been impacted by the toll of the virus, with both prices of commodities and consumption declining. The median age of farmers and ranchers in the U.S. is 56.1 years old.”¹⁸⁴



¹⁸⁴ <https://www.seniorliving.org/research/senior-employment-outlook-covid/>

“When it comes to specific job titles, a few roles are much more common for older adults than for others. For example, nearly 80 percent of funeral service managers are 55 and older, compared to much more physical roles like fence builders (7.3 percent) or lifeguards (5.8 percent).”¹⁸⁵



Percentage of workers 55 and older by job and age group (Top 10)

Age Group: 55-64

Heat treating equipment setters and operators	50%
Cleaning, washing and metal pickling equipment operators	50%
Financial examiners	48%
Funeral service managers	46%
Agricultural inspectors	44%
Electrical / electronics installers / repairers (transportation equipment)	43%
Furnace, kiln, oven, drier and kettle operators	41%
Atmospheric and space scientists	40%
Model makers and patternmakers (metal and plastic)	40%
Textile machine setters and operators	40%

Age Group: 65+

Shoe and leather workers and repairers	43%
Motor vehicle operators	39%
Legislators	37%
Models, demonstrators and product promoters	34%
Embalmers and funeral attendants	33%
Funeral service managers	31%
Farmers and ranchers	31%
Etchers and engravers	25%
Crossing guards	25%
Nuclear engineers	25%

¹⁸⁵ *Id.*

Finally, the CDC conducted a study of “Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016”¹⁸⁶ of the general population. Although the working population of the country is only a subset of the totals for the table, the data nonetheless demonstrates the significant risk that SARS-CoV-2 and COVID-19 related hazards pose to the U.S. and Virginia workers. Using the age adjusted statistical totals:

- 14.7% of the population suffer from diabetes,
- 12.2% from high cholesterol
- 30.2% suffer from hypertension
- 39.7% suffer from obesity

Table 21. Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016

Excel version (with more data years and standard errors when available): https://www.cdc.gov/nchs/hus/contents2018.htm#Table_021.

[Data are based on interviews, physical examinations, and laboratory data of a sample of the civilian noninstitutionalized population]

Health condition	1988–1994	1999–2000	2001–2002	2003–2004	2005–2006	2007–2008	2009–2010	2011–2012	2013–2014	2015–2016
Diabetes¹										
Percent of adults aged 20 and over										
Total, age-adjusted ²	8.8	10.0	11.6	11.8	11.5	12.6	12.5	12.7	13.1	14.7
Total, crude	8.3	9.6	11.2	11.8	11.9	13.0	13.2	13.4	14.0	16.0
Hypercholesterolemia³										
Total, age-adjusted ⁴	22.8	25.5	24.6	27.9	27.4	27.6	27.2	28.2	27.4	26.9
Total, crude	21.5	24.5	24.2	27.9	28.1	28.8	28.6	30.4	29.3	29.6
High total cholesterol⁵										
Total, age-adjusted ⁴	20.8	18.3	16.5	16.9	15.6	14.2	13.2	12.7	11.1	12.2
Total, crude	19.6	17.7	16.4	17.0	15.9	14.6	13.6	13.1	11.1	12.5
Hypertension⁶										
Total, age-adjusted ⁴	25.5	30.0	29.7	32.1	30.5	31.2	30.0	30.0	30.8	30.2
Total, crude	24.1	28.9	28.9	32.5	31.7	32.6	31.9	32.5	33.5	33.2
Uncontrolled high blood pressure among persons with hypertension⁷										
Total, age-adjusted ⁴	77.2	71.9	68.3	63.8	63.0	56.2	55.7	54.6	51.3	59.7
Total, crude	73.9	69.1	65.4	60.8	56.6	51.8	46.7	48.0	46.1	51.5
Overweight or obesity⁸										
Total, age-adjusted ⁴	56.0	64.5	65.6	66.4	66.9	68.1	68.8	68.6	70.4	71.3
Total, crude	54.9	64.1	65.6	66.5	67.3	68.3	69.2	69.0	70.7	71.6
Obesity⁹										
Total, age-adjusted ⁴	22.9	30.5	30.5	32.3	34.4	33.7	35.7	34.9	37.8	39.7
Total, crude	22.3	30.3	30.6	32.3	34.7	33.9	35.9	35.1	37.9	39.8
Untreated dental caries¹⁰										
Total, age-adjusted ⁴	27.7	24.4	21.3	29.8	24.4	21.7	---	25.5	31.5	26.1
Total, crude	26.2	25.0	21.7	30.2	24.5	21.8	---	25.5	31.3	25.9
Obesity¹¹										
Percent of persons under age 20										
2–5 years	7.2	10.3	10.6	14.0	11.0	10.1	12.1	8.4	9.4	13.9
6–11 years	11.3	15.1	16.3	18.8	15.1	19.6	18.0	17.7	17.4	18.4
12–19 years	10.5	14.8	16.7	17.4	17.8	18.1	18.4	20.5	20.6	20.6
Untreated dental caries¹⁰										
5–19 years	24.3	23.6	21.2	25.6	16.2	16.9	14.6	17.5	19.6	14.3

¹⁸⁶ <https://www.cdc.gov/nchs/data/hus/2018/021.pdf>

3. Virginia Statistics.

Virginia's Adult Reported Diabetes Rate in 2019 was 10.5%.¹⁸⁷

Virginia's Hypertension Rate in 2015 was 33.2%¹⁸⁸

Virginia's Adult Reported High Cholesterol Rate¹⁸⁹ in 2019 was 33%.¹⁹⁰

Virginia's Adult Reported Obesity Rate¹⁹¹ in 2019 was 30.3%.¹⁹²

All employees, but particularly those in high risk age and medical categories, would benefit from increased safety and health protections provided by a comprehensive regulation to address SARS-CoV-2 and COVID-19 related hazards. Employees in the affected industries would have to be trained on the requirements of any new regulation.

D. Impact on the Department of Labor and Industry.

No significant impact is anticipated on the Department. VOSH employees would be trained on the requirements of any new regulation. A VOSH Compliance Directive on Inspection and Enforcement Procedures would be developed by staff. Training and outreach products would be developed by VOSH Cooperative Programs staff and made available to the regulated community, employees, and the general public:

- COVID-19 Training PowerPoint for Employers and Employees with an included training certification form
- Final Standard Training PowerPoint that explains the elements of the standard with an included training certification form
- FAQs about the standard
- Infectious Disease Preparedness and Response Plan Template
- Training PowerPoint on how to develop an Infectious Disease Preparedness and Response Plan Template with an included training certification form

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¹⁸⁷ https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA

¹⁸⁸ <https://www.vdh.virginia.gov/content/uploads/sites/65/2018/05/VA-Heart-Disease-FactSheetFINAL.pdf>

¹⁸⁹ Percentage of adults who reported having their cholesterol checked and were told by a health professional that it was high.

¹⁹⁰ https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA

¹⁹¹ Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight (pre-2011 BRFSS methodology).

¹⁹² <https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-virginia>

RECOMMENDED ACTION

Staff of the Department of Labor and Industry recommends that the Safety and Health Codes Board consider for adoption the final standard, 16VAC25-220, Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19.

The Department also recommends that the Board state in any motion it may make to amend this regulation that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision of this or any other regulation.

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ATTACHMENT A: INDUSTRY SPECIFIC INFORMATION

The following is not intended to be an exhaustive list of all industries or job tasks with potential COVID-19 exposure risks (i.e., “very high,” “high,” “medium,” “lower”), but does provide a broad overview of the types of job tasks and hazards that expose employees to the various levels of COVID-19 exposure risk. The following also provides statistics and reports on work-related COVID-19 infections, non-fatal illnesses, hospitalizations, and deaths.

Reference to non-employee infections, non-fatal illnesses, hospitalizations, and deaths are provided to demonstrate the actual and potential exposure for employees at work whose job tasks involved close contact inside 6 feet with other COVID-19 infected employees and non-employees.

1. Meat and Poultry Processing.

The meat and poultry processing work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“Multiple outbreaks of COVID-19 among meat and poultry processing facility workers have occurred in the United States recently.

....

Workers involved in meat and poultry processing are not exposed to SARS-CoV-2 through the meat products they handle. However, their work environments—processing lines and other areas in busy plants where they have **close contact** with coworkers and supervisors—may contribute substantially to their potential exposures. The risk of occupational transmission of SARS-CoV-2 depends on several factors.

Some of these factors are described in the U.S. Department of Labor and U.S. Department of and Health and Human Services’ booklet “Guidance on Preparing Workplaces for COVID-19.”¹⁹³ Distinctive factors that affect workers’ risk for exposure to SARS-CoV-2 in meat and poultry processing workplaces include:

- Distance between workers – meat and poultry processing workers often work **close** to one another on processing lines. Workers may also be near one another at other times, such as when clocking in or out, during breaks, or in locker/changing rooms.
- Duration of contact – meat and poultry processing workers often have **prolonged closeness** to coworkers (e.g., for 10-12 hours per shift). Continued contact with potentially infectious individuals increases the risk of SARS-CoV-2 transmission.
- Type of contact – meat and poultry processing workers may be exposed to the infectious virus through respiratory droplets in the air – for example, when workers in the plant who have the virus cough or sneeze. It is also possible that exposure could occur from contact with contaminated surfaces or objects, such as tools, workstations, or break room tables. Shared spaces such as break rooms, locker rooms, and entrances/exits to the facility may contribute to their risk.
- Other distinctive factors that may increase risk among these workers include:

¹⁹³ <https://www.osha.gov/Publications/OSHA3990.pdf>

- A common practice at some workplaces of sharing transportation such as ride-share vans or shuttle vehicles, car-pools, and public transportation.
- Frequent contact with fellow workers in community settings in areas where there is ongoing community transmission.¹⁹⁴
(Emphasis added).

Meat and Poultry Processing COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Newsobserver.com, May 23, 2020, “Coronavirus outbreaks at processors force NC farmers to start killing 1.5M chickens”

“[North Carolina] Agriculture officials said Thursday that 2,006 workers in 26 processing plants across the state have tested positive for coronavirus. Although some plants have closed temporarily to clean and disinfect, none have shut down in North Carolina.”¹⁹⁵

Virginia Mercury.com, May 5, 2020, “COVID-19 cases keep climbing at Virginia poultry plants; some members of Congress seek better protections”

“COVID-19 cases continue to rise at Virginia’s Eastern Shore poultry plants, with Gov. Ralph Northam on Monday reporting more than 260 cases associated with two facilities run by Tyson Foods and Perdue Farms in Accomack County.

‘We are also still closely tracking cases in the Shenandoah Valley, which has a large number of plants — cases that have increased as well, but the increase is smaller and could be leveling off,’ said Northam. ‘Our focus right now remains on the Shore.’

Poultry plant-related cases now represent about 60 percent of Accomack’s confirmed cases, which according to the Virginia Department of Health totaled 425 Monday. Twenty-one people in the county have been hospitalized, and six have died. How much testing has been conducted is unclear.”¹⁹⁶

CDC, May 8, 2020, “COVID-19 Among Workers in Meat and Poultry Processing Facilities — 19 States, April 2020”

“Persons in congregate work and residential locations are at increased risk for transmission and acquisition of respiratory infections.

....

Factors potentially affecting risk for infection include difficulties with workplace physical distancing and hygiene and crowded living and transportation conditions.

....

¹⁹⁴ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>

¹⁹⁵ <https://www.newsobserver.com/news/business/article242944156.html>

¹⁹⁶ <https://www.nbc12.com/2020/05/05/covid-cases-keep-climbing-virginia-poultry-plants-some-members-congress-look-better-protections/>

Among workers, socioeconomic challenges might contribute to working while feeling ill, particularly if there are management practices such as bonuses that incentivize attendance.

....

By April 27, CDC had received aggregate data on COVID-19 cases from 19 of 23 states reporting at least one case related to this industry; there were 115 meat or poultry processing facilities with COVID-19 cases, including 4,913 workers with diagnosed COVID-19 (Table 1). Among 17 states reporting the number of workers in their affected facilities, 3.0% of 130,578 workers received diagnoses of COVID-19. The percentage of workers with diagnosed COVID-19 ranged from 0.6% to 18.2%. Twenty COVID-19–related deaths were reported among workers.

....

Sociocultural and economic challenges to COVID-19 prevention in meat and poultry processing facilities (Table 2) include accommodating the needs of workers from diverse backgrounds who speak different primary languages; one facility reported a workforce with 40 primary languages. This necessitates innovative approaches to educating and training employees and supervisors on safety and health information.

In addition, some employees were incentivized to work while ill as a result of medical leave and disability policies and attendance bonuses that could encourage working while experiencing symptoms.

Finally, many workers live in crowded, multigenerational settings and sometimes share transportation to and from work, contributing to increased risk for transmission of COVID-19 outside the facility itself. Changing transportation to and from the facilities to increase the number of vehicles and reduce the number of passengers per vehicle helped maintain physical distancing in some facilities.

Cases of COVID-19 have been observed in other congregate settings, including long-term care facilities (5), acute care hospitals (6), correctional facilities (7), and homeless shelters (8). Similarly, the crowded conditions for workers in meat and poultry processing facilities could result in high risk for SARS-CoV-2 transmission.

Respiratory disease outbreaks in this type of setting demonstrate the need for heightened attention to worker safety (9). However, COVID-19 among workers in meat and processing facilities could be due to viral transmission at the workplace or in the community.”¹⁹⁷

2. Seafood Processing.

The seafood processing work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“During 2011-2017, seafood processing workers had the highest injury/illness rate of any U.S. maritime workers at 6,670 injuries/illnesses per 100,000 workers. Occupational hazards in this industry include exposures to biological aerosols containing allergens, microorganisms, and toxins; bacteria and parasites; excessive noise levels; low temperatures; poor workplace

¹⁹⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e3.htm>

organization; poor ergonomics; and contact with machinery and equipment.”¹⁹⁸



[CDC photo of seafood processing employees working in close proximity to each other] Seafood processing worker transporting fresh mackerel while the production line prepares fish in the background.¹⁹⁹

Seafood Processing COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Seafoodsource.com, Louisiana, May 21, 2020,

“Around 100 people at three crawfish farms in Louisiana have tested positive for COVID-19, state health officials announced earlier this week.

The Louisiana Department of Health declined to name the three crawfish farms, citing “active, evolving, protected investigations,” according to The Advocate.

Louisiana Office of Public Health Assistant Secretary Alex Billioux said the outbreaks were concentrated among migrant workers living in dormitory-like settings. The local crawfish industry is highly reliant on workers – many from Mexico – who use H-2B visas to live and work temporarily in the United States. According to Louisiana State University Assistant Professor of Agriculture Economics and Agribusiness Maria Bampasidou, a review of federal data showed Louisiana had 31 seafood processing facilities file for H-2B visas. Collectively, they received nearly all of the 1,467 positions they applied for. The workers live in trailers or bunkhouses provided by

¹⁹⁸ https://www.cdc.gov/niosh/programs/cms/shs/seafood_processing.html

¹⁹⁹ *Id.*

employers in exchange for a cut of workers' paychecks, depending on the type of visa, according to *The Advocate*.

David Savoy, the operator of a crawfish farm and processing facility near Church Point, Louisiana, said working and living conditions are tight in most of the industry's facilities.

'It's like a house with a family in it,' Savoy said. 'If one person gets it, there's a good chance everyone's going to get sick. That's just the reality of the situation.'"²⁰⁰

Newscentermaine.com, Portland, ME, May 18, 2020, "Bristol Seafood voluntarily closes after workers test positive for COVID-19"

"Bristol Seafood announced Monday it is voluntarily pausing production in its Portland Fish Pier processing plant after identifying confirmed positive cases of COVID-19 among staff members.

The Maine Center for Disease Control (Maine CDC) Director Dr. Nirav Shah said in the daily coronavirus briefing Monday that they began working with the company over the weekend to investigate the outbreak and collect additional samples for testing."²⁰¹

KATU.com, Astoria, OR, May 4, 2020, "11 at Astoria seafood facility test positive for coronavirus"

"Eleven employees at a seafood processing plant in Astoria have tested positive for COVID-19, health officials said Monday.

The Clatsop County Public Health investigation started Friday when they learned an employee at Bornstein Seafood facility tested positive for the novel coronavirus, COVID-19. They ran tests on 35 other employees and found that 11 others had the virus.

The county is working closely with the facility to test the rest of the company's workforce and started contact tracing with those people who tested positive.

Borstein's facility in Astoria is closed until further notice. The company also said its employees were told to self-isolate at home while they work with public health officials.

'The 11 positive cases reported Monday included four women (one aged 30-39 and three aged 40 to 49) and seven men (two aged 30 to 39, four aged 50 to 59 and one aged 60 to 69),' Clatsop County Public Health said."²⁰²

²⁰⁰ <https://www.seafoodsource.com/news/supply-trade/covid-19-outbreak-sickens-100-workers-in-louisiana-crawfish-industry>

²⁰¹ <https://www.newscentermaine.com/article/news/health/coronavirus/bristol-seafood-voluntarily-closes-after-workers-test-positive-for-covid-19/97-6dbe22cd-1014-474e-9152-c054c42d5cb6>

²⁰² <https://katu.com/news/local/11-employees-at-astoria-borstein-seafood-processing-facility-test-positive-for-covid-19-closure>

3. Food Processing.

The food processing work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

To the extent that food processing employees “...work environments—processing lines and other areas in busy plants where they have close contact with coworkers and supervisors” mirror those in the meat and poultry processing industries, they are exposed to the same hazards and undertake the same job tasks that result in “medium” and “low” risk exposures.

Food Processing COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Martinsvillebulletin.com, Martinsville, VA, May 27, 2020, “Monogram Snacks in Henry County will shut down voluntarily for COVID-19 testing after positive tests lead to complaints about employee's safety filed with state and OSHA”

“Angela Hairston’s brother is living in isolation at a hotel, separated from his 81-year-old mother at their home in Henry County. **He is listed statistically as a “confirmed COVID-19 male, 56 years old,” along with five of his coworkers at Monogram Snacks in Martinsville.**

But Hairston’s brother not only contracted the coronavirus, **he also continued to work after being tested because he said he feared loss of income or being fired by Monogram if he didn’t.**

....

The Bulletin obtained a copy of the complaint alleging “unsafe work practices and a lack of appropriate safeguards to prevent employee injuries.”

The complaint also alleges several employees, including Hairston’s brother, have been injured on the job and that “workers are reluctant to raise concerns about conditions and procedures that they consider to be potentially hazardous with supervisors because of a fear of retaliation due to the overall company culture.”

Said Hairston: ‘OSHA did not appear to address those concerns, and the conditions ... deteriorated further in the midst of COVID-19. My brother lives with my mother, who is 81 years old and has a number of chronic health issues. Due to her age and underlying medical conditions, she is in the high-risk category for severe illness from COVID-19 ... and the virus ... could be deadly given her underlying health issues.’

Monogram Foods Communications Coordinator Sally Vaughan released a statement late Tuesday in which she praised the management and employees.

‘To date, our leaders and team members at our Martinsville, Virginia plant have done an incredible job preventing the spread of COVID-19 by implementing and executing our practices and protocols and providing constant oversight on risk reduction and mitigation,’ Vaughan said. **‘Less than 1% of our nearly 650 team members at Martinsville have tested positive for COVID-19 during the pandemic.’**

Monogram Foods employs 630 people in three manufacturing centers on a 54-acre site at the Patriot Centre Industrial Park in Henry County. The company produces prepackaged snacks.

....

On May 12, Roanoke Regional Health Director Paul Saunier notified Hairston by letter of the findings by VOSH.

‘Based on the employer’s investigation results and the documentation the employer has provided to our agency, the employer is operating in accordance with the Governor’s Executive Orders and is implementing appropriate preventive measures,’ Saunier wrote. “VOSH has determined that the investigation can now be closed.”

Hairston wrote back to Saunier that she was appalled that VOSH would accept statements made by Luffman without verifying them, so she took her concerns to her Facebook page.

On May 19, Saunier notified Hairston that VOSH had opened a second investigation on Monogram Snacks.”²⁰³

Oregonlive.com, Vancouver, WA, May 22, 2020, “Vancouver frozen fruit processor reports 27 coronavirus cases”

“A Vancouver food processing company says 27 of its employees have COVID-19. It may be the Portland area’s biggest workplace outbreak reported thus far, excluding the healthcare sector.

Josh Hinerfeld, CEO of Firestone Pacific Foods, said the company had its first confirmed case midday Sunday and learned of two more later that afternoon. The Vancouver plant shut down Monday but the infection total has now grown to 27, including 17 new cases Friday.

....

Firestone processes frozen fruit.”²⁰⁴

Vadogwood.com, Virginia, May 21, 2020, “Here Are All the Virginia Factories With Coronavirus Outbreaks”

“At least seven workers at the facility in Chesterfield County have tested positive for COVID-19 and are now in quarantine at home, WRIC-TV in Richmond reported. A spokesperson for Maruchan Virginia Inc., which is a subsidiary of Toyo Suisan Kaisha Ltd in Tokyo, told the news station that the factory remains open despite the positive cases.”²⁰⁵

“We can confirm the Maruchan Virginia report about employees testing positive for

²⁰³ https://www.martinsvillebulletin.com/news/local/monogram-snacks-in-henry-county-will-shut-down-voluntarily-for-covid-19-testing-after-positive/article_665228f4-4673-59d4-b5a5-d19824a49ac0.html

²⁰⁴ <https://www.oregonlive.com/business/2020/05/vancouver-frozen-fruit-processor-reports-10-coronavirus-cases.html>

²⁰⁵ <https://www.ktvu.com/news/coronavirus-outbreak-at-maruchan-ramen-noodle-factory-sickens-at-least-7-workers-in-virginia>

COVID-19 at their Chesterfield facility,” Chesterfield Health District Director Dr. Alexander Samuel said in a statement to Fox5.”²⁰⁶

Oregonlive.com, Albany, OR, May 12, 2020, “Oregon cites National Frozen Foods, site of coronavirus outbreak, for unsafe practices”

“Oregon regulators cited an Albany fruit and vegetable processor Monday for safety violations after a coronavirus outbreak there infected at least 34.

National Frozen Foods faces a \$2,000 penalty for failing to adopt practices to enable workers to stay at least six feet apart from one another.

....

[Oregon] OSHA said it inspected the Albany plant on April 20 in response to worker complaints. The regulatory agency said National Frozen Food allowed employees on frozen packaging lines to work within two to four feet of one another.”²⁰⁷

4. Healthcare, Nursing Home Care,²⁰⁸ and Long Term Care.²⁰⁹

The healthcare, nursing home care and long term care work environment contains various hazards and job tasks which present the full spectrum of exposure risks (Very high, High, Medium, Lower):

Very high – “Performing aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on known or suspected COVID-19 patients. Collecting or handling specimens from known or suspected COVID-19 patients.”²¹⁰

High – “Entering a known or suspected COVID-19 patient’s room. Providing care for a known or suspected COVID-19 patient not involving aerosol-generating procedures.”²¹¹

Medium – “Providing care to the general public who are not known or suspected COVID-19 patients. Working at busy staff work areas within a healthcare facility.”²¹²

Lower – “Performing administrative duties in non-public areas of healthcare facilities, away from other staff members.”²¹³

²⁰⁶ <https://www.fox5dc.com/news/health-officials-cant-provide-updates-on-covid-19-outbreak-at-virginia-maruchan-ramen-factory>

²⁰⁷ <https://www.oregonlive.com/business/2020/05/oregon-cites-national-frozen-foods-site-of-coronavirus-outbreak-for-unsafe-practices.html>

²⁰⁸ OSHA publication “COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers” references “OSHA’s COVID-19 guidance for healthcare workers and employers.”

²⁰⁹ *Id.*

²¹⁰ <https://www.osha.gov/SLTC/covid-19/healthcare-workers.html>

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

Healthcare, Nursing Home Care and Long Term Care COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

CDC.gov, May 31, 2020, “Cases & Deaths among Healthcare Personnel [HCP]”

“Data were collected from 1,417,310 people, but healthcare personnel status was only available for 304,479 (21.5%) people. For the 66,447 cases of COVID-19 among healthcare personnel, death status was only available for 37,485 (56.4%).

Cases among HCP: 66,447

Deaths among HCP: 318²¹⁴

Usatoday.com, April 13, 2020, referencing *Cincinnati Enquirer* story, “Health care workers in Ohio are testing positive for COVID-19 at an alarming rate”

“More than 1,300 health care workers in Ohio have tested positive for the novel coronavirus since the pandemic began, accounting for about 1 of every 5 positive tests in the state.

But Ohio’s public health officials aren’t talking about where all those employees work, how they’re doing now or how many may have been infected in “hot spots,” or clusters of positive tests.

State and local health departments, the Ohio Hospital Association, the Health Collaborative of Greater Cincinnati and the hospitals themselves all have refused to provide details beyond a statewide total.

The reason? Most say revealing more information could jeopardize the privacy of infected employees.

They say more specific numbers for hospitals, or even for entire cities or counties, could allow someone to figure out who got sick, thereby violating the workers’ privacy rights.

....

Not everyone thinks the secrecy is a good idea. Shortages of protective equipment and tests, along with the daily challenges of coping with a pandemic, mean health care workers are at significant risk every time they go to work.

More information about what’s happening in those workplaces, some say, could identify locations that need additional help and resources protecting the people who work there.

‘From a health care worker perspective, I think those numbers can be beneficial,’ said Michelle Thoman, president of the Registered Nurses Association at the University of Cincinnati Medical Center. ‘If you see that numbers in your facility or hospital are

²¹⁴ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

climbing, you can be prepared for that.”²¹⁵ (Emphasis added).

WRIC.com, Richmond, VA, April 30, 2020, “Canterbury Rehabilitation & Healthcare Center reports 50th COVID-19 death”

“Officials at Canterbury Rehabilitation & Healthcare Center in Henrico County today reported the facility’s 50th coronavirus-related death. The resident died yesterday in a hospital.

Canterbury officials also reported that 51 patients who previously tested positive for COVID-19 have fully recovered. A cluster of COVID-19 deaths and infections have been reported at Canterbury Rehabilitation & Healthcare Center since the outbreak began.

More than 100 residents and staff members have tested positive for the virus, making Canterbury one of the worst clusters of cases in the United States. Recent reports obtained by 8News state that Canterbury is certified as a 190-bed facility.²¹⁶

Beginning April 1, 2020, the Virginia Department of Health (VDH) conducted an assessment of the Canterbury Rehabilitation facility and of the 141 residents, 91 tested positive for COVID-19 (64.5%).²¹⁷

CDC, March 27, 2020, “COVID-19 in a Long-Term Care Facility — King County, Washington, February 27–March 9, 2020”

“On February 28, 2020, a case of coronavirus disease (COVID-19) was identified in a woman resident of a long-term care skilled nursing facility (facility A) in King County, Washington.* Epidemiologic investigation of facility A identified 129 cases of COVID-19 associated with facility A, including 81 of the residents, 34 staff members, and 14 visitors; 23 persons died. Limitations in effective infection control and prevention and staff members working in multiple facilities contributed to intra- and inter-facility spread.

COVID-19 can spread rapidly in long-term residential care facilities, and persons with chronic underlying medical conditions are at greater risk for COVID-19–associated severe disease and death. Long-term care facilities should take proactive steps to protect the health of residents and preserve the health care workforce by identifying and excluding potentially infected staff members and visitors, ensuring early recognition of potentially infected patients, and implementing appropriate infection control measures.

....

Reported symptom onset dates for facility residents and staff members ranged from February 16 to March 5. The median patient age was 81 years (range = 54–100 years) among facility residents, 42.5 years (range = 22–79 years) among staff members, and

²¹⁵ <https://www.usatoday.com/story/news/nation/2020/04/13/ohio-health-care-workers-test-positive-covid-19-alarming-rate/2981253001/>

²¹⁶ <https://www.wric.com/health/coronavirus/canterbury-rehabilitation-healthcare-center-reports-50th-covid-19-death/>

²¹⁷ <https://www.vdh.virginia.gov/content/uploads/sites/96/2020/05/Canterbury-04-16-2020-COVID-Focus-POC.pdf>

62.5 years (range = 52–88 years) among visitors; 84 (65.1%) patients were women (Table). Overall, 56.8% of facility A residents, 35.7% of visitors, and 5.9% of staff members with COVID-19 were hospitalized.

Preliminary case fatality rates among residents and visitors as of March 9 were 27.2% and 7.1%, respectively; no deaths occurred among staff members. The most common chronic underlying conditions among facility residents were hypertension (69.1%), cardiac disease (56.8%), renal disease (43.2%), diabetes (37.0%), obesity (33.3%), and pulmonary disease (32.1%). Six residents and one visitor had hypertension as their only chronic underlying condition.

....

Information received from the survey and on-site visits identified factors that likely contributed to the vulnerability of these facilities, including 1) staff members who worked while symptomatic; 2) staff members who worked in more than one facility; 3) inadequate familiarity and adherence to standard, droplet, and contact precautions and eye protection recommendations; 4) challenges to implementing infection control practices including inadequate supplies of PPE and other items (e.g., alcohol-based hand sanitizer) §; 5) delayed recognition of cases because of low index of suspicion, limited testing availability, and difficulty identifying persons with COVID-19 based on signs and symptoms alone.

....

The findings in this report suggest that once COVID-19 has been introduced into a long-term care facility, it has the potential to result in high attack rates among residents, staff members, and visitors.”²¹⁸

5. Dental Services.

Dental work environment contains various hazards and job tasks which present “high”, “medium” (close contact), and “lower” risk exposures:

“The practice of dentistry involves the use of rotary dental and surgical instruments, such as handpieces or ultrasonic scalers and air-water syringes. These instruments create a visible spray that can contain particle droplets of water, saliva, blood, microorganisms, and other debris. Surgical masks protect mucous membranes of the mouth and nose from droplet spatter, but they do not provide complete protection against inhalation of airborne infectious agents. There are currently no data available to assess the risk of SARS-CoV-2 transmission during dental practice.”²¹⁹

Dentist Offices COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

NBCbayarea.com, May, 14, 2020, “Potential COVID Aerosol Hazards in the Dentist Chair”

“I can't express enough how dangerous it is in a dental office right now, we have the ability to be asymptomatic and spread this to other people as much as

²¹⁸ https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm?s_cid=mm6912e1_w

²¹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html>

we're looking out for our own safety,' said Cindi Roddan, a dental hygienist, adding, 'Everything that we do in dentistry creates aerosols. It is so dangerous.'

Dental Hygienist Tops List of Jobs Exposed to Disease. Dental hygienists are potentially exposed to disease on a daily basis, according to federal employment data. Professions are ranked on a scale in which 100 represents daily contact, 75 is weekly, 50 is monthly and 25 is daily.

Occupation	Context
Dental Hygienists	100
Acute Care Nurses	100
Family and General Practitioners	100
Internists, General	100
Critical Care Nurses	99
Hospitalists	99
Oral and Maxillofacial Surgeons	99
Respiratory Therapists	98
Respiratory Therapy Technicians	98
Anesthesiologist Assistants	97
Occupational Therapy Aides	97
Orderlies	97
Dental Assistants	96
Medical and Clinical Laboratory Technologists	96
Nurse Anesthetists	96
Urologists	96
Allergists and Immunologists	95
Dentists, General	95
Radiation Therapists	95
Registered Nurses	95

Table: Sean Myers/NBC Bay Area • Source: [the National Center for O*NET Development](#) • Created with [Datawrapper](#)

High speed drills, ultrasonic scalers and air-water syringes are the tools used in dentistry. According to the Centers for Disease Control they are also potent spreaders of coronavirus because they “create a visible spray that contains large droplets of water, saliva, blood, microorganisms and other debris.”

If a patient is infected with the COVID-19 virus, even if they show no symptoms, those aerosols can contain enough of the virus to infect a dental hygienist, or even the next patient who sits in the dental chair.” (Emphasis added).

Dental-tribune.com, Jakarta, Indonesia, April 16, 2020, “Dentists in Indonesia are dying from COVID-19”

“The Indonesian Medical Association has confirmed that 24 medical professionals have died in the country from COVID-19, six of whom were dentists. Not all of those who died were working on the front line in the battle against the illness. The government’s COVID-19 response team has called on the health ministry to protect

doctors and dentists by advising them to close their practices.”²²⁰

Bridgemi.com, April 10, 2020, Michigan, “Ascension doctor becomes 7th Michigan health care worker to die of coronavirus”²²¹

“Seven health care workers in southeast Michigan have now died from complications of the coronavirus, including a doctor at Ascension Macomb Hospital who graduated from Wayne State University.

....

One of them was Dr. Chris Firlit, a 37-year-old husband and father of three. Firlit was a member of the Wayne State University's class of 2018, and lived in Berkley.

Firlit was a senior resident in the oral maxillofacial surgery program at Ascension Macomb Hospital. Wayne State announced his death Tuesday and said he had died this week, but did not provide the exact date.”

Docseducation.com, April 9, 2020, “The Pandemic and the Dentist”²²²

“Risk to the Dental Professional

....

The dental professional is particularly at risk if one is working on an infected patient or an asymptomatic carrier because of close contact with the patient and the risk of blood, saliva and droplet exposure. In Italy, there were 7 dental professionals who died of COVID-19 during the pandemic.”

Medrxiv.org, April 5, 2020, “Physician Deaths from Corona Virus Disease (COVID-19)”²²³

“RESULTS: We found 198 physician deaths from COVID-19, but complete details were missing for 49 individuals. The average age of the physicians that died was 63.4 years (range 28 to 90 years) and the median age was 66 years of age. Ninety percent of the deceased physicians were male (175/194). General practitioners and emergency room doctors (78/192), respirologists (5/192), internal medicine specialists (11/192) and anesthesiologists (6/192) comprised 52% of those dying. Two percent of the deceased were epidemiologists (4/192), 2% were infectious disease specialists (4/192), **5% were dentists (9/192)**, 4% were ENT (8/192), and 4% were ophthalmologists (7/192). The countries with the most reported physician deaths were Italy (79/198), Iran (43/198), China (16/198), Philippines (14/198), United States (9/192) and Indonesia (7/192).” (Emphasis added).

²²⁰ <https://www.dental-tribune.com/news/dentists-in-indonesia-are-dying-from-covid-19/>

²²¹ <https://www.bridgemi.com/michigan-health-watch/ascension-doctor-becomes-7th-michigan-health-care-worker-die-coronavirus>

²²² <https://www.docseducation.com/blog/pandemic-and-dentist>

²²³ <https://www.medrxiv.org/content/10.1101/2020.04.05.20054494v1.full.pdf>

6. Morgue and Mortuary Services

The morgue and mortuary services work environment contains various hazards and job tasks which can present risk exposures at all levels:

Very high – “Morgue workers performing autopsies, which generally involve aerosol-generating procedures, on the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death.”²²⁴

High – “Mortuary workers involved in preparing (e.g., for burial or cremation) the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death.”²²⁵

Medium – “Medium exposure risk jobs include those that require frequent and/or close contact with (i.e., within 6 feet of) people who may be infected with SARS-CoV-2, but who are not known or suspected COVID-19 patients....In areas where there is ongoing community transmission, workers in this category may have contact with the general public [funerals] (e.g., schools, high-population-density work environments, some high-volume retail settings).”²²⁶

Lower – “Lower exposure risk (caution) jobs are those that do not require contact with people known to be, or suspected of being, infected with SARS-CoV-2 nor frequent close contact with (i.e., within 6 feet of) the general public. Workers in this category have minimal occupational contact with the public and other coworkers [administrative services associated with funerals].”²²⁷

Morgue and Mortuary Services COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Tuscon.com, Tucson, AZ, May 2, 2020, “Illnesses at Tucson funeral home highlight risks to 'last responders' during pandemic”

“Numerous employees at a Tucson funeral home contracted coronavirus, but experts say it is unlikely they were infected by the body of a COVID-19 victim.

Adair Funeral Homes temporarily closed its Dodge Chapel after “a number” of staff members fell ill and were sent home to recover in self-quarantine, according to a written statement from the company.

The incident highlights lingering questions about how the virus is transmitted, and it underscores the essential work still being done by so-called “last responders” in the community’s morgues and mortuaries.

²²⁴ <https://www.osha.gov/Publications/OSHA3990.pdf> at page 19.

²²⁵ *Id.*

²²⁶ *Id.* at page 20.

²²⁷ *Id.* at page 20.

‘They really are heroes, but they don’t get the recognition they deserve, because it’s death and nobody wants to talk about that,’ said Judith Stapley, executive director of the Arizona State Board of Funeral Directors and Embalmers.

Adair did not identify the suspected source of the outbreak. It’s unclear if the Dodge Chapel has handled any of the more than 80 people who have died from the coronavirus in Pima County.

Dr. Greg Hess, chief medical examiner for the county, said it is doubtful the outbreak at the mortuary came from a corpse.

‘Are we hearing that someone has contracted COVID from a dead body? We’re not,’ Hess said. ‘It’s possible, but honestly there is a much greater risk of contracting it from somewhere else.’²²⁸

CDC.gov, “Community Transmission of SARS-CoV-2 at Two Family Gatherings [including a Funeral]” — Chicago, Illinois, February–March 2020

“Most early reports of person-to-person SARS-CoV-2 transmission have been among household contacts, where the secondary attack rate has been estimated to exceed 10% (1), in health care facilities (2), and in congregate settings (3).

However, widespread community transmission, as is currently being observed in the United States, requires more expansive transmission events between non-household contacts. In February and March 2020, the Chicago Department of Public Health (CDPH) investigated a large, multifamily cluster of COVID-19. Patients with confirmed COVID-19 and their close contacts were interviewed to better understand non-household, community transmission of SARS-CoV-2. This report describes the cluster of 16 cases of confirmed or probable COVID-19, including three deaths, likely resulting from transmission of SARS-CoV-2 at two family gatherings (a funeral and a birthday party).²²⁹ (Emphasis added).

7. Veterinary Services.

The veterinary work environment contains various hazards and job tasks which present “medium” (close contact), and “lower” risk exposures:

²²⁸ https://tucson.com/news/local/illnesses-at-tucson-funeral-home-highlight-risks-to-last-responders-during-pandemic/article_e0ea6dbc-721b-5b46-a30b-609fcdd9ae5a.html

²²⁹ https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e1.htm?s_cid=mm6915e1_w

“The findings in this investigation are subject to at least three limitations. First, lack of laboratory testing for probable cases means some probable COVID-19 patients might have instead experienced unrelated illnesses, although influenza-like illness was declining in Chicago at the time. Second, phylogenetic data, which could confirm presumed epidemiologic linkages, were unavailable. For example, patient B3.1 experienced exposure to two patients with confirmed COVID-19 in this cluster, and the causative exposure was presumed based on expected incubation periods. Patient D3.1 was a health care professional, and, despite not seeing any patients with known COVID-19, might have acquired SARS-CoV-2 during clinical practice rather than through contact with members of this cluster. Similarly, other members of the cluster might have experienced community exposures to SARS-CoV-2, although these transmission events occurred before widespread community transmission of SARS-CoV-2 in Chicago. Finally, despite intensive epidemiologic investigation, not every confirmed or probable case related to this cluster might have been detected. Persons who did not display symptoms were not evaluated for COVID-19, which, given increasing evidence of substantial asymptomatic infection (9), means the size of this cluster might be underestimated.” *Id.*

“The greatest risk of COVID-19 exposure to staff at veterinary clinics comes from person-to-person transmission through respiratory droplets from coughing, sneezing, or talking, which is the main way SARS-CoV-2 spreads.

....

We are still learning about this novel zoonotic virus, and it appears that in some rare situations, human to animal transmission can occur.

CDC is aware of a small number animals, including dogs and cats, to be infected with SARS-CoV-2 after close contact with people with COVID-19. The United States Department of Agriculture (USDA) and CDC recently reported confirmed infection with SARS-CoV-2 in two pet cats with mild respiratory illness in New York, which were the first confirmed cases of SARS-CoV-2 infections in companion animals in the United States. Both cats are expected to recover. The cats had close contact with people confirmed or suspected to have COVID-19, suggesting human-to-cat spread. Further studies are needed to understand if and how different animals could be affected by SARS-CoV-2.

Limited information is available to characterize the spectrum of clinical illness associated with SARS-CoV-2 infection in animals. Clinical signs thought to be compatible with SARS-CoV-2 infection in animals include fever, coughing, difficulty breathing or shortness of breath, lethargy, sneezing, nasal/ocular discharge, vomiting, and diarrhea.

....

If a pet owner currently has respiratory symptoms or is a suspected of or confirmed to have COVID-19, they should not visit the veterinary facility. Consider whether a telemedicine consult is appropriate. If possible, a healthy friend or family member from outside their household should bring the animal to the veterinary clinic. The clinic should use all appropriate precautions to minimize contact with the person bringing the animal to the clinic. If there is an emergency with the animal, the animal should not be denied care.

If a pet owner is suspected or confirmed to have COVID-19 and must bring their pet to the clinic, the following actions should be taken:

- Communicate via phone call or video chat to maintain social distancing.
- Retrieve the animal from the owner’s vehicle (also called curbside) to prevent the owner from having to enter the clinic or hospital.
- Maintain social distancing and PPE recommendations when interacting with clients.
- Request smaller animals be brought in a plastic carrier to facilitate disinfection of the carrier after use. Also advise the owner to leave all non-essential items at home to avoid unnecessary opportunities for additional exposure.²³⁰

Veterinary COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Avma.org, May 29, 2020, “Remembering veterinarians who have died during the pandemic:”

“Wildlife, avian veterinarian honored. Dr. Peter Sakas (Illinois ’83), a staff

²³⁰ <https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html>

veterinarian at the Animal Hospital and Bird Medical Center in Niles, Illinois, died on March 30 of COVID-19. In his work, he focused on wildlife veterinary medicine. Those who knew him say he was charismatic, had a big personality, and cared deeply for his clients and their animals.

....

‘There has been a lot of attention on human health care front-line workers, but I think people often forget that veterinarians are front-line health care workers too,’ Dr. Courtney Sakas said. ‘My father told us that he was never going to retire because he loved his job so much. I knew he was going to continue working as long as he possibly could to keep caring for the clients and animals he loved, even if it meant putting himself at risk.’²³¹

“A community-focused veterinarian celebrated. Dr. Julie R. Butler (Cornell ’83), founder of 145th Street Animal Hospital in the Harlem neighborhood of New York City, died on April 4. In her personal life, Dr. Butler was an advocate of the arts who made an excellent lemon meringue pie.

....

In her professional life, Dr. Butler was the kind of veterinarian who never turned away an animal.

Dr. Butler was the co-founder of New York Save Animals in Veterinary Emergency, a nonprofit organization that provides financial assistance for pets who need emergency care. She also served as past president of the VMA of New York City. She spent over 30 years serving the Harlem community, and she used her experience to educate and mentor other veterinary professionals.

Kylie Lang, a veterinary technician, said Dr. Butler was a role model who made work enjoyable.”²³²

8. Hand Labor Operations in Agriculture.

Hand labor operations in agriculture contain various hazards and job tasks which present “medium” (close contact), and “lower” risk exposures:

Northcarolinahealthnews.org, March 13, 2020, “For migrant workers in NC, coronavirus may be hard to avoid”

“As the growing season ramps up in North Carolina, agencies that care for and about migrant and seasonal farmworkers are hastily preparing to screen and educate them about coronavirus.

Migrant workers aren’t especially susceptible to coronavirus, but their living conditions during the growing season — trailers and rooms that house many workers — could put them at greater risk of catching the virus, which spreads through droplets, close contact and surfaces.

....

²³¹ <https://www.avma.org/javma-news/2020-07-01/remembering-veterinarians-who-have-died-during-pandemic>

²³² *Id.*

‘They all share the same bathroom, they all share the same kitchen, they’re all usually within the same living area,’ said Amy Elkins, an outreach worker at North Carolina Farmworkers’ Project, a Benson-based organization that serves an average of 3,000 migrant and seasonal workers a year. ‘So if we have one case inside a camp, it is most likely that everyone is going to be infected.’

....

Her colleague, Janeth Tapia, the organization’s outreach coordinator, said that migrant farmworkers are used to working through illness and are reluctant to reveal that they are sick for fear of being sent to their home countries before the end of the growing season.

‘That’s something we see a lot,’ Elkins said. ‘We’ll have someone who just gets pneumonia or hurts their foot and can’t work. The farmer will give them one or two days and (if the employee does not recover) he’s on a bus back to Mexico.’²³³

Hand Labor Operations Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Bloomberg.com, May 29, 2020, “Every Single Worker Has Covid at One U.S. Farm on Eve of Harvest”

“One farm in Tennessee distributed Covid-19 tests to all of its workers after an employee came down with the virus. It turned out that every single one of its roughly 200 employees had been infected.

In New Jersey, more than 50 workers had the virus at a farm in Gloucester County, adding to nearly 60 who fell ill in neighboring Salem County. Washington state’s Yakima County, an agricultural area that produces apples, cherries, pears and most of the nation’s hops, has the highest per capita infection rate of any county on the West Coast.

The outbreaks underscore the latest pandemic threat to food supply: Farm workers are getting sick and spreading the illness just as the U.S. heads into the peak of the summer produce season. In all likelihood, the cases will keep climbing as more than half a million seasonal employees crowd onto buses to move among farms across the country and get housed together in cramped bunkhouse-style dormitories.

....

The early outbreaks are already starting to draw comparisons to the infections that plunged the U.S. meat industry into crisis over the past few months. Analysts and experts are warning that thousands of farm workers are vulnerable to contracting the disease.

....

Unlike grain crops that rely on machinery, America’s fruits and vegetables are

²³³ <https://www.northcarolinahealthnews.org/2020/03/13/for-migrant-workers-in-nc-coronavirus-may-be-hard-to-avoid/>

mostly picked and packed by hand, in long shifts out in the open -- a typically undesirable job in major economies. So the position typically goes to immigrants, who make up about three quarters of U.S. farm workers.

A workforce of seasonal migrants travels across the nation, following harvest patterns. Most come from Mexico and Latin America through key entry points like southern California, and go further by bus, often for hours, sometimes for days.

There are as many as 2.7 million hired farm workers in the U.S., including migrant, seasonal, year-round and guest-program workers, according to the Migrant Clinicians Network. While many migrants have their permanent residence in the U.S., moving from location to location during the warmer months, others enter through the federal H2A visa program. Still, roughly half of hired crop farmworkers lack legal immigration status, according to the U.S. Department of Agriculture.

These are some of the most vulnerable populations in the U.S., subjected to tough working conditions for little pay and meager benefits. Most don't have access to adequate health care. Many don't speak English.

Without them, it would be nearly impossible to keep America's produce aisles filled. And yet, there's no one collecting national numbers on how many are falling sick.

'There is woefully inadequate surveillance of what's happening with Covid-19 and farm workers,' said Erik Nicholson, a national vice president for the United Farm Workers. 'There is no central reporting, which is crazy because these are essential businesses.'"²³⁴ (Emphasis added).

WBGO.org, New Jersey, May 12, 2020, "Coronavirus update: Cases spike among farmworkers"

"More than half the seasonal workers at a South Jersey farm have tested positive for COVID-19, raising fears of an unchecked outbreak ahead of the blueberry and other harvests.

At least 59 migrant workers at a farm in Upper Pittsgrove, in rural Salem County, have been infected, NJ Spotlight reported Monday. The news came just as the state Department of Health and local federally qualified health centers prepared to launch a testing program for all such workers.

Upper Pittsgrove Mayor Jack Cimprich said he didn't know how the farmer was isolating infected workers in camp dormitories, dining halls and fields. "I wouldn't be surprised, in fact, if it hasn't spread to the whole group," he told NJ Spotlight.

²³⁴ <https://www.bloomberg.com/news/articles/2020-05-29/every-single-worker-has-covid-at-one-u-s-farm-on-eve-of-harvest>

Several thousand migrant farmworkers — many from Mexico, Haiti, Puerto Rico and Central America — come to the region for the spring and summer harvests. One immigrant advocate interviewed by the outlet called the rise in cases among workers “a potential crisis.”²³⁵

9. Correctional and Detention Facilities.

The correctional and detention facilities work environments contain various hazards and job tasks which present, high, medium (close contact) to lower risk exposures:

NOTE: Virginia correctional facilities have clinics that provide certain medical services to inmates.

“Correctional and detention facilities face challenges in controlling the spread of infectious diseases because of crowded, shared environments and potential introductions by staff members and new intakes.

....

An estimated 2.1 million U.S. adults are housed within approximately 5,000 correctional and detention facilities on any given day (1). Many facilities face significant challenges in controlling the spread of highly infectious pathogens such as SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19).

Such challenges include crowded dormitories, shared lavatories, limited medical and isolation resources, daily entry and exit of staff members and visitors, continual introduction of newly incarcerated or detained persons, and transport of incarcerated or detained persons in multiperson vehicles for court-related, medical, or security reasons (2,3). During April 22–28, 2020, aggregate data on COVID-19 cases were reported to CDC by 37 of 54 state and territorial health department jurisdictions.

Thirty-two (86%) jurisdictions reported at least one laboratory-confirmed case from a total of 420 correctional and detention facilities. Among these facilities, COVID-19 was diagnosed in 4,893 incarcerated or detained persons and 2,778 facility staff members, resulting in 88 deaths in incarcerated or detained persons and 15 deaths among staff members. Prompt identification of COVID-19 cases and consistent application of prevention measures, such as symptom screening and quarantine, are critical to protecting incarcerated and detained persons and staff members.

....

Approximately one half of facilities with COVID-19 cases reported them among staff members but not among incarcerated persons.²³⁶

Correctional Facility and Detention Center COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

²³⁵ <https://www.wbgo.org/post/coronavirus-update-cases-spike-among-farmworkers-nj-curbs-wave-parades#stream/0>

²³⁶ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm>

The Virginia Department of Corrections website²³⁷ as of Noon, May 29, 2020, Cases by location, reports that 132 staff and contractors (active cases), and 1,171 offenders have tested positive COVID-19. Seven (7) offenders have died:

LOCATION	OFFENDERS ON-SITE	OFFENDERS IN HOSPITALS	DEATH OF COVID-19 POSITIVE OFFENDER	TOTAL POSITIVE OFFENDERS onsite + hospital + deaths + releases + recovered + transfers in - transfers out	STAFF active cases including employees & contractors
Appalachian Men's CCAP	0	0	0	0	0
Augusta Correctional Center	0	0	0	0	1
Baskerville Correctional Center	0	0	0	0	1
Bland Correctional Center	0	0	0	0	0
Brunswick CCAP	0	0	0	0	0
Buckingham Correctional Center	44	2	3	113	8
Caroline Correctional Unit	0	0	0	0	0
Central Virginia Correctional Unit #13	1	0	0	57	2
Chesterfield Women's CCAP	0	0	0	0	0
Coffeewood Correctional Center	0	0	0	0	0
Cold Springs CCAP	0	0	0	0	0
Cold Springs Correctional Unit #10	0	0	0	0	0
Deerfield Correctional Center (includes Deerfield Work Centers)	20	1	1	78	3
Dillwyn Correctional Center	121	2	1	322	9
Fluvanna Correctional Center for Women	0	0	0	0	0
Green Rock Correctional Center	0	0	0	0	0
Greensville Correctional Center (includes Greensville Work Center)	190	2	0	193	53
Halifax Correctional Unit	0	0	0	0	0
Harrisonburg Men's CCAP	5	0	0	26	1
Haynesville Correctional Center	114	3	0	246	9
Haynesville Correctional Unit #17	0	0	0	0	0

²³⁷ <https://www.vadoc.virginia.gov/news-press-releases/2020/covid-19-updates/>

LOCATION	OFFENDERS ON-SITE	OFFENDERS IN HOSPITALS	DEATH OF COVID-19 POSITIVE OFFENDER	TOTAL POSITIVE OFFENDERS onsite + hospital + deaths + releases + recovered + transfers in - transfers out	STAFF active cases including employees & contractors
Indian Creek Correctional Center	0	0	0	0	1
Keen Mountain Correctional Center	0	0	0	0	0
Lawrenceville Correctional Center	0	0	0	0	0
Lunenburg Correctional Center	0	0	0	0	0
Marion Correctional Treatment Center	0	0	0	0	0
Nottoway Correctional Center (includes Nottoway Work Center)	0	0	0	0	4
Patrick Henry Correctional Unit	0	0	0	0	0
Pocahontas State Correctional Center	0	0	0	0	0
Red Onion State Prison	0	0	0	0	0
River North Correctional Center	0	0	0	0	1
Rustburg Correctional Unit	0	0	0	0	0
St. Brides Correctional Center	0	0	0	0	1
Stafford Men's CCAP	0	0	0	0	0
State Farm Correctional Complex	19	1	0	20	17
Sussex I State Prison	0	0	0	0	3
Sussex II State Prison	23	1	1	71	7
Virginia Correctional Center for Women (includes State Farm Work Center)	2	0	1	45	9
Wallens Ridge State Prison	0	0	0	0	2
Wise Correctional Unit	0	0	0	0	0
Probation & Parole — Eastern Region	n/a	n/a	n/a	n/a	0
Probation & Parole — Central Region	n/a	n/a	n/a	n/a	0
Probation & Parole — Western Region	n/a	n/a	n/a	n/a	0
Administration & Operations	n/a	n/a	n/a	n/a	0
TOTALS	539	12	7	1171	132

Rrjva.org, Riverside Regional Jail, May 28, 2020, "COVID-19 Information as of May 28, 2020"

“Current Statistics:

Currently we have 45 positive cases of COVID-19 in the inmate population, We also have seven (7) staff members who have tested positive.

....

We have designated several living areas for quarantine. When inmates are initially booked in, they are placed in precautionary quarantine for 14 days. Once they are cleared, they are moved to general population.

Should an inmate test positive in general population, all inmates and staff that have been in contact are isolated and tested. If a significant number of inmates in that area were exposed, the entire living area is placed on isolation.

Staff that test positive are placed on leave until cleared by a physician.”²³⁸

Usatoday.com, April 27, 2020, “Isolated and scared: The plight of juveniles locked up during the coronavirus pandemic”

“Arjanae Avula talks to her younger brother twice a week. Phone calls last about three minutes before they’re cut off. During their last conversation, she said, he was crying.

....

Her 18-year-old brother is at Bon Air Juvenile Correctional Center, a coronavirus hot spot near Richmond, Virginia, where 27 youths and 10 employees have tested positive for COVID-19.”



This photo shows the Bon Air Juvenile Correctional Center in Bon Air, Va., Tuesday, April 21, 2020. The Virginia Department of Corrections said Monday that it will dramatically increase testing of inmates as the state struggles to control the spread of the coronavirus in prisons across the state. *Steve Helber, AP*

²³⁸ <https://rrjva.org/wp/covid-19/>

10. Manufacturing

“The manufacturing work environment—production or assembly lines and other areas in busy plants where workers have close contact with coworkers and supervisors [medium risk exposure] — may contribute substantially to workers’ potential exposures. The risk of occupational transmission of SARS-CoV-2 depends on several factors. (Emphasis added).

....

Distinctive factors that affect workers’ risk for exposure to SARS-CoV-2 in manufacturing workplaces include:

- Distance between workers – Manufacturing workers often work close to one another on production or assembly lines. Workers may also be near one another at other times, such as when clocking in or out, during breaks, or in locker/changing rooms.
- Duration of contact – Manufacturing workers often have prolonged closeness to coworkers (e.g., for 8–12 hours per shift). Continued contact with potentially infectious individuals increases the risk of SARS-CoV-2 transmission.
- Type of contact – Manufacturing workers may be exposed to the infectious virus through respiratory droplets in the air—for example, when workers in a plant who have the virus cough or sneeze. It is also possible that exposure could occur from contact with contaminated surfaces or objects, such as tools, workstations, or break room tables. Shared spaces such as break rooms, locker rooms, and entrances/exits to the facility may contribute to their risk.
- Other distinctive factors that may increase risk among these workers include:
 - A common practice at some workplaces of sharing transportation such as ride-share vans or shuttle vehicles, car-pools, and public transportation
- Frequent contact with fellow workers in community settings in areas where there is ongoing community transmission”²³⁹

Manufacturing COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

NBCnews.com, May 16, 2020, “Midwest manufacturing workers sound alarm over COVID-19 outbreaks”

“But outbreaks at manufacturing facilities that make everything from wind turbine parts to soap have also sickened scores of workers while garnering far less attention.

....

TPI Composites, a manufacturer of wind blades, shut down its Newton, Iowa, facility after approximately 20 percent of employees tested positive for the

²³⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html>

coronavirus, according to a May 2 news release.²⁴⁰ At least one worker has died.

....

Kyle Brown, 54, worked at TPI Composites for eight years, most recently in the maintenance department, his wife, Pamela Dennen, told NBC News in a phone interview. Brown died from COVID-19 on April 29.

....

Almost 500 miles away in Grand Forks, North Dakota, workers said they were ignored in March when they raised alarms about safety conditions at LM Wind Power, a General Electric-owned plant that produces wind turbine blades, according to the company's website. Weeks later, 145 people tested positive for COVID-19, according to the North Dakota Department of Health. Fifteen of those employees live outside of North Dakota, while 130 are North Dakota residents, the department told NBC News. At least one employee from the plant has died, but GE did not confirm whether it was related to the coronavirus.

....

Three weeks after Boushee raised concerns, the outbreak at LM Wind Power was so widespread that North Dakota's Department of Health issued an executive order mandating all plant employees remain under quarantine for two weeks.²⁴¹ (Emphasis added).

²⁴⁰ <https://www.nbcnews.com/news/us-news/midwest-manufacturing-workers-sound-alarm-over-covid-19-outbreaks-n1207391>

"TPI Composites, Inc. Provides Update on COVID-19 Testing Results of Its Newton, Iowa Associates May 2, 2020. SCOTTSDALE, Ariz., May 02, 2020 (GLOBE NEWSWIRE) -- TPI Composites, Inc. (Nasdaq: TPIC), the only independent manufacturer of composite wind blades with a global footprint, announced today that it has completed COVID-19 testing on nearly all of its Newton, Iowa associates. Following an increase in COVID-19 cases in Jasper, Marshall, and Polk counties, as well as a significant number of positive cases in our plant in Newton, Iowa, and in collaboration with the State of Iowa, TPI proactively conducted mandatory COVID-19 testing for nearly all of its associates at its Newton facility on April 25, 2020. During this time, TPI paused production and undertook another deep clean of the facility. TPI also provided all associates' family members with surgical masks to help prevent further community spread, and offered hotel rooms to associates who tested negative to allow for isolation. TPI has received the majority of the test results and approximately 20% of its Newton associates have tested positive to date, which is representative of test results in the broader community."

²⁴¹ <https://www.nbcnews.com/news/us-news/midwest-manufacturing-workers-sound-alarm-over-covid-19-outbreaks-n1207391>



— Workers are shown on the manufacturing line at Voyant Beauty in late March. The company makes soaps, lotions and beauty products for major brands in Countryside, Illinois. One temporary worker from Voyant has died from COVID-19, and others said the company hasn't done enough to keep them safe. *Chicago Workers Collaborative*

Above photo: “Workers are shown on the manufacturing line at Voyant Beauty in late March. The company makes soaps, lotions and beauty products for major brands in Countryside, Illinois. One temporary worker from Voyant has died from COVID-19, and others said the company hasn't done enough to keep them safe.” (Emphasis added).

11. Construction.

The construction work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“Potential sources of exposure include having close contact with a coworker or member of the public who is ill with COVID-19 and touching your nose, mouth, or eyes after touching surfaces contaminated with the virus or handling items that others

infected with COVID-19 have touched.”²⁴² (Emphasis added).

[Excerpt from April 27, 2020 NABTU (North American Building Trades Unions) and CPWR (CPWR – The Center for Construction Research and Training) COVID-19 Standards for U.S. Construction Sites]

“Respiratory protection: If workers need to be near each other to perform tasks or when working in close quarters, such as confined space work, they should wear a NIOSH-approved respirator implemented under a full respiratory protection program. NIOSH-approved respirators include filtering facepiece and elastomeric negative or positive pressure half or full facepiece respirators equipped with N95, N99, N100, R95, P95, P99, or P100 filters. Cloth face coverings are not respirators and do not replace physical distancing or respirators required when workers are in close proximity. However, cloth face coverings should be provided in other circumstances when required or recommended by state or local governments.”²⁴³

[Excerpt from April 30, 2020 Associated General Contractors (AGC) response to “NABTU COVID-19 Standards for U.S. Construction Sites”]

“Required Use of Respirators

In accordance with recent guidance issued by the CDC and OSHA, AGC recognizes that requiring workers to cover their mouths and noses will help with preventing the spread of COVID-19. Both agencies have recommended face coverings and/or face masks and not necessarily respiratory protection when social distancing cannot be achieved. It is our concern that the requirement, or mandate, to use respiratory protection will significantly increase the number of contractors who will be required to implement and maintain a written respiratory protection program as nearly every construction worker will, at some point, be required to work within six feet of a coworker to complete an assigned task.

Based on our review of the OSHA Guidance for Preparing Workplaces for COVID-19, which was prepared in partnership with the Department of Health and Human Services, construction would be considered low risk for most operations/tasks. According to the guidance, additional PPE is not recommended for workers in the low exposure risk group. It advises that workers in low risk occupations should continue to use the PPE, if any, that they would ordinarily use for other job tasks. And while some operations/tasks may fall into the medium risk category, the recommended PPE for this category does not specifically state respiratory protection must be worn. In fact, the OSHA guidance states that only in rare situations would workers in this risk category be required to use respirators. It is our belief that this level of protection is unnecessary, and that contractors allowing the use of some form of face covering or face mask will provide adequate protection to affected workers.”²⁴⁴ (Emphasis added).

²⁴² <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/construction-workers.html>

²⁴³ https://www.cpwr.com/sites/default/files/NABTU_CPWR_Standards_COVID-19.pdf

²⁴⁴ <https://www.agc.org/sites/default/files/Files/Safety%20%26%20Health/NABTU%20Covid%204.30.20.pdf>

Construction COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

NOTE: Reports are limited to Virginia and states contiguous to or near Virginia: North Carolina, Washington, DC, Maryland, West Virginia, Georgia, Pennsylvania, and Tennessee as construction contractors from those states are known to regularly conduct work in Virginia.

Charlotte Observer, May 22, 2020, “38 test positive for COVID-19 at uptown tower construction site, prompting a shutdown”

“Thirty-eight workers at the construction site for an uptown apartment tower have tested positive for the coronavirus and the project has shut down temporarily, the general contractor said Friday.

As a result of the spike in cases, most of which occurred in the past week, Hoar Construction decided to shut down the job site until June 1, Randall Curtis, the company’s executive vice president and chief operating officer, said in a statement.

While it is closed, Curtis said, Hoar will conduct a deep cleaning and sterilization of the site, which is along North College Street between 8th and 9th streets. Hoar will work with a third-party company to beef up screening on the site when it reopens, he said.”

....

It’s the latest outbreak at a Charlotte construction site, after the general contractor for the expansion of the Charlotte Convention Center confirmed four positive COVID-19 cases on that site earlier this week.

....

Curtis said up until now, Hoar has recommended the use of face coverings, but will now require it for all employees on the site. He said the company has taken a number of measures, including screening employees prior to entering the jobsite, adding handwashing and sanitation stations, and putting up social distancing markers.”²⁴⁵

Newschannel5.com, Nashville, TN, May 21, 2020, “Mass testing at construction site reveals 74 workers with COVID-19”

“Mass testing of workers at a Nashville construction site has revealed more than 70 cases of COVID-19. The Metro Health Department is monitoring the site on the campus of Montgomery Bell Academy, a prominent private school off West End Avenue. General Contractor Brasfield & Gorrie is overseeing construction of an athletic facility on the campus.

Emails obtained by News Channel 5 Investigates reveal the "first positive

²⁴⁵ <https://www.charlotteobserver.com/news/business/biz-columns-blogs/development/article242928141.html>

case" on the site was discovered earlier this month. In one email, General Contractor Brasfield & Gorrie "confirmed multiple positive cases of COVID-19 among our subcontractor employees."

The contractor then closed the site for five days for cleaning and testing of workers."²⁴⁶

WataugaDemocrat.com, Boone, NC, May 14, 2020, "16 App State construction workers test positive for COVID-19"

"Appalachian State announced on May 14 that 16 subcontracted workers for a campus construction project have tested positive for COVID-19. The workers are not Watauga County residents."²⁴⁷

Baltimore Sun, Baltimore, MD, "As construction in Maryland continues amid coronavirus, some are grateful for work while others worry about safety"

"They're staggering workers, trying to make sure there are fewer electricians, laborers and contractors on building sites at the same time. They're using video when possible to conduct meetings and site visits. But in the world of construction, workers don't always have masks, and they're almost all using the same portable toilets.

....

The state health department said it does not track the number of cases on construction sites, but the Department of General Services said five construction sites are shut down due to possible COVID-19 threats.

WAMU.org, Washington, DC, May 6, 2020, "Construction Stops In Parts of the Air and Space Museum After Workers Contract COVID-19"

"Four construction workers at the Smithsonian's National Air and Space Museum have tested positive for COVID-19, leading parts of the site to shutter for a "deep cleaning," the Huffington Post reports."²⁴⁸

WLS.com, Roanoke, VA, May 5, 2020, "25 COVID-19 cases connected to Cave Spring High School construction work"

"ROANOKE, Va. – More than two dozen coronavirus cases are connected to construction work at a local high school, according to Roanoke County Public Schools officials.

The president of Avis Construction, Troy Smith, spoke to the Roanoke County school board on Tuesday and reported as many as 25 cases of COVID-19 that are related to construction work at Cave Spring High School.

²⁴⁶ <https://www.newschannel5.com/news/newschannel-5-investigates/mass-testing-at-construction-site-reveals-74-workers-with-covid-19>

²⁴⁷ https://www.wataugademocrat.com/covid19/16-app-state-construction-workers-test-positive-for-covid-19/article_303494af-b54d-57f6-8b59-1d75b50b5843.html

²⁴⁸ <https://wamu.org/story/20/05/04/coronavirus-latest-dc-maryland-virginia-week-of-may4/#smithsonian>

Smith told school board members that not all 25 cases are construction workers, but rather, some are family members of workers.

School officials told 10 News that most cases are in workers from different out-of-state subcontractors.

All work was halted at the Cave Spring High School construction site on Monday, per recommendation from the health department.”²⁴⁹
(Emphasis added).

DCist.com, Washington, DC, April 30, 2020, “More COVID-19 Cases Reported At D.C. Construction Sites”

“More than a dozen COVID-19 cases have been reported at a residential construction site in Navy Yard, and it’s not the only site with concerns. Fears over the virus spreading further at the renovation of a congressional office building could lead to a shorter workweek at the site to prevent the spread of the virus.

There have been between 14 and 18 positive COVID cases among construction workers at D.C. Crossing, an 818-unit residential building under construction in Navy Yard, a source tells DCist. (The source asked for anonymity to protect workers at the site who shared information.) A spokesperson for the Maryland-based Clark Construction Group, which is helming the project, confirmed that there had been positive cases in mid-April, but the infected workers had not been at the worksite since. The spokesperson did not confirm how many positive cases there had been.

‘In each instance, Clark quickly performed contact tracing to identify areas of the project and workers that may have been impacted. We have kept the subcontractors and the developer informed of each confirmed case. We have worked with leadership from our subcontracting partners to ensure that workers who may have had contact with the affected individuals have taken appropriate measures in accordance with guidance provided by the CDC, including self-quarantining,’ the spokesperson said.

‘Through our thorough contact tracing and investigation, we have not been able to confirm where the individuals contracted COVID-19,’ they added.

....

Over at the Cannon House Office Building, where Clark Construction is conducting an extensive renovation of the 120-year-old building, the possibility of two new positive cases has forced the contractor to close the site from Thursday through Sunday.

....

At least 11 workers at the Cannon House Office Building project have tested

²⁴⁹ <https://www.wsls.com/news/local/2020/05/06/25-covid-19-cases-connected-to-cave-spring-high-school-construction-work/>

positive for COVID-19 so far, as DCist reported last week.”²⁵⁰

Newsbreak.com, Baltimore, MD, “Worker at Havre de Grace school construction site dies from coronavirus; site shut down day prior when he tested positive”

“Harford County schools and the company managing construction of the new Havre de Grace Middle/High School building shut down the site earlier this week after learning a contracted worker tested positive for the novel coronavirus. The worker died the next day.”²⁵¹

WJBF.com, April 16, 2020, “Plant Vogtle asking employees to voluntarily stay home amid COVID-19 outbreak”

“Augusta, Ga. (WJBF) – Representatives at Plant Vogtle tell WJBF they have seen an increase recently in positive COVID-19 cases among the workforce at Units 3 and 4 with over 40 positive test results so far. As a result, Georgia Power is asking for volunteers among the craft worker ranks to stay at home during this COVID crisis.”²⁵² (Emphasis added).

12. Air Transportation.

The air transportation work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“As a customer service representative or gate agent, potential sources of exposure could include assisting a person with COVID-19 in close contact or by touching your mouth, nose, or eyes; or handling passenger items, such as baggage, boarding passes, identification documents, credit cards, and mobile devices.”²⁵³ (Emphasis added).

“For baggage or cargo handlers, while the general risk remains low, potential sources of exposure could include surfaces touched or handled by a person with COVID-19 or by touching your mouth, nose, or eyes.”²⁵⁴ (Emphasis added).

“As an airport custodial staff, while the general risk remains low, potential sources of exposure could include handling solid waste or cleaning public facilities (such as waste bins, tables, chairs, basins, toilets) with which a person with COVID-19 has interacted or by touching your mouth, nose, or eyes.”²⁵⁵ (Emphasis added).

“As an airport passenger service worker, potential sources of exposure can occur from assisting, transporting, or escorting a person with COVID-19 and their belongings or by touching your mouth, nose, or eyes.”²⁵⁶

²⁵⁰ <https://dcist.com/story/20/04/30/more-covid-19-cases-reported-at-d-c-construction-sites/>

²⁵¹ <https://www.baltimoresun.com/coronavirus/cng-ag-hdg-school-covid-death-20200410-tuzdevg2s5ghjhdqngv6bdkw3u-story.html>

²⁵² <https://www.wjbf.com/csra-news/plant-vogtle-asking-employees-to-voluntarily-stay-home-amid-covid-19-outbreak/>

²⁵³ <https://www.cdc.gov/coronavirus/2019-ncov/community/airport-customer-factsheet.html>

²⁵⁴ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-baggage-cargo-handlers.html>

²⁵⁵ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-custodial-staff.html>

²⁵⁶ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-passenger-assistance-workers.html>

“As an aircraft maintenance worker, you could be exposed to COVID-19 in situations such as when you have close contact with someone with COVID-19, when you touch surfaces while repairing aircraft interiors and lavatories that have been touched or handled by a person with COVID-19, or by touching your mouth, nose, or eyes.”²⁵⁷ (Emphasis added).

“As an airline catering kitchen worker, you could be exposed to COVID-19 in situations such as having close contact with someone with COVID-19 or touching your mouth, nose, or eyes after handling frequently touched items used by someone with COVID-19 such as catering or food service carts or solid waste.”²⁵⁸ (Emphasis added).

“As an airline catering truck driver or helper, you could be exposed to COVID-19 in situations such as having close contact with someone with COVID-19 or touching your mouth, nose, or eyes after handling frequently touched items used by someone with COVID-19 such as catering and food service carts, used non-disposable food service items (e.g., utensils and serving trays), and solid waste.”²⁵⁹ (Emphasis added).

“As an airport retail or food service worker, potential sources of exposure can occur while working in an airport store, bar, restaurant, or food concession stand if you are if in close contact with someone with COVID-19 or by touching your mouth, nose, or eyes after handling items used by someone with COVID-19.”²⁶⁰ (Emphasis added).

Air Transportation COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Travelandleisure.com, March 27, 2020, “American and United Airlines Both Lose Employees to Coronavirus in Same Week”

“Both American and United Airlines lost employees this week due to complications from the coronavirus. American Airlines flight attendants received the news of the death of their colleague — Paul Frishkorn — on Thursday evening in a joint letter from the airline’s senior VP of flight service and presidents of the Association of Professional Flight Attendants (APFA).

A spokesperson for United also confirmed the death of their employee — Carlos Consuegra, a United ramp worker at Newark Liberty Airport — to T+L. Consuegra passed away earlier this week.²⁶¹

The 65-year-old Philadelphia-based flight attendant had worked with American Airlines since 1997. He had been twice honored as one of the airline’s Flight Service

²⁵⁷ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/aircraft-maintenance-workers.html>

²⁵⁸ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airline-catering-kitchen-workers.html>

²⁵⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airline-catering-truck-drivers.html>

²⁶⁰ <https://www.cdc.gov/coronavirus/2019-ncov/community/airport-retail-factsheet.html>

²⁶¹ <https://www.travelandleisure.com/airlines-airports/american-united-airlines-confirm-employee-deaths-coronavirus>

Champions for excellent customer service. He was also a union representative with the APFA.

NBCnews.com, April 29, 2020, “TSA says 500 of its employees have tested positive for COVID-19”

“Five hundred people who work for the Transportation Security Administration have tested positive for COVID-19, including four people who died from the disease, the agency said Wednesday.

Of the 500 who tested positive, 208 recovered from the illness caused by the coronavirus, the agency said in a statement.

Almost 40 percent of positive cases were found in employees working in the three major airports serving the greater New York City region.”²⁶²

USAToday.com, May 3, 2020, “COVID-19 deaths among FedEx workers in Newark leave families, employees questioning company’s response”

“Pamela Pope spent her days doing a mix of work at FedEx’s Newark Liberty International Airport facility, from office work to deliveries and helping unload cargo from the dozens of planes flying in and out every day. It was a job she loved, and one the 56-year-old from Neptune, New Jersey, had done for more than half her life.

....

Pope died of coronavirus on April 25, her sister said.

The day prior, eight FedEx Express domestic workers' deaths were cited in an internal document obtained by the Memphis Commercial Appeal and Bergen Record.

At least five fatalities have occurred in Newark, according to family members who spoke with reporters from both newspapers. The death of a sixth person, identified as a FedEx Newark worker on her personal LinkedIn and Facebook accounts, was also attributed to COVID-19 complications in the social media posts of family members. Attempts to reach that family were unsuccessful.”²⁶³

Tsa.gov, May 31, 2020, “TSA Confirmed COVID-19 Cases”

“Overall, TSA has had 621 federal employees test positive for COVID-19. 423 employees have recovered, and 6 have unfortunately died as a result of the virus. We have also been notified that one screening contractor has passed away due to the virus.”²⁶⁴

²⁶² <https://www.nbcoston.com/news/national-international/tsa-says-500-of-its-employees-have-tested-positive-for-covid-19/2115915/>

²⁶³ <https://www.usatoday.com/story/news/nation/2020/05/02/coronavirus-least-8-fatal-cases-fedex-workers-complaints-mount/3071150001/>

²⁶⁴ <https://www.tsa.gov/coronavirus>

UPDATE: January 4, 2020²⁶⁵

“Since the beginning of the pandemic, TSA has cumulatively had 5,154 federal employees test positive for COVID-19. 4,303 employees have recovered, and 12 have unfortunately died after contracting the virus. We have also been notified that one screening contractor has passed away due to the virus.”

13. Ground Transportation.

The ground transportation work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

Long-haul Truck Drivers – “As a long-haul truck driver, you spend many hours alone in the cab of your truck. However, there are times when you will be at increased risk of exposure to COVID-19. For long-haul truck drivers, potential sources of exposure include having close contact with truck stop attendants, store workers, dock workers, other truck drivers, or others with COVID-19, and touching your nose, mouth, or eyes after contacting surfaces touched or handled by a person with COVID-19.”²⁶⁶ (Emphasis added).

Bus Transit Operators – “For bus transit operators, potential sources of exposure include having close contact with a bus passenger with COVID-19, by contacting surfaces touched or handled by a person with COVID-19, or by touching your mouth, nose, or eyes.”²⁶⁷ (Emphasis added).

Rail Transit Operators – “For rail transit operators, potential sources of exposure include having close contact with a passenger with COVID-19, by contacting surfaces touched or handled by a person with COVID-19, or by touching your mouth, nose, or eyes.”²⁶⁸ (Emphasis added).

Transit Maintenance Workers – “For transit maintenance workers, potential sources of exposure include close contact with a coworker with COVID-19, contacting surfaces touched or handled by a person with COVID-19, or by touching your mouth, nose, or eyes.”²⁶⁹ (Emphasis added).

Transit Station Workers – “For transit station workers, potential sources of exposure include having close contact with a transit passenger with COVID-19, by touching surfaces contaminated with coronavirus, or by touching your mouth, nose, or eyes.”²⁷⁰ (Emphasis added).

Mail and Parcel Delivery Workers – “As a mail and parcel delivery driver, potential sources of exposure include having close contact with co-workers or delivery recipients, or when you touch surfaces touched or handled by a person who has

²⁶⁵ <https://www.tsa.gov/coronavirus>

²⁶⁶ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking.html>

²⁶⁷ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/bus-transit-operator.html>

²⁶⁸ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rail-transit-operator.html>

²⁶⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-maintenance-worker.html>

²⁷⁰ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-station-workers.html>

COVID-19.”²⁷¹ (Emphasis added).

Rideshare, Taxi, Limo, and other Passenger Drivers-for-Hire – “As a driver-for-hire, potential sources of exposure include having close contact with passengers with COVID-19, or touching surfaces touched or handled by a person with COVID-19.”²⁷² (Emphasis added).

Food and Grocery Pick-up and Delivery Drivers – “Potential sources of exposure include having close contact with individuals with COVID-19 when picking up or delivering food or groceries, or by touching surfaces touched or handled by a person with COVID-19.”²⁷³ (Emphasis added).

“Coronavirus in the United States—Considerations for Travelers

....

Travel increases your chances of getting and spreading COVID-19. We don’t know if one type of travel is safer than others; however, airports, bus stations, train stations, and rest stops are all places travelers can be exposed to the virus in the air and on surfaces. These are also places where it can be hard to social distance (keep 6 feet apart from other people)....

- Air travel: Air travel requires spending time in security lines and airport terminals, which can bring you in close contact with other people and frequently touched surfaces. Most viruses and other germs do not spread easily on flights because of how air circulates and is filtered on airplanes. However, social distancing is difficult on crowded flights, and you may have to sit near others (within 6 feet), sometimes for hours. This may increase your risk for exposure to the virus that causes COVID-19.
- Bus or train travel: Traveling on buses and trains for any length of time can involve sitting or standing within 6 feet of others....”²⁷⁴ (Emphasis added).

Ground Transportation COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Thecity.nyc, New York City, April 7, 2020 “Bus Drivers Hardest Hit by Deaths as COVID-19 Devastates MTA”

“For 15 years, Ernesto Hernandez drove MTA buses around his home borough of Brooklyn, based out of the Jackie Gleason depot in Sunset Park.

....

Hernandez, 57, kept that routine, his son said, until he started to feel lousy on March 20. ‘He thought it was allergies,’ Jimenez said. A little more than a week later, Hernandez became one of the MTA’s first COVID-19 fatalities

²⁷¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/mail-parcel-drivers.html>

²⁷² <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rideshare-drivers-for-hire.html>

²⁷³ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/food-grocery-drivers.html>

²⁷⁴ <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us.html>

during the pandemic — and one of seven bus operators, so far, to die from coronavirus.

Among the at least 33 subway and bus workers who have died from COVID-19, the MTA’s bus drivers have taken the biggest hit in an agency with more than 74,000 employees.

By comparison, the NYPD has lost 13 members to COVID-19 from a workforce of more than 55,000 people, while the FDNY has suffered two deaths among its more than 40,000 employees.”²⁷⁵ (Emphasis added).

Theguardian.com, April 20, 2020, “Revealed: nearly 100 US transit workers have died of Covid-19 amid lack of basic protections”

“Interviews with union officials, workers and transit authorities in a dozen major cities reveal that:

- At least 94 transit workers have succumbed to coronavirus, according to two national transit unions, New York City transit officials, and workers in New Orleans. This number includes many kinds of workers who keep transit systems running, from mechanics and maintenance workers to bus and subway operators. The number of all transit workers who have died of coronavirus across the US is likely higher.
- The New York City area has seen the majority of American transit worker deaths, with 68 fatalities among employees of the Metropolitan Transportation Authority as of Friday afternoon. Nearly 2,500 MTA transit employees had tested positive, and more than 4,000 were in quarantine, a spokesman said.
- At least 24 more transit union members have died in other cities, according to two major transit unions. Bus drivers have died from coronavirus in Boston; Chicago; St Louis; Detroit; Seattle; Newark and Dover, New Jersey; Richmond, Virginia; and Washington DC, among others. In New Orleans, city bus drivers said they had lost three colleagues to coronavirus, only one of them a union member.”²⁷⁶ (Emphasis added).

14. Water Transportation.

The water transportation work environment contains various hazards and job tasks which present “high”, “medium” (close contact) and “lower” risk exposures:

NOTE: Cruise ships provide medical services for passengers, including known or suspected COVID-19 passengers and crew.

²⁷⁵ <https://www.thecity.nyc/health/2020/4/7/21216831/bus-drivers-hardest-hit-by-deaths-as-covid-19-devastates-mta>

²⁷⁶ <https://www.theguardian.com/world/2020/apr/20/us-bus-drivers-lack-life-saving-basic-protections-transit-worker-deaths-coronavirus>

Water Transportation COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

ABCnews.go.com, April 14, 2020, “Employees sue Celebrity Cruises over COVID-19 response”

“A class action lawsuit filed Tuesday on behalf of over a thousand Celebrity Cruises employees alleges the company failed to protect its crew members working aboard ships amid the novel coronavirus outbreak.

The suit comes less than two weeks after a crew member working on the Celebrity Infinity died after being medically evacuated by the U.S. Coast Guard. The USCG confirmed the employee had coronavirus-like symptoms.

....

According to the CDC, over the last two months outbreaks on three cruise ships have caused more than 800 confirmed cases of coronavirus in the United States among passengers and crew, including 10 deaths.”²⁷⁷

Businessinsider.com, April 12, 2020, “All the cruise ships that have had confirmed cases of COVID-19 onboard”

“...Here's a look at the cruise ships at the center of the coronavirus crisis on the high seas.”²⁷⁸

²⁷⁷ <https://abcnews.go.com/Business/cruise-employees-sue-celebrity-covid-19-response/story?id=70147214>

²⁷⁸ <https://www.businessinsider.com/cruise-ships-with-confirmed-covid-19-cases-during-coronavirus-pandemic-2020-4>

Cruise ships with COVID-19 outbreaks

SHIP	PARENT COMPANY	CONFIRMED COVID-19 CASES
Diamond Princess	Carnival Corp.	712
Ruby Princess	Carnival Corp.	612
Oasis of the Seas	Royal Caribbean Cruises	157
Grand Princess	Carnival Corp.	78
Celebrity Eclipse	Royal Caribbean Cruises	76
MS A'Sara	Gate 1 Travel	45
Disney Wonder	Walt Disney Company	38
Costa Luminosa	Carnival Corp.	36
Symphony of the Seas	Royal Caribbean Cruises	31
Artania	Phoenix Reisen	27
Voyager of the Seas	Royal Caribbean Cruises	26
Ovation of the Seas	Royal Caribbean Cruises	23
Carnival Freedom	Carnival Corp.	14
Celebrity Solstice	Royal Caribbean Cruises	11
Zaandam	Carnival Corp.	9
World Dream	Genting Hong Kong	8
Silver Explorer	Royal Caribbean Cruises	6
Costa Favolosa	Carnival Corp.	6
MS Braemar	Bonheur ASA	5
Marella Explorer 2	TUI Group	5
Majesty of the Seas	Royal Caribbean Cruises	2
Costa Magica	Carnival Corp.	2
Celebrity Apex	Royal Caribbean Cruises	2
MSC Opera	Mediterranean Shipping Company	2
Jewel of the Seas	Royal Caribbean Cruises	2
Sun Princess	Carnival Corp.	1
Carnival Valor	Carnival Corp.	1
Celebrity Infinity	Royal Caribbean Cruises	1
Explorer of the Seas	Royal Caribbean Cruises	1
Norwegian Bliss	Norwegian Cruise Line Holdings	1
Norwegian Breakaway	Norwegian Cruise Line Holdings	1
Silver Shadow	Royal Caribbean Cruises	1
Costa Victoria	Carnival Corp.	1
Norwegian Encore	Norwegian Cruise Line Holdings	1
MSC Fantasia	Mediterranean Shipping Company	1

Sources: CDC; The Guardian; KUSI; NBC News; CNN; Independent; Western Australia DOH; The New South Wales Ministry of Health; Australian Broadcasting Corporation; Holland America PR; Miami Herald; COVID-19 Cruise Tracker; NY Times; USA Today; Seatrade Cruise News; WKBN; South Florida Sun-Sentinel; SILive.com; WESH; TUI Group; Cruise Law News; The Daily Mail; Axios

Updated as of April 9, 2020.

BUSINESS INSIDER

15. Post-Secondary and Higher Education.

The post-secondary and higher education work environments contains various hazards and job tasks which present “high”, “medium” (close contact) and “lower” risk exposures:

NOTE: Many colleges and universities provide on campus medical services for suspected covid-19 students. College and university affiliated hospitals provide medical services for suspected COVID-19 and COVID-19 positive students and members of the general public.

“Considerations for Institutes of Higher Education (IHE)

....

The more an individual interacts with others, and the longer that interaction, the higher the risk of COVID-19 spread. The risk of COVID-19 spread increases in IHE non-residential and residential (i.e., on-campus housing) settings as follows:

- Lowest Risk: Faculty and students engage in virtual-only learning options, activities, and events.
- More Risk: Small in-person classes, activities, and events. Individuals remain spaced at least 6 feet apart and do not share objects (e.g., hybrid virtual and in-person class structures or staggered/rotated scheduling to accommodate smaller class sizes).
- Highest Risk: Full-sized in-person classes, activities, and events. Students are not spaced apart, share classroom materials or supplies, and mix between classes and activities.”²⁷⁹

Post-secondary and Higher Education COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

WBEZ.org, April 2, 2020, “A City Colleges Of Chicago Employee Has Died Of COVID-19. Staffers Say Conditions Are Unsafe.”

“Employees at Wright College, one of the City Colleges of Chicago, are mourning the death of a campus clerical worker, Carmelita Cristobal, who died of complications from COVID-19 on March 30. Employees remembered Cristobal as a beautiful person. ‘If you needed help, she helped you,’ said Audrey Butler, executive vice president of the clerical workers. Butler worked with Cristobal, who was 71, for years. She said Cristobal’s husband had contracted the virus as well.

Staffers are accusing City Colleges' leadership of failing to do enough to ensure employee safety. At least nine cases have been confirmed at multiple campuses so far. Union leaders representing faculty and staff painted a chaotic picture of safety protocols across the seven colleges during a virtual press

²⁷⁹ <https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/considerations.html>

conference Thursday.”²⁸⁰

Clickondetroit.com, Detroit, MI, “Wayne State University employee studying at college for degree in sociology dies from coronavirus”

“A Wayne State University employee who was also studying for a degree in sociology at the college died from complications related to the coronavirus, WSU president Roy Wilson announced Saturday.

Darrin Adams worked at WSU for almost six years as a custodian primarily in the Manoogian Hall.

“This pandemic has hit Detroit hard, and we have all watched with great concern as the cases in our city have mounted. Unfortunately, our campus is not immune. We have had a number of cases, and now we mourn the loss of one of our employees.”²⁸¹

16. Child Care Programs, Pre-school, Elementary, and Secondary Education.

The child care, pre-school, elementary, secondary education work environments contains various hazards and job tasks which present “high”, “medium” (close contact) and “lower” risk exposures:

NOTE: Some schools provide on campus medical/nursing services for suspected COVID-19 students.

School Nutrition Professionals – “For school nutrition professionals...working in meal preparation and/or distribution at a school/school district site or other public settings, potential sources of exposure include close contact with co-workers, students, and families with COVID-19 and touching your nose, mouth, or eyes after touching contaminated surfaces or handling items that others infected with COVID-19 have touched. Currently there is no evidence to support transmission of COVID-19 is spread through food.”²⁸² (Emphasis added).

US K-12 Schools and Child Care Programs – “Schools, working together with local health departments, have an important role in slowing the spread of diseases to help ensure students have safe and healthy learning environments. Schools serve students, staff, and visitors from throughout the community. All of these people may have close contact in the school setting, often sharing spaces, equipment, and supplies.

Information about COVID-19 in children is somewhat limited, but the information that is available suggests that children with confirmed COVID-19 generally had mild symptoms. Person-to-person spread from or to children, as among adults, is thought to occur mainly via respiratory droplets produced when an infected person coughs,

²⁸⁰ <https://www.wbez.org/stories/a-city-colleges-of-chicago-employee-has-died-of-covid-19-staffers-say-conditions-are-unsafe/4e12e670-cd2b-4d32-9352-a4bbe9aa9708>

²⁸¹ <https://www.clickondetroit.com/news/local/2020/04/04/wayne-state-university-employee-studying-at-college-for-degree-in-sociology-dies-from-coronavirus/>

²⁸² <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/school-nutrition-professionals.html>

sneezes, or talks. Recent studies indicate that people who are infected but do not have symptoms likely also play a role in the spread of COVID-19.

However, a small percentage of children have been reported to have more severe illness. Older adults and people who have serious underlying medical conditions are at highest risk of severe illness from COVID-19. Despite lower risk of serious illness among most children, children with COVID-19-like symptoms should avoid contact with others who might be at high risk for severe illness from COVID-19.²⁸³ (Emphasis added).

Child Care Programs, Pre-school, Elementary, and Secondary Education.COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

WTVR.com, Richmond, VA, May 27, 2020, “Richmond principal diagnosed with COVID-19; his wife hospitalized”

“Parents and students who picked-up computers or supplies from Richmond’s Mary Munford Elementary School over the last two weeks have been asked to self-isolate for 14 days.

That’s because the school’s principal Greg Muzik was at those events and has since tested positive for COVID-19.

‘The only time that we’ve had any kind of event of any kind where I was around a lot of people was the computer distribution,’ Muzik told CBS 6 via Zoom on Wednesday. Muzik notified parents about his diagnosis on the school’s PTA website.

‘Both my wife and I have tested positive for COVID,’ he wrote. ‘So far I am doing just fine and just isolating at home.’

....

The school system indicated the employee was asymptomatic while attending events at the school.”²⁸⁴

ABC7ny.com, New York City, NY, May 11, 2020, “Coronavirus News: 30 teachers among 74 DOE employees to die of COVID-19”

The New York City Department of Education said it has now lost 74 employees to COVID-19. On Monday, official announced the two new deaths. All but four of the 74 DOE employees who died were based in schools across the city. The other 70 school-based employees include:

²⁸³ https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-schools.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fspecific-groups%2Fguidance-for-schools.html

²⁸⁴ <https://www.wtvr.com/news/local-news/richmond-principal-diagnosed-with-covid-19-families-told-to-self-isolate>

- 28 are paraprofessionals
- 30 are teachers
- 2 are food service staffers
- 2 are administrators
- 2 are facilities staff
- 2 are school aides
- 2 are guidance counselors
- 1 is a parent coordinator
- 1 is a School Computer Technology Specialist²⁸⁵

Blog.edweek.org, April 30, 2020, “A Third of Teachers Are at Higher Risk of Severe Illness From COVID-19”

“As states begin to consider what reopening schools might look like, a new analysis of federal data warns that teachers could be more susceptible to severe illness from COVID-19.

About 29 percent of teachers are aged 50 and older, federal data show. Older adults are at higher risk for severe illness from COVID-19—92 percent of deaths related to the disease in the United States were of people aged 55 and older, and that age group also has higher rates of coronavirus-related hospitalizations than younger adults. And as the brief report by the research group Child Trends points out, teachers have significantly more social contact than the average adult, since they're in close quarters with dozens of students every day.

Already, teachers' workplaces rank among the "germiest"—one study found that teachers have nearly 27 times more germs on their computer keyboards than other professions studied. Teachers report that they frequently come down with colds and other garden-variety illnesses over the course of the school year. After all, children are "effective transmitters of respiratory germs," Donna Mazyck, the executive director of the National Association of School Nurses, told Education Week earlier this year.

The immune system naturally deteriorates with age, the Child Trends report notes. Also, teachers are more likely to report being stressed at work than average people, and some research suggests that stress can weaken the immune system.”²⁸⁶

17. Restaurants and Bars.

The restaurants and bars work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

²⁸⁵ <https://abc7ny.com/teacher-deaths-doe-department-of-education-schools/6173896/>

²⁸⁶

https://blogs.edweek.org/teachers/teaching_now/2020/04/a_third_of_teachers_are_at_higher_risk_of_severe_illness_from_covid-19.html

“The more an individual interacts with others, and the longer that interaction, the higher the risk of COVID-19 spread. The risk of COVID-19 spread increases in a restaurant or bar setting as follows:

- Lowest Risk: Food service limited to drive-through, delivery, take-out, and curbside pickup.
- More Risk: Drive-through, delivery, take-out, and curbside pickup emphasized. On-site dining limited to outdoor seating. Seating capacity reduced to allow tables to be spaced at least 6 feet apart.
- Even More Risk: On-site dining with both indoor and outdoor seating. Seating capacity reduced to allow tables to be spaced at least 6 feet apart.
- Highest Risk: On-site dining with both indoor and outdoor seating. Seating capacity not reduced and tables not spaced at least 6 feet apart.²⁸⁷

Restaurants and Bars COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

CNN.com, May 24, 2020, Ozarks, MI, “Pool party at Lake of the Ozarks in Missouri draws a packed crowd”

“Video posted by a reporter shows partiers [at a bar] crowded together in a pool at the Lake of the Ozarks, Missouri, this Memorial Day weekend.

....

The gathering violates social distancing measures intended to limit the spread of Covid-19. As part of Missouri's reopening plan announced earlier this month, state officials said restaurants may offer dining-in services but must adhere to social distancing and other precautionary public health measures.



²⁸⁷ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/business-employers/bars-restaurants.html>

The bar posted on Facebook that this was its launch of a summer party called 'Zero Ducks Given Pool Party.' It advertised several DJs and bands performing throughout the event. The venue has worked with and taken the advice of government officials and management teams and will be following social distancing guidelines. Extra precautions and safety measures will be taken to provide a safe environment for you to enjoy the event,' the bar said.

USA Today.com, May 29, 2020, "Lake of the Ozarks pool party tests positive for coronavirus"

"SPRINGFIELD, Missouri -- A week after images of Memorial Day weekend revelers jammed into a Lake of the Ozarks pool party at Backwater Jack's Bar & Grill in Osage Beach made international headlines, the Camden County Health Department announced that a Boone County resident tested positive for the novel coronavirus after visiting the Lake of the Ozarks area over the holiday weekend.

The Boone County subject arrived at the lake on Saturday, May 23, and "developed illness" on Sunday, according to a news release obtained by LakeNewsOnline.com, which like the News-Leader is part of the USA TODAY Network.

The infected person "was likely incubating illness and possibly infectious at the time of the visit," the health department said."²⁸⁸

Ny.eater.com, May 22, 2020, "Coronavirus, Those We've Lost"

"In NYC, where COVID-19 has hit harder than anywhere else in the country, the number of people dying in the restaurant industry is growing.

...

Only three weeks after COVID-19 cases were confirmed in New York City, the metropolis became the epicenter of the virus in the United States. Restaurants and bars completely shut down for dine-in service on March 16. And weeks later, the virus has shown a dramatic and tragic impact on people within the dining community.

Top chefs and restaurateurs like Floyd Cardoz, neighborhood stalwarts like butcher Moe Albanese, and lesser-known, behind-the-scene chefs like Jesus Roman Melendez from Jean-Georges Vongerichten's Nougatine have all died due to the virus. As of Thursday, May 21, in NYC, more than 200,000 people have tested positive for COVID-19 and 20,491 people have died.

....

Jimmy Glenn, 89, bar owner

....

Lloyd Porter, 49, restaurateur

²⁸⁸ <https://www.usatoday.com/story/news/health/2020/05/29/lake-ozarks-pool-party-missouri-resident-coronavirus/5288079002/>

....
Michael Halkias, 82, event space owner
....
Jonathan Adewumi, 57, restaurateur
....
Victor Morales, 33, bar assistant
....
Deodoro Monge Gutierrez, chef and restaurateur
....
Miguel Grande, 52, chef
....
Domingo Vega, 45, restaurateur and chef
....
Vincent Mesa, 76, chef
....
Vincent Cirelli Sabatino, 68, food vendor
....
Jose Torres, 73, chef and restaurateur
....
Miguel Torres, chef
....
Samuel Hargress, Jr., 84, bar owner
....
Panayiotis Peter Panayiotou, 65, restaurateur
....
Kathleen Elizabeth McNulty, 80, restaurateur
....
Joe Joyce, 74, bar owner
....
Moe Albanese, 95, butcher
....
Kamal Ahmed, 69, hotel banquet worker
....
Joseph Migliucci, 81, restaurateur
....
Kosta Kasimis, 84, restaurateur
....
Jesus Roman Melendez, 49, chef
....
Andreas Koutsoudakis, 59, restaurateur
....
Floyd Cardoz, 59, restaurateur and chef²⁸⁹

18. Grocery Store and Food Retail (Including General Retail).

The grocery store and food retail work environments contain various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

²⁸⁹ <https://ny.eater.com/2020/5/6/21229781/nyc-coronavirus-death-restaurant-workers-chefs>

“As a grocery or food retail worker, potential sources of exposures include close contact for prolonged periods of time with a customer with COVID-19 and touching your nose, mouth, or eyes after handling items, cash, or merchandise that customers with COVID-19 have touched.”²⁹⁰

Grocery Store and Food Retail COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Boston.com, May 27, 2020, Quoting story from the *Washington Post*, “COVID-19 has killed 100 grocery store workers. Vitalina Williams was one of the first.”

“The couple [David and Vitalina Williams] worked at grocery stores near their Salem home: Vitalina Williams as a cashier at a Market Basket in Salem and security at a Walmart in Lynn, while David Williams stocked shelves at a Market Basket in Danvers. When the coronavirus pandemic hit the United States in March, they were concerned but needed to pick up extra hours to pay bills. Both were given gloves but no masks.

By the end of March, both were sick with COVID-19, the disease the virus causes. He recovered quickly, but her condition continued to deteriorate. On March 28, she was hospitalized and put on a ventilator. A week later, she died. Vitalina Williams was 59.

“As somebody who shared everything with her, it rattles in the back of my head, ‘Did I give it to her?’ ” he said. “‘Did I get it first and give it to her, or did she give it to me?’ To be honest, I don’t know.”

The Williamses’ jobs were deemed essential — putting them at grave risk of infection. At least 5,500 grocery store employees have tested positive for the novel coronavirus since late March, according to a recent Washington Post investigation and 100 workers have died of the virus. Vitalina Williams was one of the first.

....

David Williams stocks shelves, constantly changing out of his latex gloves as he wears holes into them. He isn’t sure whether his wife regularly wore gloves or whether she caught the virus at work. But two other employees at the Market Basket location where Vitalina Williams worked tested positive around the time she died.”²⁹¹ (Emphasis added).

Richmond.com, Richmond, VA, May 15, 2020, “Half of people around Richmond aren't wearing masks to go to the store. We counted.”

²⁹⁰ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/grocery-food-retail-workers.html>

²⁹¹ <https://www.boston.com/news/coronavirus/2020/05/27/covid-19-has-killed-100-grocery-store-workers-vitalina-williams-was-one-of-the-first>

“After weeks of saying that healthy people didn’t need to wear masks in public, elected leaders and health officials across the country in April reversed course and began recommending them in stores and places where it’s difficult to stay 6 feet apart. You can’t get on a plane or in an Uber without one. People are required to wear one when they leave home in New York.

But in Virginia, you can still get into a Walmart, or a Home Depot or an ABC store with an uncovered face.

Richmond Times-Dispatch reporters spent nearly 15 hours observing nearly 2,900 people entering stores for groceries and other supplies in the city and neighboring localities this week. More than half — 1,480 — didn’t wear a mask or other face covering. Two dozen more were doing it wrong: A woman walked into the Home Depot in Chester on Wednesday with a black headband wrapped behind her neck and over her mouth, with nothing covering her nose.

....

A recent study and computer model from the University of California, Berkeley’s International Computer Science Institute and Hong Kong University of Science and Technology suggested that if 80% of people would wear masks in public, the spread of the coronavirus would plummet. But the impact of masks falls dramatically in the model if the rate of people using them dips below 50%.

....

The message on masks has been jumbled since the coronavirus spread here in March: Officials with the U.S. Centers for Disease Control and Prevention and the World Health Organization initially said people shouldn’t wear them, as the world grappled with a shortage of specialized N95 masks for medical personnel and first responders.

The agencies reversed course last month, announcing that face coverings can help keep people from infecting others — even if they don’t protect the wearer.”²⁹² (Emphasis added).

9news.com, Colorado, May 16, 2020, “Costco & Walmart among grocery stores with COVID-19 outbreaks”

“There are now six grocery stores with COVID-19 outbreaks in Colorado.

Data released from the Colorado Department of Health and Environment (CDPHE) on Wednesday shows 67 confirmed COVID-19 staff cases in grocery stores throughout Colorado, four probable staff cases and three deaths.

....

These are the six grocery stores in Colorado with COVID-19 outbreaks:

King Soopers - 1155 E. 9th Ave., Denver, 8 confirmed staff cases
Costco - 1470 South Havana St., Aurora, 6 confirmed staff cases

²⁹² https://www.richmond.com/special-report/coronavirus/half-of-people-around-richmond-arent-wearing-masks-to-go-to-the-store-we-counted/article_7cd4a541-986b-5a1e-b4e9-b0e7f99147d3.html

Walmart - 14000 E. Exposition Ave., Aurora, 14 confirmed staff cases and 3 deaths
Mi Pueblo Market, 9171 Washington St., Thornton, 19 confirmed staff cases
Carniceria Sonora, 347 N. 1st St., Montrose, 7 confirmed staff cases
City Market, 400 N. Parkway, Breckenridge, 13 confirmed staff cases and 4 probable staff cases²⁹³ (Emphasis added).

Businessinsider.com, April 13, 2020, “At least 30 grocery store workers have died from the coronavirus, and their colleagues are pleading for shoppers to wear masks and respect social distancing”

“ At least 30 grocery store workers have died from the coronavirus so far, and at least 3000 have stopped working because they've been exposed or gotten sick.

In a media call on Monday, the United Food and Commercial Workers International Union, or UFCW, told journalists that over 30 of its members had died from the coronavirus. UFCW, which represents about 1.3 million grocery store workers and food processing workers, is pushing for increased protection from the government for its members. The union is asking the CDC to classify grocery workers as first responders, and to give them priority for testing and protective equipment.

Those 30 deaths are only the ones the union has accounted for, said UFCW president Marc Perrone. There are many chains, such as Whole Foods and Trader Joe's, that aren't part of the union and aren't included in the data UFCW collects.

....

In a survey conducted by the UFCW of 5000 grocery store workers, 85% of respondents said they had seen customers violating social distancing guidelines.²⁹⁴ (Emphasis added).

General Retail

Detroitnews.com, May 15, 2020, “Michiganians flock to Ohio to enjoy state's reopening”

“Ohio Gov. Mike DeWine on Friday restarted parts of his state's economy, with selected businesses opening for the first time since he issued a stay-at-home order on March 22 in response to the coronavirus emergency.

Michiganians like Hamade of Temperance flocked across the border for goods and services still not available in their own state. Dozens of vehicles bearing Michigan license plates were parked outside Toledo businesses that reopened Friday.

²⁹³ <https://www.9news.com/article/news/health/coronavirus/costco-walmart-among-grocery-store-covid-19-outbreaks/73-bde0be4d-e1e3-41f1-a56d-8cf2356d6dde>

²⁹⁴ <https://www.businessinsider.com/grocery-store-worker-deaths-from-coronavirus-at-least-30-nationwide-2020-4>

....

Hilary Wilcox said she understands that "Michigan is a little crazier" than Ohio as far as being impacted by the COVID-19 virus. Ohio has reported 26,954 COVID cases, with 1,581 deaths. That compares to 50,079 cases and 4,825 deaths in Michigan as of Friday.

"I'm just excited Ohio is opening up, and that I live close enough to drive here," said Wilcox, 31, who made the 75-mile trip from her Wixom home to enjoy her version of normal — an afternoon of lunch and shopping with her friend.

....

Rylee Rasmussen, 19, and her 14-year-old sister, Ragean Rasmussen, of Carleton in Monroe County said their shopping excursion Friday was their first since Whitmer imposed the original stay-at-home order March 24.

"It feels weird," Rylee Rasmussen said as she and her sister strolled through the Dick's Sporting Goods store in Franklin Park Mall. "We're not really looking for anything; we just wanted to get out."

Like most of the store's customers, the sisters did not wear masks.²⁹⁵



19. Drug Stores and Pharmacies.

The drug store and pharmacy work environments contain various hazards and job tasks which present “high”, “medium” (close contact) and “lower” risk exposures:

“Reduce risk during COVID-19 testing and other close-contact pharmacy care services

²⁹⁵Photo: Hilary Wilcox of Wixom spent Friday afternoon shopping at Franklin Park Mall in Toledo. (Photo: Max Ortiz, The Detroit News)” (Emphasis added).

Pharmacies that are participating in public health testing for COVID-19 should communicate with local and state public health staff to determine which persons meet the criteria for testing. State and local health departments will inform pharmacies about procedures to collect, store, and ship specimens appropriately, including during afterhours or on weekends/holidays. Some pharmacies are including self-collection options.

In the “CDC Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings,” there is guidance for collecting respiratory specimens.

Pharmacy staff conducting COVID-19 testing and other close-contact patient care procedures that will likely elicit coughs or sneezes (e.g., influenza and strep testing) should be provided with appropriate PPE. Staff who use respirators must be familiar with proper use and follow a complete respiratory protection program that complies with OSHA Respiratory Protection standard (29 CFR 1910.134). Staff should also have training in the appropriate donning and doffing of PPE. Cloth face coverings should NOT be worn by staff instead of a respirator or facemask if more than source control is required.”²⁹⁶

Drug Stores and Pharmacies COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Propublica.org, April 9, 2020, “Pharmacy Workers Are Coming Down With COVID-19. But They Can’t Afford to Stop Working.”

“A few days later, during routine calls to customers about medication ready for pickup, Peralta learned that the customer whom he had helped had tested positive for COVID-19. Peralta notified his manager that he may have been exposed to the virus. The manager checked with headquarters and told him to keep working, Peralta said.

Toward the end of March, Peralta and two colleagues started to come down with telltale symptoms: A loss of smell and taste. Fatigue. Body aches. He realized that he might be laid up for weeks — far longer than his sick pay would last.

....

Without sufficient safeguards, pharmacies could become vectors for spreading the coronavirus within communities, according to Denis Nash, a professor of epidemiology at the CUNY School of Public Health. “This is not a hospital setting per se, but it is a busy place where sick people may be going at a time when transmission of SARS-CoV-2 is high,” he said.”²⁹⁷

²⁹⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pharmacies.html>

²⁹⁷ <https://www.propublica.org/article/pharmacy-workers-are-coming-down-with-covid-19-but-they-cant-afford-to-stop-working>

20. Personal Care, Personal Grooming, Salon, and Spa Services.

The personal care, personal grooming, salon, and spa services work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

Personal Care, Personal Grooming, Salon, and Spa Services COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

CNN.com, Missouri, May 24, 2020, “A second hairstylist who worked while symptomatic potentially exposed 56 clients to Covid-19, officials say”

“The Springfield-Greene Health Department announced Saturday that a second hairstylist tested positive for coronavirus, and may have exposed 56 clients at the same Great Clips salon. A day earlier, officials had said another hairstylist with coronavirus at the same salon potentially exposed 84 customers and seven coworkers. Both stylists had symptoms while at work, officials said. They did not provide details on their conditions or when they tested positive.”²⁹⁸ (Emphasis added).

CNN.com, Missouri, May 23, 2020, “A hairstylist worked while symptomatic and exposed 91 people to coronavirus”

“A hairstylist with coronavirus worked for eight days this month while symptomatic, exposing as many as 91 customers and coworkers in Missouri, health officials said.

‘In this instance, the 84 customers exposed got services from the hairstylist at Great Clips,’ said Clay Goddard, director of the Springfield-Greene County Health Department. In addition to the customers, seven coworkers were also notified of exposure.

It's unclear when the stylist tested positive but the infection is believed to have happened while traveling. The stylist worked May 12 through Wednesday, health officials said Friday. At the time, businesses such as barbershops and hair salons were allowed to operate in the state.

‘The individual and their clients were wearing face coverings. The 84 clients potentially directly exposed will be notified by the Health Department and be offered testing, as will seven coworkers,’ the Springfield-Greene County Health Department said in a statement.’ It is the hope of the department that because face coverings were worn throughout this exposure timeline, no additional cases will result.”²⁹⁹

²⁹⁸ <https://www.cnn.com/2020/05/24/us/missouri-hairstylists-coronavirus-clients-trnd/index.html>

²⁹⁹ <https://www.cnn.com/2020/05/23/us/missouri-hairstylist-coronavirus-trnd/index.html>

(Emphasis added).

ABC7News.com, California, May 7, 2020, “Coronavirus: First case of COVID-19 community spread in California tracked to nail salon, Newsom reveals in press conference”

“The first case of community spread of novel coronavirus in California can be tracked back to a nail salon, Gov. Gavin Newsom revealed in a press conference Thursday.

The announcement wasn't part of the governor's prepared remarks; he mentioned it in only in response to a question about why churches and salons aren't being allowed to open in Stage 2 of the state's reopening.

‘This whole thing started in the state of California - the first community spread - in a nail salon. I just want to remind you, remind everybody, of that. I'm very worried about that.’

‘Community spread’ means the virus was locally contracted, not from traveling to a foreign country or by being in close proximity who recently traveled to a foreign country.

The first case of community spread in California was known to have occurred in Solano County in February. The county told ABC7 News, ‘Solano Public Health cannot confirm this information and we did not release this information when the first COVID-19 community spread occurred.’

Nail salons, spas, barbershops and the like are included in Stage 3 of reopening. They are considered higher risk environments because the business necessitates close proximity between people. Newsom pointed out that nail technicians typically wear face masks and even sometimes gloves, yet COVID-19 was apparently still transmitted. That makes the reopening of such businesses particularly challenging.”³⁰⁰

21. Sports and Entertainment, and Mass Gatherings.

The sports and entertainment venue work environments contain various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“Large events and mass gatherings can contribute to the spread of COVID-19 in the United States via travelers who attend these events and introduce the virus to new communities. Examples of large events and mass gatherings include conferences, festivals, parades, concerts, sporting events, weddings, and other types of assemblies. These events can be planned not only by organizations and communities but also by individuals.

....

³⁰⁰ <https://abc7news.com/first-case-of-coronavirus-in-california-nail-salon-covid-nails/6161231/>

Larger gatherings (for example, more than 250 people) offer more opportunities for person-to-person contact and therefore pose greater risk of COVID-19 transmission.

....

Based on what is currently known about the virus, spread from person-to-person happens most frequently among close contacts (within 6 feet)."³⁰¹

Sports and Entertainment, and Mass Gatherings COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Bleacherreport.com, "Timeline of Coronavirus' Impact on Sports"

"Saturday, March 14

10:44 p.m.: Cleveland State women's basketball head coach Chris Kielsmeier has tested positive for COVID-19, the school announced, per ESPN.

8:05 p.m.: ESPN's Adrian Wojnarowski and Stadium and The Athletic's Shams Charania reported that Detroit Pistons big man Christian Wood tested positive for the coronavirus. Per Charania, Wood "has shown no symptoms and is doing well." The 24-year-old played on March 7 against the Utah Jazz, who have two players (Rudy Gobert and Donovan Mitchell) who have tested positive for the coronavirus.

....

Tuesday, March 17

....

3:57 p.m.: The Brooklyn Nets announced four players tested positive for the coronavirus. Only one of the four is showing symptoms. The organization says it's currently notifying anyone who has had known contact with the players, including recent opponents.

....

Thursday, March 19

....

7:17 p.m.: Two Los Angeles Lakers players tested positive for COVID-19, per Shams Charania of Stadium and The Athletic. Mark Medina of USA Today reported Wednesday that "the majority" of Lakers players received tests that morning at the team's practice facility in El Segundo, California. Charania noted that the Lakers may test other players who did not take part in those tests.

6:11 p.m.: The Philadelphia 76ers announced three members of the organization have received positive tests for the coronavirus."³⁰²

Richmond Times Dispatch, April 16, 2020, "Dozens protest social distancing orders as Virginia's death toll passes 200"

³⁰¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/mass-gatherings-ready-for-covid-19.html>

³⁰² <https://bleacherreport.com/articles/2880569-timeline-of-coronavirus-impact-on-sports>



A Virginia Capitol Police officer asked demonstrators to maintain social distancing guidelines during Thursday's protest at Capitol Square. Organizers plan to hold another protest May 1.

DANIEL SANGJIB MIN/RTD

“A Virginia Capitol Police officer asked demonstrators to maintain social distancing guidelines during Thursday’s protest at Capitol Square. Organizers plan to hold another protest May 1.”

22. Homeless Shelters.

The homeless shelter work environments contain various hazards and job tasks which present “high”, “medium” (close contact) and “lower” risk exposures:

“People experiencing homelessness are at risk for infection during community spread of COVID-19.

....

Continuing homeless services during community spread of COVID-19 is critical, and homeless shelters should not close or exclude people who are having symptoms or test positive for COVID-19 without a plan for where these clients can safely access services and stay.

Decisions about whether clients with mild illness due to suspected or confirmed COVID-19 should remain in a shelter, or be directed to alternative housing sites, should be made in coordination with local health authorities. Community coalitions should identify additional temporary housing and shelter sites that are able to provide appropriate services, supplies, and staffing. Ideally, these additional sites should include:

- Overflow sites to accommodate shelter decompression (to reduce crowding)

and higher shelter demands

- Isolation sites for people who are confirmed to be positive for COVID-19
- Quarantine sites for people who are waiting to be tested, or who know that they were exposed to COVID-19
- Protective housing for people who are at highest risk of severe COVID-19

Depending on resources and staff availability, non-group housing options (such as hotels/motels) that have individual rooms should be considered for the overflow, quarantine, and protective housing sites.”³⁰³

Homeless Shelter COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Voiceofoc.org, Orange County, CA, May 29, 2020, “Coronavirus Outbreak Hits Second Orange County Homeless Shelter”

“The Fullerton Armory’s replacement shelter at Independence Park has become the second Orange County homeless shelter to have an outbreak of coronavirus cases, according to county officials.

....

The Fullerton outbreak was about a week ago, and people who tested positive were moved into the county’s motel sheltering program, county Chief Executive Officer Frank Kim said Friday in response to Voice of OC’s questions.

....

Late Friday, county spokeswoman Molly Nichelson said two people tested positive at one shelter in OC and 11 people at another, none of whom were hospitalized. She declined to say which shelter had two cases and which had 11, citing privacy.

The first known shelter outbreak was at the Salvation Army shelter in Anaheim, where two staff members tested positive for coronavirus in late March. It wasn’t clear if more people have since tested positive at the Anaheim shelter.”³⁰⁴ (Emphasis added).

KHOU.com, Houston, TX, May 25, 2020, “77 positive coronavirus cases reported at Houston homeless shelter”

“Eichenbaum said 69 residents and eight staff members have now tested positive at one shelter. ‘I consider it a spike, it seems to be isolated right now,’ Eichenbaum said. The cases are all at the Men’s Development Center downtown. Right now, it’s not accepting new clients and the city is vowing to

³⁰³ <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html>

³⁰⁴ <https://voiceofoc.org/2020/05/coronavirus-outbreak-hits-second-orange-county-homeless-shelter/>

increase homeless testing.”³⁰⁵ (Emphasis added).

23. Fitness, Gyms, and Exercise Facilities.

The fitness, gyms, and exercise facility work environments contain various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“During 24 days in Cheonan, South Korea, 112 persons were infected with severe acute respiratory syndrome coronavirus 2 associated with fitness dance classes at 12 sports facilities. Intense physical exercise in densely populated sports facilities could increase risk for infection. Vigorous exercise in confined spaces should be minimized during outbreaks.

....

By March 9, we identified 112 COVID-19 cases associated with fitness dance classes in 12 different sports facilities in Cheonan (Figure). All cases were confirmed by RT-PCR; 82 (73.2%) were symptomatic and 30 (26.8%) were asymptomatic at the time of laboratory confirmation. Instructors with very mild symptoms, such as coughs, taught classes for ≈ 1 week after attending the workshop (Appendix). The instructors and students met only during classes, which lasted for 50 minutes 2 times per week, and did not have contact outside of class.

On average, students developed symptoms 3.5 days after participating in a fitness dance class (3). Most (50.9%) cases were the result of transmission from instructors to fitness class participants; 38 cases (33.9%) were in-family transmission from instructors and students; and 17 cases (15.2%) were from transmission during meetings with coworkers or acquaintances.

....

Characteristics that might have led to transmission from the instructors in Cheonan include large class sizes, small spaces, and intensity of the workouts. The moist, warm atmosphere in a sports facility coupled with turbulent air flow generated by intense physical exercise can cause more dense transmission of isolated droplets. Classes from which secondary COVID-19 cases were identified included 5–22 students in a room ≈ 60 m² during 50 minutes of intense exercise. We did not identify cases among classes with < 5 participants in the same space.

Of note, instructor C taught Pilates and yoga for classes of 7–8 students in the same facility at the same time as instructor B (Figure; Appendix Table 2), but none of her students tested positive for the virus. We hypothesize that the lower intensity of Pilates and yoga did not cause the same transmission effects as those of the more intense fitness dance classes.”³⁰⁶, ³⁰⁷

³⁰⁵ <https://www.khou.com/article/news/health/coronavirus/77-positive-covid-19-cases-at-houston-homeless-shelter/285-f8ad7306-cb8d-4471-b8bb-4ce310ebd3a7>

³⁰⁶ https://wwwnc.cdc.gov/eid/article/26/8/20-0633_article

³⁰⁷ *Id.* “A limitation of our study is the unavailability of a complete roster of visitors to the sports facilities, which might have meant we missed infections among students during surveillance and investigation efforts. Discovery of outbreak cases centered on exercise facilities led to a survey of instructors who participated in a fitness dance workshop and provided clues to identifying additional cases among students. Early identification of asymptomatic persons with RT-PCR–confirmed infections helped block further transmissions. Because of the increased possibility of infection

24. Call Centers.

The call center work environments contain various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“Coronavirus Disease Outbreak in Call Center, South Korea

....

We describe the epidemiology of a coronavirus disease (COVID-19) outbreak in a call center in South Korea. We obtained information on demographic characteristics by using standardized epidemiologic investigation forms. We performed descriptive analyses and reported the results as frequencies and proportions for categorical variables. Of 1,143 persons who were tested for COVID-19, a total of 97 (8.5%, 95% CI 7.0%–10.3%) had confirmed cases.

Of these, 94 were working in an 11th-floor call center with 216 employees, translating to an attack rate of 43.5% (95% CI 36.9%–50.4%). The household secondary attack rate among symptomatic case-patients was 16.2% (95% CI 11.6%– 22.0%). Of the 97 persons with confirmed COVID-19, only 4 (1.9%) remained asymptomatic within 14 days of quarantine, and none of their household contacts acquired secondary infections.

....

However, if we restrict our results the 11th floor, the attack rate was as high as 43.5%. This outbreak shows alarmingly that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) can be exceptionally contagious in crowded office settings such as a call center. The magnitude of the outbreak illustrates how a high-density work environment can become a high-risk site for the spread of COVID-19 and potentially a source of further transmission. Nearly all the case-patients were on one side of the building on 11th floor.

Severe acute respiratory syndrome coronavirus, the predecessor of SARS-CoV-2, exhibited multiple superspreading events in 2002 and 2003, in which a few persons infected others, resulting in many secondary cases. Despite considerable interaction between workers on different floors of building X in the elevators and lobby, spread of COVID-19 was limited almost exclusively to the 11th floor, which indicates that the duration of interaction (or contact) was likely the main facilitator for further spreading of SARS-CoV-2.

....

In summary, this outbreak exemplifies the threat posed by SARS-CoV-2 with its propensity to cause large outbreaks among persons in office workplaces.”^{308 309}

through droplets, vigorous exercise in closely confined spaces should be avoided during the current outbreak, as should public gatherings, even in small groups.”

³⁰⁸ https://wwwnc.cdc.gov/eid/article/26/8/20-1274_article

³⁰⁹ *Id.* “This outbreak investigation has several limitations. First, we could not track these cases to another cluster, making it difficult to identify the actual index case-patient. Second, not all clinical information was available for all confirmed cases, prohibiting detailed description of clinical syndromes. Date of symptom onset by office seat would be informative in understanding SARS-CoV-2 transmission in close contact area. However, our findings demonstrate the power of screening all potentially exposed persons and show that early containment can be implemented and used in the middle of national COVID-19 outbreak. By testing all potentially exposed persons and their contacts to facilitate the isolation of symptomatic and asymptomatic COVID-19 case-patients, we might have helped interrupt transmission

Call Center COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Martinsvillebulletin.com, Martinsville, VA, May 13, 2020, “Martinsville call center Young Williams sees outbreak of COVID-19, including one death”

“An outbreak of COVID-19 has hit a Martinsville call center that has had six positive cases and one death among its employees.”

A spokesperson for the Virginia Department of Social Services confirmed via email that six employees of Young Williams Child Support Services, located in the Clocktower Building off Commonwealth Boulevard, have tested positive for the virus as of Wednesday morning.”³¹⁰

25. Package Processing Facilities.

The package processing facility work environment contains various hazards and job tasks which present “medium” (close contact) to “lower” risk exposures:

“...production or assembly lines and other areas in busy plants where workers have close contact with coworkers and supervisors—may contribute substantially to workers’ potential exposures.”³¹¹

Package Processing Facilities COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

NBCnews.com, May 21, 2020,” Eighth Amazon warehouse worker dies from COVID-19”

“Another Amazon warehouse worker has died from COVID-19, bringing the total known deaths to eight employees, the company said Thursday.

The female employee worked in packing at the fulfillment center outside Cleveland in North Randall, Ohio, known as CLE2, Amazon said. She had been with the company since November 2018.

chains. In light of the shift to a global pandemic, we recommend that public health authorities conduct active surveillance and epidemiologic investigation in this rapidly evolving landscape of COVID-19.”

³¹⁰ https://www.martinsvillebulletin.com/news/local/martinsville-call-center-young-williams-sees-outbreak-of-covid-19-including-one-death/article_4d116bb4-0dbd-58b4-bc21-984a9faa3053.html

³¹¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html>, NOTE: The CDC guidance in this document is for manufacturing workers, but to the extent that work conditions at package processing facilities mirror the work activities described in the document, the same exposure risk level analysis can be reasonably applied to package processing facilities.

The employee last went to work on April 30, the same day she was diagnosed, said Amazon spokesperson Lisa Levandowski. The e-commerce giant learned of her positive test results on May 8 and was informed of her death by her sister-in-law on May 18.

....

NBC News has confirmed that seven other Amazon warehouse workers have died after testing positive for coronavirus in Staten Island, New York; Waukegan, Illinois; Hawthorne, California; Tracy, California; Bethpage, New York; Jeffersonville, Indiana; and Indianapolis, Indiana.”³¹² (Emphasis added).

Washingtonpost.com, March 25, 2020, “Amazon workers test positive for covid-19 at 10 U.S. warehouses”

“The U.S. coronavirus outbreak has spread to at least 10 Amazon warehouses, infecting workers racing to deliver massive volumes of packages for consumers leery of leaving their homes to shop.

In the past few days, workers tested positive for covid-19 at Amazon warehouses and shipping facilities across the country, from New York to California and Michigan to Texas. In some cases, Amazon shut down facilities for cleaning, and some workers who were in close contact with their infected colleagues have been quarantined.

26. Emergency Responders Including Police, Fire, Emergency Medical Services.

The emergency responder work environment contains various hazards and job tasks which present “high”, “medium” (close contact) to “lower” risk exposures:

“Emergency medical services (EMS) play a vital role in responding to requests for assistance, triaging patients, and providing emergency medical treatment and transport for ill persons. However, unlike patient care in the controlled environment of a healthcare facility, care and transports by EMS present unique challenges because of the nature of the setting, enclosed space during transport, frequent need for rapid medical decision-making, interventions with limited information, and a varying range of patient acuity and jurisdictional healthcare resources.”³¹³ (Emphasis added).

Emergency Responder COVID-19 Reports and Statistics

The following is not intended to be an exhaustive list of COVID-19 outbreaks in this industry.

Thecity.nyc, New York City, April 7, 2020 “Bus Drivers Hardest Hit by Deaths as COVID-19 Devastates MTA”

“By comparison, the NYPD has lost 13 members to COVID-19 from a

³¹² <https://www.yahoo.com/lifestyle/eighth-amazon-warehouse-worker-dies-003500221.html>

³¹³ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>

workforce of more than 55,000 people, while the FDNY has suffered two deaths among its more than 40,000 employees.”³¹⁴ (Emphasis added).

Pressherald.com, “Seven state public health and emergency workers report COVID-19 symptoms”

“Seven employees who work at the Maine Emergency Management Agency experienced symptoms similar to COVID-19 and called in sick Thursday, forcing the state to shift its daily media briefing to a virtual event.”³¹⁵

Ems1.com, May 4, 2020, “COVID-19: EMS Deaths, Tracking the coronavirus-related deaths of EMTs and paramedics”

“As COVID-19 continues to spread around the country, the first responders on the front lines are increasingly vulnerable of contracting the virus. As was feared, the death toll now includes a growing number of EMS personnel.

What follows is a compilation of the reports, by state, of EMS personnel who have died of coronavirus-related complications. For cities with multiple diagnoses, the links are ordered chronologically, with the top being the most recent.

Note: Not all of these deaths have been confirmed as line-of-duty deaths. Deputy Chief Billy Goldfeder shared an update from the Public Safety Officers’ Benefits program as to how COVID-19 deaths will be classified.

COLORADO

Denver — Colo. paramedic, Paul Cary, 66, dies from COVID-19

MICHIGAN

Huron Township — Mich. paramedic and former fire Lt., Paul Novicki, 51, dies from COVID-19

MISSISSIPPI

Natchez — Miss. AMR paramedic, David Martin, dies from COVID-19 complications

MISSOURI

Kansas City — Mo. EMT, Billy Birmingham, dies from COVID-19

NEW JERSEY

Passaic — City of Passaic firefighter-EMT, Israel Tolentino, 33, has died from COVID-19

³¹⁴ <https://www.thecity.nyc/health/2020/4/7/21216831/bus-drivers-hardest-hit-by-deaths-as-covid-19-devastates-mta>

³¹⁵ <https://www.pressherald.com/2020/05/28/maine-reports-3-more-deaths-52-additional-covid-19-cases/>

Hackensack — Past Hackensack Volunteer Ambulance Corps captain and life member, Reuven Maroth, dies from COVID-19

Newark — EMT Liana Sá, of Monmouth-Ocean Hospital Service Corporation and Watchung Rescue Squad, dies from COVID-19

Pompton Lakes — North Bergen and Saint Clare's Hospital EMT Kevin Leiva, 24, dies from COVID-19 complications

Bergen County — Physician and NJSEA EMS member, Dr. Frank Molinari, has died from COVID-19

Monmouth County — NJ firefighter-EMT, Robert Weber, dies from COVID-19 complications

West Orange — RWJBarnabas Health EMS educator, Robert Tarrant, has died from COVID-19

Elizabeth — Trinitas Regional Medical Center EMT, Solomon Donald, dies from COVID-19

Chatham — Atlantic Health EMS educator, former Chatham police captain, Bill Nauta, 72, dies from COVID-19

Morristown — Atlantic Mobile Health EMT, Scott Geiger, dies due to COVID-19 complications

Bergen County — Firefighter, EMS instructor and NJSEA EMT, John Ferrarella, dies from COVID-19

Woodbridge — NJ volunteer EMS chief, John Careccia, 74, dies from COVID-19

Bergen County — NJ EMT, former fire chief, David Pinto, 70, dies from COVID-19 complications

NEW YORK

New York City — FDNY ambulance mechanic, James Villecco, 55, dies from COVID-19

New York City — FDNY EMT and 9/11 responder, Gregory Hodge, 59, dies from COVID-19

New York City — NYU Langone Hospital paramedic, former FDNY EMS member, Tony Thomas, dies from COVID-19

Valley Stream — LODD: NY firefighter-EMT and 9/11 responder, Mike Field, dies from COVID-19

New York City — FDNY EMT, John Redd, 63, dies due to COVID-19

New York City — FDNY EMT, Idris Bey, 60, dies due to COVID-19

New York City — FDNY EMT, 30-year EMS veteran, Richard Seaberry, 63, dies due to COVID-19

Blooming Grove — NY ambulance volunteer, Sal Mancuso, 66, dies from COVID-19

PENNSYLVANIA

Delaware County — Pa. first responders, healthcare professionals mourn paramedic, Kevin Bundy, who died from COVID-19

Robesonia — Pa. assistant fire chief and EMT, Robert Zerman, 49, dies from COVID-19³¹⁶

³¹⁶ <https://www.ems1.com/coronavirus-covid-19/articles/covid-19-ems-deaths-jk5zWFziwYVYUaM4/>

ATTACHMENT B: CURRENT LAWS AND REGULATIONS

RECOGNIZED MITIGATION STRATEGIES FOR COVID-19 NOT COVERED BY VOSH REGULATIONS OR STANDARDS

VA. CODE §40.1-51(A), THE “GENERAL DUTY CLAUSE”

Neither OSHA nor VOSH has a regulation specific to SARS-CoV-2 or COVID-19 or infectious diseases generally.³¹⁷

Certain VOSH regulations (identical to OSHA counterparts unless otherwise noted) can be used to address some SARS-CoV-2 or COVID-19 hazards.

1. VOSH Regulations

a. General Industry.

General requirements to provide personal protective equipment to employees in General Industry are contained in:

1910.132 (Personal Protective Equipment)³¹⁸,

1910.133 (Eye and Face Protection)³¹⁹, however, the scope of the regulation is limited to exposure “to eye or face hazards from flying particles, molten metal, liquid chemicals, acids or caustic liquids, chemical gases or vapors, or potentially injurious light radiation.” It does not reference exposure to airborne biological hazards.

1910.134 (Respiratory Protection)³²⁰,

1910.138 (Hand Protection)³²¹

1910.141 (Sanitation)³²²

1910.142 (Temporary Labor Camps)³²³

³¹⁷ Following the H1N1 virus outbreak in 2009, the AFL-CIO petitioned OSHA on May 28, 2009 for an infectious disease standard to be promulgated. In 2010, OSHA published a Request for Information toward developing an infectious disease standard, held stakeholder meetings, and conducted site visits. A regulatory framework document was created. In Spring 2017, on OSHA’s Regulatory Agenda an infectious disease standard was placed under long term action. No subsequent actions have been taken by OSHA toward this standard during the current administration. <https://www.osha.gov/dsg/id/>. The AFL-CIO has again recently petitioned OSHA for a standard covering COVID-19 exposure risks, and on May 18, 2020 filed a petition in the U.S. Circuit Court of Appeals for the District of Columbia asking the court to order OSHA to promulgate such a rule. *In re: AFL-CIO*, dkt. no. 20-1158 (D.C. Cir. 2020).

³¹⁸ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132>

³¹⁹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.133>

³²⁰ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>

³²¹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.138>

³²² <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.141>

³²³ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.142>

1910.1200 (Hazard Communication)³²⁴ (i.e., regulatory requirements for employee use of certain cleaning chemicals)

1910.1045 (Occupational Exposure to Hazardous Chemicals in Laboratories)³²⁵

b. Construction Industry.

1926.21(b)(2)³²⁶ (Safety Training and Education)

1926.59 (Hazard Communication)³²⁷ (i.e., regulatory requirements for employee use of certain cleaning chemicals)

1926.28³²⁸ and 1926.95³²⁹, (Personal Protective Equipment)

NOTE: The Construction Industry does not have a requirement comparable to 1910.132(d) which requires General Industry employers to conduct a written workplace assessment to “determine if hazards are present, or are likely to be present, which necessitate the use of” PPE.³³⁰

1926.102 (Eye and Face Protection)³³¹; however, the scope of the regulation is limited to exposure “to eye or face hazards from flying particles, molten metal, liquid chemicals, acids or caustic liquids, chemical gases or vapors, or potentially injurious light radiation.” It does not reference exposure to airborne biological hazards.

1926.103 (Respiratory Protection)³³²

NOTE: The Construction Industry Standards do not have a “Hand Protection” regulation similar to 1910.138.

³²⁴ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200>

³²⁵ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1450>

³²⁶ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.21>

³²⁷ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.59>

³²⁸ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.28>

³²⁹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.95>

³³⁰ 1910.132(d), Hazard assessment and equipment selection.

1910.132(d)(1), The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). If such hazards are present, or likely to be present, the employer shall:

1910.132(d)(1)(i), Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

1910.132(d)(1)(ii), Communicate selection decisions to each affected employee; and,

1910.132(d)(1)(iii), Select PPE that properly fits each affected employee.

Note: Non-mandatory appendix B contains an example of procedures that would comply with the requirement for a hazard assessment.

1910.132(d)(2)

The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

³³¹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.102>

³³² <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.103>

16VAC25-160³³³ (Construction Industry Sanitation Standard – Virginia unique regulation that is the functional equivalent of 1926.51 for Construction), sanitation requirements are limited to “Toilet facilities shall be operational and maintained in a clean and sanitary condition.”

c. Agriculture Industry.

1928.21(a)(1)³³⁴ (Temporary Labor Camps, 1910.142 applies to agricultural operations)

1928.21(a)(5)³³⁵ (Hazard Communication, 1910.1200 applies to agricultural operations) (i.e., regulatory requirements for employee use of certain cleaning chemicals)

1910.142 (Temporary Labor Camps)³³⁶ applies to the Agriculture Industry

16VAC25-180³³⁷ (Field Sanitation - Virginia unique regulation that is the functional equivalent of 1928.110 for Agriculture), sanitation requirements are limited to “(3) Maintenance. Potable drinking water and toilet and handwashing facilities shall be maintained in accordance with appropriate public health sanitation practices, including the following:

(i) Drinking water containers shall be constructed of materials that maintain water quality, shall be refilled daily or more often as necessary, shall be kept covered and shall be regularly cleaned.

(ii) Toilet facilities shall be operational and maintained in clean and sanitary condition.

(iii) Handwashing facilities shall be refilled with potable water as necessary to ensure an adequate supply and shall be maintained in a clean and sanitary condition; and

(iv) Disposal of wastes from facilities shall not cause unsanitary conditions.

NOTE: There are no regulatory requirements in the Agriculture Industry for PPE, including respiratory protection.

d. Maritime Industry.

NOTE: VOSH has jurisdiction of state and local government maritime related activities only. OSHA retains jurisdiction over private sector maritime activities in Virginia.

1915.88³³⁸, Shipyard Employment (Sanitation)

³³³ <https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-160-10>

³³⁴ <https://www.osha.gov/laws-regs/regulations/standardnumber/1928/1928.21>

³³⁵ <https://www.osha.gov/laws-regs/regulations/standardnumber/1928/1928.21>

³³⁶ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.142>

³³⁷ <https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-180-10>

³³⁸ <https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.88>

1915.152³³⁹, Shipyard Employment (Personal Protective Equipment)

1915.153³⁴⁰, Shipyard Employment (Eye and Face Protection); however, the scope of the regulation is limited to exposure “to eye or face hazards from flying particles, molten metal, liquid chemicals, acids or caustic liquids, chemical gases or vapors, or potentially injurious light radiation.” It does not reference exposure to airborne biological hazards.

1915.154³⁴¹, Shipyard Employment (Respiratory Protection)

1915.157³⁴², Shipyard Employment (Hand and Body Protection)

1917.127³⁴³, Marine Terminal Operations (Sanitation)

1917.1(a)(2)(vi)³⁴⁴, Marine Terminal Operations (Hazard Communication, 1910.1200)

1917.92 and 1917.1(a)(2)(x)³⁴⁵, Marine Terminal Operations (Respiratory Protection, 1910.134)

1917.91³⁴⁶, Marine Terminal Operations (Eye and Face Protection)

1917.95³⁴⁷, Marine Terminal Operations (PPE, Other Protective Measures)

1918.95³⁴⁸, Longshoring (Sanitation)

1918.90³⁴⁹, Longshoring (Hazard Communication)

1918.102³⁵⁰ Longshoring (Respiratory Protection)

1918.101³⁵¹ Longshoring (Eye and Face Protection)

2. Recognized Mitigation Strategies for COVID-19 Not Covered by VOSH Regulations or Standards.

There are no VOSH or OSHA regulations or standards that would require:

Physical distancing of at least six feet where feasible (also known as Social Distancing)

³³⁹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.152>

³⁴⁰ <https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.153>

³⁴¹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.154>

³⁴² <https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.157>

³⁴³ <https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.127>

³⁴⁴ [https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.1#1917.1\(a\)\(2\)\(ix\)](https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.1#1917.1(a)(2)(ix))

³⁴⁵ *Id.*

³⁴⁶ <https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.91>

³⁴⁷ <https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.95>

³⁴⁸ <https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.95>

³⁴⁹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.90>

³⁵⁰ <https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.102>

³⁵¹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.101>

Disinfection of work areas where known or suspected COVID-19 employees or other persons accessed or worked³⁵²

Employers to develop policies and procedures for employees to report when they are sick or experiencing symptoms consistent with COVID-19

Employers to, prior to the commencement of each work shift, prescreen of employees and other persons to verify each employee or person is not COVID-19 symptomatic

Employers to prohibit known and suspected COVID-19 employees and other persons from reporting to or being allowed to remain at work or on a job site until cleared for return

Employers to develop and implement policies and procedures for known COVID-19 or suspected COVID-19 employees to return to work using either a symptom-based or test-based strategy depending on local healthcare and testing circumstances

Employers to prohibit COVID-19 positive employees from reporting to or being allowed to remain at work or on a job site until cleared for return to work

Employers to provide employees assigned to work stations and in frequent contact with other persons inside six feet with alcohol based hand sanitizers at their workstations

Employers with hazards or job tasks classified at very high, high, or medium exposure risk to develop a written Infectious Disease Preparedness and Response Plan

³⁵² <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.141>

1910.141(a)(3)(i) provides that “All places of employment shall be kept **clean** to the extent that the nature of the work allows.” (Emphasis added). The term “sanitary” is not used, although it is used in reference to “washing facilities”, “waste disposal”, “food storage”, “sweepings”, and “drinking water”.

1910.141(a)(4)(i) provides that “Any receptacle used for putrescible solid or liquid waste or refuse shall be so constructed that it does not leak and may be thoroughly cleaned and maintained in a **sanitary** condition. Such a receptacle shall be equipped with a solid tight-fitting cover, unless it can be maintained in a **sanitary** condition without a cover. This requirement does not prohibit the use of receptacles which are designed to permit the maintenance of a **sanitary** condition without regard to the aforementioned requirements.” (Emphasis added).

1910.141(a)(4)(ii) provides that “All sweepings, solid or liquid wastes, refuse, and garbage shall be removed in such a manner as to avoid creating a menace to health and as often as necessary or appropriate to maintain the place of employment in a **sanitary** condition.” (Emphasis added).

1910.141(b)(1)(iii) provides that “Portable drinking water dispensers shall be designed, constructed, and serviced so that **sanitary** conditions are maintained, shall be capable of being closed, and shall be equipped with a tap.” (Emphasis added).

1910.141(d)(1) provides that “Washing facilities shall be maintained in a **sanitary** condition.” (Emphasis added).

1910.141(g)(3) provides that “Waste disposal containers. Receptacles constructed of smooth, corrosion resistant, easily cleanable, or disposable materials, shall be provided and used for the disposal of waste food. The number, size, and location of such receptacles shall encourage their use and not result in overfilling. They shall be emptied not less frequently than once each working day, unless unused, and shall be maintained in a **clean and sanitary** condition. Receptacles shall be provided with a solid tight-fitting cover unless **sanitary** conditions can be maintained without use of a cover.” (Emphasis added).

1910.141(g)(4) provides that “**Sanitary** storage. No food or beverages shall be stored in toilet rooms or in an area exposed to a toxic material.” (Emphasis added).

Employee training on SARS-CoV-2 and COVID-19 hazards, with the exception of 1926.21(b)(2) referenced above for the Construction Industry

NOTE: Employers that provide training to employees will be able to avail themselves of an affirmative defense to VOSH citations and penalties known as the “Employee Misconduct Defense,” which is codified in VOSH regulation 16 VAC 25-60-260.B:³⁵³

B. A citation issued under subsection A of this section to an employer who violates any VOSH law, standard, rule, or regulation shall be vacated if such employer demonstrates that:

1. Employees of such employer have been provided with the proper training and equipment to prevent such a violation;
2. Work rules designed to prevent such a violation have been established and adequately communicated to employees by such employer and have been effectively enforced when such a violation has been discovered;
3. The failure of employees to observe work rules led to the violation; and
4. Reasonable steps have been taken by such employer to discover any such violation. (Emphasis added)

In order for an employer to avail themselves of the above affirmative defense, which can result in dismissal of COVID-19 citations and penalties, they have to be able to demonstrate that employees were trained on hazards regulated by and the requirements of the ETS/ER. Including a training requirement in the ETS/ER will assure that employers have preserved an important legal right.

3. Va. Code §40.1-51(a), the “General Duty Clause”.

While neither OSHA nor VOSH has a regulation specific to SARS-CoV-2 or COVID-19, Va. Code §40.1-51(a), otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1))³⁵⁴ of the OSH Act of 1970), provides that:

“It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees....”

While Congress intended that the primary method of compliance and enforcement under the

³⁵³ <https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-60-260>

³⁵⁴ https://www.osha.gov/laws-regs/oshact/section_5, 29 U.S.C. § 654(a)(1).

OSH Act of 1970 would be through the adoption of occupational safety and health standards³⁵⁵, it also provided the general duty clause as an enforcement tool that could be used in the absence of an OSHA (or VOSH) regulation.

As is evident from the wording of the general duty statute, it does not directly address the issue of SARS-CoV-2 or COVID-19 related hazards. While preferable to no enforcement tool at all, the general duty clause does not provide either the regulated community, employees, or the VOSH Program with substantive and consistent requirements on how to reduce or eliminate SARS-CoV-2 or COVID-19 related hazards.

Federal case law has established that the general duty clause can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer’s requirements, requirements of the Centers for Disease Control (CDC), or an employer’s safety and health rules.

However, there are limitations to use of the general duty clause that make it problematic to enforce and result in its infrequent use. The recent 2019 decision of the Occupational Safety and Health Review Commission’s (OSHRC) in *Secretary of Labor v. A. H. Sturgill Roofing, Inc.*,³⁵⁶ demonstrates the complexities and difficulties of establishing a heat-related illness general duty “recognized hazard” and accompanying violation in a case where an employee of a roofing contractor collapsed and later died with a diagnosis of heat stroke where the employee’s core body temperature was determined to be 105.4°F.³⁵⁷

One limitation of use of the general duty clause can result in unfortunate outcomes in at a worksite with multiple employers. For instance, a general duty clause violation can only be issued to an employer whose own employees were exposed to the alleged hazardous condition.³⁵⁸ In the context of a COVID-19 situation, consider a subcontractor who sends one employee to a multi-employer worksite who is COVID-19 positive and knowingly allows that employee to work around disease free employees of a second subcontractor, which results in the transmission of the disease to one or more of the second contractors’ employees.

In such a situation, because no uninfected employees of the first contractor were exposed to the disease at the worksite, the contractor who created the hazard could not be issued a general duty violation or accompanying monetary penalty.

There is no ability to cite “other-than-serious” general duty violations (“other than serious” violations normally do not carry a monetary penalty) because the statutory language specifies that the hazard be one that is “causing or likely to cause death or serious physical harm.”

³⁵⁵ *The Law of Occupational Safety and Health*, Nothstein, 1981, page 259.

³⁵⁶ OSHRC Docket No. 13-0224, <https://www.oshrc.gov/assets/1/18/A.H. Sturgill Roofing Inc.%5E13-0224%5EComplete Decision signed%5E022819%5EFINAL.pdf?8324>

³⁵⁷ *Id.* at pages 2-3, Contributing factors included that the worker had some preexisting medical conditions, it was his first day on the job, and the outside temperature at the time of collapse was estimated to be 82°F with 51 percent relative humidity. The work took place on a flat roof with periods of direct sun alternating with clouds; and involved removing a single-ply sheet rubber membrane and Styrofoam insulation so that a new roof could be installed.

³⁵⁸

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf, VOSH Field Operations Manual (FOM), Chapter 10, page 18)

In the context of the COVID-19 pandemic, the primary problem with the use of the general duty clause is the inability to use it to enforce any national consensus standard, manufacturer's requirements, CDC recommendations, or employer safety and health rules which use "should," "may," "it is recommended," and similar non-mandatory language.³⁵⁹

a. Use of the General Duty Clause to Enforce OSHA and CDC Guidelines.

All of the "Guidelines" published by OSHA, both of general application and directed to specific industries are by their own wording, unenforceable under the General Duty Clause:

"This guidance is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace."³⁶⁰

With regard to CDC guidelines generally, as an example, its "Meat and Poultry Processing Workers and Employers, Interim Guidance from CDC and the Occupational Safety and Health Administration (OSHA)"³⁶¹ states that:

"All meat and poultry processing facilities developing plans for continuing operations in the setting of COVID-19 occurring among workers or in the surrounding community should (1) work directly with appropriate state and local public health officials and occupational safety and health professionals; (2) incorporate relevant aspects of CDC guidance, including but not limited to this document and the CDC's Critical Infrastructure Guidance; and (3) incorporate guidance from other authoritative sources or regulatory bodies as needed."³⁶² (Emphasis added).

The above-referenced CDC Interim Guidance document contains very little "mandatory" language:

- "shall" is never used
- "much" is used 8 times but mostly with regard to OSHA regulatory requirements
- "should" is used 56 times
- "may" is used 39 times
- "recommend" or "recommendation" is used 7 times

In addition, the large majority of CDC's documents providing employers with mitigation strategies for COVID-19 identify them as "recommendations" rather than mandatory requirements, which makes use of the General Duty Clause to enforce them very problematic.

³⁵⁹ Courts and the [Occupational Safety and Health Review] Commission have held that OSHA must define an alleged hazard in such a way as to give the employer fair notice of its obligations under the OSH Act. In *Ruhlin Co.* [*Ruhlin Co.*, 21 OSH Cases 1779], the Commission held that the employer 'lacked fair notice that it could have an obligation under section 5(a)(1) to require its employees to wear high visibility vests.' The Commission found that a May 2004 interpretive letter by OSHA refers to a provision of the Federal Highway Administration manual which contained optional, not mandatory language."

³⁶⁰ <https://www.osha.gov/Publications/OSHA3990.pdf>, at page 2.

³⁶¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html>

³⁶² *Id.*

For instance, the CDC’s “Interim Guidance for Restaurants and Bars”³⁶³ appears unenforceable under the General Duty Clause, even though the body of the document lists what read like “requirements” without any qualifying “should” or “may” language, because the opening paragraph says the following:

“This guidance provides considerations for businesses in the food service industry (e.g., restaurants and bars) on ways to maintain healthy business operations and a safe and healthy work environment for employees, while reducing the risk of COVID-19 spread for both employees and customers. Employers should follow applicable Occupational Safety and Health Administration (OSHA) and CDC guidance for businesses to plan and respond to COVID-19. All decisions about implementing these recommendations should be made in collaboration with local health officials and other State and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of activities towards pre-COVID-19 operating practices. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.” (Emphasis added).

b. Use of the General Duty Clause to Enforce “Mandatory” Requirements in Virginia Executive Orders.

Where Virginia Executive Order 61³⁶⁴ provides for mandatory measures to be taken by an employer to protect employees (e.g., wearing of “face covering” or “physical distancing” of 6 feet), the Department believes that it would be able to use the General Duty Clause to enforce such requirements. However, only those mitigation measures that contain “mandatory” language that result in protection for employees can be enforced using the General Duty Clause.

4. Va. Code §18.2-422, Prohibition of wearing of masks in certain places; exceptions.³⁶⁵

Section 18.2-422 provides as follows:

“It shall be unlawful for any person over 16 years of age to, with the intent to conceal his identity, wear any mask, hood or other device whereby a substantial portion of the face is hidden or covered so as to conceal the identity of the wearer, to be or appear in any public place, or upon any private property in this Commonwealth without first having obtained from the owner or tenant thereof consent to do so in writing. However, the provisions of this section shall not apply to persons (i) wearing traditional holiday costumes; (ii) engaged in professions, trades, employment or other activities and

³⁶³ <https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf#page=53>

³⁶⁴ [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf)

³⁶⁵ <https://law.lis.virginia.gov/vacode/18.2-422/>

wearing protective masks which are deemed necessary for the physical safety of the wearer or other persons; (iii) engaged in any bona fide theatrical production or masquerade ball; or (iv) wearing a mask, hood or other device for bona fide medical reasons upon (a) the advice of a licensed physician or osteopath and carrying on his person an affidavit from the physician or osteopath specifying the medical necessity for wearing the device and the date on which the wearing of the device will no longer be necessary and providing a brief description of the device, or (b) the declaration of a disaster or state of emergency by the Governor in response to a public health emergency where the emergency declaration expressly waives this section, defines the mask appropriate for the emergency, and provides for the duration of the waiver. The violation of any provisions of this section is a Class 6 felony.” (Emphasis added).

Virginia Executive Order 62 continues the waiver of Va. Code §18.2-422 of the Code of Virginia so as to allow the wearing of a medical mask, respirator, or any other protective face covering for the purpose of facilitating the protection of one’s personal health in response to the COVID-19 public health emergency declared by the State Health Commissioner on February 7, 2020, and reflected in Executive Order 51 declaring a state of emergency in the Commonwealth. Executive Order 51 is so further amended. This waiver is effective as of March 12, 2020.

ATTACHMENT C: OTHER STATE COVID-19 LAWS, STANDARDS AND REGULATIONS

Washington.

The State of Washington’s Division of Occupational Safety and Health (DOSH) just enacted Emergency COVID-19 Safety Rules³⁶⁶ on “Prohibited Business Activities and Conditions for Operations.”³⁶⁷

DOSH enacted an emergency rule that, on its face, allows the agency to cite Washington employers who fail to follow the patchwork of rules and guidance related to COVID-19, as set out by the State of Washington and associated safety and health authorities.

Oregon.

Effective November 16, 2020, adopted a Temporary Rule Addressing COVID-19 Workplace Risks,³⁶⁸ which applies to all employees working in places of employment subject to Oregon OSHA’s jurisdiction.

On May 11, 2020, Oregon adopted a Temporary Rule addressing the COVID-19 emergency in employer-provided housing, labor-intensive agricultural operations, and agricultural transportation.

The Oregon Occupational Safety and Health Administration (Oregon OSHA) adopted a temporary rule³⁶⁹ addressing the COVID-19 emergency in employer-provided housing, labor-intensive agricultural operations, and agricultural transportation with an effective date of May 11, 2020 and end date of October 23, 2020.³⁷⁰ The temporary rule provides for:

- enhanced sanitation requirements for toilet and handwashing facilities in the field;
- procedures to identify and isolate suspect COVID-19 cases “with sleeping, eating, and bathroom accommodations that are separate from others” (“Sick people should be isolated from others, have adequate hygiene facilities, and be taken care of by only one person in the household. If such isolation is not possible, follow guidance provided by the Oregon Health Authority or the local public health authority to make appropriate arrangements”.);
- procedures for isolating confirmed COVID-19 cases and only housing them with other confirmed cases with separate bathroom, cooking and eating facilities separate from people who have not been diagnosed with COVID-19. (“Sick people should be isolated from others, have adequate hygiene facilities, and be taken care of by only one person in the household. If such isolation is not possible, follow guidance provided by the Oregon Health Authority or the local public health authority to make appropriate arrangements.”); and
- “Affected employers must post a notice describing the requirements of these rules, including their application to COVID-19 risks, and advising where workers may file complaints regarding field sanitation matters. It must be in the language of the majority of the workers.”

³⁶⁶ https://www.lni.wa.gov/rulemaking-activity/AO20-10/2010CR103E.pdf?utm_medium=email&utm_source=govdelivery

³⁶⁷ <https://www.environmentalsafetyupdate.com/states/washington/wa-dosh-issues-emergency-covid-19-safety-rule-mandating-compliance-with-emergency-proclamation-and-safe-start-reopening-guidance/>

³⁶⁸ <https://osha.oregon.gov/OSHARules/div1/437-001-0744.pdf>

³⁶⁹ <https://osha.oregon.gov/OSHARules/adopted/2020/ao2-2020-text-emergency-rules-ag-covid.pdf>

³⁷⁰ *Id.*

NOTE: The Virginia Department of Health is responsible for conducting pre-occupancy inspections of temporary labor camps under 1910.142, and has issued “Interim Guidance for Migrant Labor Camp Operators and Employees Regarding COVID-19.”³⁷¹

California.

The California Division of Occupational Safety and Health (Cal/OSHA) Aerosol Transmissible Diseases (ATD) standard³⁷² is aimed at preventing worker illness from infectious diseases that can be transmitted by inhaling air that contains viruses (including SARS-CoV-2), bacteria or other disease-causing organisms. The Cal/OSHA ATD standard is only mandatory for certain healthcare employers in California.

Cal/OSHA also adopted COVID-19 Prevention Emergency Temporary Standards³⁷³ on December 1, 2020. These new temporary standards apply to most workers in California not covered by Cal/OSHA’s AT D standard.

³⁷¹ <https://www.vdh.virginia.gov/environmental-health/environmental-health-services/migrant-labor-camps/9505-2/>

³⁷² <https://www.cdph.ca.gov/Programs/CCDC/DEODC/OHB/Pages/ATDStd.aspx>

³⁷³ <https://www.dir.ca.gov/dosh/coronavirus/ETS.html>

ATTACHMENT D: FINDING OF “GRAVE DANGER” TO SUPPORT THE ADOPTION OF THE EMERGENCY TEMPORARY STANDARD (ETS) FOR INFECTION DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19, 16VAC25-220, EFFECTIVE JULY 27, 2020

Workplace exposures to SARS-CoV-2 and COVID-19 constitute a grave danger to employees and employers in Virginia necessitating the adoption of an emergency temporary standard pursuant to Va. Code §40.1-22(6a).

1. Statutory Construction of Va. Code §40.1-22(6a).

Va. Code §40.1-22(6), is specific to the Board and provides procedures for adopting an Emergency Temporary Standard:

§ 40.1-22. Safety and Health Codes Commission continued as Safety and Health Codes Board.

....

(6) Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 shall apply to the adoption of rules and regulations under this section and to proceedings before the Board.

(6a) The Board shall provide, without regard to the requirements of Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2, for an emergency temporary standard to take immediate effect upon publication in a newspaper of general circulation, published in the City of Richmond, Virginia, if it determines that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and that such emergency standard is necessary to protect employees from such danger. The publication mentioned herein shall constitute notice that the Board intends to adopt such standard within a period of six months. The Board by similar publication shall prior to the expiration of six months give notice of the time and date of, and conduct a hearing on, the adoption of a permanent standard. The emergency temporary standard shall expire within six months or when superseded by a permanent standard, whichever occurs first, or when repealed by the Board.

(Emphasis added).

The terms “grave danger” and “necessity” are not defined in the statute, but have been addressed in federal court cases surrounding federal OSHA’s similar statutory requirement in the OSH Act, §6(c) (identical language underlined):

“(1) The Secretary shall provide, without regard to the requirements of chapter 5, title 5, Unites States Code, for an emergency temporary standard to take immediate effect upon publication in the Federal Register if he determines –

(A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and
(B) that such emergency standard is necessary to protect employees from such danger. (Emphasis added).

29 U.S.C. § 655(c).

From *Asbestos Information Ass'n/North America v. OSHA*, 727 F.2d 415 (5th Cir. 1984) – review of OSHA’s Emergency Temporary Standard (ETS) lowering the PEL for asbestos under Section 6(c) of the OSH Act (29 U.S.C. § 655(c):

“As the Supreme Court has noted, the determination of what constitutes a risk worthy of Agency action is a policy consideration that belongs, in the first instance to the Agency. [citation omitted] The Secretary determined that eighty lives at risk is a grave danger. We are not prepared to say it is not. The Agency need not support its conclusion ‘with anything approaching scientific certainty. [citation omitted] ... so long as the Agency supports its conclusion with ‘a body of reputable scientific thought,’ it may ‘use conservative assumptions’ to support that conclusion. The Agency also has prerogative to choose between conflicting evidence of equivalent quality, and a court will consider a finding consistent with one authority or another to be supported by substantial evidence.”

From *Florida Peach Growers Ass'n v. Dept. of Labor*, 489 F.2d 120 (5th Cir. 1974) – review of OSHA ETS regarding protecting farmworkers from exposure to certain pesticides during cultivation of various crops:

“The Act requires determination of danger from exposure to harmful substances, not just a danger of exposure; and, not exposure to just a danger, but to a grave danger; and, not the necessity of just a temporary standard, but that an emergency standard is necessary.

OSHA relied on a report finding that 800 persons are killed annually from the improper use of pesticides, and 80,000 injured. The court found this did not support a conclusion that the per se use of the pesticides presents a “grave danger.” *Id.* at 131. There was not enough data in the record on deaths from use of pesticide in the workplace (as opposed to ingestion by children, etc.).

The court looked at petitioner’s evidence “detailing the generally mild nature of the relatively few cases of illness reported by crop workers exposed solely to residues. ... from time to time a group of workers will experience nausea, excessive salivation and perspiration, blurred vision, abdominal cramps, vomiting, and diarrhea, in approximately that sequence....these are not grave illnesses, however, and do not support a determination of a grave danger....no deaths have been conclusively attributed to exposure to residues.” *Id.* at 131.

The court said “We reject any suggestion that deaths must occur before health and safety standards may be adopted. Nevertheless, the danger of incurable, permanent, or fatal consequences to workers, as opposed to easily curable and fleeting effects on their health, becomes important in the consideration of the necessity for emergency measures to meet a grave danger.” *Id.* at 132.

From *International Union, United Auto., Aerospace, and Agr. Implement Workers of America, UAW v. Donovan*, 590 F. Supp. 747 (D.D.C. 1984), where OSHA declined to promulgate an ETS on formaldehyde in the workplace. The court action was brought in district court challenging decision under the federal APA:

“The ‘grave danger’ and ‘necessity’ findings must be based on evidence of actual, prevailing industrial conditions, i.e., current levels of employee exposure to the substance in question.” *Id.* at 751.

From *Dry Color Mfrs. Ass’n, Inc. v. Brennan*, 486 F.2d 98 (3d Cir. 1973), a review of OSHA’s emergency regulations regarding 14 carcinogenic substances under Section 6(c) of the OSH Act (29 U.S.C. § 655(c)):

“...the most that can be said is that DCB and EI pose a ‘potential’ cancer hazard to men. Although the danger to cancer is surely “grave,” subsection 6(c)(1) of the Act requires a grave danger of exposure to substances ‘determined to be toxic or physically harmful.’ 486 F.2d 98, 104.

“While the Act does not require an absolute certainty as to the deleterious effect of a substance on man, an emergency temporary standard must be supported by evidence that shows more than some possibility that a substance may cause cancer in man. On this record, the evidence supplies no more than some possibility that DCB and EI may cause cancer in man.” *Id.* at 104-5.

Finding that SARS-CoV-2 and COVID-19 constitute a grave danger to employees in Virginia that necessitates the adoption of an emergency temporary standard to protect Virginia employees from such danger.

The staff of the Department of Labor and Industry recommends that the Board find that SARS-CoV-2 and COVID-19 related hazard and job task employee exposures constitute a grave danger to employees in Virginia that necessitate the adoption of an emergency temporary standard to protect Virginia employees from the spread of the SARS-CoV-2 virus that causes COVID-19 under Va. Code §40.1-22(6a).

As is supported by the information presented below and in the administrative record presented to the Board, there currently exists in the Commonwealth of Virginia an emergency situation due to the ongoing spread of the potentially deadly SARS-CoV-2 virus that causes COVID-19.

A state of emergency has been declared by Governor Northam, due to the presence of COVID-19, a communicable disease which poses a public health threat as declared by the State Health Commissioner.

In the context of the Board’s authority to regulate occupational safety and health hazards in Virginia, COVID-19 poses a threat of “material impairment of health or functional capacity” to employees. The threat is new, immediate, dangerous, and potentially life threatening to employees and presents a grave danger to employees that necessitates the adoption of an emergency temporary standard.

The onslaught of the SARS-CoV-2 virus and COVID-19 disease are by their own definitions new and “novel,” involving a sudden, unforeseen, and fast spreading epidemic which evolved into a worldwide pandemic in a matter of months. In the U.S. it quickly spread to all 50 states and territories and became one of the leading causes of death in the country in just four months at over 112,000 deaths so far. As of June 11, 2020, thirty-seven

(37) U.S. jurisdictions report more than 10,000 COVID-19 cases,³⁷⁴ including the Virginia border states of Maryland (over 60,100 cases, and 2,875 deaths), North Carolina (over 38,100, and 1,053 deaths), Kentucky (over 11,800, and 484 deaths), Tennessee (over 28,000, and 456 deaths). The District of Columbia has over 9,500 cases, and 499 deaths.³⁷⁵

Virginia now has 52,647 cases, 5,306 people hospitalizations, and 1,520 deaths as of June 11, 2020. The COVID-19 impact on Virginia's employees and employers has been widespread, significant and devastating. Employee deaths under VOSH investigation now total 11 in a span of four months (which would represent 30% of the average number of deaths investigated by VOSH on a calendar year basis), with at least four employee hospitalizations under VOSH investigation. Both are expected to increase over the coming months.

According to Virginia Workers' Compensation Commission statistics, over 3,150 claims have been submitted in a four month period across a wide range of industries and job classifications. On May 11, 2020, VWCC was reporting 2,182 workers' compensation claims; and by May 31, 2020 the total had increased by 972 claims to 3,154, a 44.5% increase in a 20 day time period. For a number of reasons, these numbers significantly underrepresent the number of actual workers' compensation claims and COVID-19 illnesses suffered by Virginia employees on the job. In addition, over 40 claims have been submitted for Virginia state employees from a wide variety of agencies during the same period.

According to a CDC study, among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%. The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.³⁷⁶

The federal and state governments have almost universally acknowledged the emergency presented by the disease with declarations of emergencies around the country and implementation of a combination of voluntary and mandatory mitigation efforts to attempt to slow the progress of the disease. The effectiveness of those efforts remain an open question. Statistics, studies, and news reports demonstrate that employees are becoming infected, seriously ill, and dying from COVID-19 because of workplace exposures in a wide variety of industries.

Complications can include pneumonia and trouble breathing, organ failure in several organs, heart problems, a severe lung condition that causes a low amount of oxygen to go through your bloodstream to your organs (acute respiratory distress syndrome), blood clots, acute kidney injury, additional viral and bacterial infections, permanent long term injury to the body, and death.

Early studies indicate that COVID-19's "infection fatality rate" may be substantially higher than the seasonal influenza – potentially resulting in death ten or more times frequently than the seasonal flu.

³⁷⁴ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

³⁷⁵ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

³⁷⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

Susceptibility to COVID-19 is near universal in the workplace as there is no pre-existing immunity to this novel virus among humans. There is currently no specific treatment for or vaccine to prevent COVID-19. The best way to prevent workplace related illness is to prevent workplace exposure to the SARS-CoV-2 virus.

SARS-CoV-2 is easily transmitted through the air from person-to-person through respiratory aerosols created by coughing, sneezing, talking, and even singing. Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period, and asymptomatic transmission has been suggested in other reports. SARS-CoV-2 aerosols can settle and deposit on environmental surfaces where they can remain viable for days, although it is thought that transmission of the virus in this manner is not thought to be the primary mode of transmission.

The CDC's current best estimate of the percentage of persons with positive COVID-19 infections that are asymptomatic is 35%. The CDC's current best estimate of the percentage of COVID-19 disease transmission occurring prior to symptom onset is 40%. This means that until an effective vaccine is developed and deployed, healthy employees will run a continuing risk of exposure to COVID-19 despite an employer's best efforts to conduct pre-shift screening of employees, customers, and other persons to identify suspected COVID-19 carriers of the disease.

Researchers think that the reproduction number for COVID-19 is between 2 and 3, which means that one person can infect two to three other people. There are also documented cases in the U.S. of "superspreader" events where, one person has been shown to have infected dozens of people at a single mass gathering event.

"The threshold for combined [COVID-19] vaccine efficacy, once one is developed and herd immunity needed for disease extinction" is estimated between 55% and 82% "(i.e., >82% of the population has to be immune, through either vaccination or prior infection, to achieve herd immunity to stop transmission)." Development and deployment of a vaccine in the United States remains at least six months away and perhaps many more months beyond that.

CDC's current "best guess" is that — in a scenario without any further social distancing or other efforts to control the spread of the virus — roughly 4 million patients would be hospitalized in the U.S. with COVID-19 and 500,000 would die over the course of the pandemic.

Although all employees are potentially susceptible to serious health complications from exposure to the SARS-CoV-2 virus and COVID-19 disease, there are sound reasons to be significantly concerned about workplace exposures to employees in high risk categories (age and medical condition). A substantial portion of the workforce are individuals of 65 years or older, or suffering from chronic medical conditions such as diabetes, obesity, hypertension, high cholesterol, or underlying respiratory conditions.

Continued spread of the virus in the general population and the workplace is anticipated for months to come. The disease is spread through "very, very casual interpersonal contact." Despite all the efforts of national, state, and local government leaders, there are currently (as of June 4, 2020) 19 states that have averaged more new cases over the past week than the prior week, while 13 are holding steady and 18 are seeing a downward trend. In addition, it

is still widely expected that a late fall or early winter second wave of COVID-19 could be even more deadly in the U. S., as it would coincide with the flu season, which already puts a strain on hospitals.

There is ample evidence to support the conclusion that spread of the SARS-CoV-2 virus and the potentially deadly COVID-19 disease will persist in Virginia's workplaces for many months to come. It is well documented that employers will be confronted with employees who work despite being symptomatic for fear of job loss, and customers who will refuse to observe physical distancing or face covering requirements, even in the face of Governor's executive orders, thereby exposing employees to a continuing risk of exposure unless mandatory mitigation efforts are implemented through an emergency regulation.

In addition, as contractors from other states cross borders into and out of Virginia, combined with the loosening of travel restrictions and opening of state economies, more people from other states and localities with ongoing high rates of community transmission will potentially bring the SARS-CoV-2 virus and COVID-19 disease to Virginia's workplaces and communities.

As previously noted, there is currently no vaccine for COVID-19. While officials are hopeful a vaccine to prevent COVID-19 will be ready in the first half of 2021, it's far from guaranteed. Producing and deploying a vaccine to a sufficient number of the U. S. population (over 329,000,000 people) to achieve a minimum of 50% of the population with effective COVID-19 antibodies will take some time to accomplish. In addition the fact that the vaccine may have an effectiveness rate below 100%, successful deployment of a vaccine will depend on the willingness of the U.S. population to actually take the vaccine. There is evidence to support a conclusion that a not insignificant portion of the population may refuse to take the vaccine.

The need for an emergency temporary standard is demonstrated by the rapid and overwhelmingly widespread onslaught of the SARS-CoV-2 virus and COVID-19 disease in the country, to states surrounding Virginia, and to Virginia itself and its places of employment. The deadly virus is both new and "novel," involving a sudden, unforeseen, and fast spreading epidemic which evolved into a worldwide pandemic in a matter of months.

A significant number of employee deaths and workers' compensation claims have been reported in Virginia in just a four month period. Virginia employees are becoming infected, seriously ill, and dying from COVID-19 because of workplace exposures in a wide variety of industries.

Susceptibility to COVID-19 is near universal in the workplace as there is no pre-existing immunity to this novel virus among humans. There is currently no specific treatment for or vaccine to prevent COVID-19. Development and deployment of a vaccine in the United States remains at least six months away and perhaps many more months beyond that.

Due to the high potential for pre-symptomatic and asymptomatic persons to unknowingly spread the SARS-CoV-2 virus in a public or workplace setting, until an effective vaccine is developed and deployed, healthy employees will run a continuing risk of exposure to COVID-19 despite an employer's best efforts to conduct pre-shift screening of employees, customers, and other persons to identify suspected COVID-19 carriers of the disease.

The most effective way to ensure that no Virginia “employee will suffer material impairment of health or functional capacity” is to prevent the spread of workplace related COVID-19 infections through the adoption of mandatory employee protection and virus mitigation requirements.

There currently is no occupational law, standard, or regulation that specifically addresses infectious diseases such as the SARS-CoV-2 virus that causes the COVID-19 disease. While there are some VOSH regulations that can be applied toward some mitigation efforts (i.e., personal protective equipment, respiratory protection equipment), those regulations are not universal across all Virginia industries, and none would require:

- Physical distancing of at least six feet where feasible
- Disinfection of work areas where known or suspected COVID-19 employees or other persons accessed or worked³⁷⁷
- Employers to develop policies and procedures for employees to report when they are sick or experiencing symptoms consistent with COVID-19
- Employers to, prior to the commencement of each work shift, prescreen of employees to verify each employee is not COVID-19 symptomatic
- Employers to prohibit known and suspected COVID-19 employees from reporting to or being allowed to remain at work or on a job site until cleared for return to work
- Employers to develop and implement policies and procedures for known COVID-19 or suspected COVID-19 employees to return to work using either a symptom-based or test-based strategy depending on local healthcare and testing circumstances
- Employers to prohibit COVID-19 positive employees from reporting to or being allowed

³⁷⁷ <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.141>

1910.141(a)(3)(i) provides that “All places of employment shall be kept **clean** to the extent that the nature of the work allows.” (Emphasis added). The term “sanitary” is not used, although it is used in reference to “washing facilities”, “waste disposal”, “food storage”, “sweepings”, and “drinking water”.

1910.141(a)(4)(i) provides that “Any receptacle used for putrescible solid or liquid waste or refuse shall be so constructed that it does not leak and may be thoroughly cleaned and maintained in a **sanitary** condition. Such a receptacle shall be equipped with a solid tight-fitting cover, unless it can be maintained in a **sanitary** condition without a cover. This requirement does not prohibit the use of receptacles which are designed to permit the maintenance of a **sanitary** condition without regard to the aforementioned requirements.” (Emphasis added).

1910.141(a)(4)(ii) provides that “All sweepings, solid or liquid wastes, refuse, and garbage shall be removed in such a manner as to avoid creating a menace to health and as often as necessary or appropriate to maintain the place of employment in a **sanitary** condition.” (Emphasis added).

1910.141(b)(1)(iii) provides that “Portable drinking water dispensers shall be designed, constructed, and serviced so that **sanitary** conditions are maintained, shall be capable of being closed, and shall be equipped with a tap.” (Emphasis added).

1910.141(d)(1) provides that “Washing facilities shall be maintained in a **sanitary** condition.” (Emphasis added).

1910.141(g)(3) provides that “Waste disposal containers. Receptacles constructed of smooth, corrosion resistant, easily cleanable, or disposable materials, shall be provided and used for the disposal of waste food. The number, size, and location of such receptacles shall encourage their use and not result in overfilling. They shall be emptied not less frequently than once each working day, unless unused, and shall be maintained in a **clean and sanitary** condition. Receptacles shall be provided with a solid tight-fitting cover unless **sanitary** conditions can be maintained without use of a cover.” (Emphasis added).

1910.141(g)(4) provides that “**Sanitary** storage. No food or beverages shall be stored in toilet rooms or in an area exposed to a toxic material.” (Emphasis added).

to remain at work or on a job site until cleared for return to work

- Employers to provide employees assigned to work stations and in frequent contact with other persons inside six feet with alcohol based hand sanitizers at their workstations
- Employers with hazards or job tasks classified at very high, high, or medium exposure risk to develop a written Infectious Disease Preparedness and Response Plan
- Employee training on SARS-CoV-2 and COVID-19 hazards, with the exception of 1926.21(b)(2) requirements for the Construction Industry³⁷⁸

The current patchwork of VOSH and OSHA standards and regulations do not ensure that similarly situated employees and employers exposed to the same SARS-CoV-2 and COVID-19 related hazards and job tasks in similar exposure settings are provided the same level of occupational safety and health protections. Examples include but are not limited to:

- Construction Industry employers would be required to provide training to employees on an emergency temporary standard/emergency regulation, but no other employers covered by VOSH jurisdiction would be required to do so. Section 1926.21(b)(2)³⁷⁹ (Safety Training and Education).
- The Agricultural Industry has no standards or regulations to provide respiratory or personal protective equipment to employees.
- Sanitation requirements in the Construction Industry are limited to “Toilet facilities shall be operational and maintained in a clean and sanitary condition.”
- Neither the Construction Industry nor the Agricultural Industry have a requirement comparable to 1910.132(d) which requires General Industry employers to conduct a written workplace assessment to “determine if hazards are present, or are likely to be present, which necessitate the use of” PPE.³⁸⁰

³⁷⁸With the exception of the Construction Industry regulation at 1926.21(b)(2) (Safety Training and Education)

³⁷⁹ <https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.21>

³⁸⁰ 1910.132(d), Hazard assessment and equipment selection.

1910.132(d)(1), The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE). If such hazards are present, or likely to be present, the employer shall:

1910.132(d)(1)(i), Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

1910.132(d)(1)(ii), Communicate selection decisions to each affected employee; and,

1910.132(d)(1)(iii), Select PPE that properly fits each affected employee.

Note: Non-mandatory appendix B contains an example of procedures that would comply with the requirement for a hazard assessment.

1910.132(d)(2)

The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

The Board's statutory mandate in Va. Code §40.1-22(5) to:

“... adopt, alter, amend, or repeal rules and regulations to further, protect and promote the safety and health of employees in places of employment over which it has jurisdiction and to effect compliance with the federal OSH Act of 1970...as may be necessary to carry out its functions established under this title. The Commissioner shall enforce such rules and regulations. All such rules and regulations shall be designed to protect and promote the safety and health of such employees. In making such rules and regulations to protect the occupational safety and health of employees, the Board shall adopt the standard which most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity. However, such standards shall be at least as stringent as the standards promulgated by the Federal Occupational Safety and Health Act of 1970 (P.L. 91-596). In addition to the attainment of the highest degree of health and safety protection for the employee, other considerations shall be the latest available scientific data in the field, the feasibility of the standards, and experience gained under this and other health and safety laws....” (Emphasis added).

As is discussed in greater detail in section above, while the General Duty Clause, Va. Code §40.1-51(a), can be used in certain limited circumstances to enforce mandatory requirements in Governor Northam's Executive Orders, there are severe limitations to its use that make it problematic to enforce and results in its infrequent use. As is evident from the wording of the statute, it does not directly address the issue of SARS-CoV-2 or COVID-19 related hazards.

While preferable to no enforcement tool at all, the general duty clause does not provide either the regulated community, employees, or the VOSH Program with substantive and consistent requirements on how to reduce or eliminate SARS-CoV-2 or COVID-19 related hazards, serious illnesses and deaths, that can otherwise be clearly and uniformly established in an emergency temporary standard. It cannot be used to enforce OSHA Guidelines at all, and can only be used to enforce CDC guidelines that use “mandatory” language such as “shall” and “will” as opposed to language that “suggests” or “recommends” employer action through words such as “should” or “may”. Of the specific mitigation efforts listed above only the physical distancing and enhanced sanitation requirements are addressed in Governor Northam's Executive Orders and therefore enforceable through the General Duty Clause.

Further, federal OSHA has taken the position that it will not be promulgating an emergency temporary standard pursuant to its authority under the OSH Act of 1970,³⁸¹ instead opting to rely upon many voluntary guidelines for various business sectors. These guidelines, while useful for employers with the intention of complying with health and safety standards, will be irrelevant for businesses who choose not to take steps to protect employees from the grave danger posed by COVID-19.

Many of the guidelines are explicit that they are voluntary, and may not be used to impose legal obligations upon employers. Employers' voluntary compliance with relevant

³⁸¹ https://www.osha.gov/laws-regs/oshact/section_6

guidelines, which has also been asserted by OSHA as a reason a standard is unnecessary, is antithetical to the goal of protecting all employees, particularly in those workplaces with recalcitrant employers.

An emergency regulation is also necessary to establish clear baseline standards employers can rely upon as to how to protect employees, rather than having them rely upon ad hoc "interim" guidance documents from various agencies. In a similar case where federal OSHA relied solely upon voluntary guidance and employers' voluntary compliance instead of an emergency temporary standard, the D.C. Circuit Court of Appeals found OSHA had "embarked upon the least responsive course short of inaction" and ordered OSHA to expedite rulemaking for an ethylene oxide standard. *Public Citizen Health Research Group v. Auchter*, 702 F.2d 1150, 1153 (D.C. Cir. 1983).

The following items are intended to support and supplement the above finding, but the Board reserves the right to rely on other evidence presented in the administrative record to support the finding and its decision to adopt an emergency temporary standard, should it decide to do so.

- On February 7, 2020, the State Health Commissioner declared COVID-19 a communicable disease of public health threat³⁸² as defined in Va. Code §44-146.16 in part as "an illness of public health significance....caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create a risk of death or significant injury or impairment...."
- In the context of VOSH's jurisdiction over places of employment and the Safety and Health Codes Board's authority to regulate occupational safety and health hazards in Virginia, COVID-19 poses a threat of "material impairment of health or functional capacity" to employees. Va. Code §40.1-22(5).
- Infectious respiratory diseases can spread in a workplace setting when a healthy person comes in contact with virus particles expelled by someone who is sick — usually through a cough or sneeze.³⁸³ SARS-CoV-2 is easily transmitted through the air from person-to-person through respiratory aerosols, and the aerosols can settle and deposit on environmental surfaces where they can remain viable for days.³⁸⁴
- Susceptibility to COVID-19 will be universal in the workplace as there is no pre-existing immunity to this novel virus among humans. "The virus is spread through very, very casual interpersonal contact." W. David Hardy, a professor of infectious disease at Johns Hopkins University School of Medicine, told STAT.³⁸⁵
- "Although most people with COVID-19 have mild to moderate symptoms, the [COVID-

³⁸² <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf>

³⁸³ <https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/>

³⁸⁴ <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/coronavirus-disease-2019-covid-19-frequently-asked-questions>

³⁸⁵ <https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/>

19] disease can cause severe medical complications and lead to death in some people. Older adults or people with existing chronic medical conditions are at greater risk of becoming seriously ill with COVID-19.”³⁸⁶ “Younger adults are also being hospitalized in the U.S. Adults 20–44 account for 20% of hospitalizations, 12% of ICU admissions.”³⁸⁷ Some research indicates that SARS-CoV-2 infection can cause significant morbidity in relatively young persons without severe underlying medical conditions.³⁸⁸

- “Those most at risk are ‘people 65 years and older, people who live in a nursing home or long-term care facility, people with chronic lung, heart, kidney and liver disease,’ said Dr. Gary Weinstein, pulmonologist/critical care medicine specialist at Texas Health Presbyterian Hospital Dallas (Texas Health Dallas). Additionally, he said others who could be at risk are those with compromised immune systems and people with morbid obesity or diabetes. “Finally, when patients have lung failure, they frequently have failure or dysfunction of their other organs, such as the kidney, heart, and brain.’”³⁸⁹ (Emphasis added).
- In all 50 states and the District of Columbia, at least 20 percent of adults ages 65 to 74 are in the workforce. In seven states, more than 30 percent are working. Since 2013, 46 of 51 had seen increases in workforce participation of 75-and-older residents. Seniors represent significant portions of the workforce for many professions that require close contact with others, including bus drivers, ushers, ticket takers, taxi drivers, street vendors, chiropractors, dentists, barbers and many more.³⁹⁰
- The CDC conducted a study of “Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016”³⁹¹ of the general population. Although the working population of the country is only a subset of the totals for the table, the data nonetheless demonstrates the significant risk that SARS-CoV-2 and COVID-19 related hazards pose to the U.S. and Virginia workers. Using the age adjusted statistical totals:
 - 14.7% of the population suffer from diabetes
 - 12.2% from high cholesterol
 - 30.2% suffer from hypertension
 - 39.7% suffer from obesity

³⁸⁶ <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>

³⁸⁷

https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19_SA_RS_CoV_2_

³⁸⁸ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e1.htm>

³⁸⁹ <https://www.healthline.com/health-news/what-we-know-about-the-long-term-effects-of-covid-19#COVID-19-might-affect-the-brain-stem>

³⁹⁰ <https://www.seniorliving.org/research/senior-employment-outlook-covid/>

³⁹¹ <https://www.cdc.gov/nchs/data/hus/2018/021.pdf>

NOTE: Virginia’s Adult Diabetes Rate in 2019 was 10.5%.³⁹²

Virginia’s Hypertension Rate in 2015 was 33.2%.³⁹³

Virginia’s Adult High Cholesterol Rate³⁹⁴ in 2019 was 33%.³⁹⁵

Virginia’s Adult Obesity Rate³⁹⁶ in 2019 was 30.3%.³⁹⁷

- The largest cohort of >44,000 persons with COVID-19 from China showed that illness severity can range from mild to critical:
 - Mild to moderate (mild symptoms up to mild pneumonia): **81%**
 - Severe (dyspnea, hypoxia, or >50% lung involvement on imaging): **14%**
 - Critical (respiratory failure, shock, or multi-organ system dysfunction): **5%**
- “In this study, all deaths occurred among patients with critical illness and the overall case fatality rate was 2.3%. The case fatality rate among patients with critical disease was 49%. Among children in China, illness severity was lower with 94% having asymptomatic, mild or moderate disease, 5% having severe disease, and <1% having critical disease. Among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%. The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.”³⁹⁸ (Emphasis added).
- Asymptomatic and Pre-Symptomatic Transmission. Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period, and asymptomatic transmission has been suggested in other reports. Virologic studies have also detected SARS-CoV-2 with RT-PCR low cycle thresholds, indicating larger quantities of viral RNA, and cultured viable virus among persons with asymptomatic and pre-symptomatic SARS-CoV-2 infection. The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear. Risk of transmission is thought to be greatest when patients are symptomatic since viral shedding is greatest at the time of symptom onset and declines over the course of several days to weeks. However, the proportion of SARS-CoV-2 transmission in the population due to asymptomatic or pre-symptomatic infection compared to symptomatic infection is unclear.³⁹⁹
- “Complications can include pneumonia and trouble breathing, organ failure in several organs, heart problems, a severe lung condition that causes a low amount of oxygen to go through your bloodstream to your organs (acute respiratory distress syndrome), blood

³⁹² https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA

³⁹³ <https://www.vdh.virginia.gov/content/uploads/sites/65/2018/05/VA-Heart-Disease-FactSheetFINAL.pdf>

³⁹⁴ Percentage of adults who reported having their cholesterol checked and were told by a health professional that it was high.

³⁹⁵ https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA

³⁹⁶ Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight (pre-2011 BRFSS methodology).

³⁹⁷ <https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-virginia>

³⁹⁸ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

³⁹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

clots, acute kidney injury, additional viral and bacterial infections.”⁴⁰⁰

- There is significant evidence of workplace exposures for employees to COVID-19 in many different industries in Virginia and around the country (see section IV.O.1 to .26).
- Early studies indicate that COVID-19 “infection fatality rate” may be substantially higher than the seasonal influenza. The generally accepted approximate IFR-S of seasonal influenza is 0.1%.⁴⁰¹ A study by the University of Washington using data through April 20, 2020, calculated the U.S. “infection mortality rate” among symptomatic cases (IFR-S) to be 1.3%⁴⁰² [13 times the seasonal influenza rate]. Another study calculated a global IFR of 1.04%⁴⁰³ [10.4 times the seasonal influenza rate]. A study by the London School of Hygiene and Tropical Medicine estimated the infection fatality rate on the Diamond Princess Cruise Ship to be 1.2%⁴⁰⁴ [12 times the seasonal influenza rate] Nearly the entire cruise ships 3,711 passengers and crew were tested.
- The CDC’s current best estimate of the percentage of persons with positive COVID-19 infections that are asymptomatic is 35%.⁴⁰⁵ The CDC’s current best estimate of the percentage of COVID-19 disease transmission occurring prior to symptom onset is 40%.⁴⁰⁶ This means that until an effective vaccine is developed and deployed, healthy employees will run a continuing risk of exposure to COVID-19 despite an employer’s best efforts to conduct pre-shift screening of employees.

⁴⁰⁰ *Id.*

⁴⁰¹ *Id.* referencing <https://www.cdc.gov/flu/about/burden/2018-2019.html>

⁴⁰² <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00455>; Study assumptions: We make three assumptions for our analysis: (1) Errors in the numerator and the denominator lead to underreporting of true COVID-19 deaths and cases, respectively; error is smaller for deaths than for cases. (2) Both the errors are declining over time. (3) The errors in the denominator are declining at a faster rate than the error in the numerator.

Assumption #1 is self-evident; both the deaths and the actual cases are undercounted during the initial phase of the epidemic. Because deaths are much more visible events than infections, which, in the case of COVID-19, can go asymptomatic during the first few days of infection, we posit that, at any point in time, the errors in the denominator are larger than the errors in the numerator. Hence, this assumption leads to CFR estimates being larger than the IFR-S, which is typically believed to be true based on observed data.

Assumption #2 is our central assumption, which states that under some stationary processes of care delivery, health care supply, and reporting, which are all believed to be improving over time, the errors in both the numerator and the denominator are declining. It implies that we are improving in the measurement of both the numerator and denominator over time, albeit at different rates in different jurisdictions.

Assumption #3 posits that the error in the denominator is declining faster than the error in the numerator. This assumption indicates that the CFR rates, based on the number of cumulative COVID-19 deaths and the cumulative reported COVID-19 cases, are declining over time and are confirmed based on our observed data (described in detail below).

⁴⁰³ <https://www.medrxiv.org/content/10.1101/2020.05.11.20098780v1>

⁴⁰⁴ <https://www.medrxiv.org/content/10.1101/2020.03.05.20031773v2>

⁴⁰⁵ <https://www.cnn.com/2020/05/22/health/cdc-coronavirus-estimates-symptoms-deaths/index.html>

⁴⁰⁶ *Id.*

- The CDC has documented multiple “superspreaders” of the virus at mass gathering events involving a choir practice,⁴⁰⁷ a church service,⁴⁰⁸ a funeral,⁴⁰⁹ and a birthday party⁴¹⁰ where dozens of persons were infected by a single “superemitter” of the virus.
- Since February, 2020, the Virginia Workers’ Compensation Commission has received 3,154 COVID-19 related claims as of May 31, 2020 in a wide variety of occupational settings, representing a nearly 44.5% increase in claims over a 20 day period since May 11, 2020 (2,182 claims).
- Since February, 2020, the Virginia Department of Human Resources Workers’ Compensation Statistics has received 42 COVID-19 related claims for state employees in a wide variety of occupational settings (see section IV.A.2).
- Pursuant to Va. Code §40.1-51.1.D⁴¹¹, eight (8) COVID-19 related employee deaths have been reported by employers to the Department. An additional three (3) employee deaths have been reported to the Department by the Virginia Workers’ Compensation Commission.
- The VOSH Program has investigated an average of 37 annual work-related employee deaths over the last five calendar years. The eleven (11) COVID-19 death notifications so far in 2020 would represent 30% of the deaths investigated by VOSH in an average year. It is not unreasonable to assume that had no mitigation efforts been undertaken by state and local governments beginning in mid-March (e.g., stay at home requests and orders, business shutdowns, physical distancing requirements, face covering recommendations and requirements, etc.), that the number of COVID-19 death notifications would be even higher than the 11 reported to date. It is anticipated that VOSH will be receiving more notifications of employee deaths in the coming weeks and months.
- “[As of May 20, 2020] The CDC's current "best guess" is that — in a scenario without any further social distancing or other efforts to control the spread of the virus — roughly 4 million patients would be hospitalized in the U.S. with COVID-19 and 500,000 would die over the course of the pandemic. That's according to the agency's new parameters that the Center for Public Integrity plugged into a simple epidemiological model.”⁴¹²
- Researchers think that the R_0 [reproduction number] for COVID-19 is between 2 and 3. This means that one person can infect two to three other people.⁴¹³ Depending on the level of contagiousness of COVID-19 expressed in the R_0 ⁴¹⁴ value, “the threshold for combined

⁴⁰⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm>

⁴⁰⁸ https://www.cdc.gov/mmwr/volumes/69/wr/mm6920e2.htm?s_cid=mm6920e2_w

⁴⁰⁹ https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e1.htm?s_cid=mm6915e1_w

⁴¹⁰ *Id.*

⁴¹¹ <https://law.lis.virginia.gov/vacode/40.1-51.1/>

⁴¹² <https://www.npr.org/sections/health-shots/2020/05/22/860981956/scientists-say-new-lower-cdc-estimates-for-severity-of-covid-19-are-optimistic>

⁴¹³ <https://www.webmd.com/lung/what-is-herd-immunity#1>

⁴¹⁴ “The basic reproduction number (R_0), pronounced “R naught,” is intended to be an indicator of the contagiousness or transmissibility of infectious and parasitic agents.... R_0 has been described as being one of the fundamental and most

[COVID-19] vaccine efficacy and herd immunity needed for disease extinction” is estimated between 55% and 82% “(i.e., >82% of the population has to be immune, through either vaccination or prior infection, to achieve herd immunity to stop transmission).”⁴¹⁵

- There is anecdotal evidence to support the conclusion that employers will be confronted with employees who work despite being symptomatic and customers who will refuse to observe physical distancing or face covering requirements, even in the face of Governor’s executive orders (see section IV.O.17, Restaurants and Bars; section IV.O.18, Grocery Retail and Food Retail; section IV.O.20, Personal Care, Personal Grooming, Salon, and Spa Services; section IV.O.21, Sports and Entertainment, and Mass Gatherings).
- “As U.S. states push forward with reopening plans, nearly as many are seeing coronavirus caseloads trending upward as those where case numbers are declining, an analysis of Johns Hopkins data shows. Nineteen states have averaged more new cases over the past week than the prior week, while 13 are holding steady and 18 are seeing a downward trend. Louisiana is one of those downward-trending states and is set to begin Phase 2 of its plan to reopen the economy Friday, allowing businesses to open at 50% capacity, according to Gov. John Bel Edwards....Texas and Florida are still recording increasing weekly averages of new cases as they take steps toward reopening.”⁴¹⁶
- “It is not yet known whether weather and temperature affect the spread of COVID-19. Some other viruses, like those that cause the common cold and flu, spread more during cold weather months but that does not mean it is impossible to become sick with these viruses during other months. There is much more to learn about the transmissibility, severity, and other features associated with COVID-19 and investigations are ongoing.”⁴¹⁷
- “Robert Redfield, MD, the director of the Centers for Disease Control and Prevention (CDC), warned yesterday [April 21, 2020] that a late fall or early winter wave of COVID-19 could be even more deadly in the United States, as it would coincide with the flu season, which already puts a strain on hospitals.”⁴¹⁸
- There is currently no vaccine for COVID-19. “U.S. officials and scientists are hopeful a vaccine to prevent Covid-19 will be ready in the first half of 2021 - 12 to 18 months since Chinese scientists first identified the coronavirus and mapped its genetic sequence. It’s far from guaranteed. Even the most optimistic epidemiologists hedge their bets when they say it could be ready that quickly. And a lot can go wrong that could delay their progress,

often used metrics for the study of infectious disease dynamics (7–12). An R_0 for an infectious disease event is generally reported as a single numeric value or low–high range, and the interpretation is typically presented as straightforward; an outbreak is expected to continue if R_0 has a value >1 and to end if R_0 is <1 (13). The potential size of an outbreak or epidemic often is based on the magnitude of the R_0 value for that event (10), and R_0 can be used to estimate the proportion of the population that must be vaccinated to eliminate an infection from that population (14,15). R_0 values have been published for measles, polio, influenza, Ebola virus disease, HIV disease, a diversity of vectorborne infectious diseases, and many other communicable diseases (14,16–18).

https://wwwnc.cdc.gov/eid/article/25/1/17-1901_article

⁴¹⁵ https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article#suggestedcitation

⁴¹⁶ <https://www.cnn.com/2020/06/04/health/us-coronavirus-thursday/index.html>

⁴¹⁷ <https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Coronavirus-Disease-2019-Basics>

⁴¹⁸ <https://www.cidrap.umn.edu/news-perspective/2020/04/coroner-first-us-covid-19-death-occurred-early-february>

scientists and infectious disease experts warn.”⁴¹⁹

- Producing and deploying a vaccine to a sufficient number of the U. S. population (over 329,000,000 people) to achieve a minimum of 50% of the populations with effective COVID-19 antibodies will take some time to accomplish. The U.S. Census estimates that Virginia’s population as of July 1, 2019 was 8,535,519, and that 15.4% (1,314,469) of Virginia’s population was 65 years or older.⁴²⁰
- Successful deployment of a COVID-19 vaccine will depend on the willingness of the U.S. population to actually take the vaccine. In a Reuters’ survey⁴²¹ of 4,428 U.S. adults taken between May 13 and May 19: “Fourteen percent of respondents said they were not at all interested in taking a vaccine, and 10% said they were not very interested. Another 11% were unsure.”

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⁴¹⁹ <https://www.cnbc.com/2020/05/21/coronavirus-vaccine-why-it-may-be-ready-early-next-year-and-what-could-go-wrong.html>

⁴²⁰ <https://www.census.gov/quickfacts/fact/table/VA#>

⁴²¹ <https://www.reuters.com/article/us-health-coronavirus-vaccine-poll-exclu/exclusive-a-quarter-of-americans-are-hesitant-about-a-coronavirus-vaccine-reuters-ipsos-poll-idUSKBN22X19G>

ATTACHMENT E: OSHA RECORDKEEPING GUIDELINES FOR RECORDING COVID-19 OCCUPATIONALLY RELATED CASES

OSHA's changing guidance in April and May, 2020, concerning employer responsibilities to record COVID-19 occupationally related illnesses has over the short term resulted in reduced access to accurate workplace exposure and illness data related to COVID-19.

On **April 10, 2020**, OSHA issued a memorandum on "Enforcement Guidance for Recording Cases of Coronavirus Disease 2019 (COVID-19)"⁴²² to provide "interim guidance to Compliance Safety and Health Officers (CSHOs) for enforcing the requirements of 29 CFR Part 1904 with respect to the recording of occupational illnesses, specifically cases of Coronavirus Disease 2019 (COVID-19)....This guidance is intended to be time-limited to the current public health crisis:

Under OSHA's recordkeeping requirements, COVID-19 is a recordable illness, and employers are responsible for recording cases of COVID-19, if: (1) the case is a confirmed case of COVID-19, as defined by Centers for Disease Control and Prevention (CDC);[1] (2) the case is work-related as defined by 29 CFR § 1904.5;[2] and (3) the case involves one or more of the general recording criteria set forth in 29 CFR § 1904.7.[3] On March 11, the World Health Organization (WHO) declared COVID-19 a global pandemic, and the extent of transmission is a rapidly evolving issue.

In areas where there is ongoing community transmission, employers other than those in the healthcare industry, emergency response organizations (e.g., emergency medical, firefighting, and law enforcement services), and correctional institutions may have difficulty making determinations about whether workers who contracted COVID-19 did so due to exposures at work. In light of those difficulties, OSHA is exercising its enforcement discretion in order to provide certainty to the regulated community.

Employers of workers in the healthcare industry, emergency response organizations (e.g., emergency medical, firefighting, and law enforcement services), and correctional institutions must continue to make work-relatedness determinations pursuant to 29 CFR § 1904. Until further notice, however, OSHA will not enforce 29 CFR § 1904 to require other employers to make the same work-relatedness determinations, except where:

1. There is objective evidence that a COVID-19 case may be work-related. This could include, for example, a number of cases developing among workers who work closely together without an alternative explanation; and
2. The evidence was reasonably available to the employer. For purposes of this memorandum, examples of reasonably available evidence include information given to the employer by employees, as well as information that an employer learns regarding its employees' health and safety in the ordinary course of managing its business and employees.

This enforcement policy will help employers focus their response efforts on implementing good hygiene practices in their workplaces, and otherwise mitigating

⁴²² <https://www.osha.gov/memos/2020-04-10/enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>

COVID-19's effects, rather than on making difficult work-relatedness decisions in circumstances where there is community transmission. (Emphasis added).

On **May 19, 2020**⁴²³, OSHA revised its April 10, 2020 guidance as follows:

“Confirmed cases of COVID-19 have now been found in nearly all parts of the country, and outbreaks among workers in industries other than healthcare, emergency response, or correctional institutions have been identified. As transmission and prevention of infection have become better understood, both the government and the private sector have taken rapid and evolving steps to slow the virus's spread, protect employees, and adapt to new ways of doing business. As the virus's spread now slows in certain areas of the country, states are taking steps to reopen their economies and workers are returning to their workplaces. All these facts—incidence, adaptation, and the return of the workforce—indicate that employers should be taking action to determine whether employee COVID-19 illnesses are work-related and thus recordable. Given the nature of the disease and ubiquity of community spread, however, in many instances it remains difficult to determine whether a COVID-19 illness is work-related, especially when an employee has experienced potential exposure both in and out of the workplace.

In light of these considerations, OSHA is exercising its enforcement discretion in order to provide certainty to employers and workers. Accordingly, until further notice, OSHA will enforce the recordkeeping requirements of 29 CFR 1904 for employee COVID-19 illnesses for all employers according to the guidelines below.

....

Because of the difficulty with determining work-relatedness, OSHA is exercising enforcement discretion to assess employers' efforts in making work-related determinations. In determining whether an employer has complied with this obligation and made a reasonable determination of work-relatedness, CSHOs should apply the following considerations:

- The reasonableness of the employer's investigation into work-relatedness. Employers, especially small employers, should not be expected to undertake extensive medical inquiries, given employee privacy concerns and most employers' lack of expertise in this area. It is sufficient in most circumstances for the employer, when it learns of an employee's COVID-19 illness, (1) to ask the employee how he believes he contracted the COVID-19 illness; (2) while respecting employee privacy, discuss with the employee his work and out-of-work activities that may have led to the COVID-19 illness; and (3) review the employee's work environment for potential SARS-CoV-2 exposure. The review in (3) should be informed by any other instances of workers in that environment contracting COVID-19 illness.
- The evidence available to the employer. The evidence that a COVID-19 illness was work-related should be considered based on the information reasonably available to the employer at the time it made its work-relatedness determination. If the employer later learns more information related to an employee's COVID-19 illness, then that information should be taken into account as well in determining whether an employer made a reasonable work-relatedness determination.

⁴²³ <https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>

- The evidence that a COVID-19 illness was contracted at work. CSHOs should take into account all reasonably available evidence, in the manner described above, to determine whether an employer has complied with its recording obligation. This cannot be reduced to a ready formula, but certain types of evidence may weigh in favor of or against work-relatedness. For instance:
 - COVID-19 illnesses are likely work-related when several cases develop among workers who work closely together and there is no alternative explanation.
 - An employee's COVID-19 illness is likely work-related if it is contracted shortly after lengthy, close exposure to a particular customer or coworker who has a confirmed case of COVID-19 and there is no alternative explanation.
 - An employee's COVID-19 illness is likely work-related if his job duties include having frequent, close exposure to the general public in a locality with ongoing community transmission and there is no alternative explanation.
 - An employee's COVID-19 illness is likely not work-related if she is the only worker to contract COVID-19 in her vicinity and her job duties do not include having frequent contact with the general public, regardless of the rate of community spread.
 - An employee's COVID-19 illness is likely not work-related if he, outside the workplace, closely and frequently associates with someone (e.g., a family member, significant other, or close friend) who (1) has COVID-19; (2) is not a coworker, and (3) exposes the employee during the period in which the individual is likely infectious.
 - CSHOs should give due weight to any evidence of causation, pertaining to the employee illness, at issue provided by medical providers, public health authorities, or the employee herself.

If, after the reasonable and good faith inquiry described above, the employer cannot determine whether it is more likely than not that exposure in the workplace played a causal role with respect to a particular case of COVID-19, the employer does not need to record that COVID-19 illness.” (Emphasis added).

ATTACHMENT F: VOSH INVESTIGATION AND INSPECTION PROCEDURES

1. VOSH Inspection Priority Categories.

<u>Priority</u>	<u>Category</u>
First	Imminent Danger as defined in the VOSH <u>Administrative Regulation Manual</u> (ARM).
Second	Fatality Inspections (regardless of whether our inspection is in response to specific evidence of hazardous conditions or not).
Third	Accident / First Report of Accident Inspections.
Fourth	Complaints / Referrals.
Fifth	Follow-up / Monitoring.
Sixth	Programmed Inspections, i.e., General Schedule, Construction Schedule, National & Local Emphasis Programs AND unprogrammed inspections in response to alleged hazardous working conditions that would normally be classified as Other-Than-Serious.

2. VOSH Informal Investigation and Inspection Procedures.

COVID-19 “Investigations”

- Informal investigations (phone/fax/email/letter) are often conducted in response to employee complaints (with the permission of the employee); and referrals from the Virginia Department of Health
- The employer is provided the opportunity to provide a response to the complaint/referral items with a short turnaround time
- If no response or an unsatisfactory response is received, an inspection will be conducted
- If the response is considered satisfactory, it is provided to the Complainant for review and comment. If the Complainant provides reasonable information challenging the validity of the response provided, an inspection will be conducted.

Summary of How VOSH Initially Handled COVID-19 Related Complaints Early in the Pandemic:

COVID-19 related employee complaints received by the VOSH program that are within VOSH's jurisdiction are being addressed with employers. In an abundance of caution, at the beginning of the COVID-19 outbreak in Virginia the Department decided to modify its normal complaint processing procedures for both the safety and health of the employees at the work sites and its VOSH compliance officers by trying to limit exposure to the virus as much as possible while carrying out statutory enforcement mandates.

Rather than conducting a combination of onsite inspections and informal investigations as is the case under normal situations, COVID-19 complaints were initially handled through the VOSH program's complaint investigation process, which involves contacting the employer by phone, fax, email, or letter.

VOSH informed the employer of the complaint allegation and required a written response concerning the validity of the complaint allegation, any safety and health measures taken to date to protect employees against potential COVID-19 related hazards, and any measures to be taken in response to valid complaint allegations.

Employers were required to post a copy of VOSH's correspondence where it would be readily accessible for review by employees; and provide a copy of the correspondence and the employer's response to a representative of any recognized union or safety committee at the facility. Complainants were provided a copy of the employer's response.

Depending on the specific facts of the employee's alleged complaint, an employer's failure to respond or inadequate response could result in additional contact by the VOSH program with the employer, a referral to local law enforcement officials, an onsite VOSH inspection, or other enforcement options available to the VOSH program.

COVID-19 "Inspections"

- Can result in violations and substantial penalties
- Inspections are opened for COVID-19 related employee deaths
- Inspections may be opened for COVID-19 related hospitalizations or handled through an investigation
- Inspection files with proposed violations will be reviewed by Headquarters and receive a legal review before a decision to issue or not issue is made

3. Violation and Penalty Structure.

The emergency temporary standard/emergency regulation would be enforced in the same manner as all other VOSH laws, standards, and regulations. The types of civil violations that VOSH can cite are "serious", "other than serious", "repeat", "willful," and "failure to abate. Maximum penalties for each type are:

Serious and Other-than-serious \$13,277

Willful and Repeat	\$132,764
Failure-to-Abate	\$13,277 per day

In calculating penalties, Va. Code §40.1-49.4.A.4 .a provides:

In determining the amount of any proposed penalty [the Commissioner] shall give due consideration to the appropriateness of the penalty with respect to the size of the business of the employer being charged, the gravity of the violation, the good faith of the employer, and the history of previous violations. (Emphasis added).

Chapter 11 of the VOSH FOM explains how penalties are calculated:

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf

Employers can receive penalty reductions for “size” based on the number of employees as follows:

1 - 25	70%
26-100	40%
101-250	20%
251 or more	zero

A penalty reduction of up to 25 percent is permitted in recognition of an employer’s “good faith” in increments of 0%, 5%, 10%, 15%, 20% and 25%.

History. A reduction of 10% shall be given to employers who have not been cited by VOSH for any serious, willful or repeated violations in the past three years.

The minimum penalty for a serious violation is \$600.00.

4. Employee Misconduct Defense.

The “Employee Misconduct” affirmative defense to VOSH citations and penalties is codified in VOSH regulation 16 VAC 25-60-260.B:

B. A citation issued under subsection A of this section to an employer who violates any VOSH law, standard, rule, or regulation shall be vacated if such employer demonstrates that:

1. Employees of such employer have been provided with the proper training and equipment to prevent such a violation;
2. Work rules designed to prevent such a violation have been established and adequately communicated to employees by such employer and have been **effectively enforced** when such a violation has been discovered;

3. The failure of employees to observe work rules led to the violation; and

4. Reasonable steps have been taken by such employer to discover any such violation. (Emphasis added)

5. De Minimis Violation Policy.

Va. Code §40.1-49.4.A.2⁴²⁴ provides “The Commissioner may prescribe procedures for calling to the employer's attention *de minimis* violations which have no direct or immediate relationship to safety and health.” (Emphasis added).

The Virginia Occupational Safety and Health (VOSH) Field Operations Manual (FOM)⁴²⁵ describes the Commissioner’s procedures for *de minimis* violations in Chapter 10, pp. 38-39:

De minimis violations are violations of standards which have no direct or immediate relationship to safety or health. Compliance Officers identifying *de minimis* violations of a VOSH standard shall not issue a citation for that violation, but should verbally notify the employer and make a note of the situation in the inspection case file. The criteria for classifying a violation as *de minimis* are as follows:

1. Employer Complies with Clear Intent of Standard.

An employer complies with the clear intent of the standard but deviates from its particular requirements in a manner that has no direct or immediate relationship to employee safety or health. These deviations may involve distance specifications, construction material requirements, use of incorrect color, minor variations from recordkeeping, testing, or inspection regulations, or the like.

....

2. Employer Complies with Proposed Standard.

An employer complies with a proposed standard or amendment or a consensus standard rather than with the standard in effect at the time of the inspection and the employer’s action clearly provides equal or greater employee protection or the employer complies with a written interpretation issued by OSHA or VOSH.

3. Employer Technically Exceeds Standard.

An employer’s workplace is at the “state of the art” which is technically beyond the requirements of the applicable standard and provides equivalent or more effective employee safety or health protection.

Note: Maximum professional discretion must be exercised in determining the point at which noncompliance with a standard constitutes a *de minimis* violation.

⁴²⁴ <https://law.lis.virginia.gov/vacode/40.1-49.4/>

⁴²⁵

https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf

The FOM⁴²⁶ further provides:

The Compliance Officer shall discuss all conditions noted during the walkaround considered to be *de minimis*, indicating that such conditions are subject to review by the Regional Safety or Health Director in the same manner as apparent violations but, if finally classified as *de minimis*, will not be included on the citation. (Emphasis added).

6. Multi-employer Worksite Regulation and Defense.

Section 16VAC25-60-260.F contains requirements for employers:

“F. On multi-employer worksites for all covered industries, citations shall normally be issued to an employer whose employee is exposed to an occupational hazard (the exposing employer). Additionally, the following employers shall normally be cited, whether or not their own employees are exposed:

1. The employer who actually creates the hazard (the creating employer);
2. The employer who is either:
 - a. Responsible, by contract or through actual practice for safety and health conditions on the entire worksite, and has the authority for ensuring that the hazardous condition is corrected (the controlling employer); or
 - b. Responsible, by contract or through actual practice for safety and health conditions for a specific area of the worksite or specific work practice or specific phase of a construction project, and has the authority for ensuring that the hazardous condition is corrected (the controlling employer); or
3. The employer who has the responsibility for actually correcting the hazard (the correcting employer).

Section 16VAC25-60-260.G contains the multi-employer worksite defense:

“G. A citation issued under subsection F of this section to an exposing employer who violates any VOSH law, standard, rule, or regulation shall be vacated if such employer demonstrates that:

1. The employer did not create the hazard;
2. The employer did not have the responsibility or the authority to have the hazard corrected;
3. The employer did not have the ability to correct or remove the hazard;

⁴²⁶ *Id.* at Chapter 5, p. 76.

4. The employer can demonstrate that the creating, the controlling, or the correcting employers, as appropriate, have been specifically notified of the hazards to which the employer's employees were exposed;
5. The employer has instructed his employees to recognize the hazard and, where necessary, informed them how to avoid the dangers associated with it;
6. Where feasible, an exposing employer must have taken appropriate alternative means of protecting employees from the hazard; and
7. When extreme circumstances justify it, the exposing employer shall have removed the employer's employees from the job.

DRAFT

Report on “How COVID-19 Deaths Are Counted”.⁴²⁷

“As coronavirus has swept through the United States, finding the true number of people who have been infected has been stymied due to lack of testing. Now, official counts of coronavirus deaths are being challenged, too.

....

The reality is that assigning a cause of death is not always straightforward, even pre-pandemic, and a patchwork of local rules and regulations makes getting valid national data challenging. However, data on excess deaths in the United States over the past several months suggest that COVID-19 deaths are probably being undercounted rather than over counted.

....

Death certificates can be signed by a physician who was responsible for a patient who died in a hospital, which accounts for many COVID-19 deaths. They can also be signed by medical examiners or coroners, who are independent officials who work for individual counties or cities. ‘Many COVID-19 death certificates are being handled by physicians unless the death occurred outside of the hospital, in which case a medical examiner or coroner would step in’, said Dr. Sally Aiken, the president of the National Association of Medical Examiners (NAME).

....

For COVID-19, the immediate cause of death might be listed as respiratory distress, with the second line reading “due to COVID-19.” Contributing factors such as heart disease, diabetes or high blood pressure would then be listed further down. This has led to some confusion by people arguing that the “real” cause of death was heart disease or diabetes, Aiken said, but that’s not the case.

‘Without the COVID19 being the last straw or the thing that led to the chain of events that led to death, they probably wouldn’t have died,’ she said.

....

‘Most COVID-19 deaths seen at Mount Sinai Health System in New York are in people who have comorbid (or co-occurring) conditions such as coronary artery disease or kidney disease’, said Dr. Mary Fowkes, the chief of autopsy services at Mount Sinai. But it’s not typically difficult to tell what killed them.

‘Most of the cases are pretty straightforward,’ Fowkes told Live Science. ‘The lungs are usually so severely involved with pathology, so they are two to three times or more the normal weight of a normal lung.’

(The excess weight is due to fluid and cell detritus from damaged lung tissues.)

....

Another complication for assigning a cause of death for COVID-19 is that some younger people have died of strokes and heart attacks and then tested positive for COVID-19 without any history of respiratory symptoms. The virus is now known to cause blood clots, suggesting that COVID-19 was the killer in these cases, too. Fowkes and her colleagues conducted a microscopic inspection of the brains of 20 COVID-19 victims in her hospital system and found that six of them contained tiny blood clots that had caused small strokes before death.

⁴²⁷ <https://www.scientificamerican.com/article/how-covid-19-deaths-are-counted/>

‘We’re seeing it in younger patients than you would expect, and we’re seeing it in a distribution that you wouldn’t expect, so we think it’s related to the COVID,’ Fowkes said.

The Centers for Disease Control and Prevention (CDC) has issued guidelines⁴²⁸ for how to attribute a death to COVID-19. The guidelines urge using information from COVID-19 testing, where possible, but also allow for deaths to be listed as “presumed” or “probable” COVID-19 based on symptoms and the best clinical judgment of the person filling out the death certificate. A medical examiner trying to determine a cause of death in the absence of testing would comb medical records and query family and loved ones about the person’s symptoms before they died, Aiken said. Postmortem COVID-19 tests may be possible, depending on the jurisdiction.”⁴²⁹

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⁴²⁸ <https://www.cdc.gov/nchs/covid19/coding-and-reporting.htm>

⁴²⁹ *Id.*

ATTACHMENT H: VOSH Violations Issued in COVID-19 Cases Opened From February 1, 2020 to December 30, 2020

VOSH Violations Issued in COVID-19 Cases Opened From February 1, 2020 to December 30, 2020		
NOTE: 43 of the 94 Inspections Opened During the Period Remain in Progress		
Violation	Initial Violation Type	Standard
16VAC25-220-40.B.5	Serious	ETS
16VAC25-220-40.G	Serious	ETS
16VAC25-220-40.K.5	Serious	ETS
16VAC25-220-60.C.1.e	Serious	ETS
16VAC25-220-60.C.1.k	Serious	ETS
1904.29(a)	Other-than-Serious	Recordkeeping
1904.29(b)(3)	Other-than-Serious	Recordkeeping
1904.30(a)	Other-than-Serious	Recordkeeping
1904.33(a)	Other-than-Serious	Recordkeeping
1904.40(a)	Other-than-Serious	Recordkeeping
1904.5(a)	Other-than-Serious	Recordkeeping
1910.1030(c)(1)(ii)	Serious	Bloodborne Pathogens
1910.1030(c)(1)(ii)	Serious	Bloodborne Pathogens
1910.1030(c)(2)(i)	Serious	Bloodborne Pathogens
1910.1030(f)(1)(i)	Other-than-Serious	Bloodborne Pathogens
1910.1030(g)(2)(ii)(B)	Other-than-Serious	Bloodborne Pathogens
1910.1030(g)(2)(ii)(B)	Other-than-Serious	Bloodborne Pathogens
1910.1030(h)(2)	Serious	Bloodborne Pathogens
1910.1200(e)(1)	Other-than-Serious	Hazard Communication
1910.1200(e)(1)	Other-than-Serious	Hazard Communication
1910.1200(e)(1)	Serious	Hazard Communication
1910.1200(e)(1)	Serious	Hazard Communication
1910.1200(e)(1)	Serious	Hazard Communication
1910.1200(e)(1)	Other-than-Serious	Hazard Communication
1910.1200(f)(6)	Serious	Hazard Communication
1910.1200(f)(6)(ii)	Serious	Hazard Communication
1910.1200(g)(11)	Other-than-Serious	Hazard Communication
1910.1200(g)(8)	Serious	Hazard Communication
1910.1200(g)(8)	Other-than-Serious	Hazard Communication
1910.1200(g)(8)	Serious	Hazard Communication
1910.1200(g)(8)	Other-than-Serious	Hazard Communication
1910.1200(g)(8)	Other-than-Serious	Hazard Communication
1910.1200(h)(1)	Other-than-Serious	Hazard Communication
1910.1200(h)(1)	Serious	Hazard Communication
1910.1200(h)(1)	Serious	Hazard Communication
1910.1200(h)(1)	Serious	Hazard Communication

1910.1200(h)(1)	Other-than-Serious	Hazard Communication
1910.132(d)(1)	Serious	PPE
1910.132(d)(1)	Serious	PPE
1910.132(d)(1)(i)	Serious	PPE
1910.132(d)(1)(i)	Serious	PPE
1910.132(d)(2)	Other-than-Serious	PPE
1910.132(d)(2)	Serious	PPE
1910.132(d)(2)	Other-than-Serious	PPE
1910.132(d)(2)	Serious	PPE
1910.132(d)(2)	Other-than-Serious	PPE
1910.132(f)(1)	Serious	PPE
1910.133(a)(1)	Serious	Eye and Face Protection
1910.134(c)(1)	Other-than-Serious	Respiratory Protection
1910.134(c)(1)	Serious	Respiratory Protection
1910.134(d)(1)(i)	Serious	Respiratory Protection
1910.134(d)(1)(ii)	Serious	Respiratory Protection
1910.134(e)(1)	Serious	Respiratory Protection
1910.134(e)(6)(i)	Other-than-Serious	Respiratory Protection
1910.134(e)(6)(i)	Other-than-Serious	Respiratory Protection
1910.134(f)(1)	Serious	Respiratory Protection
1910.134(f)(1)	Serious	Respiratory Protection
1910.134(f)(2)	Serious	Respiratory Protection
1910.134(h)(1)	Other-than-Serious	Respiratory Protection

1910.134(m)(1)	Serious	Respiratory Protection
1910.134(m)(1)	Serious	Respiratory Protection
1910.134(m)(2)(i)	Other-than-Serious	Respiratory Protection
1910.134(m)(2)(i)	Serious	Respiratory Protection
1910.134(m)(2)(i)	Serious	Respiratory Protection
1910.134(m)(2)(i)(B)	Other-than-Serious	Respiratory Protection
1910.134(m)(2)(i)(B)	Other-than-Serious	Respiratory Protection
1910.134(m)(2)(i)(C)	Other-than-Serious	Respiratory Protection
1910.134(m)(2)(i)(E)	Other-than-Serious	Respiratory Protection
1910.134(m)(2)(i)(E)	Other-than-Serious	Respiratory Protection
1910.134(m)(4)	Serious	Respiratory Protection
1910.141(a)(3)(i)	Serious	Sanitation
1910.151(b)	Other-than-Serious	First Aid
40.1-51.1.A	Serious	General Duty Clause
40.1-51.1.A	Serious	General Duty Clause
40.1-51.1.A	Serious	General Duty Clause
40.1-51.1.D	Other-than-Serious	Failure to Notify DOLI

DRAFT

January 4, 2021

16VAC25-220, DRAFT Final Permanent Standard for

Infectious Disease Prevention of the

SARS-CoV-2 Virus That Causes COVID-19

As Adopted by the

Safety and Health Codes Board

on _____



VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY (DOLI)

Effective Date: To be Determined, but no later than January 27, 2021

16VAC25-220

January 4, 2021

[LANGUAGE HIGHLIGHTED IN YELLOW REPRESENTS CHANGES FROM JULY 24, 2020]

[LANGUAGE HIGHLIGHTED IN BLUE REPRESENTS CHANGES FROM DECEMBER 10, 2020]

[DATES ARE HIGHLIGHTED IN GREEN]

DRAFT Final Permanent Standard for

Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19

16VAC25-220

16VAC25-220-10. Purpose, scope, and applicability.

A. This standard is designed to establish requirements for employers to control, prevent, and mitigate the spread of SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19) to and among employees and employers.

B. ~~This standard shall not be extended or amended without public participation in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and 16VAC25-60-170.~~

~~C.~~ This standard is adopted in accordance with subdivision 6 a of § 40.1-22 of the Code of Virginia and shall apply to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program as described in 16VAC25-60-20 and 16VAC25-60-30.

~~D.~~ This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective

equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply.

Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.

ED. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons.

Commented [WJ(1): (i) and (ii) numbering added by Registrar of Regulations Office (RRO), and semicolons deleted 1.4.2021

Commented [WJ(2): Added by Administration

Commented [WJ(3): DOLI interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms."

DOLI will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

2. Factors that shall be considered in determining exposure risk level include, but are not limited to:

a. The job tasks being undertaken, the work environment (e.g. indoors or outdoors), the known or suspected presence of the SARS-CoV-2 virus, the presence of a person known or suspected to be infected with the SARS-CoV-2 virus, the number of employees and other persons in relation to the size of the work area, the working distance between employees and other employees or persons, and the duration and frequency of employee exposure through contact inside of six feet with other employees or persons (e.g., including shift work exceeding 8 hours per day); and

b. The type of hazards encountered, including **exposure to respiratory droplets and potential** exposure to the airborne transmission of SARS-CoV-2 virus; contact with contaminated surfaces or objects, such as tools, workstations, or break room tables, and shared spaces such as shared workstations, break rooms, locker rooms, and entrances and exits to the facility; shared work vehicles; and industries or places of employment where employer sponsored shared transportation is a common practice, such as ride-share vans or shuttle vehicles, car-pools, and public transportation, etc.

Commented [WJ(4)]: VDH comment

~~F. This standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency.~~

~~GE. 1.~~ To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC

recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.

Commented [WJ(5): Added for consistency with first sentence in this subsection

2F. A public or private institution of higher education that has received certification from the State Council of Higher Education of Virginia that the institution's re-opening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor's Office in conjunction with the Virginia Department of Health shall be considered in compliance with this standard, provided the institution operates in compliance with its certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard. A public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and who operate in compliance with the public school division's or private school's submitted plans shall be considered in compliance with this standard. An institution's actual compliance with recommendations contained in CDC guidelines or the Virginia Department of Education guidance, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by a provision of this

Commented [WJ(6): Language added by Administration.

Reference:

§ 40.1-51. State Health Commissioner to provide advice and aid; rules and regulations.

A. The State Health Commissioner shall be responsible for advising and providing technical aid to the Commissioner on matters pertaining to occupational health on request.

B. The Department of Labor and Industry shall be responsible for drafting and submitting to the Virginia Safety and Health Codes Board for adoption rules and regulations pertaining to control measures to protect the health of workers. In formulating rules and regulations pertaining to health, the Department of Labor and Industry shall request the advice and technical aid of the Department of Health.

Commented [WJ(7): Added for consistency with second sentence in this subsection

standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. **The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.**

Commented [WJ(8): Language added by Administration.
Reference:
§ 40.1-51. State Health Commissioner to provide advice and aid; rules and regulations.
A. The State Health Commissioner shall be responsible for advising and providing technical aid to the Commissioner on matters pertaining to occupational health on request.
B. The Department of Labor and Industry shall be responsible for drafting and submitting to the Virginia Safety and Health Codes Board for adoption rules and regulations pertaining to control measures to protect the health of workers. In formulating rules and regulations pertaining to health, the Department of Labor and Industry shall request the advice and technical aid of the Department of Health.

HGHG. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Commented [WJ(9): Lettering correction by RRO 1.4.2021

16VAC25-220-20. Effective dates.

A. Adoption Process.

1. This standard shall take effect ~~[to be determined, but no later than January 27, 2021]~~ upon approval review by the Governor, and if no revisions are requested, filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

Commented [WJ(10): Commas deleted - RRO typo change 1.4.2021

2. If the Governor's review results in one or more requested revisions to the standard, the Safety and Health Codes Board shall reconvene to approve, amend, or reject the requested revisions.

Commented [WJ(11): Added by Administration

3. If the Safety and Health Codes Board approves the requested revisions to the standard as submitted, the standard shall take effect upon filing with the Registrar of Regulations

and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

4. Should the Governor fail to review the standard under subsection A 1 of this section within thirty (30) days of its approval by the Safety and Health Codes Board, the Board will not need to reconvene to take further action, and the standard shall take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

Commented [WJ(12): Reference number change made by RRO 1.4.2021

Commented [WJ(13): RRO change 1.4.2021

B. The requirements for 16VAC25-220-70 shall take effect on March 26, 2021.

The training requirements in 16VAC25-220-80 shall take effect on March 26, 2021.

Commented [WJ(14): This date assumes the permanent standard has an effective date of January 27, 2021.

Commented [WJ(15): This date assumes the permanent standard has an effective date of January 27, 2021.

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency

Commented [WJ(16): Comment 86152.

and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

Commented [WJ(17): RRO change 1.4.2021

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Commented [WJ(18): RRO change made 1.4.2021

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Commented [WJ(19): The new language in 16VAC25-220.C requires the Board to make a "determination" of whether there is continued need for the standard. The Department has identified three "determination" options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

Commented [WJ(20): With regard to the phrase "notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to," the intent of the language is to give the Board the maximum amount of flexibility to "notice" the Board meeting within 14 days even if the Board may not actually meet within 14 days

16VAC25-220-30. Definitions.

The following words and terms when used in this standard shall have the following meanings unless the context clearly indicates otherwise:

"Administrative control" means any procedure that significantly limits daily exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks by control or

manipulation of the work schedule or manner in which work is performed. The use of personal protective equipment is not considered a means of administrative control.

"Airborne infection isolation room" or "AIIR," formerly a negative pressure isolation room, means a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs provide (i) negative pressure in the room so that air flows under the door gap into the room, (ii) an air flow rate of 6-12 air changes per hour (ACH) (6 ACH for existing structures, 12 ACH for new construction or renovation), and (iii) direct exhaust of air from the room to the outside of the building or recirculation of air through a High Efficiency Particulate Air (HEPA) filter before returning to circulation.

"Asymptomatic" means a person who does not have symptoms.

"Building or facility owner" means the legal entity, including a lessee, that exercises control over management and record keeping functions relating to a building or facility in which activities covered by this standard take place.

"CDC" means Centers for Disease Control and Prevention.

"Cleaning" means the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, cleaning decreases their number and therefore any risk of spreading infection.

"Community transmission," also called "community spread," means people have been infected with SARS-CoV-2 in an area, including some who are not sure how or where they became infected. The level of community transmission is classified by the CDC as:

1. "No to minimal" where there is evidence of isolated cases or limited community transmission, case investigations are underway, and no evidence of exposure in large communal settings (e.g., healthcare facilities, schools, mass gatherings, etc.);¹
2. "Moderate" where there is sustained community transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases;
3. "Substantial, controlled" where there is large scale, controlled community transmission, including communal settings (e.g., schools, workplaces, etc.); or
4. "Substantial, uncontrolled" where there is large scale, uncontrolled community transmission, including communal settings (e.g., schools, workplaces, etc.).

Commented [WJ(21): Make consistent with CDC guidance language

"COVID-19" means Coronavirus Disease 2019, which is primarily a respiratory disease, caused by the SARS-CoV-2 virus.

"Disinfecting" means using chemicals approved for use against SARS-CoV-2, for example EPA-registered disinfectants, to kill germs on surfaces. The process of disinfecting does not necessarily clean dirty surfaces or remove germs, but killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html>

"Duration and frequency of employee exposure" means how long ("duration") and how often ("frequency") an employee is potentially exposed to the SARS-CoV-2 virus or COVID-19 disease. Generally, the greater the frequency or length of exposure, the greater the probability is for potential infection to occur. Frequency of exposure is generally more significant for acute acting agents or situations, while duration of exposure is generally more significant for chronic acting agents or situations. An example of an acute SARS-CoV-2 virus or COVID-19 disease situation would be an unprotected could involve a customer, patient, or other person not wearing a face covering or other personal protective equipment, or coughing or sneezing directly into the face of an employee. An example of a chronic situation would be could involve a job task that requires an employee to interact either for an extended period of time inside six feet with a smaller static group of other employees or persons or for an extended period of time inside six feet with a larger group of other employees or persons in succession but for periods of shorter duration.

"Economic feasibility" means the employer is financially able to undertake the measures necessary to comply with one or more requirements in this standard. The cost of corrective measures to be taken will not usually be considered as a factor in determining whether a violation of this standard has occurred. If an employer's level of compliance lags significantly behind that of its industry, an employer's claim of economic infeasibility will not be accepted.

"Elimination" means a method of exposure control that removes the employee completely from exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks.

"Employee" means an employee of an employer who is employed in a business of his employer. Reference to the term "employee" in this standard also includes, but is not limited to, January 4, 2021

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temporary employees and other joint employment relationships, persons in supervisory or management positions with the employer, etc., in accordance with Virginia occupational safety and health laws, standards, regulations, and court rulings.

"Engineering control" means the use of substitution, isolation, ventilation, and equipment modification to reduce exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks.

"Exposure risk level" means an assessment of the possibility that an employee could be exposed to the hazards associated with SARS-CoV-2 virus and the COVID-19 disease. The exposure risk level assessment should address all risks and all modes of transmission, including airborne transmission, as well as transmission by asymptomatic and presymptomatic individuals. Risk levels should be based on the risk factors present that increase risk exposure to COVID-19 and are present during the course of employment regardless of location. Hazards and job tasks have been divided into four risk exposure levels: very high, high, medium, and lower:

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"Very high" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure to known or suspected sources of the SARS-CoV-2 virus (e.g., laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures:

1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus;

2. Collecting or handling specimens from a patient or person known or suspected to be infected with the SARS-CoV-2 virus (e.g., manipulating cultures from patients known or suspected to be infected with the SARS-CoV-2 virus); and

3. Performing an autopsy that involves aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.

"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARS-CoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk, including, but not limited to:

1. Healthcare (physical and mental health) delivery and support services provided to a patient known or suspected to be infected with the SARS-CoV-2 virus, including field hospitals (e.g., doctors, nurses, cleaners, and other hospital staff who must enter patient rooms or areas);

2. Healthcare (physical and mental) delivery, care, and support services, wellness services, non-medical support services, physical assistance, etc., provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus involving skilled nursing services, outpatient medical services, clinical services, drug treatment programs, medical outreach services, mental health services, home health care, nursing home care, assisted living care, memory care support and services, hospice care,

rehabilitation services, primary and specialty medical care, dental care, COVID-19 testing services, blood donation services, **contact tracer services**, and chiropractic services;

Commented [WJ(25)]: VDH comment. Also listed under Medium risk exposure

3. First responder services provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus;

4. Medical transport services (loading, transporting, unloading, etc.) provided to patients known or suspected to be infected with the SARS-CoV-2 virus (e.g., ground or air emergency transport, staff, operators, drivers, pilots, etc.); and

5. Mortuary services involved in preparing (e.g., for burial or cremation) the bodies of persons who are known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.

"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Medium exposure risk hazards or job tasks may include, but are not limited to, operations and services in:

1. Poultry, meat, and seafood processing; agricultural and hand labor; commercial transportation of passengers by air, land, and water; on campus educational settings in schools, colleges, and universities; daycare and afterschool settings; restaurants and bars; grocery stores, convenience stores, and food banks; drug stores and pharmacies; manufacturing settings; indoor and outdoor construction settings; correctional facilities,

jails, detentions centers, and juvenile detention centers; work performed in customer premises, such as homes or businesses; retail stores; call centers; package processing settings; veterinary settings; personal care, personal grooming , salon, and spa settings; venues for sports, entertainment, movies, theaters, and other forms of mass gatherings; homeless shelters; fitness, gym, and exercise facilities; airports, and train and bus stations; etc.; and

2. Situations not involving exposure to known or suspected sources of SARS-CoV-2: hospitals, other healthcare (physical and mental) delivery and support services in a non-hospital setting, wellness services, physical assistance, etc.; skilled nursing facilities; outpatient medical facilities; clinics, drug treatment programs, and medical outreach services; non-medical support services; mental health facilities; home health care, nursing homes, assisted living facilities, memory care facilities, and hospice care; rehabilitation centers, doctors' offices, dentists' offices, and chiropractors' offices; first responders services provided by police, fire, paramedic and emergency medical services providers, medical transport; contact tracers, etc.

"Lower" exposure risk hazards or job tasks are those not otherwise classified as very high, high, or medium exposure risk that do not require contact inside six feet with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2. Employees in this category have minimal occupational contact with other employees, other persons, or the general public, such as in an office building setting; or are able to achieve minimal occupational contact **with others** through the implementation of engineering, administrative and work practice controls, such as, but not limited to **to**.

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1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time);

2. Telecommuting;

3. Staggered work shifts that allow employees to maintain physical distancing from other employees, other persons, and the general public;

4. Delivering services remotely by phone, audio, video, mail, package delivery, curbside pickup or delivery, etc., that allows employees to maintain physical distancing from other employees, other persons, and the general public; and

5. Mandatory physical distancing of employees from other employees, other persons, and the general public.

Employee use of face coverings for contact inside six feet of coworkers, customers, or other persons is not an acceptable administrative or work practice control to achieve minimal occupational contact. ~~However, when it is necessary for an employee to have brief contact with others inside the six feet distance a face covering is required.~~

Commented [WJ(28): Moved to 16VAC25-220-40.H per VDH comment

"Face covering" means an item made of two or more layers of washable, breathable fabric that fits snugly against the sides of the face without any gaps, completely covering the nose and mouth and fitting securely under the chin. Neck gaiters made of two or more layers of washable, breathable fabric, or folded to make two such layers are considered acceptable face coverings. Face coverings shall not have exhalation valves or vents, which allow virus particles to escape,

and shall not be made of material that makes it hard to breathe, such as vinyl.² normally made of cloth, or various other materials with elastic bands or cloth ties to secure over the wearer's nose and mouth in an effort to contain or reduce the spread of potentially infectious respiratory secretions at the source (i.e., the person's nose and mouth). A face covering is not normally intended to protect the wearer, but it may serve as a source control to reduce the spread of virus from the wearer to others. A face covering is not a surgical/medical procedure mask or respirator. A face covering is not subject to testing and approval by a state or government agency, so it is not considered a form of personal protective equipment or respiratory protection equipment under VOSH laws, rules, regulations, and standards.

"Face shield" means a form of personal protective equipment made of transparent, impermeable materials intended to protect the entire face or portions of the face primarily used for eye protection from droplets or splashes for the person wearing it. A face shield is not a substitute for a face covering, surgical/medical procedure mask, or respirator.³

"Feasible" as used in this standard includes both technical and economic feasibility.

"Filtering facepiece respirator" means a negative pressure air purifying particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering medium. Filtering facepiece respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH).

Commented [WJ(29)]: VDH comment

Commented [WJ(30)]: Comment 86327 contends it is wrong to assert that face covering are "not intended to protect the wearer".

Commented [WJ(31)]: CDC guidance indicates that face coverings can serve to protect both the wearer and others from the spread of SARS-CoV-2. <https://www.cdc.gov/coronavirus/2019-ncov/more/masking-science-sars-cov2.html>
"Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger)⁹ but they can also block the exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns.... Studies demonstrate that cloth mask materials can also reduce wearers' exposure to infectious droplets through filtration, including filtration of fine droplets and particles less than 10 microns."

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² <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>

³ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html>

"Hand sanitizer" means an alcohol-based hand rub containing at least 60% alcohol, unless otherwise provided for in this standard.

"HIPAA" means Health Insurance Portability and Accountability Act.

"Known to be infected with the SARS-CoV-2 virus" means a person, whether symptomatic or asymptomatic, who has tested positive for SARS-CoV-2, and the employer knew or with reasonable diligence should have known that the person has tested positive for SARS-CoV-2.

"May be infected with SARS-CoV-2 virus" means any person not currently a person known or suspected to be infected with SARS-CoV-2 virus ~~and not currently vaccinated against the SARS-CoV-2 virus.~~

Commented [WJ(34)]: VDH comment

"Minimal occupational contact" means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet); healthcare employees providing only telemedicine services; a long distance truck driver.⁴

Commented [WJ(35)]: Comments 85259, 85492.

"Occupational exposure" means the state of being actually or potentially exposed to contact with SARS-CoV-2 virus or COVID-19 disease related hazards at the work location or while engaged in work activities at another location.

⁴ <https://www.osha.gov/SLTC/covid-19/hazardrecognition.html>

"Personal protective equipment" means equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. These injuries and illnesses may result from contact with chemical, radiological, physical, electrical, mechanical, biological, or other workplace hazards. Personal protective equipment may include, but is not limited to, items such as gloves, safety glasses, goggles, shoes, earplugs or muffs, hard hats, respirators, surgical/medical procedure masks, impermeable gowns or coveralls, face shields, coveralls, vests, and full body suits.

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"Physical distancing" also called "social distancing" means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

Commented [WJ(38)]: Comment 85955. Clarification that floor to ceiling wall is one form of providing physical distancing.

Commented [WJ(39)]: VDH comment

"Respirator" means a protective device that covers the nose and mouth or the entire face or head to guard the wearer against hazardous atmospheres. Respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH). Respirators may be (i) tight-fitting, which means either a half mask that covers the mouth and nose or a full face piece that covers the face from the hairline to below the chin or (ii) loose-fitting, such as hoods or helmets that cover the head completely.

There are two major classes of respirators:

1. Air-purifying, which remove contaminants from the air; and
2. Atmosphere-supplying, which provide clean, breathable air from an uncontaminated source. As a general rule, atmosphere-supplying respirators are used for more hazardous exposures.

"Respirator user" means an employee who in the scope of their current job may be assigned to tasks that may require the use of a respirator in accordance with this standard or required by other provisions in the VOSH and OSHA standards.

"SARS-CoV-2" means a betacoronavirus, like MERS-CoV and SARS-CoV, the novel virus that causes coronavirus disease 2019, or COVID-19. Coronaviruses are named for the crown-like spikes on their surfaces. The SARS-CoV-2 causes what has been designated as the Coronavirus Disease 2019 (COVID-19).

Commented [WJ(40)]: VDH comment

"Severely immunocompromised" means being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days.⁵ The degree of immunocompromise is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Commented [WJ(41)]: Definition added per VDH comment under "return to work" requirements in 16VAC25-220-40

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"Signs of COVID-19" are abnormalities that can be objectively observed, and may include fever, trouble breathing or shortness of breath, cough, persistent pain or pressure in the chest, vomiting, new confusion, inability to wake or stay awake, bluish lips or face, etc.

Commented [WJ(43)]: VDH comment

⁵ Footnote 1, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).

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"Suspected to be infected with SARS-CoV-2 virus" means a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza).

"Symptoms of COVID-19" are abnormalities that are subjective to the person and not observable to others, and may include chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, congestion or runny nose, diarrhea, etc.

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"Symptomatic" means the employeea person is experiencing signs and/or symptoms similar to those attributed to COVID-19 including fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea. A person may become symptomatic may appear in two2 to 14 days after exposure to the SARS-CoV-2 virus.

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"Technical feasibility" means the existence of technical know-how as to materials and methods available or adaptable to specific circumstances that can be applied to one or more requirements in this standard with a reasonable possibility that employee exposure to the SARS-CoV-2 virus and COVID-19 disease hazards will be reduced. If an employer's level of compliance lags significantly behind that of the employer's industry, allegations of technical infeasibility will not be accepted.

"USBC" means Virginia Uniform Statewide Building Code.

"VDH" means Virginia Department of Health.

"VOSH" means Virginia Occupational Safety and Health.

"Work practice control" means a type of administrative control by which the employer modifies the manner in which the employee performs assigned work. Such modification may result in a reduction of exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks through such methods as changing work habits, improving sanitation and hygiene practices, or making other changes in the way the employee performs the job.

16VAC25-220-40. Mandatory requirements for all employers.

A. Employers ~~in all exposure risk levels~~ shall ensure compliance with the requirements in this section to protect employees ~~in all exposure risk levels~~ from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease.

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B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs **and/or symptoms** of **an oncoming** illness.

3. Serological testing, also known as antibody testing, is a test to determine if persons have been infected with SARS-CoV-2 virus. Serological testing has not been determined if persons who have the antibodies are immune from infection.

a. Serologic test results shall not be used to make decisions about returning employees to work who were previously classified as known or suspected to be infected with the SARS-CoV-2 virus.

b. Serologic test results shall not be used to make decisions concerning employees who were previously classified as known or suspected to be infected with the SARS-CoV-2 virus about grouping, residing in or being admitted to congregate settings, such as schools, dormitories, etc.

4. Employers shall develop and implement policies and procedures for employees to report when **employees they** are experiencing **signs and/or** symptoms consistent with

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COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees shall be designated by the employer as “suspected to be infected with SARS-CoV-2 virus.”

5. Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work (see subsection C of this section). Nothing in this standard shall prohibit an employer from permitting an employee known or suspected to be infected with SARS-CoV-2 virus from engaging in teleworking or other form of work isolation that would not result in potentially exposing other employees to the SARS-CoV-2 virus.

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

7. Employers shall discuss with subcontractors and companies that provide contract or temporary employees **about** the importance **and requirement of to exclude from work** employees or other persons **(e.g., volunteers)** who are known or suspected to be infected with the SARS-CoV-2 virus **of staying home**. Subcontractor, contract, or temporary employees known or suspected to be infected with the SARS-CoV-2 virus shall not report to or be allowed to remain at the work site until cleared for return to work. Subcontractors shall not allow their **employees** known or suspected to be infected with

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the SARS-CoV-2 virus **employees** to report to or be allowed to remain at work or on a job site until cleared for return to work.

8. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within **2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test), the previous 14 days from the date of positive test, and the e** employers shall notify:

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a. The employer's own employees who may have been exposed, within 24 hours of discovery of the **employees** possible exposure, while keeping confidential the identity of the **person** known to be infected with SARS-CoV-2 virus **person** in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations; and

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b. In the same manner as subdivision 8 a of this subsection, other employers whose employees were present at the work site during the same time period; and

c. In the same manner as subdivision 8 a of this subsection, the building or facility owner. The building or facility owner will require all employer tenants to notify the owner of the occurrence of a SARS-CoV-2-positive test for any employees or residents in the building. This notification will allow the owner to take the necessary steps to sanitize the common areas of the building. In addition, the building or facility owner

will notify all employer tenants in the building that one or more cases have been discovered and the floor or work area where the case was located. The identity of the individual will be kept confidential in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations; and

d. The Virginia Department of Health **within 24 hours of the discovery of a positive case, during a declaration of an emergency by the Governor pursuant to § 44-146.17 of the Code of Virginia.** Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had **two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.** Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp; and

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Commented [WJ(62): RRO change 1.4.2021

Commented [WJ(63): VDH comment to make clear that certain double reporting to VDH is not required.

e. The Virginia Department of Labor and Industry within 24 hours of the discovery of three or more **of its own** employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.

Commented [WJ(64)]: §40, FAQ 21

9. Employers shall ensure employee access to the employee's own SARS-CoV-2 virus and COVID-19 disease related exposure and medical records in accordance with the standard applicable to its industry. Employers in the agriculture, public sector marine terminal, and public sector longshoring industries shall ensure employees' access to the employees' own SARS-CoV-2 virus and COVID-19 disease related exposure and medical records in accordance with 16VAC25-90-1910.1020, Access to Employee Exposure and Medical Records.

C. Return to work.

1. ~~The employer shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work. using either a symptom-based or test-based strategy, depending on local healthcare and testing circumstances. While an employer may rely on other reasonable options, a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the symptoms based strategy requirements in subdivision 1 a of this subsection will constitute compliance with the requirements of this subsection.~~

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⁶ See Frequently Asked Question (FAQ) §40, FAQ 21, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

a. ~~For Symptomatic employees~~ known or suspected to be infected with the SARS-CoV-2 virus ~~employees the symptom-based strategy excludes an employee are excluded~~ from returning to work until ~~all three of the following have been met:~~

~~(i)(1) at least three days (72~~ ~~hours) have passed since recovery, defined as resolution of fever~~ ~~without the use of fever-reducing medications,~~

~~and (ii)(2) improvement in respiratory symptoms (e.g., cough, and~~ ~~shortness of breath) have improved, and~~

~~(iii)(3) at least 10 days have passed since symptoms first appeared.~~

~~However, a limited number of employees with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.~~

~~b. The test-based strategy excludes an employee from returning to work until (i) resolution of fever without the use of fever-reducing medications, (ii) improvement in respiratory symptoms (e.g., cough, shortness of breath), and (iii) negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or more apart (total of two negative specimens).~~

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~~i. If a known or suspected to be infected with the SARS-CoV-2 virus employee refuses to be tested, the employer compliance with subdivision 1 a of this subsection, symptom based strategy, will be considered in compliance with this standard. Nothing in this standard shall be construed to prohibit an employer from requiring a known or suspected to be infected with the SARS-CoV-2 virus employee to be tested in accordance with subdivision 1 b of this subsection.~~

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~~ii. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. The employer shall not require the employee to pay for the cost of COVID-19 testing for return to work determinations.~~

Commented [WJ(73): Language became duplicative with other VDH changes to this section. See 16VAC25-220-40.C.1.c below

~~2b. The employer shall develop and implement policies and procedures for Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms asymptomatic employees to return to work using either a time based or test based strategy depending on local healthcare and testing circumstances are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA. While an employer may rely on other reasonable options, a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the time based strategy requirements in subdivision 2 a of this subsection will constitute compliance with the requirements of this subsection.~~

Commented [WJ(74): "signs" added for consistency with other parts of standard

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~~a. The time based strategy excludes an employee from returning to work until at least 10 days have passed since the date of the employee's first positive COVID-19~~

diagnostic test assuming the employee has not subsequently developed symptoms since the employee's positive test. If the employee develops symptoms, then the symptom-based or test-based strategy shall be used.

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b. The test-based strategy excludes an employee from returning to work until negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or more apart (total of two negative specimens).

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i. If a known to be infected with SARS-CoV-2 asymptomatic employee refuses to be tested, employer compliance with subdivision 2 a of this subsection, time-based strategy, will be considered in compliance with this standard. Nothing in this standard shall be construed to prohibit an employer from requiring a known to be infected with SARS-CoV-2 asymptomatic employee to be tested in accordance with subdivision 2 b of this subsection.

Commented [WJ(79)]: VDH comment

ii. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. The employer shall not require the employee to pay for the cost of COVID-19 testing for return to work determinations. If an employer's health insurance covers the entire cost of COVID-19 testing, use of the insurance coverage would not be considered a violation of 16VAC25-220-40-C, 2-d.⁷

Commented [WJ(80)]: §40 FAQ 23

Commented [WJ(81)]: RRO changes made 1.4.2021

⁷ See Frequently Asked Question (FAQ) §40, FAQ 23, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

D. Unless otherwise provided in this standard, employers shall **establish and implement policies and procedures that** ensure **that** employees observe physical distancing while on the job and during paid breaks on the employer's property, including policies and procedures that:

1. Use verbal announcements, signage, or visual cues to promote physical distancing.
2. Decrease worksite density by limiting non-employee access to the place of employment or restrict access to only certain workplace areas to reduce the risk of exposure.

3. An employer's compliance with occupancy limits contained in any applicable Virginia executive order or order of public health emergency will constitute compliance with the requirements in this subsection.

E. Access to common areas, breakrooms, or lunchrooms shall be closed or controlled.

1. If the nature of an employer's work or the work area does not allow employees to consume meals in the employee's workspace while observing physical distancing, an employer may designate, reconfigure, and alternate usage of spaces where employees congregate, including lunch and break rooms, locker rooms, time clocks, etc., with controlled access, provided the following conditions are met:

- a. At the entrance of the designated common area or room **the** employers shall clearly post the policy limiting the occupancy of the space, and requirements for physical distancing, hand washing and hand sanitizing, and cleaning and disinfecting of shared surfaces.

Commented [WJ(82): Comment by Virginia Hospital and Healthcare Association, <https://www.doli.virginia.gov/wp-content/uploads/2020/09/Virginia-Hospital-and-Healthcare-Association-Comment-on-Permanent-Regulations-092520.pdf>

Commented [WJ(83): D.2 and D.3 combined to make clear that occupancy limit originally referenced in D.3 applies to D.2.

Commented [WJ(84): Typo correction

b. ~~The eE~~employer shall limit occupancy of the designated common area or room so that occupants can maintain physical distancing from each other. ~~The eE~~employers shall enforce the occupancy limit.

c. Employees shall be required to clean and disinfect the immediate area in which they were located prior to leaving, or ~~the~~employers may provide for cleaning and disinfecting of the common area or room at regular intervals throughout the day, and between shifts of employees using the same common area or room (i.e., where an employee or groups of employees have a designated lunch period and the common area or room can be cleaned in between occupancies).

d. Hand washing facilities, and hand sanitizer where feasible, are available to employees. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable and use and storage in hot environments can result in a hazard.

F. When multiple employees are occupying a vehicle for work purposes, ~~employers shall;~~

1. ~~the employers shall eE~~nsure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry. ~~Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons.~~⁸

Commented [WJ(85): Comment 86145.

⁸ <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html>

2. Provide access to fresh air ventilation (e.g., open windows, do not recirculate cabin air).

3. Where physical distancing cannot be maintained, establish procedures to maximize separation between employees during travel.

G. Employers shall also ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency.

HG. Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements from employees or other persons, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry. In such situations, and until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings.

H. When it is necessary for employees solely exposed to lower risk hazards or job tasks to have brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet), a face covering is required.

I. When required by this standard, face coverings shall be worn over the wearer's nose and mouth and extend under the chin.⁹

Commented [WJ(86)]: §40, FAQ 20

Commented [WJ(87)]: Comment 85187.

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html>

11. Nothing in this standard shall require the use of a respirator, surgical/medical procedure mask, or face covering by any employee for whom doing so would be contrary to the employee's health or safety because of a medical condition; however, nothing in this standard shall negate an employer's obligations to comply with personal protective equipment and respiratory protection standards applicable to its industry.

1. Although face shields are not considered a substitute for face coverings as a method of source control and not used as a replacement for face coverings among people without medical contraindications, face shields may provide some level of protection against contact with respiratory droplets. In situations where a face covering cannot be worn due to medical contraindications, employers shall provide and employees shall wear either:¹⁰

Commented [WJ(88)]: VDH comment of 10.14.2020

a. A face shield that wraps around the sides of the wearer's face and extends below the chin; or

Commented [WJ(89)]: RRO change 1.4.2021

b. A hooded face shield; and

c. To the extent feasible, employees wearing face shields in accordance with this subsection shall observe physical distancing requirements in this standard.

2. Face shield wearers shall wash their hands before and after removing the face shield and avoid touching their eyes, nose and mouth when removing it.

3. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.

¹⁰ *Id.*

4. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.

JK. Requests to the Department for religious waivers from the required use of respirators, surgical/medical procedure masks, or face coverings will be handled in accordance with the requirements of applicable federal and state law, standards, regulations and the U.S. and Virginia Constitutions, after Department consultation with the Office of the Attorney General.

KL. Sanitation and disinfecting.

1. In addition to the requirements contained in this standard, employers shall comply with the VOSH sanitation standard applicable to its industry.

2. Employees that interact with customers, the general public, contractors, and other persons shall be provided with and immediately use supplies to clean and disinfectant surfaces contacted during the interaction where there is the potential for exposure to the SARS-CoV-2 virus by themselves or other employees.

3. In addition to the requirements contained in this standard, employers shall comply with the VOSH hazard communication standard applicable to the employers' industry for cleaning and disinfecting materials and hand sanitizers.

4. Areas in the place of employment where employees or other persons known or suspected to be infected with the SARS-CoV-2 virus employees or other persons accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas. Where feasible, a period of 24 hours will be observed prior to cleaning and

Commented [WJ(90)]: VDH comment of 12.2.2020

disinfecting. This requirement shall not apply if the areas in question have been unoccupied for seven or more days.

5. All common spaces, including bathrooms (including port-a-johns, privies, etc.)¹¹ frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at least once during or at the end of each the shift. Where multiple shifts are employed, such spaces shall be cleaned and disinfected no less than once every 12 hours. All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another.

Commented [WJ(91)]: §40, FAQ 13

Commented [WJ(92)]: Comments 85955, 86145.

6. Employers shall ensure that cleaning and disinfecting products are readily available to employees to accomplish the required cleaning and disinfecting. In addition, employers shall ensure use of only disinfecting chemicals and products indicated in the Environmental Protection Agency (EPA) List N for use against SARS-CoV-2.

7. Employers shall ensure that the manufacturer's instructions for use of all disinfecting chemicals and products are complied with (e.g., concentration, application method, contact time, PPE, etc.).

8. Employees shall have easy, frequent access and permission to use soap and water, and hand sanitizer where feasible, for the duration of work. Employees assigned to a work station where job tasks require frequent interaction inside six feet with other persons shall be provided with hand sanitizer where feasible at the employees work station.

¹¹ See DOLI Frequently Asked Questions (FAQ), §40, FAQ 13. <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

9. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a work site and shall have transportation immediately available to nearby toilet facilities and handwashing facilities that meet the requirements of VOSH laws, standards, and regulations dealing with sanitation. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable, and use and storage in hot environments can result in a hazard.

9.10. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower as presenting potential exposure risk for purposes of application of the requirements of this standard. In situations other than emergencies, the employer shall ensure that protective measures are put in place to prevent cross-contamination.

LM. Unless otherwise provided in this standard, when engineering, work practice, and administrative controls are not feasible or do not provide sufficient protection, employers shall provide personal protective equipment to their employees and ensure the equipment's proper use in accordance with VOSH laws, standards, and regulations applicable to personal protective equipment, including respiratory protection equipment.

16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk.

A. The requirements in this section for employers with hazards or job tasks classified as very high or high exposure risk apply in addition to requirements contained in 16VAC25-220-40, 16VAC25-220-70, and 16VAC25-220-80.

B. Engineering controls.

1. Employers shall ensure that appropriate air-handling systems **under their control**:

Commented [WJ(93)]: Virginia Department of Housing and Community Development (DHCD) comment

a. Are installed and maintained in accordance with **the USBC and** manufacturer's instructions in healthcare facilities and other places of employment treating, caring for, or housing persons **with known** or suspected to be infected with the SARS-CoV-2 virus; and

Commented [WJ(94)]: VDH comment

~~b. Comply with minimum American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a), which covers both outdoor and total air ventilation in healthcare facilities. Based on risk assessments or owner project requirements, designers of new and existing facilities can go beyond the minimum requirements of these standards.~~

Commented [WJ(95)]: DHCD comment

Commented [WJ(96)]: A number of commenters questioned the legality of this provision as a potential violation of the Virginia Uniform Statewide Building Code (USBC), <https://www.dhcd.virginia.gov/usbc>

ALTERNATIVE LANGUAGE is provided which is derived from current CDC guidance, and similar language was put forward by a number of commenters from the business community (Comment 86145 and comment <https://www.doli.virginia.gov/wp-content/uploads/2020/09/Virginia-Manufacturers-Association-Public-Comments-on-Proposed-Permanent-Regulation-9.25.2020.pdf>)

b. Where feasible and within the design parameters of the system, are utilized as follows:¹²

- (1) Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open).**

Commented [WJ(97)]: RRO number changes made (1) through (9) 1.4.2021

Commented [WJ(98)]: DOLI change based on comment by DHCD: Increased airflow is not always a good thing. For example, doors may become hard to operate. This could be a bad thing especially if the user happens to be the aging community. For the record, the IMC is based on ASHRAE 62 airflow rates. Those designated rates took everything into account, in each specific occupancy, when the numbers were established. Tweaking certain parts of any complete set of regulations is always a bad idea.

¹² <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>

iii(2) In ground transportation settings, use natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of inside air when environmental conditions and transportation safety and health requirements allow;

iii(3) Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;

iv(4) Increase air filtration to as high as possible in a manner that will still enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;

v(5) Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;

vi(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

vii(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

Commented [WJ(99): DOLI change to limit application to transportation settings (cars, trucks, buses, etc.).

DHCD comment noted the following problems if this language applied to all indoor applications: This is not always a good idea in a situation where health issues may be present, like respiratory, allergies, etc....The cost of doing a 2 hour full-fledged air change with 100% outside air (same as b.ii. above) is going to overburden HVAC equipment that is not designed to accommodate such a load and the energy cost are going to skyrocket in these applications and prematurely wear equipment....not many systems are going to be able to work like these guidelines suggest and exercising them as them as ii and iv suggest is going to cause equipment failures.

Commented [WJ(100): DHCD comment: They want to increase air rates but with as high a MERV as possible. It doesn't work that way in an existing system. You will burn up the fans to get higher rates through more filters. Our engineers just did a presentation that most existing systems out there cannot handle more than MERV 16.

viii. (8) If the system's design can accommodate such an adjustment and is allowed

by the air handler manufacturer's installation instructions and listing, improve

central air filtration to MERV-13 and seal edges of the filter to limit bypass;¹³ and

ix. (9) Check filters to ensure they are within service life and appropriately installed.

c. Comply with USBC and applicable referenced American Society of Heating,

Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards.

Commented [WJ(101)]: DHCD comment: Using higher levels of filtration above what the equipment was designed for can violate listings and damage equipment. Exceeding the design MERV rating will burn up air handler blower motors.

2. For employers not covered by subdivision 1 of this subsection, ensure that air-handling systems where installed and under their control are appropriate to address the SARS-CoV-2 virus and COVID-19 disease related hazards and job tasks that occur at the workplace:

a. Are maintained in accordance with the manufacturer's instructions; and

b. Comply with subdivisions 1 b and 1 c of this subsection.

3. Hospitalized patients with known or suspected to be infected with the SARS-CoV-2 virus, where feasible and available, shall be placed in an airborne infection isolation room (AIIRs).

Commented [WJ(102)]: VDH comment

4. Employers shall use AIIRs rooms when available for performing aerosol-generating procedures on patients with known or suspected to be infected with the SARS-CoV-2 virus.

Commented [WJ(103)]: VDH comment

¹³ <https://www.ashrae.org/technical-resources/filtration-disinfection#iso>

5. For postmortem activities, employers shall use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of **persons** **known** or suspected to be infected with the SARS-CoV-2 virus **persons** at the time of their death.

Commented [WJ(104)]: VDH comment

6. Employers shall use special precautions associated with Biosafety Level 3 (BSL-3), as defined by the U.S. Department of Health and Human Services Publication No. (CDC) 21-1112 “Biosafety in Microbiological and Biomedical Laboratories” (Dec. 2009), which is hereby incorporated by reference, when handling specimens from **patients or persons** **known** or suspected to be infected with the SARS-CoV-2 virus ~~patients or persons~~.

Commented [WJ(105)]: VDH comment

Diagnostic laboratories that conduct routine medical testing and environmental specimen testing for COVID-19 are not required to operate at BSL-3.¹⁴

Commented [WJ(106)]: VDH comment; §50, FAQ 3

7. To the extent feasible, employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.

C. Administrative and work practice controls.

1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.

¹⁴ See Frequently Asked Question (FAQ) §50, FAQ 3. <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

2. In healthcare facilities, ~~an~~ employers shall follow existing guidelines and facility standards of practice for identifying and isolating infected persons and for protecting employees.

3. ~~An Ee~~ employer shall limit non-employee access to the place of employment or restrict access to only certain workplace areas to reduce the risk of exposure. An employer's compliance with occupancy limits contained in any applicable Virginia executive order or order of public health emergency will constitute compliance with the requirements of this paragraph.

4. ~~An Ee~~ employer shall post signs requesting patients and family members to immediately report signs and/or symptoms of respiratory illness on arrival at the healthcare facility and use disposable face coverings.

Commented [WJ(107)]: RRO change made 1.4.2021

Commented [WJ(108)]: VDH comment

5. ~~An Ee~~ employers shall offer enhanced medical monitoring of employees during COVID-19 outbreaks.

~~6. An employer shall provide all employees with job-specific education and training on preventing transmission of COVID-19, including initial and routine and refresher training in accordance with 16VAC25-220-80.~~

Commented [WJ(109)]: Duplicative of 16VAC25-220-80.

~~76. To the extent feasible, ~~an~~ employers shall ensure that psychological and behavioral support is available to address employee stress at no cost to the employee.~~

Commented [WJ(110)]: This language was accidentally deleted when the Word document was converted to PDF on December 10, 2020, and is being reinserted.

~~87. In health care settings, ~~an~~ employers shall provide alcohol-based hand sanitizers containing at least 60% ethanol or 70% isopropanol to employees at fixed work sites and~~

to emergency responders and other personnel for decontamination in the field when working away from fixed work sites.

98. Employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus non-employees to contain respiratory secretions until the non-employees are able to leave the site (i.e., for medical evaluation and care or to return home).

Commented [WJ(111)]: VDH comment

109. Where feasible, employers shall:

- a. Implement flexible worksites (e.g., telework).
- b. Implement flexible work hours (e.g., staggered shifts).
- c. Increase physical distancing between employees at the worksite to six feet.
- d. Increase physical distancing between employees and other persons to six feet.
- e. Implement flexible meeting and travel options (e.g., use telephone or video conferencing instead of in person meetings; postpone non-essential travel or events; etc.).
- f. Deliver services remotely (e.g. phone, video, internet, etc.).
- g. Deliver products through curbside pick-up.

D. Personal protective equipment (PPE).

1. Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132), shall comply with the following

requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection:

a. ~~The e~~Employers shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). ~~The e~~Employers shall provide for employee and employee representative involvement in the assessment process.

b. If such hazards or job tasks are present or likely to be present, ~~the e~~employers shall:

~~(1.)~~(1) Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment;

~~(2.)~~(2) Communicate selection decisions to each affected employee; and

~~(3.)~~(3) Select PPE that properly fits each affected employee.

2. ~~The e~~Employers shall verify that the required SARS-CoV-2 virus and COVID-19 disease workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date of the hazard assessment; and the document as a certification of hazard assessment.

3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915,

Commented [WJ(112): RRO numbering changes (1) through (3) 1.4.2021

16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.

4. ~~The employer~~ shall implement a respiratory protection program in accordance with 16VAC25-90-1910.134 (b) through (d) (except (d)(1)(iii)), and (f) through (m), that covers each employee required to use a respirator.

5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. ~~Where indicated by the hazard assessment and equipment selection requirements in subsection D of this section, such employees shall also be provided with and wear a surgical/medical procedure mask. Gowns shall be large enough to cover the areas requiring protection; the correct size to assure protection.~~

~~E. Employee training shall be provided in accordance with the requirements of 16VAC25-220-80 of this standard.~~

~~E. Employee training shall be provided in accordance with the requirements of 16VAC25-220-80 of this standard.~~

16VAC25-220-60. Requirements for hazards or job tasks classified at medium exposure risk.

A. The requirements in this section for employers with hazards or job tasks classified as medium exposure risk apply in addition to requirements contained in 16VAC25-220-40, 16VAC25-70, and 16VAC25-80.

B. Engineering controls.

Commented [WJ(113)]: VDH comment

Commented [WJ(114)]: VDH comment

Commented [WJ(115)]: Duplicative of 16VAC25-220-80

Commented [WJ(116)]: This language was accidentally deleted when the Word document was converted to PDF on December 10, 2020, and is being reinserted.

1. Employers shall ensure that air-handling systems **under their control where installed in accordance with the** appropriate to address the SARS-CoV-2 virus and COVID-19 disease-related hazards and job tasks that occur at the workplace and:

Commented [WJ(117): DHCD comment

Commented [WJ(118): RRO change 1.4.2021

a. Are maintained in accordance with the manufacturer's instructions; and

~~b. Comply with minimum American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a), which covers both outdoor and total air ventilation in healthcare facilities. Based on risk assessments or owner project requirements, designers of new and existing facilities can go beyond the minimum requirements of these standards.~~

Commented [WJ(119): DHCD comment

b. Where feasible and within the design parameters of the system, are utilized as follows:¹⁵

Commented [WJ(120): A number of commenters questioned the legality of this provision as a potential violation of the Virginia Uniform Statewide Building Code (USBC), <https://www.dhcd.virginia.gov/usbc>

ALTERNATIVE LANGUAGE is provided which is derived in part from current CDC guidance, and similar language put forward by a number of commenters from the business community (Comment 86145 and at <https://www.doli.virginia.gov/wp-content/uploads/2020/09/Virginia-Manufacturers-Association-Public-Comments-on-Proposed-Permanent-Regulation-9.25.2020.pdf>)

~~i. (1) Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open).~~

Commented [WJ(121): RRO numbering changes made (1) through (9) 1.4.2021

~~ii. (2) In ground transportation settings, use natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of inside air~~

Commented [WJ(122): DOLI change based on the following comment by DHCD: Increased airflow is not always a good thing. For example, doors may become hard to operate. This could be a bad thing especially if the user happens to be the aging community. For the record, the IMC is based on ASHRAE 62 airflow rates. Those designated rates took everything into account, in each specific occupancy, when the numbers were established. Tweaking certain parts of any complete set of regulations is always a bad idea.

¹⁵ <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>

when environmental conditions and transportation safety and health requirements allow;

iii.(3) Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;

iv.(4) Increase air filtration to as high as possible in a manner that will enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;

v.(5) Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;

vi.(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

vii.(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

viii.(8) If the system's design can accommodate such an adjustment and is allowed by the air handler manufacturer's installation instructions and listing, improve central air filtration to MERV-13 and seal edges of the filter to limit bypass;¹⁶and

ix.(9) Check filters to ensure they are within service life and appropriately installed.

Commented [WJ(123): DOLI change to limit application to transportation settings (cars, trucks, buses, etc.).

DHCD comment noted the following problems if this language applied to all indoor applications: This is not always a good idea in a situation where health issues may be present, like respiratory, allergies, etc....The cost of doing a 2 hour full-fledged air change with 100% outside air (same as b.ii. above) is going to overburden HVAC equipment that is not designed to accommodate such a load and the energy cost are going to skyrocket in these applications and prematurely wear equipment....not many systems are going to be able to work like these guidelines suggest and exercising them as them as ii and iv suggest is going to cause equipment failures.

Commented [WJ(124): DHCD comment: They want to increase air rates but with as high a MERV as possible. It doesn't work that way in an existing system. You will blow the fans to get higher rates through more filters. Our engineers just did a presentation that most existing systems out there cannot handle more than MERV 16.

Commented [WJ(125): RRO change made 1.4.2021

Commented [WJ(126): DHCD comment: Using higher levels of filtration above what the equipment was designed for can violate listings and damage equipment. Exceeding the design MERV rating will burn up air handler blower motors.

¹⁶ <https://www.ashrae.org/technical-resources/filtration-disinfection#iso>

c. Comply with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards.

2. Where feasible, employers shall install physical barriers (e.g., such as clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission.

C. Administrative and work practice controls.

1. To the extent feasible, employers shall implement the following administrative and work practice controls:

a. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.

b. Provide face coverings to non-employees suspected to be infected with SARS-CoV-2 non-employees to contain respiratory secretions until the non-employees are able to leave the site (i.e., for medical evaluation and care or to return home).

c. Implement flexible worksites (e.g., telework).

d. Implement flexible work hours (e.g., staggered shifts).

e. Increase physical distancing between employees at the worksite to six feet.

Commented [WJ(127)]: VDH comment

f. Increase physical distancing between employees and other persons, including customers, to six feet (e.g., drive-through physical barriers) where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission, etc.

~~g. To the extent feasible, install physical barriers (e.g., such as clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission.~~

Commented [WJ(128): This provision moved to 16VAC25-220-60.A.2 as it is an engineering control. Comment 85910.

hg. Implement flexible meeting and travel options (e.g., using telephone or video conferencing instead of in person meetings; postponing non-essential travel or events; etc.).

ih. Deliver services remotely (e.g. phone, video, internet, etc.).

ii. Deliver products through curbside pick-up or delivery.

kj. Require employers to shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.

lk. Require employers to shall provide and require employees in customer or other person facing jobs to wear face coverings.

D. Personal protective equipment.

1. Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132) shall comply with the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection:

a. The employer shall assess the workplace to determine if SARS-CoV-2 or COVID-19 hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). The employer shall provide for employee and employee representative involvement in the assessment process. If such hazards or job tasks are present or likely to be present, the employer shall:

i. Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment;

ii. Communicate selection decisions to each affected employee; and

iii. Select PPE that properly fits each affected employee.

2. The employer shall verify that the required SARS-CoV-2 virus and COVID-19 disease workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date of the hazard assessment; and the document as a certification of hazard assessment.

3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915, 16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.

4. PPE ensembles for employees in the medium exposure risk category will vary by work task, the results of the employer's hazard assessment, and the types of exposures employees have on the job.

16VAC25-220-70. Infectious disease preparedness and response plan.

A. Employers with hazards or job tasks classified as:

1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan;
2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.

B. The plan and training requirements tied to the plan shall only apply to those employees classified as very high, high, and medium covered by this section.

C. Employers shall designate a person to be responsible for implementing their plan. The plan shall:

1. Identify the name or title of the person responsible for administering the plan. This person shall be knowledgeable in infection control principles and practices as the principles and practices apply to the facility, service, or operation.

2. Provide for employee involvement in development and implementation of the plan.

3. Consider and address the level of SARS-CoV-2 virus and COVID-19 disease risk associated with various places of employment, the hazards employees are exposed to at those sites, and job tasks employees perform at those sites. Such considerations shall include:

a. Where, how, and to what sources of the SARS-CoV-2 virus or COVID-19 disease might employees be exposed at work, including:

~~1.~~ (1) The general public, customers, other employees, patients, and other persons;

~~2.~~ (2) **Persons** known or suspected to be infected with the SARS-CoV-2 virus **persons** or those at particularly high risk of COVID-19 infection (e.g., local, state, national, and international travelers who have visited locations with ongoing COVID-19 community transmission and healthcare employees who have had unprotected exposures to **persons** known or suspected to be infected with SARS-CoV-2 virus **persons**); and

~~3.~~ (3) Situations where employees work more than one job with different employers and encounter hazards or engage in job tasks that present a very high, high, or medium level of exposure risk; **and**

Commented [WJ(129): RRO number changes (1) through (3) made 1.4.2021

Commented [WJ(130): VDH comment

iv. Situations where employees work during higher risk activities involving potentially large numbers of people or enclosed work areas such as at large social gatherings, weddings, funerals, parties, restaurants, bars, hotels, sporting events, concerts, parades, movie theaters, rest stops, airports, bus stations, train stations, cruise ships, river boats, airplanes, etc.¹⁷

Commented [WJ(131)]: VDH comment

b. To the extent permitted by law, including HIPAA, employees' individual risk factors for severe disease. For example, people of any age with one or more of the following conditions are at increased risk of severe illness from COVID-19: chronic kidney disease; COPD (chronic obstructive pulmonary disease); immunocompromised state (weakened immune system) from solid organ transplant; obesity (body mass index or BMI of 430¹⁸ or higher); serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; sickle cell disease; or type 2 diabetes mellitus). Also, for example, people with one or more of the following conditions might be at an increased risk for severe illness from COVID-19: asthma (moderate-to-severe); cerebrovascular disease (affects blood vessels and blood supply to the brain); cystic fibrosis; hypertension or high blood pressure; immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines; neurologic

Commented [WJ(132)]: VDH comment

Commented [WJ(133)]: VDH comment

¹⁷ <https://www.vdh.virginia.gov/coronavirus/coronavirus/travel-to-areas-with-widespread-ongoing-community-spread/>

<https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>

¹⁸ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

conditions, such as dementia; liver disease; pregnancy; pulmonary fibrosis (having damaged or scarred lung tissues); smoking; thalassemia (a type of blood disorder); type 1 diabetes mellitus; etc.). **The risk for severe illness from COVID-19 also increases with age.**¹⁹

Commented [WJ(134)]: VDH comment

c. Engineering, administrative, work practice, and personal protective equipment controls necessary to address those risks.

4. Consider **and address** contingency plans for situations that may arise as a result of outbreaks **and impact employee safety and health**, such as:

Commented [WJ(135)]: DOLI change – make language consistent with 70.B.3

Commented [WJ(136)]: In response to comments requesting elimination of business considerations unrelated to occupational safety and health. Comments 85259, 85492.

a. Increased rates of employee absenteeism **(an understaffed business can be at greater risk for accidents);**²⁰

b. The need for physical distancing, staggered work shifts, downsizing operations, delivering services remotely, and other exposure-reducing workplace control measures such as elimination and substitution, engineering controls, administrative and work practice controls, and personal protective equipment; **(e.g., respirators, surgical/medical procedure masks, etc.);**

Commented [WJ(137)]: Typo correction

c. Options for conducting essential operations **in a safe and healthy manner** with a reduced workforce, **including cross-training employees across different jobs in order to continue operations or deliver surge services;** and

Commented [WJ(138)]: Language deleted In response to comments requesting elimination of business considerations unrelated to occupational safety and health. Comments 85259, 85492.

¹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>

²⁰ <https://smallbusiness.chron.com/absenteeism-affect-safety-workplace-62089.html>

d. Interrupted supply chains or delayed deliveries **of safety and health related products and services essential to business operations.**

Commented [WJ(139): Subsection clarified In response to comments requesting elimination of business considerations unrelated to occupational safety and health. Comments 85259, 85492.

5. Identify **basic** infection prevention measures to be implemented:

Commented [WJ(140): VDH comment

a. Promote frequent and thorough hand washing, including by providing employees, customers, visitors, the general public, and other persons to the place of employment with a place to wash their hands. If soap and running water are not immediately available, provide hand sanitizers.

b. Maintain regular housekeeping practices, including routine cleaning and disinfecting of surfaces, equipment, and other elements of the work environment.

c. Establish policies and procedures for managing and educating visitors to the place of employment.

6. Provide for the prompt identification and isolation of **employees** known or suspected to be infected with the SARS-CoV-2 virus **employees** away from work, including procedures for employees to report when they are experiencing **signs and/or** symptoms of COVID-19.

Commented [WJ(141): VDH comment

Commented [WJ(142): VDH comment

Commented [WJ(143): VDH comment

Commented [WJ(144): RRO change to delete "and/" 1.4.2021

7. Address infectious disease preparedness and response with outside businesses, including, but not limited to, subcontractors who enter the place of employment, businesses that provide **or** contract or temporary employees to the employer, and other persons accessing the place of employment to comply with the requirements of this standard and the employer's plan.

Commented [WJ(145): Typo correction

8. Identify the mandatory and non-mandatory recommendations in any CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard, as provided for in 16VAC25-220-10 G 1 and G 2.

9. Ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency related to the SARS-CoV-2 virus or COVID-19 disease.

16VAC25-220-80. Training.

A. Employers with hazards or job tasks classified as very high, high, or medium exposure risk at a place of employment shall provide training on the hazards and characteristics of the SARS-CoV-2 virus and COVID-19 disease to all employees working at the place of employment regardless of employee risk classification. The training program shall enable each employee to recognize the hazards of the SARS-CoV-2 virus and signs and symptoms of COVID-19 disease and shall train each employee in the procedures to be followed in order to minimize these hazards.

B. The training required under subsection A shall include:

1. The requirements of this standard;
2. The mandatory and non-mandatory recommendations provisions in any CDC guidelines or State Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard as provided for in section 16VAC25-220-10 EG 1 and EG 2;
3. The characteristics and methods of transmission of the SARS-CoV-2 virus;

Commented [WJ(146)]: VDH comment

Commented [WJ(147)]: VDH comment

4. The signs and symptoms of ~~the~~ COVID-19 disease;

5. Risk factors ~~effor~~ severe COVID-19 illness ~~with~~including underlying health conditions ~~and advancing age~~;

Commented [WJ(148)]: VDH comment

6. Awareness of the ability of ~~persons~~ pre-symptomatic~~ally~~ and asymptomatic~~ally~~ infected ~~with SARS-CoV-2/COVID-19 persons~~ to transmit the SARS-CoV-2 virus;

7. Safe and healthy work practices, including but not limited to, physical distancing, ~~the~~ wearing of face coverings, disinfection procedures, disinfecting frequency, ventilation,

Commented [WJ(149)]: VDH comment

noncontact methods of greeting, etc.;

Commented [WJ(150)]: RRO punctuation change made 1.4.2021

8. **Personal protective equipment (PPE)**:

a. When PPE is required;

b. What PPE is required;

c. How to properly don, doff, adjust, and wear PPE;

d. The limitations of PPE;

e. The proper care, maintenance, useful life, and disposal of PPE; ~~and~~

~~f. Strategies to extend PPE usage during periods of limited supply; and~~

Commented [WJ(151)]: VDH comment

~~fg.~~ Heat-related illness prevention including the signs and symptoms of heat-related

illness ~~associated with the use of COVID-19 PPE and face coverings~~;

Commented [WJ(152)]: Added to clarify purpose of this provision being limited to impact COVID-19 related PPE can have in hot work environments

9. The anti-discrimination provisions in 16VAC25-220-90; and

10. The employer's Infectious Disease Preparedness and Response Plan, where applicable.

C. Employers covered by 16VAC25-220-50 shall verify compliance with 16VAC25-220-80 A by preparing a written certification record for those employees exposed to hazards or job tasks classified as very high, high, or medium exposure risk levels.

1. The written certification record shall contain:

a. The name or other unique identifier of the employee trained,

b. The trained employee's physical or electronic signature,

c. The date of the training, and

d. The name of the person who conducted the training, or for computer-based training, the name of the person or entity that prepared the training materials.

2. A physical or electronic signature is not necessary if other documentation of training completion can be provided (e.g., electronic certification through a training system; security precautions that enable the employer to demonstrate that training was accessed by passwords and usernames unique to each employee, etc.).

3. If the employer relies on training conducted by another employer or completed prior to the effective date of this standard, the certification record shall indicate the date the employer determined the prior training was adequate rather than the date of actual training.

4. The latest training or retraining certification shall be maintained.

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Commented [WJ(154)]: Language added from DOLI §80 FAQ 2

E. When **the an** employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required by 16VAC25-220-80 A, the employer shall retrain each such employee. Circumstances where retraining is required include, but are not limited to, situations where:

1. Changes in the workplace, SARS-CoV-2 virus or COVID-19 disease hazards exposed to, or job tasks performed render previous training obsolete;
2. Changes are made to the employer's Infectious Disease Preparedness and Response Plan; or
3. Inadequacies in an affected employee's knowledge or use of workplace control measures indicate that the employee has not retained the requisite understanding or skill.

F. Employers with hazards or job tasks classified at lower risk shall provide written or oral information to employees exposed to such hazards or engaged in such job tasks on the hazards and characteristics of SARS-COV-2 and the symptoms of COVID-19 and measures to minimize exposure. The Department of Labor and Industry shall develop an information sheet containing information on the items listed in subsection G, which an employer may utilize to comply with this subsection.

G. The information required under subsection F shall include at a minimum:

1. The requirements of this standard;
2. The characteristics and methods of transmission of the SARS-CoV-2 virus;
3. The **signs and** symptoms of **the** COVID-19 disease;

Commented [WJ(155)]: VDH comment

4. The ability of persons pre-symptomatic^{ally} and asymptotically infected with SARS-CoV-2 COVID-19 persons to transmit the SARS-CoV-2 virus;

Commented [WJ(156)]: VDH comment

5. Safe and healthy work practices and control measures, including but not limited to, physical distancing, the benefits of wearing face coverings, sanitation and disinfection practices; and

Commented [WJ(157)]: VDH comment

6. The anti-discrimination provisions of this standard in 16VAC25-220-90.

16VAC25-220-90. Discrimination against an employee for exercising rights under this standard is prohibited.

A. No person shall discharge or in any way discriminate against an employee because the employee has exercised rights under the safety and health provisions of this standard, Title 40.1 of the Code of Virginia, and implementing regulations under 16VAC25-60-110 for themselves or others.

B. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including but not limited to a respirator, face shield, gown, or gloves, or face covering if such equipment is not provided by the employer, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. No person shall discharge or in any way discriminate

Commented [WJ(158)]: VDH comment

Commented [WJ(159)]: VDH comment because "face coverings" are not considered PPE.

against an employee who voluntarily provides and wears the employee's own face covering, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees.

Commented [WJ(160)]: VDH comment

C. No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer's agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

D. Nothing in this standard shall limit an employee from refusing to do work or enter a location that the employee feels is unsafe. However, employees should familiarize themselves with 16VAC25-60-110, which contains the requirements concerning discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of injury or death.

DRAFT



COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

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DRAFT: January 10, 2021

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM
DRAFT FINAL PERMANENT STANDARD FOR INFECTIOUS DISEASE
PREVENTION OF THE SARS-COV-2 WHICH CAUSES COVID-19,
16VAC25-220

DEPARTMENT STANDARD RESPONSES TO ISSUES RAISED
BY PUBLIC COMMENTERS

Background

The Department received 238 written comments through the Virginia Regulatory Townhall for the 30 day written comment period from December 10, 2020 to January 9, 2021.

There were 21 written comments sent directly to the Department during the 30 day written comment period, although a number of those were also posted by the Commenter on the Virginia Regulatory Townhall.

There were 24 oral comments received during the public hearing on January 5, 2020.

Following are Department standard responses to issues raised by public commenters.

1. Pandemic Statistics.

The Department respectfully disagrees with the Commenter's assertion that the pandemic is much less impactful than originally feared. As of January 1, 2021, the pandemic 341,199 deaths have been attributed to COVID-19 in the U.S.¹ and 5,117 in Virginia.²

2. Notification to VDH – Reporting of Two or More Cases.

DOLI is recommending to the Board the following revision to 16VAC25-220-40.B.8.d [notification to VDH of positive cases] in the final standard:

“d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had **two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.** Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp;” (Emphasis added).

3. Employer requirement to assess risk exposure for hazards and job tasks.

The Revised Proposed Standard, 16VAC25-220-40.B, provides that:

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

The Standard also provides in 16VAC25-220-10.D.1 provides in part:

¹ https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

² <https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/>

D. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard.

While employers are required to conduct the risk assessment, that determination is subject to review by the VOSH program as to whether the assessment was conducted in a reasonable fashion in accordance with the requirements of the standard.

4. Board Action in Response to Expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency.

DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The new language in 16VAC25-220.C requires the Board to make a “determination” of whether there is continued need for the standard. The Department has identified three “determination” options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

With regard to the phrase “notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to,” the intent of the language is to give the Board the maximum amount of flexibility to “notice” the Board meeting within 14 days even if the Board may not actually meet within 14 days

5. Alternative Diagnosis/Test Based Strategy.

Commenter 87847: The proposed standard requires employees known or to be infected with the SARS-CoV2 virus; not return to work until certain criteria are met, one of those criteria being a minimum of 10 days away from onset of symptoms. Unfortunately, COVID-19 virus signs and symptoms are consistent with several other common illness

or conditions; Flu, common Cold, sinus infections, migraine, allergies, food poisoning, etc.). This standard now eliminates the opportunity for an employee to prove they do not have COVID-19 and allow them return to work.

Department response: The Commenter is incorrect in stating that "This standard now eliminates the opportunity for an employee to prove they do not have COVID-19 and allow them return to work." 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis."

<https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

“a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza).”

If an employee HAS HAD “[close contact](#)” with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define “close contact” as meaning “you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”³

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an “alternative diagnosis”, and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours

³ <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html>

without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

6. Employees wearing face coverings with political statements.

Commenter 87852: If an employee continues to wear a political face covering and tries to cite this regulation as to why I can't fire him/her for doing so when political statements are not permitted in business attire, this will become a highly litigious situation.

Department response: The Department does not believe this Standard interferes with an employer's abilities to set workplace rules regarding the content of statements, designs, pictures, etc. on face coverings or any form of personal protective equipment or respirator required to provided and worn under VOSH laws, standards or regulations.

However, the Department is recommending the following language addition to 16VAC25-220-90.B: "Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings."

7. Surgical masks versus face coverings.

Commenter 87876: The definitions of face covering and surgical mask in the proposed standard apparently aim to categorically disqualify, for reason unclear, use of surgical masks as face coverings. As an unintended result, the terminology has potential to increase employee risk, eliminate highly effective face covering options and thereby trigger a rush to buy compliant face coverings which may result in inadequate availability.

Department response: The Commenter is mistaken that the Standard disqualifies the use of surgical masks in favor of face coverings. Surgical masks are a form of personal protective equipment permitted under the standard. All employers in general industry (i.e., all companies not in construction, agriculture or maritime) are covered by the federal OSHA identical standard 1910.132, Personal Protective Equipment, and that standard requires covered employers in 1910.132(d):

1910.132(d)

Hazard assessment and equipment selection.

1910.132(d)(1)

The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE) [SUCH AS SURGICAL MASKS OR RESPIRATORS FOR POTENTIAL COVID-19 EXPOSURE]. If such hazards are present, or likely to be present, the employer shall:

1910.132(d)(1)(i)

Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

1910.132(d)(1)(ii)

Communicate selection decisions to each affected employee; and,

1910.132(d)(1)(iii)

Select PPE that properly fits each affected employee.

Note: Non-mandatory appendix B contains an example of procedures that would comply with the requirement for a hazard assessment.

1910.132(d)(2)

The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

Requirements similar to 1910.132(d) also apply to employers in construction, agriculture and public sector maritime (federal OSHA has jurisdiction over private sector maritime) by virtue of 16VAC25-220-50.D and 16VAC25-220-60.D.

In addition, 16VAC25-220-50.D.5 (very high and high risk) specifically provides:

"5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection."

Also, 16VAC220-60.C.1.j (medium risk) provides:

j. Employers shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.

8. Rapid Testing.

Commenter 87912: In addition, I urge VOSH and the DOLI to require all employers to test all workers frequently (e.g., using rapid tests) as an additional public-health tool to reduce the spread of COVID-19 throughout the state of Virginia. Too many people are dying daily. Virginia must protect all workers, their families, their friends, and their surrounding communities. I have included links to three articles about the importance of rapid testing during the COVID-19 pandemic.⁴

Department response: While the Department acknowledges the Commenter's request to require rapid testing, it does not plan to recommend to the Safety and Health Codes Board that such a requirement be added to the standard. As noted in the articles referenced by the Commenter, there are issues about widespread availability of the testing materials and costs associated with obtaining them in sufficient supply to conduct daily workplace testing, that are best suited to be addressed at the federal government level rather than at the state level.

9. VOSH Enforcement.

While VOSH is charged with assuring the protection of Virginia employees from occupational safety and health hazards, it has a long history of working cooperatively with employers to achieve that protection. It also has the legal authority to enforce applicable laws, standards, regulations and executive orders in situations where employers decide they do not want to take advantage of a cooperative working relationship.

COVID-19 related employee complaints received by the VOSH program that are within VOSH's jurisdiction are being addressed with employers. In an abundance of caution, at the beginning of the COVID-19 outbreak in Virginia the Department decided to modify its normal complaint processing procedures for both the safety and health of the employees at the work sites and its VOSH compliance officers by trying to limit exposure to the virus as much as possible while carrying out statutory enforcement mandates.

Rather than conducting a combination of onsite inspections and informal investigations as is the case under normal situations, COVID-19 complaints were initially handled through the VOSH program's complaint investigation process, which involves contacting the employer by phone, fax, email, or letter.

VOSH informed the employer of the complaint allegation and required a written response concerning the validity of the complaint allegation, any safety and health measures taken to date to protect employees against potential COVID-19 related hazards, and any measures to be taken in response to valid complaint allegations.

⁴ <https://www.harvardmagazine.com/2020/08/covid-19-test-for-public-health>
<https://www.wgbh.org/news/national-news/2020/11/23/harvard-epidemiologist-10-20-million-rapid-at-home-tests-per-day-would-be-enough-to-stop-the-outbreaks-across-the-united-states>
<https://time.com/5912705/covid-19-stop-spread-christmas/>

Employers were required to post a copy of VOSH’s correspondence where it would be readily accessible for review by employees; and provide a copy of the correspondence and the employer’s response to a representative of any recognized union or safety committee at the facility. Complainants were provided a copy of the employer’s response.

Depending on the specific facts of the employee’s alleged complaint, an employer’s failure to respond or inadequate response could result in additional contact by the VOSH program with the employer, a referral to local law enforcement officials, an onsite VOSH inspection, or other enforcement options available to the VOSH program.

COVID-19 “Inspections”

- Can result in violations and substantial penalties
- Inspections are opened for COVID-19 related employee deaths
- Inspections may be opened for COVID-19 related hospitalizations or handled through an investigation
- Inspection files with proposed violations will be reviewed by Headquarters and receive a legal review before a decision to issue or not issue is made

Since February, 2020, the Virginia Workers’ Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020 in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has received 1,537 employee complaints and referrals from other government agencies. It has received notifications of 30 COVID-19 related employee deaths and 61 employee hospitalizations. To date, VOSH has opened 103 inspections, a number of which resulted from employers not taking advantage of either working cooperatively with the Virginia Department of Health, or not taking advantage of VOSH’s informal investigation process, which does not result in citations and penalties, provided the employer provides a satisfactory response.

Of the first 94 inspections conducted by VOSH, 43 remained under investigation as of January 4, 2021, 25 were closed with no violations issued, and 26 resulted in the issuance of violations (29 serious and 29 other-than-serious violations) and a total of \$226,780.00 in penalties.

10. Where Virginia Ranks in Controlling the Spread of the Virus.

Commenter 10004: “Indeed, while the agriculture industry continues to have success in controlling the virus on our operations, we have seen no similar correlation between decreased positivity or control of spread in the general population as a result of the ETS.”

Department response: The Department notes that the Commenter has not provided any data to support its contention that “the agriculture industry continues to have success in controlling the virus on our operations.”

The Department notes that a recent report by the U.S. Department of Agriculture found:

“On the health front, “The rural share of COVID-19 cases and deaths increased markedly during the fall of 2020. Rural areas have 14% of the population but accounted for 27% of COVID-19 deaths during the last three weeks of October 2020,” according to “Rural America at a Glance: 2020 Edition” from the U.S. Department of Agriculture's Economic Research Service, or ERS.”⁵

Study: More Than 125,000 Farmworkers Have Contracted Covid-19:⁶

“TUESDAY, SEPTEMBER 22, 2020

The Covid-19 virus has infected more than 125,000 U.S. farmworkers, according to the latest estimates in an ongoing study by Purdue University.

To arrive at their estimates, researchers applied the county-by-county rate of the infection’s spread to the number of farmworkers and farmers in those counties. As could be expected, the states with the most farmworkers – as estimated by farm labor spending in the U.S. Agricultural Census – top Purdue’s list. Three of the five states with the most farmworkers lead the list of infections. Texas has 15,410 farmworker infections, California has 10,640 and Florida has 6,380.

But after the top states, outliers pop up. The fourth through sixth highest number of farmworker infections are in Iowa (5,680), Tennessee (4,410) and Missouri (3,960). Each of those states ranked much higher in Covid-19 infections than in number of farmworkers.

What could account for the disparity?

Each of those states is notable for having no mandatory protections for farmworkers to fight Covid-19. Missouri and Tennessee have not even developed a set of voluntary guidelines for employers and employees to follow, and Iowa has recommended guidelines but no mandatory rules.”

The Department acknowledges that, as it predicted back in June and July of this year in its presentations to the Safety and Health Codes Board, that the COVID-19 pandemic could get much worse before it got better, which was a major reason for recommending adoption of an ETS. The Department notes the following statistics which are also highlighted in the January 4, 2021 Briefing Package for the Board⁷ beginning on page 36:

⁵ <https://www.agweek.com/business/agriculture/6819831-USDA-report-studies-pandemics-effect-on-rural-America>

⁶ <https://www.ewg.org/news-and-analysis/2020/09/study-more-125000-farmworkers-have-contracted-covid-19>

⁷ <https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf>

As of December 22, 2020, Virginia ranked 45th in state rankings for total cases per 100K. The Virginia border states of Tennessee, Kentucky, North Carolina, Maryland, and West Virginia, none of which has an ETS, rank higher than Virginia:

7 - Tennessee

29 - Kentucky

39 - North Carolina

42 - Maryland

43 - West Virginia

45 – Virginia

As of December 26, 2020, Virginia ranked 30th in state rankings for average daily cases per 100K in last seven days. The Virginia border states of Tennessee, Kentucky, North Carolina, and West Virginia, none of which has an ETS, rank higher than Virginia. The only border state that outperformed Virginia in this metric was Maryland:

1 - Tennessee

6 - West Virginia

19 - North Carolina

25 - Kentucky

30 - Virginia

39 – Maryland

The Department is not suggesting that the ETS is the sole reason for Virginia's significantly better performance on key COVID-19 indicators than many other states. There are many factors that go into such an evaluation, not the least of which is the impact of Governor's Executive Orders and the commitment of Virginia's citizens, employers and employees to follow safe and health practices and implementing sound mitigation strategies.

11. Employee self-monitoring.

Commenter 20014: 16VAC25-220-40.B.2., page 22 - Employers to communicate to employees to self-monitor - is this meant to ensure reporting if suspect possible exposure? or just self-monitor? PLEASE CLARIFY.

Department Response: 16VAC25-220-40.B.2 provides:

"2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs or symptoms of an illness.

16VAC25-220-40.B.2 is solely directed at self-monitoring of employees. It does not require employers to report "suspect possible exposure." Employee notification

requirements are contained in 16VAC25-220-40.B.8 and only apply to "positive SARS-CoV-2 tests."

12. Economic Impact Analysis.

An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04⁸ will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.⁹

The Department does not intend to recommend that the Safety and Health Codes Board hold an additional comment period solely for the purpose of comment on the EIA.

Many of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in various Governor's Executive Orders, including most recently Executive Order 72. To the extent that a requirement is included in both Executive Orders and the standard, the Department does not consider the standard to impose any new cost burden on a covered locality.

In addition, many of the costs associated with dealing with workplace hazards associated with COVID-19 are the result of requirements contained in current federal OSHA or VOSH unique standards and regulations already applicable to local governments, and therefore the Department does not consider them to be new costs associated with adoption of the standard.

Following are federal OSHA identical and state unique standards and regulations applicable in the Construction Industry, Agriculture Industry, Maritime Industry (public sector employment only as OSHA retains jurisdiction over private sector employment in Virginia), and General Industry ("General Industry" covers all employers not otherwise classified as Construction, Agriculture, or Maritime) that can be used in certain situations to address COVID-19 hazards in the workplace:

General Industry

- 1910.132, Personal Protective Equipment in General Industry (including workplace assessment)
- 1910.133, Eye and Face Protection in General Industry
- 1910.134, Respiratory Protection in General Industry
- 1910.138, Hand Protection
- 1910.141, Sanitation in General Industry (including handwashing facilities)
- 1910.1030, Bloodborne pathogens in General Industry
- 1910.1450, Occupational exposure to hazardous chemicals in laboratories in General Industry

⁸ <https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/>

⁹ <http://www.chmuraecon.com/>

Construction Industry

- 1926.95, Criteria for personal protective equipment in Construction
- 1926.102, Eye and Face Protection in Construction
- 1926.103, Respiratory Protection in Construction
- 16VAC25-160, Sanitation in Construction (including handwashing facilities)

Agriculture

- 16VAC25-190, Field Sanitation (including handwashing facilities) in Agriculture

Public Sector Maritime

- 1915.152, Shipyard Employment (Personal Protective Equipment)
- 1915.153, Shipyard Employment (Eye and Face Protection)
- 1915.154, Shipyard Employment (Respiratory Protection)
- 1915.157, Shipyard Employment (Hand and Body Protection)
- 1917.127, Marine Terminal Operations (Sanitation)
- 1917.92 and 1917.1(a)(2)(x), Marine Terminal Operations (Respiratory Protection, 1910.134)
- 1917.91, Marine Terminal Operations (Eye and Face Protection)
- 1917.95, Marine Terminal Operations (PPE, Other Protective Measures)
- 1918.95, Longshoring (Sanitation)
- 1918.102, Longshoring (Respiratory Protection)
- 1918.101, Longshoring (Eye and Face Protection)

Multiple Industries

- 16VAC25-220, Emergency Temporary Standard in General Industry, Construction, Agriculture and Public Sector Maritime
- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture and Public Sector Maritime
- 1910.142, Temporary Labor Camps (including handwashing facilities) in Agriculture and General Industry
- 1910.1020, Access to employee exposure and medical records in General Industry, Construction, and Public Sector Maritime (excludes Agriculture)
- 1910.1200, Hazard Communication in General Industry, Construction, Agriculture and Public Sector Maritime
- 16VAC25-60-120 (General Industry), 16VAC25-60-130 (Construction Industry), 16VAC25-60-140 (Agriculture), and 16VAC25-60-150 (Public Sector Maritime), Manufacturer's specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment (can be used to apply to operation and

maintenance of air handling systems in accordance with manufacturer's instructions)

In addition, Va. Code §40.1-51.1.A, provides that:

“ A. It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.”

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer's requirements, requirements of the Centers for Disease Control (CDC), or an employer's safety and health rules.

To the extent that the general duty clause could be used by the Department to address COVID-19 workplace hazards to the same extent as and in the same manner as the standard were the standard not in effect, the Department does not consider any of the costs associated with such use of the clause to be new costs associated with adoption of the standard.

13. Conflict Between Executive Orders and the ETS or final standard.

Commenter 20004: Conflict between EO and ETS: which to follow? Who has authority to enforce conflicts?

Department Response: Any conflicts identified between Governor's Executive Orders and the standard would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

14. Changes in effective date for employee training.

Commenter 20015: Delayed effective date for training, etc. will leave gap in coverage. Especially since ETS currently has those requirements.

Department Response: The Department is recommending an expanded time for employee training from 30 days to 60 days in response to employer concerns expressed during multiple public comment opportunities about the ability to develop and provide effective training to management personnel and employees in 30 days. The Department does not believe the request is unreasonable in light of the unprecedented nature of the

pandemic and the need for employers to modify orientation and training materials for new hires and retraining materials for current employees. In addition, new businesses are being opened on a regular basis and should be afforded a sufficient time to develop and provide training. The Department does not intend to change its recommendation in response to the comment.

15. Outbreak notification changes.

Commenter 20015: "Outbreak" provision changes - we support current outbreak reporting as it is critical to report outbreaks to CDC/VDH.

Department Response: At the request of VDH, the Department proposed changing the COVID-19 case reporting requirement threshold from one case to two cases so that it aligned with current statutory/regulatory/procedural VDH reporting requirements. The lower reporting threshold was negatively impacting VDH's ability to effectively and efficiently use its limited employee resources and caused some confusion in the regulated community. The Department does not intend to change its recommendation in response to the comment.

16. Non-applicability of Administrative Process Act to adoption of a permanent standard under Va. Code §40.1-22(6a).

Commenter 20002: "I have substantial concerns with the proposed rule and strongly recommend the Board follow the full procedures of the Virginia Administrative Process Act (VAPA) (Va. Code 2.2-4000 et seq), as the Board committed to do."

Department Response: It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA."

The Commenter is incorrect in stating that the Board committed to follow the full procedures of the Virginia Administrative Process Act (VAPA) (Va. Code 2.2-4000 et seq). The Board did make clear its intent during the adoption process for the ETS that during any process to adopt a permanent replacement standard it would attempt to substantially comply with the core requirements in the APA within the time constraints of the requirements of Va. Code §40.1-22(6a) by holding a 60 day written comment period and a public hearing along with obtaining an Economic Impact Analysis and holding a meeting to consider a final standard. All four of those conditions have or will be met by January 11, 2021.

17. PPE Shortages.

Commenter 20016:

Department Response: The Department respectfully disagrees with the Commenter's statement that "Proposed permanent standard rolls back on those protections by allowing "face coverings" when respirators are needed in certain circumstances. Current ETS was more appropriate and maintained respirator requirement when determined to be necessary."

16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms." The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

18. Reuse of Respirators.

The VOSH Program follows OSHA's April 3, 2020 Memorandum entitled "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" which "outlines enforcement discretion to permit

the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer’s recommended shelf life (sometimes referred to as “expired”).”¹⁰

The VOSH Program also follows OSHA’s April 24, 2020 Memorandum entitled “Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic.”¹¹

19. Impact of Vaccines.

Impact of Vaccines. “Community immunity [or herd immunity]: A situation in which a sufficient proportion of a population is immune to an infectious disease (through vaccination and/or prior illness) to make its spread from person to person unlikely. Current estimates for achieving community immunity in the U.S. range from 70% to 90%. There are over 329,000,000 people living in the United States, which means that between 230,000,000 and 296,000,000 people would have to develop immunity through either infection or vaccination. Vaccine manufacturing and deployment will take many months to reach the necessary number of people.

According to the CDC, “The protection someone gains from having an infection (called natural immunity) varies depending on the disease, and it varies from person to person. Since this virus is new, we don’t know how long natural immunity might last. Current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection. Regarding vaccination, we won’t know how long immunity lasts until we have a vaccine and more data on how well it works.”¹²

Virus mutations are also a known concern: “A new, highly contagious coronavirus variant that was first identified in Britain has reached the United States, officials in Colorado confirmed Tuesday, reporting the first known U.S. case of the strain more than two weeks after it was discovered — a worrying development as Covid-19 infections and deaths climb nationwide.

....

Researchers believe this new coronavirus variant — which U.K. officials disclosed earlier this month — is about 56% more contagious than other versions of the virus, an alarming figure even though it doesn’t appear to lead to deadlier infections. As of last week, the variant was already responsible for the majority of London’s Covid-19 infections, and officials have partly blamed it for a recent spike in U.K. Covid-19 cases that has forced much of the country back into strict lockdowns. Dozens of countries have banned or restricted travel from the United Kingdom in response, including the United States, which began requiring all U.K. travelers to show a negative coronavirus test before flying to the U.S. this week.

....

¹⁰ <https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus>

¹¹ <https://www.osha.gov/memos/2020-04-24/enforcement-guidance-decontamination-filtering-facepiece-respirators-healthcare>

¹² <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

Most infectious disease experts aren't surprised to see the new variant arrive in the United States. Last week, Dr. Anthony Fauci told ABC News it's "certainly possible" the mutation was already present in the country. But experts fear a more transmissible form of Covid-19 could make controlling the virus' spread even more difficult, adding to an already-dire surge in cases throughout the United States." (Emphasis added).

13

As of December 29, 2020, the CDC says: "While experts learn more about the protection that COVID-19 vaccines provide under real-life conditions, it will be important for everyone to continue using all the tools available to us to help stop this pandemic, like covering your mouth and nose with a mask, washing hands often, and staying at least 6 feet away from others. Together, COVID-19 vaccination and following CDC's recommendations for how to protect yourself and others will offer the best protection from getting and spreading COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before deciding to change recommendations on steps everyone should take to slow the spread of the virus that causes COVID-19. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.

...

There is not enough information currently available to say if or when CDC will stop recommending that people wear masks and avoid close contact with others to help prevent the spread of the virus that causes COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before making that decision. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision."¹⁴

20. Removal of references to Executive Orders and Orders of Public Health Emergency.

The Department is recommending removal of the following provisions from the standard:

16VAC25-220-10.F:

F. This standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency.

16VAC25-220-40.G:

G. Employers shall also ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency.

16VAC25-220-70.C.9:

¹³ <https://www.forbes.com/sites/joewalsh/2021/12/29/first-us-case-of-new-covid-mutation-discovered-in-colorado/?sh=5560175e1d79>

¹⁴ <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html>

9. Ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency related to the SARS-CoV-2 virus or COVID-19 disease.

Department Response: After discussions with legal counsel, the Department is recommending removal of the above language.

In addition, the language is considered redundant in light of Executive Order 72, Order of Public Health Emergency, Commonsense Surge Restrictions, Certain Temporary Restrictions Due to Novel Coronavirus (COVID-19), adopted on December 14, 2020, which provides as follows:

IV. ADDITIONAL PROVISIONS

A. Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19”

Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

21. Sick leave issue.

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at: <https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

The Consolidated Appropriations Act (CAA 2021) was signed into law on December 27, 2020. “The CAA 2021 allows FFCRA-covered employers to voluntarily extend two types of emergency paid leaves through March 31, 2021 that were originally mandated between April 1, 2020 and December 31, 2020 by the Families First Coronavirus Response Act (FFCRA). These FFCRA leaves are Emergency Paid Sick Leave (EPSL) and Emergency Family and Medical Leave (EFMLA).

The FFCRA provided up to 10 days of EPSL, with varying levels of pay, for any of six COVID-19 qualifying reasons between April 1, 2020 and December 31, 2020. Carryover

of unused EPSL into 2021 was not allowed under the FFCRA—at least not as originally written.

The CAA 2021, however, amends the carryover provision of EPSL. Employers may now voluntarily choose to permit the carryover of unused 2020 EPSL into the first quarter of 2021. If they do, EPSL tax credits associated with this paid leave can be taken through March 31, 2021. The tax credits are an incentive for FFCRA-covered employers to choose to carryover unused EPSL.

It is important to note that the CAA 2021 does not provide employees with additional EPSL. Employees who emptied their EPSL tank of 10 days in 2020 have nothing to carry over into the first quarter of 2021 should their employers decide to allow EPSL carryover. The CAA 2021 merely extends the tax credit available to private employers under the FFCRA, and does not create new EPSL leave.

<https://www.jdsupra.com/legalnews/extension-of-emergency-ffcra-leaves-21991/>

22. Online Complaint Reporting to VDH.

Commenter 89272: I've been to many places where owners, employees, and customers alike all basically say 'screw it' and either wear a mask ineffectively (under the nose, or just all the way down the chin exposing nose and mouth) or don't wear them at all. I see offenders everywhere. Start writing tickets for not wearing masks/wearing them incorrectly. Check in on restaurants, gas stations, etc., without warning and fine the business for employees not masked.

Department Response: The Department does not have the legal authority to issue violations and penalties to members of the general public or employees, only to employers. See Va. Code §40.1-49.4. VDH has an online complaint system where you can file complaints about customers not wearing face coverings:

<https://redcap.vdh.virginia.gov/redcap/surveys/?s=Y4P9H7DTWA>

23. Return to work requirements for asymptomatic persons.

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

24. Enforcement responsibility for face covering requirements of the general public.

Commenter 87857: We have mask mandates, curfews and limits on social gatherings... and who is enforcing that? I don't mean who is supposed to enforce it, I want to know who is actually enforcing that? They're great ideas and people ought to follow them. But at least in my town, no one is enforcing these rules. Customers do whatever they want and employees keep their mouths shut because their crummy minimum wage job isn't

worth getting screamed at or assaulted....And who gets cited? The business is cited because the Commonwealth isn't standing up to the individual people outright defying the law. Yes, workers need to be protected and some standard should be in place... but can we level the playing field a little?

Department Response: The Department recognizes and understands the frustrations expressed by the Commenter about the unwillingness of some people to wear face coverings; however, please note that some people do have legitimate health concerns with wearing face coverings that are excused from having to wear them.

The Standard does not address the rights or protections of the general public, and more specifically, it does not contain a face covering mandate for the general public. That issue is the purview of the Virginia Department of Health and Governor's Executive Orders (e.g., Executive Order 72). VDH has legal authority under Executive Order 72 to enforce requirements (e.g., face covering mandates, curfews and limits on social gatherings) contained in that order.

[https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-(COVID-19).pdf)

VDH also has an online complaint form that can be filled out by anyone to report violations of EO 72.

<https://redcap.vdh.virginia.gov/redcap/surveys/?s=Y4P9H7DTWA>

While the Virginia Department of Health (VDH) has some statutory and regulatory responsibilities in certain industries (restaurant permitting, temporary labor camp permitting, nursing home licensing, etc.), its primary focus is public safety, customer safety and patient safety. VDH has very limited and in some cases no enforcement options when it comes to requiring many of Virginia's industries to limit the spread of SARS-CoV-2 among employees and employers in the workplace.

In such cases where VDH does intervene in a workplace setting that does not fall under its jurisdiction, it will attempt to obtain the employer's agreement with Governor's Executive Orders, but it does not attempt to obtain the employer's agreement to comply with VOSH laws, standards, and regulations, such as VOSH's COVID-19 ETS or other applicable VOSH standards and regulations (e.g., personal protective equipment, respiratory protective equipment, etc.).

In cases where either an employer refuses to comply with Governor's Executive Orders or VDH suspects potential violations of VOSH laws, standards and regulations, it will make a referral to VOSH for either an informal investigation or an onsite inspection. Accordingly, it is neither legal nor appropriate from a policy standpoint for VOSH to cede jurisdiction to VDH to handle all COVID-19 issues.

25. Contact Tracing.

Commenter 88954: Reporting cases to VDH and/or VDL should only be required when workplace transmission of the virus has been established during contact tracing. Employees confirmed cases of COVID-19 that are attributable to exposures outside of the workplace, where contact tracing establishes no other employees have been in routine close contact in the workplace, should not be reportable. These are cases which are not the result of, or cause of, outbreaks in the workplace and therefore should not be reportable.

Department Response: The Department notes that 16VAC25-220-10.H. provides:

"Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease."

The Department does not intend to make the Commenter's suggested change that would require employers to conduct contact tracing in order to determine whether an employee's positive COVID-19 test was the result of exposure at work or outside of work, as that would add a significant new compliance burden for employers. VDH already has responsibility to conduct contact tracing and the expertise and resources to do so.

26. Return to work issues for employees who have had close contact with a positive COVID-19 person.

The CDC defines "close contact" as "Close contact" means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does not address the issue of "quarantine."

Requirements for returning to work from "quarantine" is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

VDH has responsibility for quarantine issues by statute and regulation.

27. Working age population exposure to virus.

The Department respectfully disagrees with the Commenter's statement that "The COVID-19 data for the working age population does not support a direct and immediate danger." There is overwhelming evidence to the contrary. The January 4, 2021 Briefing

Package for the Safety and Health Codes Board contains information in section V.C on the aging of the workforce and the high percentages of the American populace that are in COVID-19 high risk health categories:

“Older adults make up a large percentage of many of the jobs in these industries. For example, nearly half of bus drivers are older than 55, while almost 1 in 5 ticket takers and ushers are 65 or older. And although the BLS didn’t specifically call them out, farmers have also been impacted by the toll of the virus, with both prices of commodities and consumption declining. The median age of farmers and ranchers in the U.S. is 56.1 years old.” <https://www.seniorliving.org/research/senior-employment-outlook-covid/>

The CDC conducted a study of “Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016” of the general population. Although the working population of the country is only a subset of the totals for the table, the data nonetheless demonstrates the significant risk that SARS-CoV-2 and COVID-19 related hazards pose to the U.S. and Virginia workers. Using the age adjusted statistical totals:

- 14.7% of the population suffer from diabetes,
- 12.2% from high cholesterol
- 30.2% suffer from hypertension
- 39.7% suffer from obesity

<https://www.cdc.gov/nchs/data/hus/2018/021.pdf>

The Briefing package also contains Virginia specific information on COVID-19 related workers' compensation claims, employee hospitalizations and employee deaths in section IV.E:

Since February, 2020, the Virginia Workers’ Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020.

Thirty employee deaths and 61 employee hospitalizations have been reported to VOSH as of January 1, 2021.

NOTE: The VOSH Program has investigated an average of 37 annual work-related employee deaths over the last five calendar years. The 30 COVID-19 death notifications so far in 2020 would represent 81% of the deaths investigated by VOSH in an average year.

November 4, 2020

**VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM
PROPOSED PERMANENT STANDARD FOR INFECTIOUS DISEASE
PREVENTION OF SARS-COV-2 WHICH CAUSES COVID-19, 16VAC25-220**

**DEPARTMENT STANDARD RESPONSES TO ISSUES RAISED
BY PUBLIC COMMENTERS**

Background

The Department received 993 written comments through the Virginia Regulatory Townhall for the 60 day written comment period from August 27, 2020 to September 25, 2020.

There were 33 written comments sent directly to the Department during the 60 day written comment period, although a number of those were also posted by the Commenter on the Virginia Regulatory Townhall.

There were 29 oral comments received during the public hearing on September 30, 2020.

Following are Department standard responses to issues raised by public commenters.

1. “No Mask Only” comments.

Over 200 comments were received in response to the Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (“Standard”), solely opposed to any form of face covering (or “face mask”) requirement. The following responses are provided by VOSH in response to face covering issues raised by the comments:

The standard does not contain a public face covering mandate

16VAC25-220-10.C provides that the Standard applies “to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program....” The Standard does not contain a face covering mandate for the general public. That issue is the purview of the Virginia Department of Health and Governor’s Executive Orders (e.g., Executive Order 63¹⁵).

The Standard does require employees to wear either personal protective equipment, respiratory protection equipment, or face coverings in situations where physical distancing of six feet from other persons cannot be maintained.

Face covering requirements are not unconstitutional

For those commenters who argued that that certain gubernatorial mandates (e.g., “face mask” mandate) are unconstitutional, according to the Office of the Attorney General on at least twelve occasions the Governor’s COVID-19 restrictions have been upheld by circuit courts throughout the Commonwealth.¹⁶ Two of these specifically challenged the face covering requirements. *Schilling et al. v. Northam*, CL20-799 (Albemarle Co. Cir. Ct. July 20, 2020)¹⁷; *Strother, et al. v. Northam*, CL20-260 (Fauquier Co. Cir. Ct. June 29, 2020).¹⁸

Regulation versus legislation

Some commenters were under the impression that the Standard was being proposed as legislation to the General Assembly. That is incorrect. The Standard is being considered for adoption by the Virginia Safety and Health Codes Board pursuant to Va. Code §40.1-22(6a)¹⁹ and would be enforced by the Department of Labor and Industry’s (DOLI) Virginia Occupational Safety and Health (VOSH) Program.

Permanence of the standard

Some commenters raised concerns about a face covering mandate being “permanent”. The use of the word “permanent” in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire.

¹⁵ <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf>

¹⁶ <https://oag.state.va.us/media-center/news-releases/1769-july-21-2020-herring-again-successfully-defends-mask-requirement> (July 21, 2020, accessed Aug. 3, 2020).

¹⁷ Accessible at <https://oag.state.va.us/files/2020/Schilling-et-al-v-Northam.pdf>.

¹⁸ Accessible at <https://www.oag.state.va.us/files/2020/maskRequirementsCase.pdf>.

¹⁹ <https://law.lis.virginia.gov/vacode/40.1-22/>

However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen.

A medical exemption is provided for face coverings

Some commenters expressed concern about any face covering requirement that could present medical problems for a person with a pre-existing medical condition, such as asthma, etc. 16VAC25-220-40.I provides that:

“I. Nothing in this standard shall require the use of a respirator, surgical/medical procedure mask, or face covering by any employee for whom doing so would be contrary to the employee's health or safety because of a medical condition....”

Situations involving employers with an employee with a medical condition that does not allow them to wear a face covering when required while performing job tasks where physical distancing of six feet cannot be maintained are subject to requirements of the Americans With Disabilities Act (ADA). The ADA is enforced by the federal Equal Employment Opportunity Commission (EEOC).

The following link to the EEOC webpage with guidance on the ADA and COVID-19 issues can be used to research the core issue of whether the “high risk” category that the employee falls into is a “medical condition” that meets the definition of a “disability” under the ADA or not. Section D contains FAQs on “reasonable accommodations” that are provided to employees with a disability. The term “undue hardship” is referenced, and should be researched to see if it applies to the employer’s situation.

<https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws>

Commenters suggesting that sick people stay home instead of requiring the wearing of face coverings

Some commenters suggested that sick people stay home instead of requiring the wearing of face coverings. 16VAC25-220.B.5 specifically requires employers to assure that employees either known or suspected of being infected with SARS-CoV-2 not report to or remain at the work site or engage in work at a customer or client location until cleared for return to work.

However, it is well-documented in scientific literature that an estimated 20%²⁰ or more of persons infected with SARS-CoV-2 have no symptoms (are “asymptomatic”), while others may be infected and not show symptoms for several days (presymptomatic). Accordingly, simply telling sick people to stay home does not address the problem of potential asymptomatic and presymptomatic spread of SARS-CoV-2.

“Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-

²⁰ <https://www.healthline.com/health-news/20-percent-of-people-with-covid-19-are-asymptomatic-but-can-spread-the-disease#Only-20%-remained-asymptomatic>

symptomatic incubation period, and asymptomatic transmission has been suggested in other reports. Virologic studies have also detected SARS-CoV-2 with RT-PCR low cycle thresholds, indicating larger quantities of viral RNA, and cultured viable virus among persons with asymptomatic and pre-symptomatic SARS-CoV-2 infection.

The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear. Risk of transmission is thought to be greatest when patients are symptomatic since viral shedding is greatest at the time of symptom onset and declines over the course of several days to weeks. However, the proportion of SARS-CoV-2 transmission in the population due to asymptomatic or pre-symptomatic infection compared to symptomatic infection is unclear.”²¹

Face coverings help in protecting against infection spread in the community and at work

“During a pandemic, cloth masks may be the only option available; however, they should be used as a last resort when medical masks and respirators are not available.”²²

....

The general public can use cloth masks to protect against infection spread in the community. In community settings, masks may be used in 2 ways. First, they may be used by sick persons to prevent spread of infection (source control), and most health organizations (including WHO and CDC) recommend such use. In fact, a recent CDC policy change with regard to community use of cloth masks²³ is also based on high risk for transmission from asymptomatic or presymptomatic persons.²⁴ According to some studies, ~25%–50% of persons with COVID-19 have mild cases or are asymptomatic and potentially can transmit infection to others. So in areas of high transmission, mask use as source control may prevent spread of infection from persons with asymptomatic, presymptomatic, or mild infections. If medical masks are prioritized for healthcare workers, the general public can use cloth masks as an alternative. Second, masks may be used by healthy persons to protect them from acquiring respiratory infections; some randomized controlled trials have shown masks to be efficacious in closed community settings, with and without the practice of hand hygiene.²⁵ Moreover, in a widespread pandemic, differentiating asymptomatic from healthy persons in the community is very difficult, so at least in high-transmission areas, universal face mask use may be beneficial. The general public should be educated about mask use because cloth masks may give users a false sense of protection because of their limited protection against acquiring infection.²⁶ Correctly putting on and taking off cloth masks improves

²¹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>

²² <http://www.ijic.info/article/view/11366>

²³ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html>

²⁴ <https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-019-4109-x>

²⁵ MacIntyre CR, Chughtai AA. Facemasks for the prevention of infection in healthcare and community settings. *BMJ*. 2015;350(apr09 1):h694.

²⁶ Institute of Medicine. Reusability of facemasks during an influenza pandemic: facing the flu. Washington (DC): The National Academies Press; 2006.

protection.²⁷ Taking a mask off is a high-risk process²⁸ because pathogens may be present on the outer surface of the mask and may result in self-contamination during removal.²⁹

Commenter's statements expressing a refusal to wear face coverings

To the extent that the commenters who opposed a mandatory face covering requirement can be considered to represent any significant percentage of people living, working or traveling through Virginia, their views expressing a refusal to wear masks in public or business settings, unintentionally strengthens the case for a face covering (or other personal protective equipment and respiratory protection equipment) requirement in the Standard.

The stated commenters bolster the credibility of research presented to the Board by the VOSH during the adoption process for the Emergency Temporary Standard (ETS),³⁰ that employees will face a higher risk of virus exposure in the coming months because a certain segment of the population will refuse to wear face coverings or observe physical distancing of at least 6 feet when interacting with employees.

2. Commenter's suggestion that a permanent standard is not needed.

The use of the word “permanent” in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen.

3. Commenter's suggestion that it is not VOSH's job to “police” infections likely caused outside the workplace.

While many people become infected with SARS-CoV-2 in community settings that are not work-related, every person that becomes infected who is also an employee becomes a potential workplace source and transmitter of the virus if they report to work while still capable of transmitting the disease. There are numerous documented examples of the workplace spread SARS-CoV-2, which is also considered to be highly contagious. The introduction of an infectious disease into a workplace setting, regardless of the source, constitutes a workplace health hazard subject to regulation and enforcement by VOSH.

4. Commenter's suggestion that COVID-19 protections are better left to the Virginia Department of Health and Local Health Departments.

The VOSH program has clear statutory and regulatory jurisdiction over workplace safety and health issues in the Commonwealth, including the potential for spread of infectious diseases among employees and employers, and when those employees and employers

²⁷ <https://wwwnc.cdc.gov/eid/article/26/10/20-0948-t1>

²⁸ <https://www.sciencedirect.com/science/article/pii/S0196655318306801?via%3Dihub>

²⁹ <https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-019-4109-x>

³⁰ <https://www.doli.virginia.gov/wp-content/uploads/2020/07/RIS-filed-RTD-Final-ETS-7.24.2020.pdf>

are potentially exposed to other persons who may be carriers of the infectious diseases (patients, customers, independent contractors, etc.).

While the Virginia Department of Health (VDH) has some statutory and regulatory responsibilities in certain industries (restaurant permitting, temporary labor camp permitting, nursing home licensing, etc.), its primary focus is public safety, customer safety and patient safety. VDH has very limited and in some cases no enforcement options when it comes to requiring many of Virginia's industries to limit the spread of SARS-CoV-2 among employees and employers in the workplace.

In such cases where VDH does intervene in a workplace setting that does not fall under its jurisdiction, it will attempt to obtain the employer's agreement with Governor's Executive Orders, but it does not attempt to obtain the employer's agreement to comply with VOSH laws, standards, and regulations, such as VOSH's COVID-19 ETS or other applicable VOSH standards and regulations (e.g., personal protective equipment, respiratory protective equipment, etc.).

In cases where either an employer refuses to comply with Governor's Executive Orders or VDH suspects potential violations of VOSH laws, standards and regulations, it will make a referral to VOSH for either an informal investigation or an onsite inspection. Accordingly, it is neither legal nor appropriate from a policy standpoint for VOSH to cede jurisdiction to VDH to handle all COVID-19 issues.

5. Definition of “suspected to be infected with sars-cov-2 virus” and the option for an alternative diagnosis.

16VAC25-220-40.B.4 of the COVID-19 Emergency Temporary Standard (ETS), provides that “Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza)...” Such employees are then classified as “Suspected to be infected with SARS-CoV-2 virus” and may not report to the workplace until they have been cleared for return to work in accordance with ETS requirements. In situations where there is the possibility for an alternative diagnosis (such as allergies, the common cold, the flu, an ear infection, etc.) the employer has a number of options, including but not limited to, a positive test for influenza or the employee obtaining an alternative diagnosis from a medical authority.

In addition, the Virginia Department of Health provides the following guidance:

If the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an “alternative diagnosis”, and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

6. Commenter's suggestion that businesses are already subject to too many regulations.

There is substantial scientific evidence and infection, hospitalization and death statistics that support the conclusion that SARS-CoV-2 presents a danger to employees in the workplace.

It is the Department's position that the danger posed to employees and employers by the SARS-CoV-2 virus and COVID-19 disease are necessary and appropriate to regulate after the expiration of the current COVID-19 Emergency Temporary Standard (ETS) on January 26, 2021. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. It is well recognized that one or more vaccines will not be widely available to the public and employees until well after January 26, 2021.

The Department also believes that the Standard will ultimately help businesses to grow and bring customers back when those customers see that employers are providing employees with appropriate protections required by the Standard from SARS-CoV-2. If customers don't feel safe because employees don't feel safe, it will be hard for a business to prosper in a situation where there is ongoing community spread.

7. Commenter's suggestion that employers should just have to comply with CDC and Virginia Department of Health requirements.

The Department notes that the Standard provides flexibility to business through 16VAC25-220-10.G.1 which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard."

The Department does not intend to recommend any change to 16VAC25-220-10.G.1. A specific reference to "hospitals, health systems, and other facilities under their control" is unnecessary as the above provision applies to all employers wishing to take advantage of its provisions.

8. Commenter’s suggestion that public and private institutions of higher education and public and private schools should just have to comply with CDC, Virginia Department of Health and/or SCHEV requirements.

The Department notes that the Standard provides flexibility to schools through 16VAC25-220-10.G.2 which provides that “Public and private institutions of higher education that have received certification from the State Council of Higher Education of Virginia that the institution’s re-opening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor’s Office in conjunction with the Virginia Department of Health, shall be considered in compliance with this standard, provided the institution operates in compliance with their certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard.”

The Department notes that the Standard provides flexibility to schools through 16VAC25-220-10.G.2 “A public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and who operate in compliance with the public school division’s or private school’s submitted plans shall be considered in compliance with this standard. An institution’s actual compliance with recommendations contained in CDC guidelines or the Virginia Department of Education guidance, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.”

9. Return to work requirements in the standard are different from the CDC requirements.

The issue of the differences between the Standard's return to work requirement and those of the CDC will be addressed in the revised proposed permanent standard. A Frequently Asked Question (FAQ) provided by DOLI addresses the issue as it pertains to the current Emergency Temporary Standard (ETS).

On July 22, 2020, the CDC changed its guidance with regard to symptoms-based strategies from exclusion for 10 days after symptom onset and resolution of fever for at least 3 days to exclusion for 10 days after symptom onset and resolution of fever for at least 24 hours (i.e., the change was from 72 hours to 24 hours). For persons who never develop symptoms (i.e., asymptomatic), isolation and other precautions can be discontinued 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

16VAC25-220-10.G.1 provides in part that:

To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard.... (Emphasis added).

Employers who comply with the above-referenced change in CDC guidance issued July 22, 2020, will be considered to be providing protection equivalent to protection provided by complying with the requirements in the ETS.

However, nothing in the FAQ shall be construed to prohibit an employer from complying with the symptom-based or time-based strategies for return to work determinations in the ETS. (See §40 FAQ 18, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>)

10. Commenter's suggestion that if workers aren't willing to take responsibility for themselves out in public then employers should not be forced to take the responsibility for them.

The Commenter asks why employers should provide strong workplace protections to prevent the spread of SARS-CoV-2, when employees can get infected anyway by not maintaining the same kind of protections in their private life, and then apparently bring that infection back into the workplace. It is exactly because there currently is a real possibility that infections obtained outside of work – whether by an employee, or a customer, or a patient, or a subcontractor – that employers need to maintain workplace COVID-19 protections for those employees who do act responsibly away from work.

11. Political commentary.

The Department has no response to the Commenter's political commentary.

12. Notice and comment procedures followed on the Standard.

The proposed permanent standard has been subject to the following notice and comment procedures. The Virginia Safety and Health Codes Board held a 60 day written comment period for the Proposed Permanent Standard, with the comment period running from August 27, 2020 to September 25, 2020. The Board held a Public Hearing on September 30, 2020. A revised draft of the Proposed Permanent Standard will be published with an additional 30 day comment period prior to any Board action. A public hearing will also be held.

13. The Department does not anticipate a large increase in litigation with regard to the Emergency Temporary Standard or any permanent standard.

Review of all COVID-19 related inspections under the Emergency Temporary Standard is conducted centrally by the Department with both a programmatic and legal review prior to a decision to issue or not issue violations/penalties to assure consistent

enforcement across the Commonwealth. The Department does not anticipate any significant increase in litigation with regard to the Emergency Temporary Standard or any permanent standard.

14. No substantive issues raised.

The Department acknowledges the Comment and has no additional response as the Commenter did not raise any substantive issues.

15. Travel regulations.

The Standard does not contain travel regulations.

16. Six foot separation at all times.

If your employees are able to maintain physical distancing of 6 feet from other persons (employees, customers, etc.) at all times, than it is appropriate for their job tasks to be classified as “lower risk.” Please note that the definition for “lower risk” also provides that “when it is necessary for an employee to have brief contact with others inside the six feet distance a face covering is required”, and still allows the job tasks to remain classified as lower risk.

Employers that are able to modify job tasks and mitigate potential exposure to SARS-CoV-2 to the extent that they can classify their employees as lower risk greatly reduce their compliance burden under the Standard. Such employers will not have to comply with the additional requirements contained in 16VAC25-220-60 for medium risk hazards and job tasks; nor will they have to develop an infectious disease preparedness and response plan under 16VAC25-220-70.

Finally, such employers will be able avoid the large majority of the training requirements under 16VAC25-220-80, with the exception that employees have to be provided with written or oral information on the hazards and characteristics of SARS-COV-2 and the symptoms of COVID-19 and measures to minimize exposure. The Department has developed an information sheet which satisfies this requirement which can be found at: <https://www.doli.virginia.gov/wp-content/uploads/2020/07/Lower-Risk-Training-1.pdf>.

17. Greater hazard issues.

The Standard requires employers to provide and employees in customer facing positions to wear a face covering. If the employer is concerned that employee use of a face covering may present a greater safety or health hazard to employees than compliance with the Standard (e.g., the inability to communicate coherently with another employee during a potentially hazardous job task) the issue needs to be assessed during the personal protective equipment (PPE) hazard assessment process required either under the Standard (see 16VAC25-220-50.D for very high and high risk situations, and 16VAC25-220.60.D for medium risk situations) or 1910.132(d) for general industry employers. The PPE hazard assessment process will allow the employer to identify any

potential situations where there may be a greater hazard presented and develop alternative protections for employees.

PPE

16VAC25-220-40.F provides: "F. When multiple employees are occupying a vehicle for work purposes, the employer shall ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry. If the employer is concerned that employee use of a face covering may present a greater safety or health hazard to employees than compliance with the Standard (e.g., the inability to communicate coherently with another employee during a potentially hazardous job task) the issue needs to be assessed during the personal protective equipment (PPE) hazard assessment process required either under the Standard (see 16VAC25-220-50.D for very high and high risk situations, and 16VAC25-220.60.D for medium risk situations) or 1910.132(d) for general industry employers. The PPE hazard assessment process will allow the employer to identify any potential situations where there may be a greater hazard presented and develop alternative protections for employees.

Heat Illness

If the employer is concerned that employee use of a face covering may present a greater safety or health hazard to employees to employees exposed to hot environments than compliance with the Standard (e.g., the inability to communicate coherently with another employee during a potentially hazardous job task) the issue needs to be assessed during the personal protective equipment (PPE) hazard assessment process required either under the Standard (see 16VAC25-220-50.D for very high and high risk situations, and 16VAC25-220.60.D for medium risk situations) or 1910.132(d) for general industry employers. The PPE hazard assessment process will allow the employer to identify any potential situations where there may be a greater hazard presented due to hot environments and develop alternative protections for employees.

In addition, 16VAC25-220-80.B.8.f provides that training on the standard provided to employees shall include with regard to PPE: "Heat-related illness prevention including the signs and symptoms of heat-related illness...."

18. Regulation versus legislation.

This Standard is not being proposed as legislation to the General Assembly. The Standard is being considered for adoption by the Virginia Safety and Health Codes Board pursuant to Va. Code §40.1-22(6a) and would be enforced by the Department of Labor and Industry's (DOLI) Virginia Occupational Safety and Health (VOSH) Program.

19. Similarly situated employees should be provided the same level of protection (request for healthcare industry exemption from the standard).

Employees and employers in the healthcare industry are exposed to the same and even greater COVID-19 related hazards and job tasks as employees in other industries. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections.

An exemption from the Standard for employers and employees in the healthcare industry is therefore inappropriate.

20. The Standard does not address the rights of the general public.

16VAC25-220-10.C provides that the Standard applies “to every employer, employee, and place of employment in the Commonwealth of Virginia within the jurisdiction of the VOSH program....” The Standard does not address the rights or protections of the general public.

21. Small business resources.

The Department acknowledges that all of its VOSH laws, standards and regulations can serve to place compliance burdens on employers and employees, particularly in the small business sector. The Department also believes that employers that embrace providing sound and comprehensive workplace safety and health protections can make their business more efficient and profitable through such benefits as reduced injuries, illnesses and fatalities, reduced workers’ compensation costs, reduced insurance costs, improvements in morale and innovation, and increased productivity.

The Department strongly encourages Virginia’s small business owners to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

In addition, free Outreach, Training, and Educational materials to assure compliance with COVID-19 requirements can be found at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

22. “At will employment”.

The Department has no response concerning the Commenter's reference to "at will employment" in Virginia other than to note that employers within the jurisdiction of the VOSH program are required to provide safe and health workplaces for their employees.

23. Other States that have adopted COVID-19 related workplace safety and health regulations.

The states of Virginia, Washington, Michigan, Oregon and California have adopted COVID-19 related workplace safety and health regulations.

24. Whistleblower provision in 16VAC25-220-90.C does not provide protection for unsubstantiated or false claims against an employer.

The Department does not intend to recommend any change to 16VAC25-220-90.C as it is the position of the Department that it reflects the current state of case law on the subject.

Pursuant to Va. Code §40.1-51.2:1, employees are protected from discrimination when they engage in activities protected by Title 40.1 of the Code of Virginia (“because the employee has filed a safety or health complaint or has testified or otherwise acted to exercise rights under the safety and health provisions of this title for themselves or others.”).

Whether an employee engaged in a “protected activity” under Title 40.1 is very fact specific, but can include occupational safety and health information shared by an employee about their employer on a social media or other public platform in certain situations.

16VAC25-220-90.C provides that:

No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer’s agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

If an employee raises an unsubstantiated COVID-19 related claim or makes a false COVID-19 related claim against their employer through print, online, social, or any other media, such an act by an employee would not be considered “reasonable” under the ETS and disciplinary action taken against the employee in accordance with the employer’s human resource policies would not be considered “discrimination” under the ETS/ER or Va. Code §40.1-51.2:1.

25. ASHRAE air handling requirements.

The Department acknowledges the comment and notes that the ASHRAE air handling requirements issue raised by the Commenter is undergoing a legal review.

25. Quarantine and isolation explained.

The Standard does not address the issue of "quarantine". “Quarantine” is separation of people who were in “close contact” with a person with COVID-19 from others. The Standard does address the issue of "isolation".

“Isolation” is the separation of people with COVID-19 from others. People in isolation need to stay home and separate themselves from others in the home as much as possible. Requirements for returning to work from isolation is covered by the ETS in 16VAC25-220-40.C. However, please note that in lieu of complying with 16VAC25-220-40.C, employers may comply with recently updated CDC guidelines (see §40 FAQ 18, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>).

26. Economic impact analysis/cost analysis.

An economic impact analysis/cost analysis will be prepared for the revised proposed permanent standard.

27. VOSH penalties.

Any penalties collected by the Commonwealth in response to VOSH COVID-19 related inspections is deposited in the General Fund of the Commonwealth and not the Department of Labor and Industry's budget.

28. The Standard does not cover other infectious diseases.

The Standard does not cover other infectious diseases like influenza, tuberculosis, etc.

29. Employee temperature checks are not specifically required during prescreening.

Although it is a generally accepted practice, the Standard does not specifically require that employers check the temperatures of employees. 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

30. Safe harbor issue.

With regard to the "safe harbor" issue, the Department notes that the Standard provides flexibility to business through 16VAC25-220-10.G.1 which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard."

The Standard is clear that employer's wishing to take advantage of 16VAC25-220-10.G.1 must comply with both mandatory and non-mandatory provisions in the specific CDC guidelines, and those provisions must provide equivalent or greater protection than provided by a provision of the Standard.

The Department does not plan to recommend that 16VAC25-220-10.G be returned to its original language. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.G assures such protections.

31. FAQs.

Frequently Asked Questions (FAQs) are available at:
<https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

32. Price gouging for PPE.

Price gouging complaints during a state of emergency in Virginia can be filed with the Office of the Attorney General (OAG): https://www.oag.state.va.us/consumer-protection/index.php?option=com_content&view=article&id=181#:~:text=File%20a%20Price%20Gouging%20complaint,Office%20of%20Weights%20and%20Measures.

33. Face covering definition.

The Department intends to recommend a change to the definition of face covering.

34. Commenter's suggestion that only Virginia citizens should be able to file comments.

The Department does not have any control over who can file comments to standards and regulations. That is within the purview of the General Assembly.

35. Commenter's suggestion that the Standard is "one size fits all".

The Department disagrees that the Standard is a "one size fits all" regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

36. Vaccinations.

COVID-19 vaccines will be an important part of the Commonwealth's and the country's ability to significantly reduce the ongoing spread of the SARS-CoV-2 virus in the workplace and in the community. However, with the projected population-level efficacy of COVID-19 vaccine to be 50-70%, no one can definitively state that someone vaccinated will not subsequently be free from infection.

There is also anecdotal information and scientific surveys that appear to indicate that a certain sector of the American population will refuse to be vaccinated. Accordingly, it is anticipated that SARS-CoV-2 will continue to infect a certain sector of the populace and be present in the workplace for months and years to come.

The Department does not intend to include a requirement in the Standard for employees to be vaccinated; however, the Standard is designed to incentivize employers to implement mitigation strategies against the spread of SARS-CoV-2, and vaccinations are one such strategy.

37. Physical separation of employees at low-risk businesses by a permanent, solid floor to ceiling wall.

The language referenced by the Commenter (physical separation of employees at low-risk businesses by a permanent, solid floor to ceiling wall) is one method described in the Standard for mitigating the spread of SARS-CoV2; however, employers are not required to do so.

The Department intends to recommend a language change to the Standard that makes this clear.

38. Risk classification by job task and hazard.

The language referenced by the Commenter (Requiring employers to determine the risk of each employee instead of basing that on their job tasks) is not accurate. The Standard specifically provides in 16VAC25-220-40.B.1 that “Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed....”

39. Cleaning and disinfecting at the same intervals.

The language referenced by the Commenter (All businesses must clean and disinfect at the same intervals whether it’s a 9 to 5 office setting or a factory with round-the-clock shifts. Again, imposing burdens without any rationale.) is assumed by the Department to refer to 16VAC25-220-40.K.5 which provides “All common spaces, including bathrooms, frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at the end of each shift.”

The Department disagrees that there is no rationale for the requirement. The provision states that the cleaning will take place “at the end of each shift”, the rationale being to prevent the spread of the SARS-CoV-2 virus from one group of employees to another (employers with multiple shifts); or from the same group of employees from one day to another when they have been away from work during the time in between shifts and potentially exposed to SARS-CoV-2 in the interim, or for locations where customers enter, for the same reason.

40. Comprehensive infectious disease standard.

The Safety and Health Codes Board has the option to begin consideration of a comprehensive infectious disease standard at any time; however the Department recommends that the focus for now remain on addressing SARS-CoV-2 and COVID-19 workplace hazards.

41. Privacy issues.

With regard to the privacy issue raised, the Standard specifically references the Health Insurance Portability and Accountability Act (HIPAA) in two places when dealing with potential employee and employer privacy concerns (16VAC25-220-40.B.8 and 16VAC25-220-70.C.3.b).

42. Exemption from the Standard for hospitals and healthcare providers.

The issue of an exemption from the Emergency Temporary Standard for hospitals and healthcare providers was previously considered by the Safety and Health Codes Board and not adopted.

43. Commenter's suggestion that the ETS conflicts with federal regulations.

The Department is not aware of any conflicts of the Standard with federal regulations. Federal OSHA does not have an infectious disease regulation that applies to SARS-CoV-2 and COVID-19.

44. Commenter's comparison of COVID-19 with influenza and common cold.

With regard to the issue of comparing SARS-CoV-2 and Covid-19 to influenza and the common cold, there are a number of significant differences which are discussed in detail in the Department's Briefing Package on the Emergency Temporary Standard dated June 23, 2020, which can be found at: <https://www.doli.virginia.gov/wp-content/uploads/2020/06/BP-Emergency-Regulation-Under-2.2-4011-SARS-CoV-2-That-Causes-COVID-19-FINAL-6.23.2020.pdf> (e.g., lack of a vaccine, limited treatment options, infection fatality rate; there is currently no vaccine; treatment options are still limited; superspreader transmission, etc.).

45. The ETS cannot be extended.

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

46. The framework of the Standard is based on an OSHA document.

The Department notes that the basic framework for the Standard (classifying COVID-19 hazards and job tasks by risk classification - very high, high, medium and lower - is based on a document prepared by federal OSHA which can be found at: <https://www.osha.gov/Publications/OSHA3990.pdf>

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

47. VOSH Anti-discrimination jurisdiction.

The Department of Labor and Industry's (DOLI) Virginia Occupational Safety and Health (VOSH) program only has jurisdiction when there is an employer - employee relationship. It has no legal authority to investigate discrimination against members of the general public.

48. VOSH jurisdiction to enforce Executive Orders.

The Department of Labor and Industry's (DOLI) Virginia Occupational Safety and Health (VOSH) program only has jurisdiction when there is an employer - employee relationship. It has no legal authority to enforce provisions of Executive Orders against members of the general public.

49. COVID-19 U.S. Death toll.

The United States Census Bureau as of October 28, 2020, estimates the current population of the U. S. to be approximately 330,513,000, <https://www.census.gov/popclock/>. If 1% of the U. S. Population dies from SARS-CoV-2 or complications involving COVID-19, the number of deaths would be 330,513. The current U.S. death toll is calculated to be 212,328 by the CDC as of October 28, 2020, approximately two-thirds of the 1% figure cited by the Commenter, and that only over a 7 month period, <https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm>.

50. Potential language change recommendations to the Standard (Examples).

The Department acknowledges the issues raised by the Commenter (training time period and contact tracers), and will consider potential language changes in the revised proposed Standard.

The Department intends to recommend a definition of "minimal occupational contact" be added to the revised proposed standard.

The Department intends to recommend language changes to the "business consideration" language in 16VAC25-220-70.C.5 referenced by the Commenter to make clear that the language is related to occupational safety and health concerns.

The Department intends to recommend that the return to work provisions of the standard be updated to reflect current CDC and VDH guidance.

The Department intends to recommend revisions to 16VAC25-220-40.F, which currently provides: "F. When multiple employees are occupying a vehicle for work purposes, the employer shall ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry.

The Department intends to recommend a language change to 16VAC25-220-40.D.

The Department intends to recommend a language change to 16VAC25-220-50.B.6.

The Department intends to recommend revisions to 16VAC25-220-40.K.5 which currently provides: "5. All common spaces, including bathrooms, frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at the end of each shift. All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another."

The Department intends to recommend a language change to the amount of time permitted to train employees under the Standard.

The Commenter referenced the fact that 16VAC25-220-80.B.8.f provides that training on the standard provided to employees shall include with regard to PPE: "Heat-related illness prevention including the signs and symptoms of heat-related illness...." The Department intends to recommend a revision to this requirement to make clear that it relates COVID-19 related hazards specifically (e.g., impact of wearing a respirator in a hot environment).

51. Work-relatedness of COVID-19 employee infection.

16VAC25-220-40.B.8.e requires employers to notify the Department within 24 hours of the discovery of three or more employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.

DOLI and the Virginia Department of Health (VDH) have collaborated on a Notification Portal for employers to report COVID-19 cases in accordance with Emergency Temporary Standard (ETS) Sections 16VAC25-220-40.B.8.d and -40.B.8.e that satisfies COVID-19 reporting requirements for both agencies. The portal went live on September 28, 2020. Here is a link:

<https://www.doli.virginia.gov/report-a-workplace-fatality-or-severe-injury-or-covid-19-case/>

If an employer is contacted by VOSH either through an informal investigation (phone/fax/email/letter) or as a result of an onsite inspection, it will be provided the opportunity to present information on whether it believes the employee's infection occurred as a result of a workplace exposure or was contracted away from work.

52. Request for exposure log and requirements for managing cases.

The Standard contains a framework for managing cases:

1. Identify cases.

16VAC25-220-40.B.4 provides that “Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees shall be designated by the employer as “suspected to be infected with SARS-CoV-2 virus.”

2. Remove from work known cases and those “suspected to be infected with SARS-CoV-2 virus.”

16VAC25-220-40.B.5 provides that “Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work.”

3. Notify employees and others of known cases.

16VAC25-220-40.B.8 provides “To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within the previous 14 days from the date of positive test....”

4. Provide for return to work.

16VAC25-220-40.C.1 provides that “The employer shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work....”

Federal OSHA’s Recordkeeping regulation contains requirements for employer maintenance of injury and illness logs in part 1904. <https://www.osha.gov/laws-regs/regulations/standardnumber/1904/>. Section 1904 contains recording criteria, <https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.4>. OSHA provides further guidance at: <https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>

The VOSH program is prohibited from requiring or allowing recordkeeping requirements contrary to those set by federal OSHA so that a consistent, statistically reliable national data collection system can be maintained. See 16VAC25-60-190.A.2, <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-60-190>, “2. No variances on record keeping requirements required by the U.S. Department of Labor shall be granted by the commissioner....”

53. How does an employer determine employee exposure in the context of 16VAC25-220-40.B.8.a ([notify:] The employer's own employees who may have been exposed, within 24 hours of discovery of the employees possible exposure....”)

16VAC25-220-40.B.8.a provides in part:

8. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within the previous 14 days from the date of positive test, and the employer shall notify:

a. The employer's own employees who may have been exposed, within 24 hours of discovery of the employees possible exposure,...

The following Frequently Asked Question was developed by the Department on this issue (§40, FAQ 24, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

24. The owners of a salon have a question about alerting the employees at their workplace when an employee tests positive for COVID-19. They are under the impression that only employees in “close contact” (as defined by the CDC) with the positive employee must be alerted. The salon has a strict physical distancing requirement of six feet or more for employees, so they alerted no one at the workplace of the positive case. Is this correct?

No. Employees were required to be notified. The term “close contact” is not used in the ETS. The term “close contact” is used by the CDC for determining when contact tracing should be conducted and is defined as “any individual within 6 feet of an infected person for at least 15 minutes.” 16VAC25-220-10.H specifically provides that:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

16VAC25-220.40.B.8.a requires employers to notify their “own employees who may have been exposed, within 24 hours of discovery of the employees’ possible exposure....”

Just because an employer has a strict policy of physical distancing as the company alleges does not mean that all employees, customers or persons complied at all times. The intent of the notification requirement is to provide employees information of a “possible” exposure so that employees can make decisions for themselves on the appropriate course of action to take.

In a situation such as a typical beauty salon where the “footprint” of the floor space would not be considered large, and all employees work in the same work space on the same floor, the employer must notify all employees that were “present at the place of employment within the previous 14 days from the date of positive test.”

54. Commenter suggests its industry should be “classified” as lower instead of medium.

While the Standard lists a number of industries under the definition of “medium” exposure risk level, the language specifically states that “Medium exposure risk hazards or job tasks **may include**, but are not limited to, operations and services in....(Emphasis added). The definition of “medium” exposure risk level does not classify

the listed industries as medium risk, but instead when read in conjunction with other portions of the Standard, indicates that the listed industries “may” fall into that category, depending on how the employer assesses and classifies the types of hazards employees are exposed to and the type of job tasks they undertake, in accordance with the requirements in 16VAC25-220-40.B, which provides that:

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

The Standard also provides in 16VAC25-220-10.E.1 provides in part:

E. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard.

55. Employer’s responsibility to establish screening procedures.

The Department respectfully disagrees with the Commenter’s suggestion that the Standard “establishes company "Health officers" to become de facto certified, accredited, licensed doctors to diagnose symptoms and the health of employees.” No such language is included in the Standard.

For instance, although it is a generally accepted practice, the Standard does not specifically require that employers check the temperatures of employees. 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

OSHA provides guidance on screening employees in the construction industry that can be used by non-medical personnel at: <https://www.osha.gov/SLTC/covid-19/construction.html>.

56. Sick leave issue.

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at:

<https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

57. Notification requirement for tenants.

The Standard does not apply to non-business tenants in an apartment building.

The Department does not plan to recommend that the notification requirements to tenants be removed from the Standard. The Department notes that the Standard does not apply to non-business tenants in an apartment building. The intent of the notification requirement is to provide employees information of a “possible” exposure so that employees can make decisions for themselves on the appropriate course of action to take.

58. Hand sanitizers.

The Department does not intend to recommend the removal of hand sanitizers from the Standard. Use of hand sanitizers is well-recognized method to mitigate the spread of SARS-CoV-2. Also see DOLI Frequently Asked Questions §40, FAQ 9 and §40, FAQ 17 at: <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/> Handwashing facilities, which are required in OSHA and VOSH standards and regulations, are not always immediately or readily accessible for employees who need to disinfect their hands without leaving their immediate work area.

59. Notification to Department of Health.

The Department does not plan to recommend the elimination of reporting requirements to the Department of Health, although it does intend to recommend a change to the trigger number of positive cases.

DOLI and the Virginia Department of Health (VDH) have collaborated on a Notification Portal for employers to report COVID-19 cases in accordance with Emergency Temporary Standard (ETS) Sections 16VAC25-220-40.B.8.d and -40.B.8.e that satisfies COVID-19 reporting requirements for both agencies. The portal went live on September 28, 2020. Here is a link:

<https://www.doli.virginia.gov/report-a-workplace-fatality-or-severe-injury-or-covid-19-case/>

60. Whistleblower refusal to work provision.

The Department does not plan to recommend eliminating the Whistleblower provision regarding refusal to work referenced by the Commenter.

16VAC25-220-90.D was added by the Safety and Health Codes Board, not by DOLI. It is a restatement of current regulatory requirements in 16VAC25-60-110 and specifically refers to that section, and is considered by the Board to be a restatement of employee rights consistent with current law.

61. Classification of hazards and job tasks.

The Standard already requires that employers assess and classify the types of hazards employees are exposed to and the type of job tasks they undertake, in accordance with the requirements in 16VAC25-220-40.B.

62. PPE hazard assessments under 1910.132 and the ETS.

16VAC25.60.D.1 provides that "Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910)...." which means it applies to those employers not in general industry. If, as the Commenter notes, they have already completed a hazard assessment under 1910.132 that addressed SARS-CoV-2 and COVID-19 related hazards and job tasks, then they do not have to complete another one.

It is the Department's position that general industry employers are required to update their pre-COVID-19 PPE hazard assessments.

63. Notification to employers about the ETS.

While the Department constantly strives to improve information dissemination about its programs, and will continue to look for new ways to do so, it feels that there was widespread notice to the business community and the general public about the adoption of the Emergency Temporary Standard through print, television, and social media.

64. PPE and Respirators in Prison and Jail Environments.

It is the Department's position that general industry employers, such as prisons and jails, are required to update their pre-COVID-19 PPE hazard assessments and take into account SARS-CoV-2 and COVID-19 related hazards and job tasks, particularly where known COVID-19 persons are housed. In such situations, it is the Department's position that enhanced personal protective equipment beyond face coverings, up to and including respirators, would be a minimum requirement under 1910.132 and 1910.134 in certain situations.

65. COVID-19 Employee Deaths.

The Department notes that in recent years, VOSH has investigated an average of approximately 35 to 40 occupationally related fatalities per year. As of October 30, 2020, VOSH has investigated over 30 employee deaths attributable to COVID-19 alone. The large majority of those cases remain under investigation to determine if they were occupationally related or not, and if occupationally related, whether violations of the Emergency Temporary Standard or mandatory requirements in Governor's Executive Orders should be cited or not.

66. PPE supply and cost; insurance reimbursement.

The Department does not have legal authority to regulate supply chains for items such as personal protective equipment (PPE) and other products, but is well aware of the shortages of such items at various times as N-95 respirators, cleaning and disinfecting chemicals, hand sanitizer and other medical products to provide safety and health protections to employees.

The Standard was designed to provide employers with flexibility and takes into account the "feasibility" of an employer to comply with certain requirements, particularly in areas involving PPE that is not readily commercially available at this time.

See Federal OSHA's "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" (which employers in Virginia can rely on) for further information and guidance on respiratory protection. <https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus>

Please note that price gouging complaints during a state of emergency in Virginia can be filed with the Office of the Attorney General (OAG):

https://www.oag.state.va.us/consumer-protection/index.php?option=com_content&view=article&id=181#:~:text=File%20a%20Price%20Gouging%20complaint,Office%20of%20Weights%20and%20Measures.

The Department does not have legal authority to regulate the rate at which insurance companies reimburse medical practices.

67. Technical feasibility definition.

The Standard's definition of "technical feasibility" is based on a longstanding definition contained in the VOSH Field Operations Manual (FOM) and federal OSHA's FOM. The Department does not intend to recommend any change to the definition.

68. Infeasibility defense.

Feasibility is defined (based on longstanding definitions of OSHA and VOSH in their respective Field Operations Manuals) and referenced numerous times in the Standard to provide a level of flexibility to employers to achieve compliance with the requirements of the Standard and to mitigate the spread of SARS-CoV-2 to employees while at work.

Here is a summary of the defense:

Infeasibility Defense (previously known as the “impossibility” defense)

A citation may be vacated if the employer proves that:

1. The means of compliance prescribed by the applicable standard would have been infeasible under the circumstances in that either:
 - a. Its implementation would have been technologically or economically infeasible or
 - b. Necessary work operations would have been technologically or economically infeasible after its implementation; and
2. Either:
 - a. An alternative method of protection was used or
 - b. There was no feasible alternative means of protection.

NOTE: Evidence as to the unreasonable economic impact of compliance with a standard may be relevant to the infeasibility defense.

Source: Occupational Safety and Health Law, Randy S. Rabinowitz, 2nd Edition (2002)

69. Signs and symptoms.

The Department intends to recommend changes to the Standard to update references to signs, symptoms and symptomatic.

70. Human resource policies.

The Department respectfully disagrees with the Commenter's assertion that mitigation strategies (referred to by the Commenter as "human resource policies") to prevent the spread of SARS-CoV-2 in the workplace, exceeds the authority of the Board.

The Department intends to recommend some language changes to the provisions referenced by the Commenter.

71. Infectious disease preparedness and response plan.

The Department does not intend to recommend any change to which employers are required to develop and implement an Infectious disease preparedness and response plan under 16VAC25-220-70. The current requirement exempts employers with 10 or fewer employees which eases the burden on the smallest employers with the most limited resources. The Department notes that a free template for a plan is provided on the Department's website at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

In addition, the Department strongly encourages Virginia's small business owners to take advantage of free and confidential occupational safety and health onsite and virtual

consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

72. Definition of employee.

The Department does not intend to recommend a change to the definition of “employee” in the Standard, which reflects current statutory, regulatory and case law.

73. Definition of medium.

The Department does not intend to change the definition of medium risk exposure. That definition applies to SARS-CoV-2 and COVID-19 related hazards and job tasks, not "jobs."

74. Surgical/medical procedure mask definition.

The Department does not intend to change the definition of surgical/medical procedure mask as that definition is consistent with Food and Drug Administration (FDA) guidance. The FDA regulates surgical/medical procedure masks.

75. Multi-employer worksites where there is no contractual relationship between the employers.

The Department does not plan to recommend that the notification requirements to subcontractors, etc., referenced by the Commenter, be removed from the Standard.

The intent of the notification requirement is to provide employees information of a “possible” exposure so that employees can make decisions for themselves on the appropriate course of action to take. The Department notes that the notification provision in the Standard referenced by the Commenter would only require notification by the employer to one of its own subcontractors. So in the situation described by the Commenter, vendor number one with a known to be infected employee would only be required to notify another vendor number two at the site, if vendor number two was a subcontractor to the vendor number one.

76. Physical distancing in construction.

The Department agrees with the Commenter that when physical distancing can be maintained - either indoors or outdoors - that is a preferred method of mitigating the spread of the SARS-CoV-2 virus. Conversely, when physical distancing cannot be observed – whether inside or outside – the Standard requires the employer consider other mitigation strategies.

77. OSHA and DOT jurisdiction issues for trucking companies.

The Commenter notes that federal OSHA states, “While traveling on public highways, the [U.S.] Department of Transportation (DOT) has jurisdiction. However, while loading and unloading trucks, OSHA regulations govern the safety and health of the workers and the responsibilities of employers to ensure their safety at the warehouse, at the dock, at the rig, at the construction site, at the airport terminal and in all places

truckers go to deliver and pick up loads.” <https://www.osha.gov/trucking-industry/other-federal-agencies>

However, the above statement is not as straightforward as it seems. Congress, in section 4(b)(1) of the OSH Act of 1970, took into account the other Federal agencies which in the exercise of their statutory responsibilities may issue regulations or standards which affect occupational safety and health issues. Section 4(b)(1) provides, in pertinent part:

Nothing in this Act shall apply to working conditions with respect to which other Federal agencies . . . exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety and health.

The various federal Circuits across the United States have interpreted section 4(b)(1) and its application differently. For instance, a discussion by OSHA of how the 4th Circuit, which includes Virginia, has ruled states:

“The most common type of circumstances involving section 4(b)(1) of the OSH Act is where there is a statute whose primary purpose is to protect the public and transportation equipment but which also protects employees in the sense that in the effort to protect the public, the employees are also protected. Examples of this type of legislation are most of the statutes administered and enforced by the Department of Transportation (DOT). A practical example is the Federal Aviation Administration (FAA) In FAA's efforts to protect the flying public and air transport cargo, the crew of the aircraft are necessarily protected at the same time by the same FAA regulations.

Whenever a Section 4(b)(1) issue is presented in the context of a DOT statute which is designed to protect the public, transportation equipment, or cargo, the issue is usually of the type that is known popularly as the "gap theory," or "hazard-by-hazard" approach. That is, the question is whether the other agency has an enforceable regulation which, if that agency chooses to enforce that regulation, would reduce or eliminate the workplace hazard in question. If the other agency has no such regulation applicable to the hazard, then there exists a "gap" in worker protection which is filled by the residual jurisdiction of the OSH Act with its very broad coverage intended by Congress as the means for assuring ". . . every working man and woman in the Nation safe and healthful working conditions." Sec. 2(b), OSH Act, P.L. 91-596; see also, *Northwest Airlines, Inc.*, 8 OSHC 1982, 1980 OSHD 24,751 (1980), petition for review dismissed, Nos. 80-4218, 80-4222 (2d Cir. 1981).

The so called "gap theory" has also been upheld by the courts. In the courts' decision, however, this same issue is cast in terms of the Section 4(b)(1) term "working conditions." In general, it can be stated that the following line of appellate court decisions affirm the "hazard-by-hazard" approach even though the courts sometimes have chosen different words which have to be explained and understood in context. For example, in *Southern Railway v. OSHRC*, 539 F.2d 335 (4th Cir. 1976) cert. denied 429 U.S. 999, 97 S.Ct. 525, the Fourth Circuit defined the term "working conditions" in Section 4(b)(1) as meaning "the

environmental area in which an employee customarily goes about his daily tasks." That phrase of the court's decision seems to extend the term "working conditions" beyond hazards, but the phrase is not clear because while geographically, so to speak, the environmental area is broad under that decision, the "area" has no meaning if not viewed in terms of the regulations and hazards present in that area."

A far better articulation of the "hazard-by-hazard" approach is found in a Fifth Circuit case; that is, in *Southern Pacific v. Usery*, 539 F.2d 386 (5th Cir. 1976), cert. denied 434 U.S. 874, 98 S.Ct. 222. In this case, the Fifth Circuit defined the term "working conditions" in Section 4(b)(1) to mean to include "surroundings" or "hazards" which the court stated could be a location, a grouping of items, or a single item. In *Southern Railway* in the Fourth Circuit and the Fifth Circuit's *Southern Pacific* definitions, we see, when viewed together, a narrowing of the term "working conditions." The most recent decisions even more clearly articulate the scope of Section 4(b)(1); that is, if the other agency's regulation (or the lack of one) does not cover the hazard in question, then the OSH Act's requirements are not preempted. For example, in *Donovan v. Red Star Marine Services Inc.*, 739 F.2d 774 (2d Cir. 1984), cert. denied 470 U.S. 1003, 105 S.Ct. 1355, the Second Circuit did not preempt OSHA's regulation of noise aboard an inspected vessel because, while the Coast Guard generally covered such vessels, the Coast Guard confined its regulation to life saving and fire-fighting equipment and had issued no noise abatement regulation. The Eleventh Circuit also analyzed a Section 4(b)(1) issue in the same way. In *re Inspection of Norfolk Dredging Co.*, 783 F.2d 1526 (11th Cir. 1986), reh. denied, 790 F.2d 88 (11th Cir. 1986), cert. denied 107 S.Ct. 271 (1986), the Eleventh Circuit did not preempt OSHA application to crane operations because the Coast Guard simply did not have regulations addressing crane hazards. The Eleventh Circuit in *Norfolk Dredging* stated that, "the effect of Section 4(b)(1) turns upon the precise working conditions at issue . . ."

....

There is no industry-wide exemption for motor vehicle common carriers, *Greyhound Lines. Inc.*, 5 OSHC 1132, 1977-78 OSHD 21,610 (1977), nor is there any industry-wide exemption for over-the-road truckers, *Lee way Motor Freight. Inc.*, 4 OSHC 1968, 1976-77 OSHD 21,464 (1977).

However, as discussed previously in the analysis of the term "working conditions" or the "gap theory," if OMCS has a regulation addressing a certain working condition (or hazard), then OSHA would be preempted from applying its standards to that hazard. The lead OSHA case on this issue under Section 4(b)(1) in the context of OMCS' jurisdiction is *Mushroom Transportation Co.*, Docket No. 1588, 1973-74, CCH OSHD 16,881 (R.C. 1973). *Mushroom* involved the hazard of possible movement of trucks while they were being loaded or unloaded with the use of powered industrial trucks. Both OSHA and OMCS had regulations dealing with brakes as well as other methods of preventing unwanted movement of a

truck during loading and unloading operations. The Commission held that because the OMCS had such a regulation covering the same hazard as the OSHA standard, the OSH Act's standard was held inapplicable pursuant to the provisions of section 4(b)(1) of the OSH Act.(1)

....

Mushroom also stands for the proposition that the other agency's regulation need not be as stringent as the OSHA standard to effectuate preemption of the OSH standard. The Review Commission stated:

Once another Federal agency exercises its authority over specific working conditions, OSHA cannot enforce its own regulations covering the same conditions. Section 4(b)(1) does not require that another agency exercise its authority in the same manner or in an equally stringent manner. [Footnote omitted; emphasis supplied.] Mushroom, supra, 16,881 at 21,491.

To our knowledge, there have been no decisions of OSHRC or the courts since Mushroom specifically involving truck or bus operators. Citations have been issued, but these were mainly for alleged violations in loading areas and maintenance and repair shops.

....

In conclusion, as we can see from the cases, there are three main principles in 4(b)(1) situations: (1) OSHA cannot enforce its authority with respect to working conditions over which another Federal agency has exercised its authority even if the other agency's standards are not as stringent or as stringently enforced as OSHA's; (2) if a Federal agency fails to exercise its authority with respect to working conditions, OSHA has jurisdiction to inspect and to cite for violations of standards; and (3) a negative exercise of authority can oust OSHA from jurisdiction. It must be noted, however, that 4(b)(1) situations must be considered on a case by case basis and deference given to a sister agency's interpretation of its authority. (Emphasis added).

<https://www.osha.gov/laws-regs/standardinterpretations/1989-07-10>

78. Serologic testing.

The serologic testing language in the Standard is consistent with CDC guidance.

<https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html>

79. Applicable industry standards.

OSHA and VOSH standards and regulations fall into the following categories: Construction Industry, Agricultural Industry, Maritime Industry and General Industry

(all employers not covered by Construction, Agricultural or Maritime Industry Standards are covered by the General Industry Standards.

80. Briefing package for ETS.

The Department's Briefing Package on the Emergency Temporary Standard with background and legal justifications can be found at: <https://www.doli.virginia.gov/wp-content/uploads/2020/06/BP-Emergency-Regulation-Under-2.2-4011-SARS-CoV-2-That-Causes-COVID-19-FINAL-6.23.2020.pdf>

81. Occupancy limit.

The current "occupancy limit" language in the Standard provides flexibility for employer to decide how best to mitigate the spread of SARS-CoV-2. While the Commenter's suggestion to incorporate a FEMA recommendation of 113 square feet per person could serve as one method for an employer to determine occupancy limits, it would increase the compliance burden on employers generally and is not recommended by the Department.

82. Training period for Infectious disease preparedness and response plan.

The Department does not intend to recommend any change to train employees on the Infectious disease preparedness and response plan under 16VAC25-220-70, currently set at 60 days. In addition, the Department strongly encourages Virginia's small business owners to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

83. Multi-employer worksite situations.

In situations involving multi-employer worksites, the Department has a regulation on the subject multi-employer worksite responsibilities and the multi-employer worksite defense, which can be found at 16VAC25-60-260.F and -260.G. <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-60-260>. Additional information can also be found on the topic in the VOSH Field Operations Manual at <https://townhall.virginia.gov/L/ViewGDoc.cfm?gdid=5354>.

84. General duty clause uses and limitations.

The Department's Briefing Package on the Emergency Temporary Standard with background on the use and limitations of the general duty clause: <https://www.doli.virginia.gov/wp-content/uploads/2020/06/BP-Emergency-Regulation-Under-2.2-4011-SARS-CoV-2-That-Causes-COVID-19-FINAL-6.23.2020.pdf>

85. Six foot physical distancing requirement.

The Department does not intend to revise the definition of physical distancing or to eliminate physical distancing as a recognized mitigation strategy. The six foot physical distancing requirement remains a best practice recognized by the CDC and VDH.

86. Medical removal.

The Department does not intend to recommend the addition of medical removal protections to the Standard.

[OPTION 2: The Department does not intend to recommend the addition to the standard of medical removal protections or guaranteed compensation requirements for employees who are away from work due to COVID-19 issues.]

Some employees will be able to use sick leave during the time they are away from work. While the Standard does not require employers to provide sick leave to employees, it does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at: <https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

Some employees will be able to receive workers' compensation while they are away from work. http://www.vwc.state.va.us/sites/default/files/documents/COVID-19-Statistics-FAQs_o.pdf

87. Employee involvement.

The Department does not intend to recommend any additional employee involvement language to the Standard. Such involvement is currently required in 16VAC25-220-50.D.1.a, 16VAC25-220-60.D.1.a, and 16VAC25-220-70.C.2.

88. Records of PPE stockpile (inventory) and availability.

The Department does not intend to recommend adding a requirement for employer to maintain records of PPE stockpile (inventory) and availability; however, the Department does intend to recommend revised language to 16VAC25-220-70.C.4.d that employers required to maintain an Infectious disease preparedness and response plan address contingency plans for situations where supply chains for safety and health related products and services may be impacted by the pandemic.

89. Mobile employees working at private homes.

The Commenter references the difficulties with providing employee safety and health protections for mobile employees that work at private homes.

First, it should be noted that the Standard does not address the rights or protections of the general public, and more specifically, it does not contain a face covering mandate for the general public. That issue is the purview of the Virginia Department of Health and Governor's Executive Orders (e.g., Executive Order 63).

The Commenter represents an industry that has always been covered by 1910.132, Personal Protective Equipment Standard, which requires employers to conduct hazard assessments of the workplace to determine what PPE is required. This includes an assessment of what kind of infectious disease hazards employees might encounter, pre- and post-COVID19, when visiting a private home. The Standard does not change this basic requirement for the Commenter's industry, so there should be no confusion about what protections such employer's need to provide. If pre-COVID-19, such an employer rightly considered the potential for its employees to be exposed to, for instance, tuberculosis at a private home, conducting the same type of assessment for COVID-19 should not present any substantial difficulties.

90. ASHRAE legal issue and air handling issues.

The Department notes that the ASHRAE air handling requirements are undergoing a legal review which may result in recommended changes that could address some of air handling issues raised by the Commenter.

91. N-95 respirator determinations.

The issue of N-95 respirators raised by the Commenter is appropriate to address during the personal protective equipment (PPE) hazard assessment process required in General Industry under 1910.132.

92. Employee Involvement.

The Department does not intend to recommend any additional employee involvement language to the Standard. Such involvement is currently required in 16VAC25-220-50.D.1.a, 16VAC25-220-60.D.1.a, and 16VAC25-220-70.C.2.

93. Paid time for cleaning.

The Department does not intend to recommend adding requirements that employers be required to provide pay for cleaning activities by employees. Payment of wage issues fall under Va. Code §40.1-29, <https://law.lis.virginia.gov/vacode/40.1-29/>, and not within the enabling statutes of the VOSH program.

94. Disinfectant selection.

The Department does not intend to recommend revising the standard to address the Commenter's concern about those disinfectants containing substances known to cause adverse health effects, such as those containing quaternary ammonia that is a known respiratory irritant. That issue is more appropriately dealt with under the requirements of the Hazard Communication Standard applicable to the employer's industry.

95. Face shield.

The Department intends to recommend revisions to the Standard dealing with face shield issues.

96. Jail and correctional facility issues.

The Department does not intend to recommend revising the Standard to address access and egress issues at jails and correctional facilities. Control over access and egress issues at jails and correctional facilities falls under the purview of either the controlling authority and/or the Virginia Department of Health.

The Department does not intend to recommend any changes to the pre-screening requirements in the Standard. 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

The Commenter references industries that have always been covered by 1910.132, Personal Protective Equipment Standard, which requires employers to conduct hazard assessments of the workplace to determine what PPE is required. This includes an assessment of what kind of infectious disease hazards employees might encounter, pre- and post-COVID19, when visiting a private home. The Standard does not change this basic requirement for the Commenter's industry, so there should be no confusion about what protections such employer's need to provide. If pre-COVID-19, such an employer rightly considered the potential for its employees to be exposed to, for instance, tuberculosis at a private home, conducting the same type of assessment for COVID-19 should not present any substantial difficulties. The proper assessment will determine whether and what kind of PPE and/or respiratory protection equipment is required.

The Department notes that the Standard that employee involvement is currently required for hazard assessment determinations in 16VAC25-220-50.D.1.a and 16VAC25-220-60.D.1.a.

97. Definition of "May be infected with SARS-CoV-2 virus".

The Department does not intend to recommend that the definition of "May be infected with SARS-CoV-2 virus" be removed from the Standard. While many people become infected with SARS-CoV-2 in community settings that are not work-related, every person that becomes infected who is also an employee becomes a potential workplace source and transmitter of the virus if they report to work while still capable of transmitting the disease. There are numerous documented examples of the workplace spread SARS-CoV-2, which is also considered to be highly contagious. The introduction of an infectious disease into a workplace setting, regardless of the source, constitutes a workplace health hazard subject to regulation and enforcement by VOSH. The VOSH program has clear statutory and regulatory jurisdiction over workplace safety and health issues in the Commonwealth, including the potential for spread of infectious diseases

among employees and employers, and when those employees and employers are potentially exposed to other persons who may be carriers of the infectious diseases (patients, customers, independent contractors, etc.).

98. Occupational exposure definition.

The Department does not intend to recommend that the definition of “occupational exposure” be revised. It is based on a longstanding definition contained the VOSH Field Operations Manual (FOM) and federal OSHA's FOM.

99. Definition of "Suspected to be infected with SARS-CoV-2 virus".

The Department does not intend to recommend that the definition of "Suspected to be infected with SARS-CoV-2 virus." The definition includes persons who have not yet been tested for SARS-CoV-2.

100. Second jobs.

The Department does not intend to recommend changes to 16VAC25-220-70 based on the Commenter's suggestions. The Department is not aware of any legal restrictions against an employer establishing a policy that employees inform them about outside jobs.

101. Railroads.

The Commenter contends that Virginia's unique COVID-19 standard would present compliance burdens for its Railroad members because it differs from federal OSHA requirements that apply in states covered by federal OSHA jurisdiction. Virginia currently has nine other unique standards and regulations in addition to the proposed COVID-19 Standard that apply to the Commenter's members.

<https://www.doli.virginia.gov/vosh-programs/virginia-unique/>. The Department sees no reason to treat the situation of its COVID-19 Standard any differently than the application of its other unique standards. We respectfully disagree that the act of comparing a particular CDC guideline that an employer wants to rely on to the language in Virginia's COVID-19 standard is an "impossible" task.

The Commenter also suggests that its members would have difficulty in "figuring out how to apply a different set of rules once a state border is crossed." The same argument could be made with regard to Virginia's other unique standards. Again, the Department sees no reason to treat the situation of its COVID-19 Standard any differently than the application of its other unique standards.

When Congress established the OSH Act of 1970, it had the opportunity to establish a system that would suit the needs of the Commenter's members, but it chose to allow states, such as Virginia, to apply for state plan status under §18 of the OSH Act. Virginia has such a state plan, and as a sovereign Commonwealth has the legal right to establish standards and regulations that are at least as effective as that of federal OSHA in providing protections for Virginia employees and employers, This includes the ability to adopt standards and regulations that are more stringent than federal OSHA's or cover a

hazard or industry that OSHA has yet to provide protective standards and regulations for.

The Department does not plan to recommend that 16VAC25-220-10.G be changed as suggested by the Commenter. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.G assures such protections.

January 10, 2021

AMMENDMENT – CM

16VAC25-220, DRAFT ~~Final Permanent~~ Emergency Temporary Standard for

Department Response: The Department does not support the proposed amendment. It is the position the Department, after discussions with legal counsel, that the current ETS cannot be extended under Va. Code §40.1-22(6a).

16VAC25-220, **DRAFT** Final Permanent Standard for

Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19

As Adopted by the
Safety and Health Codes Board
on _____



VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY (DOLI)

Effective Date: **To be Determined**

16VAC25-220

January 10, 2021

[TEXT HIGHLIGHTED IN **YELLOW** REPRESENTS CHANGES FROM JULY 24, 2020 PROPOSED STANDARD TO DECEMBER 4, 2020 REVISED PROPOSED STANDARD]

[TEXT HIGHLIGHTED IN **BLUE** REPRESENTS CHANGES FROM DECEMBER 10, 2020 REVISED PROPOSED STANDARD TO JANUARY 4, 2021 DRAFT FINAL STANDARD]

[DATES ARE HIGHLIGHTED IN **GREEN**]

[BOARD MEMBER AMENDMENTS ARE IN **RED LETTERING**]

[FOOTNOTES ARE INCLUDED FOR REFERENCE ONLY. FOOTNOTES ARE NOT PART OF THE TEXT OF THE STANDARD AND WOULD NOT BE PUBLISHED WITH ANY ADOPTED FINAL STANDARD.]

DRAFT Final Permanent Standard for

Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19

16VAC25-220

16VAC25-220-10. Purpose, scope, and applicability.

A. This standard is designed to establish requirements for employers to control, prevent, and mitigate the spread of SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19) to and among employees and employers.

~~B. This standard shall not be extended or amended without public participation in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and 16VAC25-60-170.~~

C. This standard is adopted in accordance with subdivision 6 a of § 40.1-22 of the Code of Virginia and shall apply to every employer, employee, and place of employment in the

Commonwealth of Virginia within the jurisdiction of the VOSH program as described in 16VAC25-60-20 and 16VAC25-60-30.

DC. This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply.

AMENDMENT - TP AND AJ

16VAC25-220-10.C, Purpose, scope, and applicability.

~~C. Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.~~

TP: This is unnecessary. In my opinion, this doesn't belong in a standard and any enforcement actions should be determined by the agency using their discretion and not codified in a standard. The agency can and should exercise discretion in issuing citations when employers determine PPE is needed, attempt to obtain it, and cannot. The added language isn't necessary to give the agency authority to exercise discretion, but could provide an excuse to not provide PPE when needed.

AJ: This is an exception that opens the door to anything goes. At least we need to define what "commercially reasonable terms." I will make more comments on this after doing a little research.

Department Response: This language was specifically added by the Administration. The Department does not support removal of the language.

Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard; if (i) such PPE is not readily available on commercially reasonable terms; and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces.

DEPARTMENT NOTE: Above language added by Administration.

DOLI interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms."

DOLI will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

ED. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons.

2. Factors that shall be considered in determining exposure risk level include, but are not limited to:

AMENDMENT - CM

16VAC25-220-10.D.2, Purpose, scope, and applicability.

a. The job tasks being undertaken, the work environment (e.g. indoors or outdoors), the known or suspected presence of the SARS-CoV-2 virus, the presence of a person known or suspected to be infected with the SARS-CoV-2 virus, the number of employees and other persons in relation to the size of the work area, the working distance between employees and other employees or persons, and the duration and frequency of employee exposure through contact inside of ~~six feet~~ **close contact** with other employees or persons (e.g., including shift work exceeding 8 hours per day); and

Department Response: The Department does not support the proposed amendment.

The CDC defines “close contact” as “Close contact” means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. “Quarantine” is separation of people who were in “close contact” with a person with COVID-19 from others. The Standard does not address the issue of “quarantine.”

Requirements for returning to work from “quarantine” is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

VOSH does not have the resources to deal with contact tracing and quarantine issues, both currently the responsibility of VDH.

a. The job tasks being undertaken, the work environment (e.g. indoors or outdoors), the known or suspected presence of the SARS-CoV-2 virus, the presence of a person known or suspected to be infected with the SARS-CoV-2 virus, the number of employees and other persons in relation to the size of the work area, the working distance between employees and other employees or persons, and the duration and frequency of employee exposure through contact inside of six feet with other employees or persons (e.g., including shift work exceeding 8 hours per day); and

b. The type of hazards encountered, including exposure to respiratory droplets and potential exposure to the airborne transmission of SARS-CoV-2 virus; contact with contaminated surfaces or objects, such as tools, workstations, or break room tables,

and shared spaces such as shared workstations, break rooms, locker rooms, and entrances and exits to the facility; shared work vehicles; and industries or places of employment where employer sponsored shared transportation is a common practice, such as ride-share vans or shuttle vehicles, car-pools, and public transportation, etc.

AMENDMENT - CM

16VAC25-220-10.F, Purpose, scope, and applicability.

F. This standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency.

CM: It seems to make sense to reinsert this paragraph, as conflicts between Executive Orders and the standard are raising confusion. Employers need a single, clear rule that does not conflict with other law.

DEPARTMENT RESPONSE: The Department does not support the proposed amendment.

After discussions with legal counsel, the Department is recommending removal of the below language. In addition, the language is considered redundant in light of Executive Order 72, Order of Public Health Emergency, Commonsense Surge Restrictions, Certain Temporary Restrictions Due to Novel Coronavirus (COVID-19), adopted on December 14, 2020, which provides as follows:

IV. ADDITIONAL PROVISIONS

A. Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19”

Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

~~F. This standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency~~

AMENDMENT - CM

16VAC25-220-10.E, Purpose, scope, and applicability.

E. To the extent that an employer complies with requirements contained in CDC publications to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by this standard/regulation, the employer's actions shall be considered in compliance with this standard/regulation.

~~E To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.~~

DEPARTMENT RESPONSE: The Department does not support the proposed amendment.

The original language was submitted by the Administration.

It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.G assures such protections.

G.1.E To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.

DEPARTMENT NOTE: The above sentence was added by the Administration.

REFERENCE: Reference:

§ 40.1-51. State Health Commissioner to provide advice and aid; rules and regulations.

A. The State Health Commissioner shall be responsible for advising and providing technical aid to the Commissioner on matters pertaining to occupational health on request.

B. The Department of Labor and Industry shall be responsible for drafting and submitting to the Virginia Safety and Health Codes Board for adoption rules and regulations pertaining to control measures to protect the health of workers. In formulating rules and regulations pertaining to health, the Department of Labor and Industry shall request the advice and technical aid of the Department of Health.

2F. A public or private institution of higher education that has received certification from the State Council of Higher Education of Virginia that the institution's re-opening plans are in compliance with guidance documents, whether mandatory or non-mandatory, developed by the Governor's Office in conjunction with the Virginia Department of Health shall be considered in

compliance with this standard, provided the institution operates in compliance with its certified reopening plans and the certified reopening plans provide equivalent or greater levels of employee protection than this standard.

AMENDMENT - AJ

16VAC25-220-10.G, Purpose, scope, and applicability.

Create a separate section "G." for "public school division or private school"

AJ: Wasn't this a separate section at one time? It should be because they are 2 different entities.

DEPARTMENT RESPONSE: The Department supports proposed amendment.

G. A public school division or private school that submits its plans to the Virginia Department of Education to move to Phase II and Phase III that are aligned with CDC guidance for reopening of schools that provide equivalent or greater levels of employee protection than a provision of this standard and who operate in compliance with the public school division's or private school's submitted plans shall be considered in compliance with this standard. An institution's actual compliance with recommendations contained in CDC guidelines or the Virginia Department of Education guidance, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines.

DEPARTMENT NOTE: The above sentence was added by the Administration.

REFERENCE: Reference:

§ 40.1-51. State Health Commissioner to provide advice and aid; rules and regulations.

A. The State Health Commissioner shall be responsible for advising and providing technical aid to the Commissioner on matters pertaining to occupational health on request.

B. The Department of Labor and Industry shall be responsible for drafting and submitting to the Virginia Safety and Health Codes Board for adoption rules and regulations pertaining to control measures to protect the health of workers. In formulating rules and regulations pertaining to health, the Department of Labor and Industry shall request the advice and technical aid of the Department of Health.

QUESTION – AJ:

We use “good faith” in this a lot but I don’t think that most employers know what it is. Why don’t we define this.

DEPARTMENT RESPONSE: The Department does not recommend providing a definition for “good faith.” Legal terms of art such as “good faith” and “reasonable” are usually the subject of case law, and the analysis of which tend to be very fact specific.

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

16VAC25-220-20. Effective dates.

DEPARTMENT NOTE: Sections A and C added by the Administration.

A. Adoption Process.

1. This standard shall take effect ~~to be determined, but no later than January 27, 2021~~ upon approval review by the Governor, and if no revisions are requested, filing with

the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

2. If the Governor's review results in one or more requested revisions to the standard, the Safety and Health Codes Board shall reconvene to approve, amend, or reject the requested revisions.

3. If the Safety and Health Codes Board approves the requested revisions to the standard as submitted, the standard shall take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

4. Should the Governor fail to review the standard under **subsection A 1** of this section within thirty ~~(30)~~ days of its approval by the Safety and Health Codes Board, the Board will not need to reconvene to take further action, and the standard shall take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia.

B. The requirements for 16VAC25-220-70 shall take effect on March 26, 2021.

AJ: Since these requirements [for an Infectious disease preparedness and response plan] above were in the original ETS, I don't see why we are giving them 2 months to comply. This only benefits the employers who failed to comply with the ETS. We drafted these for about 20 clients and we can get all of them up to speed in 10 days.

Department Response: The Department recommends retaining the same time period as was in the ETS. Even in a pandemic, new businesses are being opened on a regular basis and should be afforded a sufficient time to develop a plan.

The training requirements in 16VAC25-220-80 shall take effect on March 26, 2021.

AJ: Same is true here [for training] above. We only gave them 30 days for the ETS. Now those who failed to train under the ETS get a bonus by having 2 more months to train. It is unfair to those who complied with the ETS. I would make compliance required on the effective date, because there were virtually no changes to the required curriculum.

Department Response: The Department is recommending an expanded time for employee training from 30 days to 60 days in response to employer concerns expressed during multiple public comment opportunities about the ability to develop and provide effective training to management personnel and employees in 30 days. The Department does not believe the request is unreasonable in light of the unprecedented nature of the pandemic and the need for employers to modify orientation and training materials for new hires and retraining materials for current employees. In addition, new businesses are being opened on a regular basis and should be afforded a sufficient time to develop and provide training.

AMENDMENT - CM

16VAC25-220-20.C, Effective Dates

C. This emergency temporary standard shall expire (i) within six months of its effective date, upon expiration of the Governor's State of Emergency or (ii) when repealed by the Virginia Safety and Health Codes Board.

~~C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.~~

AJ: Wasn't this a separate section at one time? It should be because they are 2 different entities.

DEPARTMENT RESPONSE: The Department supports the proposed amendment.

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and

Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

DEPARTMENT NOTE: The new language in 16VAC25-220.20.C requires the Board to make a “determination” of whether there is continued need for the standard. The Department has identified three “determination” options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

With regard to the phrase “notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to,” the intent of the language is to give the Board the maximum amount of flexibility to “notice” the Board meeting within 14 days even if the Board may not actually meet within 14 days.

16VAC25-220-30. Definitions.

The following words and terms when used in this standard shall have the following meanings unless the context clearly indicates otherwise:

"Administrative control" means any procedure that significantly limits daily exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks by control or manipulation of the work schedule or manner in which work is performed. The use of personal protective equipment is not considered a means of administrative control.

"Airborne infection isolation room" or "AIIR," formerly a negative pressure isolation room, means a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by

droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIRs provide (i) negative pressure in the room so that air flows under the door gap into the room, (ii) an air flow rate of 6-12 air changes per hour (ACH) (6 ACH for existing structures, 12 ACH for new construction or renovation), and (iii) direct exhaust of air from the room to the outside of the building or recirculation of air through a High Efficiency Particulate Air (HEPA) filter before returning to circulation.

"Asymptomatic" means a person who does not have symptoms.

"Building or facility owner" means the legal entity, including a lessee, that exercises control over management and record keeping functions relating to a building or facility in which activities covered by this standard take place.

"CDC" means Centers for Disease Control and Prevention.

AMENDMENT - CM

16VAC25-220-30, Effective Dates. Definition of "Cleaning"

"Cleaning" means the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, cleaning decreases their number and therefore any the risk of spreading infection.

"Cleaning" means the removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs. But by removing the germs, cleaning decreases their number and therefore any risk of spreading infection.

AJ: Add definition for “Commercially reasonable terms”

"Community transmission," also called "community spread," means people have been infected with SARS-CoV-2 in an area, including some who are not sure how or where they became infected. The level of community transmission is classified by the CDC as:

1. "No to minimal" where there is evidence of isolated cases or limited community transmission, case investigations are underway, and no evidence of exposure in large communal settings (e.g., healthcare facilities, schools, mass gatherings, etc.);¹
2. "Moderate" where there is sustained community transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases;
3. "Substantial, controlled" where there is large scale, controlled community transmission, including communal settings (e.g., schools, workplaces, etc.); or
4. "Substantial, uncontrolled" where there is large scale, uncontrolled community transmission, including communal settings (e.g., schools, workplaces, etc.).

"COVID-19" means Coronavirus Disease 2019, which is primarily a respiratory disease, caused by the SARS-CoV-2 virus.

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html>

AMENDMENT - CM

16VAC25-220-30, Effective Dates. Definition of "Disinfecting"

"Disinfecting" means using chemicals approved or effective for use against SARS-CoV-2, for example EPA-registered disinfectants, to kill germs on surfaces. The process of disinfecting does not necessarily clean dirty surfaces or remove germs, but killing germs remaining on a surface after cleaning further reduces ~~any~~ the risk of spreading infection.

"Disinfecting" means using chemicals approved for use against SARS-CoV-2, for example EPA-registered disinfectants, to kill germs on surfaces. The process of disinfecting does not necessarily clean dirty surfaces or remove germs, but killing germs remaining on a surface after cleaning further reduces any risk of spreading infection.

AJ: [In definition of "Duration and frequency of employee exposure," change the phrase "the greater the frequency or length of exposure" with "the greater the frequency or duration of exposure."

Department Response: It is not a generally accepted practice to use the word being defined ("duration") in the definition for that word ("Duration and frequency of employee exposure"). The Department proposes the following wording to address AJ's comment: "the greater the frequency or length of time of the exposure"

AMENDMENT - CM

16VAC25-220-30, Effective Dates. Definition of "Duration and frequency of employee exposure"

....An example of a chronic situation would be could involve a job task that requires an employee to interact either for an extended period of time ~~inside six feet with~~ within close contact of a smaller static group of other employees or persons or for an extended period of time inside ~~six feet~~ close contact with a larger group of other employees or persons in succession but for periods of shorter duration.

CM: Global change. This gives employers room to follow CDC's changing guidance on close contact.

Department Response: As previously stated, the Department does not support the proposed amendment.

The CDC defines "close contact" as "Close contact" means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does not address the issue of "quarantine."

Requirements for returning to work from "quarantine" is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

VOSH does not have the resources to deal with contact tracing and quarantine issues, both currently the responsibility of VDH.

"Duration and frequency of employee exposure" means how long ("duration") and how often ("frequency") an employee is potentially exposed to the SARS-CoV-2 virus or COVID-19 disease. Generally, the greater the frequency or length of exposure, the greater the probability is for potential infection to occur. Frequency of exposure is generally more significant for acute acting agents or situations, while duration of exposure is generally more significant for chronic acting agents or situations. An example of an acute SARS-CoV-2 virus or COVID-19 disease situation would be an unprotected could involve a customer, patient, or other person not wearing a face covering or other personal protective equipment, or coughing or sneezing directly into the face of an employee. An example of a chronic situation would be could involve a job task that requires an employee to interact either for an extended period of time inside six feet with a smaller static group of other employees or persons or for an extended period of time inside six feet with a larger group of other employees or persons in succession but for periods of shorter duration.

AMENDMENT - CM

16VAC25-220-30, Effective Dates. Definition of "Economic feasibility"

If an employer's level of compliance lags significantly behind that of its industry, an employer's claim of economic infeasibility will not ~~be accepted~~ support a VOSH decision to decline to take enforcement action.

"Economic feasibility" means the employer is financially able to undertake the measures necessary to comply with one or more requirements in this standard. The cost of corrective measures to be taken will not usually be considered as a factor in determining whether a violation

of this standard has occurred. If an employer's level of compliance lags significantly behind that of its industry, an employer's claim of economic infeasibility will not be accepted.

"Elimination" means a method of exposure control that removes the employee completely from exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks.

AMENDMENT – AJ

16VAC25-220-30. Definitions, "Employee"

"Employee" means an employee of an employer who is ~~employed~~ engaged in ~~the a~~ business of his employer.

Department Response: The Department does not support the proposed amendment. The above language as it originally appears in the standard comes verbatim from Va. Code §40.1-49.3.

AMENDMENT – CM

16VAC25-220-30. Definitions, "Employee"

"Employee" means an employee of an employer who is employed ~~in a business of~~ by his employer.

Department Response: The Department does not support the proposed amendment. The above language as it originally appears in the standard comes verbatim from Va. Code §40.1-49.3.

"Employee" means an employee of an employer who is employed in a business of his employer. Reference to the term "employee" in this standard also includes, but is not limited to, temporary employees and other joint employment relationships, persons in supervisory or management positions with the employer, etc., in accordance with Virginia occupational safety and health laws, standards, regulations, and court rulings.

AJ: Do people know what this ("joint employment relationships") is?

Department Response: "Joint employment relationship" is another legal term of art that is frequently addressed in case law. The Department does not recommend that a definition be added for that reason. An example of a joint employment relationship is provided immediately before the phrase in the above definition ("temporary employees"): for VOSH/OSHA enforcement purposes, "temporary employees" are jointly employed by the temporary employment agency and the host employer who contracted with the agency for the services of the employee.

"Engineering control" means the use of substitution, isolation, ventilation, and equipment modification to reduce exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks.

AMENDMENT – CM

16VAC25-220-30. Definitions, "Exposure risk level"

"Exposure risk level" means ~~an assessment of~~ the level of possibility that an employee could be exposed to the hazards associated with SARS-CoV-2 virus and the COVID-19 disease....

Department Response: The Department supports the proposed amendment.

"Exposure risk level" means an assessment of the possibility that an employee could be exposed to the hazards associated with SARS-CoV-2 virus and the COVID-19 disease. The exposure risk level assessment should address all risks and all modes of transmission, including airborne transmission, as well as transmission by asymptomatic and presymptomatic individuals. Risk levels should be based on the risk factors present that increase risk exposure to COVID-19 and are present during the course of employment regardless of location. Hazards and job tasks have been divided into four risk exposure levels: very high, high, medium, and lower:

"Very high" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure to known or suspected sources of the SARS-CoV-2 virus (e.g., laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures:

1. Aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on a patient or person known or suspected to be infected with the SARS-CoV-2 virus;
2. Collecting or handling specimens from a patient or person known or suspected to be infected with the SARS-CoV-2 virus (e.g., manipulating cultures from patients known or suspected to be infected with the SARS-CoV-2 virus); and
3. Performing an autopsy that involves aerosol-generating procedures on the body of a person known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.

AMENDMENT – CM

16VAC25-220-30. Definitions, “Exposure risk level,” “High”

"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside ~~six feet~~ close contact with known or suspected sources of SARS-CoV-2....

Department Response: The Department does not support the proposed amendment.

"High" exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARS-CoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk, including, but not limited to:

1. Healthcare (physical and mental health) delivery and support services provided to a patient known or suspected to be infected with the SARS-CoV-2 virus, including field hospitals (e.g., doctors, nurses, cleaners, and other hospital staff who must enter patient rooms or areas);
2. Healthcare (physical and mental) delivery, care, and support services, wellness services, non-medical support services, physical assistance, etc., provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus involving skilled nursing services, outpatient medical services, clinical services, drug treatment programs, medical outreach services, mental health services, home health care, nursing

home care, assisted living care, memory care support and services, hospice care, rehabilitation services, primary and specialty medical care, dental care, COVID-19 testing services, blood donation services, ~~contact tracer services~~, and chiropractic services;

3. First responder services provided to a patient, resident, or other person known or suspected to be infected with the SARS-CoV-2 virus;

4. Medical transport services (loading, transporting, unloading, etc.) provided to patients known or suspected to be infected with the SARS-CoV-2 virus (e.g., ground or air emergency transport, staff, operators, drivers, pilots, etc.); and

5. Mortuary services involved in preparing (e.g., for burial or cremation) the bodies of persons who are known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.

AMENDMENT – TT

16VAC25-220-30. Definitions, “High exposure risk”

6. Correctional facilities, jails detention centers, and juvenile detention centers.

AMENDMENT – CM

16VAC25-220-30. Definitions, “Exposure risk level,” “Medium”

<p>"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational <u>close</u> contact inside six-feet <u>close contact</u> with other employees, other persons, or the general public who may be infected with SARS-CoV-2</p>
<p>CM: Global change. I believe VOSH intends to make the standard consistent internally and with CDC terminology.</p>
<p>Department Response: The Department does not support the proposed amendment.</p>

"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Medium exposure risk hazards or job tasks may include, but are not limited to, operations and services in:

1. Poultry, meat, and seafood processing; agricultural and hand labor; commercial transportation of passengers by air, land, and water; on campus educational settings in schools, colleges, and universities; daycare and afterschool settings; restaurants and bars; grocery stores, convenience stores, and food banks; drug stores and pharmacies; manufacturing settings; indoor and outdoor construction settings; correctional facilities,

jails, detentions centers, and juvenile detention centers; work performed in customer premises, such as homes or businesses; retail stores; call centers; package processing settings; veterinary settings; personal care, personal grooming , salon, and spa settings; venues for sports, entertainment, movies, theaters, and other forms of mass gatherings; homeless shelters; fitness, gym, and exercise facilities; airports, and train and bus stations; etc.; and

2. Situations not involving exposure to known or suspected sources of SARS-CoV-2: hospitals, other healthcare (physical and mental) delivery and support services in a non-hospital setting, wellness services, physical assistance, etc.; skilled nursing facilities; outpatient medical facilities; clinics, drug treatment programs, and medical outreach services; non-medical support services; mental health facilities; home health care, nursing homes, assisted living facilities, memory care facilities, and hospice care; rehabilitation centers, doctors' offices, dentists' offices, and chiropractors' offices; first responders services provided by police, fire, paramedic and emergency medical services providers, medical transport; contact tracers, etc.

AMENDMENT – CM

16VAC25-220-30. Definitions, “Exposure risk level,” “Lower”

"Lower" exposure risk hazards or job tasks are those not otherwise classified as very high, high, or medium exposure risk that do not require contact inside ~~six feet~~ close contact with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2. Employees in this category have minimal ~~occupational contact~~ close contact with other employees, other persons, or the general public, such as in an office building setting; or are able to achieve minimal ~~occupational contact~~ close contact with others through the implementation of engineering, administrative and work practice controls, such as, but not limited to:

Department Response: The Department does not support the proposed amendment.

"Lower" exposure risk hazards or job tasks are those not otherwise classified as very high, high, or medium exposure risk that do not require contact inside six feet with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2. Employees in this category have minimal occupational contact with other employees, other persons, or the general public, such as in an office building setting; or are able to achieve minimal occupational contact with others through the implementation of engineering, administrative and work practice controls, such as, but not limited to:

1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time);
2. Telecommuting;
3. Staggered work shifts that allow employees to maintain physical distancing from other employees, other persons, and the general public;
4. Delivering services remotely by phone, audio, video, mail, package delivery, curbside pickup or delivery, etc., that allows employees to maintain physical distancing from other employees, other persons, and the general public; and
5. Mandatory physical distancing of employees from other employees, other persons, and the general public.

DEPARTMENT NOTE: Struck through language below moved to 16VAC25-220-40.H per VDH comment.

AMENDMENT – CM

16VAC25-220-30. Definitions, “Exposure risk level,” “Lower”

Employee use of face coverings for contact inside ~~six feet~~ close contact of coworkers, customers, or other persons is not ~~an acceptable~~ sufficient administrative or work practice control to achieve minimal ~~occupational contact~~ close contact.

Department Response: The Department does not support the proposed amendment.

Employee use of face coverings for contact inside six feet of coworkers, customers, or other persons is not an acceptable administrative or work practice control to achieve minimal occupational contact. ~~However, when it is necessary for an employee to have brief contact with others inside the six feet distance a face covering is required.~~

DEPARTMENT NOTE: With regard to the revised definition of “face covering” below, CDC guidance indicates that face coverings can serve to protect both the wearer and others from the spread of SARS-CoV-2.

<https://www.cdc.gov/coronavirus/2019-ncov/more/masking-science-sars-cov2.html>

“Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger)⁹ but they can also block the exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns.... Studies demonstrate that cloth mask materials can also reduce wearers’ exposure to infectious droplets through filtration, including filtration of fine droplets and particles less than 10 microns.”

“Face covering” means an item made of two or more layers of washable, breathable fabric that fits snugly against the sides of the face without any gaps, completely covering the nose and mouth and fitting securely under the chin. Neck gaiters made of two or more layers of washable, breathable fabric, or folded to make two such layers are considered acceptable face coverings. Face coverings shall not have exhalation valves or vents, which allow virus particles to escape, and shall not be made of material that makes it hard to breathe, such as vinyl.² ~~normally made of cloth, or various other materials with elastic bands or cloth ties to secure over the wearer’s nose and mouth in an effort to contain or reduce the spread of potentially infectious respiratory secretions at the source (i.e., the person’s nose and mouth). A face covering is not normally~~

² <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html>

~~intended to protect the wearer, but it may serve as a source control to reduce the spread of virus from the wearer to others.~~ A face covering is not a surgical/medical procedure mask or respirator. A face covering is not subject to testing and approval by a state or government agency, so it is not considered a form of personal protective equipment or respiratory protection equipment under VOSH laws, rules, regulations, and standards.

AJ: [With regard to the revised definition of “face covering” above] Since face coverings are not PPE, it seems to me that they are a work practice control and we should call them such.

“Face shield” means a form of personal protective equipment made of transparent, impermeable materials intended to protect the entire face or portions of the face primarily used for eye protection from droplets or splashes for the person wearing it. A face shield is not a substitute for a face covering, surgical/medical procedure mask, or respirator.³

“Feasible” as used in this standard includes both technical and economic feasibility.

“Filtering facepiece respirator” means a negative pressure air purifying particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering medium. Filtering facepiece respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH).

AJ: Add definition for “Good faith.”

³ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html>

The Department does not recommend providing a definition for “good faith.” Legal terms of art such as “good faith” and “reasonable” are usually the subject of case law, and the analysis of which tend to be very fact specific.

“Hand sanitizer” means an alcohol-based hand rub containing at least 60% alcohol, unless otherwise provided for in this standard.

“HIPAA” means Health Insurance Portability and Accountability Act.

“Known to be infected with the SARS-CoV-2 virus” means a person, whether symptomatic or asymptomatic, who has tested positive for SARS-CoV-2, and the employer knew or with reasonable diligence should have known that the person has tested positive for SARS-CoV-2.

AMENDMENT – AJ

16VAC25-220-30, DEFINITIONS, “May be infected with SARS-CoV-2 virus”

“May be infected with SARS-CoV-2 virus” means any person not currently ~~a person~~ known or suspected to be infected with SARS-CoV-2 virus ~~and not currently vaccinated against the SARS-CoV-2 virus.~~

AJ: A “person” is currently a person.

Department Response: The Department supports the amendment.

“May be infected with SARS-CoV-2 virus” means any person not currently a person known or suspected to be infected with SARS-CoV-2 virus ~~and not currently vaccinated against the SARS-CoV-2 virus.~~

AMENDMENT – CM

16VAC25-220-30. Definitions, “Minimal occupational contact”

“Minimal ~~occupational~~ close contact” means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others inside ~~six feet~~ close contact (e.g., passing another person in a hallway that does not allow physical distancing of ~~six feet~~ close contact); healthcare employees providing only telemedicine services; a long distance truck driver.

Department Response: The Department does not support the proposed amendment.

“Minimal occupational contact” means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet); healthcare employees providing only telemedicine services; a long distance truck driver.⁴

"Occupational exposure" means the state of being actually or potentially exposed to contact with SARS-CoV-2 virus or COVID-19 disease related hazards at the work location or while engaged in work activities at another location.

⁴ <https://www.osha.gov/SLTC/covid-19/hazardrecognition.html>

AMENDMENT – AJ

16VAC25-220-30, DEFINITIONS, "Personal protective equipment"

.... Personal protective equipment for COVID-19 exposure may include, but is not limited to, ~~items such as....~~

AJ: [Add] "for COVID-19 exposure"

Department Response: The Department does not support the addition of the phrase "for COVID-19 exposure" as it adds little to the clarity of the definition, but instead appear to limit the application of definition to situations where there is only known COVID-19 exposure.

If the Board wants to adopt some clarifying language here, the Department would instead recommend "for actual or potential exposure to SARS-CoV-2 or COVID-19...."

The Department supports that part of the amendment that deletes ~~"items such as."~~

"Personal protective equipment" means equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. These injuries and illnesses may result from contact with chemical, radiological, physical, electrical, mechanical, biological, or other workplace hazards. Personal protective equipment may include, but is not limited to, items such as gloves, safety glasses, goggles, shoes, earplugs or muffs, hard hats, respirators, surgical/medical procedure masks, impermeable gowns or coveralls, face shields, coveralls, vests, and full body suits.

AMENDMENT – CM

16VAC25-220-30. Definitions, “Physical distancing”

"Physical distancing" also called "social distancing" means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least ~~six feet~~ close contact from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that ~~six feet~~ close contact of physical distance is maintained from others around the edges or sides of the wall as well.

Department Response: The Department does not support the proposed amendment.

"Physical distancing" also called "social distancing" means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

"Respirator" means a protective device that covers the nose and mouth or the entire face or head to guard the wearer against hazardous atmospheres. Respirators are certified for use by the National Institute for Occupational Safety and Health (NIOSH). Respirators may be (i) tight-fitting, which means either a half mask that covers the mouth and nose or a full face piece that covers the face from the hairline to below the chin or (ii) loose-fitting, such as hoods or helmets that cover the head completely.

There are two major classes of respirators:

1. Air-purifying, which remove contaminants from the air; and
2. Atmosphere-supplying, which provide clean, breathable air from an uncontaminated source. As a general rule, atmosphere-supplying respirators are used for more hazardous exposures.

"Respirator user" means an employee who in the scope of their current job may be assigned to tasks that may require the use of a respirator in accordance with this standard or required by other provisions in the VOSH and OSHA standards.

"SARS-CoV-2" means ~~a betacoronavirus, like MERS-CoV and SARS-CoV~~the novel virus that causes coronavirus disease 2019, or COVID-19. Coronaviruses are named for the crown-like spikes on their surfaces. ~~The SARS-CoV-2 causes what has been designated as the Coronavirus Disease 2019 (COVID-19).~~

AMENDMENT – AJ AND DEPARTMENT

16VAC25-220-30, DEFINITIONS, “Severely immunocompromised”

AJ: This [definition of “Severely immunocompromised”] does not really define the term. It just gives an example. It needs some work to make it more understandable to the layman.

The Department agrees with the Board member’s comment and proposes the below revision.

“Severely immunocompromised” means a seriously weakened immune system which lowers the body’s ability to fight infection, and may increase the risk of getting severely sick from SARS-CoV-2,⁵ from....

“Severely immunocompromised” means being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days.”⁶ The degree of immunocompromise is determined by the treating provider, and preventive actions are tailored to each individual and situation.

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

⁶ *Id* Footnote 1.

AMENDMENT – AJ AND DEPARTMENT

16VAC25-220-30, DEFINITIONS, “Signs of COVID-19”

AJ: I don't like this term [“abnormalities” in the definition of “Signs of COVID-19”].
The Department agrees with the Board member's comment and proposes the below revision.
"Signs of COVID-19" are abnormalities <u>medical conditions</u>

"Signs of COVID-19" are abnormalities that can be objectively observed, and may include fever, trouble breathing or shortness of breath, cough, persistent pain or pressure in the chest, vomiting, new confusion, inability to wake or stay awake, bluish lips or face, etc.

"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).

"Suspected to be infected with SARS-CoV-2 virus" means a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza).

AMENDMENT – AJ AND DEPARTMENT

16VAC25-220-30, DEFINITIONS, "Symptoms of COVID-19"

AJ: As before: "I don't like this term ["abnormalities" in the definition of "Symptoms of COVID-19"].
The Department agrees with the Board member's comment and proposes the below revision.
"Symptoms of COVID-19" are abnormalities <u>medical conditions</u>

"Symptoms of COVID-19" are abnormalities that are subjective to the person and not observable to others, and may include chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, congestion or runny nose, diarrhea, etc.

"Symptomatic" means the employee a person is experiencing signs and/or symptoms similar to those attributed to COVID-19 including fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea. A person may become symptomatic may appear in two 2 to 14 days after exposure to the SARS-CoV-2 virus.

"Technical feasibility" means the existence of technical know-how as to materials and methods available or adaptable to specific circumstances that can be applied to one or more

requirements in this standard with a reasonable possibility that employee exposure to the SARS-CoV-2 virus and COVID-19 disease hazards will be reduced. If an employer's level of compliance lags significantly behind that of the employer's industry, allegations of technical infeasibility will not be accepted.

"USBC" means Virginia Uniform Statewide Building Code.

"VDH" means Virginia Department of Health.

"VOSH" means Virginia Occupational Safety and Health.

AJ: Mask [face covering] wearing is a work practice control.

"Work practice control" means a type of administrative control by which the employer modifies the manner in which the employee performs assigned work. Such modification may result in a reduction of exposure to SARS-CoV-2 virus and COVID-19 disease related workplace hazards and job tasks through such methods as changing work habits, improving sanitation and hygiene practices, or making other changes in the way the employee performs the job.

16VAC25-220-40. Mandatory requirements for all employers.

A. Employers in all exposure risk levels shall ensure compliance with the requirements in this section to protect employees in all exposure risk levels from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease.

AJ: I have some issues with this section but I need to review this more.

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs ~~and/or symptoms~~ of ~~an oncoming~~ illness.

AMENDMENT – AJ

16VAC25-220-40.B.8.e, Mandatory requirements for all employers.

<p>3.Serological testing has not been determined if persons who have the antibodies are immune from infection. <u>It has not been determined that persons who test positive for the presence of antibodies by serological testing</u> are immune from infection.</p>
<p>Department Response: The Department supports the proposed amendment.</p>

3. Serological testing, also known as antibody testing, is a test to determine if persons have been infected with SARS-CoV-2 virus. Serological testing has not been determined if persons who have the antibodies are immune from infection.

a. Serologic test results shall not be used to make decisions about returning employees to work who were previously classified as known or suspected to be infected with the SARS-CoV-2 virus.

b. Serologic test results shall not be used to make decisions concerning employees who were previously classified as known or suspected to be infected with the SARS-CoV-2 virus about grouping, residing in or being admitted to congregate settings, such as schools, dormitories, etc.

4. Employers shall develop and implement policies and procedures for employees to report when employees they are experiencing signs and/or symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees shall be designated by the employer as “suspected to be infected with SARS-CoV-2 virus.”

5. Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work (see subsection C of this section). Nothing in this standard shall prohibit an employer from permitting an employee known or suspected to be infected with SARS-CoV-2 virus from engaging in teleworking or other form of work isolation that would not result in potentially exposing other employees to the SARS-CoV-2 virus.

AMENDMENT – CM

16VAC25-220-40.B.6, Mandatory requirements for all employers.

6. Employers shall not permit employees or other persons who have had close contact with a person known to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until the expiration of time as set forth in CDC quarantine guidelines. Nothing in this standard shall prohibit an employer from permitting such an employee or person from engaging in teleworking or other form of work isolation that would not result in potentially exposing other employees to the SARS-CoV-2 virus.

~~To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.~~

Department Response: The Department does not support the proposed amendment.

The CDC defines “close contact” as “Close contact” means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. “Quarantine” is separation of people who were in “close contact” with a person with COVID-19 from others. The Standard does not address the issue of “quarantine.”

Requirements for returning to work from “quarantine” is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-fags/>

VOSH does not have the resources to deal with contact tracing and quarantine issues, both currently the responsibility of VDH.

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

7. Employers shall discuss with subcontractors and companies that provide contract or temporary employees ~~about~~ the importance and requirement of to exclude from work employees or other persons (e.g., volunteers) who are known or suspected to be infected with the SARS-CoV-2 virus ~~of staying home~~. Subcontractor, contract, or temporary employees known or suspected to be infected with the SARS-CoV-2 virus shall not report to or be allowed to remain at the work site until cleared for return to work. Subcontractors shall not allow their employees known or suspected to be infected with the SARS-CoV-2 virus ~~employees~~ to report to or be allowed to remain at work or on a job site until cleared for return to work.

8. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within 2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test). ~~the previous 14 days from the date of positive test, and the e-~~Employers shall notify:

- a. The employer's own employees who may have been exposed, within 24 hours of discovery of the employees' possible exposure, while keeping confidential the identity of the person known to be infected with SARS-CoV-2 virus ~~person~~ in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations; and

b. In the same manner as subdivision 8 a of this subsection, other employers whose employees were present at the work site during the same time period; and

c. In the same manner as subdivision 8 a of this subsection, the building or facility owner. The building or facility owner will require all employer tenants to notify the owner of the occurrence of a SARS-CoV-2-positive test for any employees or residents in the building. This notification will allow the owner to take the necessary steps to sanitize the common areas of the building. In addition, the building or facility owner will notify all employer tenants in the building that one or more cases have been discovered and the floor or work area where the case was located. The identity of the individual will be kept confidential in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations; and

d. The Virginia Department of Health ~~within 24 hours of the discovery of a positive case.~~ during a declaration of an emergency by the Governor pursuant to § 44-146.17 of the Code of Virginia. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is

closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp; and

AMENDMENT – TP

16VAC25-220-40.B.8.e, Mandatory requirements for all employers.

e. The Virginia Department of Labor and Industry within 24 hours of the discovery of ~~three~~ two or more....

TP: This should be changed back to “two” for consistency.

Department Response: The Department does not support the proposed amendment.

VOSH does not have the resources to deal with a notification requirement lowered from three to two. “Three” was chosen because of the previous long time requirement for employers to report catastrophic events where three or more employees were hospitalized.

e. The Virginia Department of Labor and Industry within 24 hours of the discovery of three or more **of its own**⁷ employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.

AMENDMENT – CM

16VAC25-220-40.B.8.f, [NEW] Mandatory requirements for all employers.

f. For the purposes of subsections (d) and (e) of this section, a reported positive SARS-CoV-2 test does not need to be reported more than once, and will not be used for the purpose of identifying more than one outbreak or more than one 14-day period.

CM: The intent is to provide language to clarify that a case does not have to be reported more than once or used to calculate a VDH outbreak or a VOSH 14-day window more than once.

9. Employers shall ensure employee access to the employee's own SARS-CoV-2 virus and COVID-19 disease related exposure and medical records in accordance with the standard applicable to its industry. Employers in the agriculture, public sector marine terminal, and public sector longshoring industries shall ensure employees' access to the employees' own SARS-CoV-2 virus and COVID-19 disease related exposure and medical records in accordance with 16VAC25-90-1910.1020, Access to Employee Exposure and Medical Records.

⁷ See Frequently Asked Question (FAQ) §40, FAQ 21, <https://www.doli.virginia.gov/conronavirus-covid-19-faqs/>

C. Return to work.

AJ: Since the testing option has been removed in accordance with CDC what if an employer wants to test? This should be accepted also. Many employers would prefer to test, because all this counting is a pain to manage. This should indicate that the testing is acceptable.

Department Response: The Department and VDH jointly developed a series of FAQs (§40, FAQs 18, 25, 26, 27, 28, 29 and 30) on the topic of return to work which can be found at <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>.

Some excerpts follow:

“Isolation” is the separation of people with COVID-19 from others....“Quarantine” is separation of people who were in “close contact” with a person with COVID-19 from others....“Close contact” means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you....

Requirements for returning to work from “quarantine” is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30).

....

[§40, FAQ 29.] Can an employee’s negative test for SARS-CoV-2 after close contact with a COVID-19 case release an employee from quarantine?

No. It is possible for an employee to test negative for SARS-CoV-2 after the close contact and still develop symptoms of COVID-19 up to 14 days after the close contact. Employers and employees must follow appropriate quarantine requirements discussed in FAQs 26 and 27 for employees who were close contacts of a COVID-19 case before allowing such employees to return to work.

....

[§40, FAQ 30] 30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as “Suspected to be infected with SARS-CoV-2 virus”), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness....

If an employee HAS HAD “close contact” with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case....

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an “alternative diagnosis”, and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee

has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

1. ~~The e~~ Employer shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work, ~~using either a symptom-based or test-based strategy, depending on local healthcare and testing circumstances. While an employer may rely on other reasonable options, a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the symptom-based strategy requirements in subdivision 1 a of this subsection will constitute compliance with the requirements of this subsection.~~

a. ~~For Symptomatic employees~~ known or suspected to be infected with the SARS-CoV-2 virus ~~employees the symptom-based strategy excludes an employee are excluded~~ from returning to work until all three of the following have been met:

~~(i)(1)~~ (1) at least three days (72 hours), ~~The employee is fever-free (less than 100.0° F) for at least 24 hours,~~ have passed since recovery, defined as resolution of fever without the use of fever-reducing medications,

~~and (2) improvement in r~~ (2) improvement in r Respiratory symptoms, such as (e.g., cough, and shortness of breath), have improved, and

~~(iii)(3) a~~ (3) a At least 10 days have passed since symptoms first appeared.

AJ: This section below [continuation of 16VAC25-220-40.C.1.a], while it may be true, does not give the employer any info about what this means or what to do. This just makes me nervous. It needs some clarification.

Department Response: The phrase “consider consultation with infection control experts” means that the employer should consider contacting VDH or other medical professionals about the specific situation.

However, a limited number of employees with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.

AMENDMENT – CM

16VAC25-220-40.C.1.a, Mandatory requirements for all employers.

However, a limited number of employees with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts. VOSH will consult with VDH when identifying severe employee illnesses that may warrant extended duration of isolation or severely immunocompromised employees required to undergo testing.

CM: This language is intended to help employers define when these additional requirements are necessary.

b. The test-based strategy excludes an employee from returning to work until (i) resolution of fever without the use of fever-reducing medications, (ii) improvement in respiratory symptoms (e.g., cough, shortness of breath), and (iii) negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or more apart (total of two negative specimens).

i. If a known or suspected to be infected with the SARS-CoV-2 virus employee refuses to be tested, the employer compliance with subdivision 1 a of this subsection, symptom-based strategy, will be considered in compliance with this standard. Nothing in this standard shall be construed to prohibit an employer from requiring a known or suspected to be infected with the SARS-CoV-2 virus employee to be tested in accordance with subdivision 1 b of this subsection.

ii. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. The employer shall not require the employee to pay for the cost of COVID-19 testing for return-to-work determinations.

AJ: [With regard to the RT-PCR test for SARS-CoV-2 RNA referenced below] What about the other types of tests?

Department Response: The language below comes directly from VDH and is based on current CDC guidance.

~~2b. The employer shall develop and implement policies and procedures for Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms asymptomatic employees to return to work using either a time-based or test-based strategy depending on local healthcare and testing circumstances. are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA. While an employer may rely on other reasonable options, a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the time-based strategy requirements in subdivision 2 a of this subsection will constitute compliance with the requirements of this subsection.~~

~~a. The time-based strategy excludes an employee from returning to work until at least 10 days have passed since the date of the employee's first positive COVID-19 diagnostic test assuming the employee has not subsequently developed symptoms since the employee's positive test. If the employee develops symptoms, then the symptom-based or test-based strategy shall be used.~~

~~b. The test-based strategy excludes an employee from returning to work until negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected 24 hours or more apart (total of two negative specimens).~~

~~i. If a known to be infected with SARS-CoV-2 asymptomatic employee refuses to be tested, employer compliance with subdivision 2 a of this subsection, time based strategy, will be considered in compliance with this standard. Nothing in this standard shall be construed to prohibit an employer from requiring a known to be infected with SARS-CoV-2 asymptomatic employee to be tested in accordance with subdivision 2 b of this subsection.~~

~~ii.c.~~ For purposes of this section, COVID-19 testing is considered a “medical examination” under § 40.1-28 of the Code of Virginia. ~~The e~~ Employers shall not require ~~the employees~~ to pay for the cost of COVID-19 testing for return to work determinations. If an employer’s health insurance covers the entire cost of COVID-19 testing, use of the insurance coverage would not be considered a violation of 16VAC25-220-40 C, 2 + c.⁸

D. Unless otherwise provided in this standard, employers shall establish and implement policies and procedures that ensure ~~that~~ employees observe physical distancing while on the job and during paid breaks on the employer’s property, including policies and procedures that:

1. Use verbal announcements, signage, or visual cues to promote physical distancing.
2. Decrease worksite density by limiting non-employee access to the place of employment or restrict access to only certain workplace areas to reduce the risk of exposure. ~~3.~~ An employer’s compliance with occupancy limits contained in any applicable Virginia

⁸ See Frequently Asked Question (FAQ) §40, FAQ 23, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

executive order or order of public health emergency will constitute compliance with the requirements in this subsection.

E. Access to common areas, breakrooms, or lunchrooms shall be closed or controlled.

1. If the nature of an employer's work or the work area does not allow employees to consume meals in the employee's workspace while observing physical distancing, an employer may designate, reconfigure, and alternate usage of spaces where employees congregate, including lunch and break rooms, locker rooms, time clocks, etc., with controlled access, provided the following conditions are met:

a. At the entrance of the designated common area or room ~~the employers~~ shall clearly post the policy limiting the occupancy of the space, and requirements for physical distancing, hand washing and hand sanitizing, and cleaning and disinfecting of shared surfaces.

b. ~~The e~~ Employers shall limit occupancy of the designated common area or room so that occupants can maintain physical distancing from each other. ~~The e~~ Employers shall enforce the occupancy limit.

c. Employees shall be required to clean and disinfect the immediate area in which they were located prior to leaving, or ~~the employers~~ may provide for cleaning and disinfecting of the common area or room at regular intervals throughout the day, and between shifts of employees using the same common area or room (i.e., where an employee or groups of employees have a designated lunch period and the common area or room can be cleaned in between occupancies).

d. Hand washing facilities, and hand sanitizer where feasible, are available to employees. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable and use and storage in hot environments can result in a hazard.

AMENDMENT – TT

16VAC25-220-40.F, Mandatory requirements for all employers.

(F) When multiple employees are occupying a vehicle for work purposes, employers shall use the hierarchy of hazard controls to prevent employee exposures by:

1. Eliminating the need for employees to share work vehicles and arrange for alternative means for additional employees to travel to work sites.

2. When employees must share work vehicles because no other alternatives are available, employees shall be provided with respiratory protection, such as an N95 filtering face piece respirator.

3. Increase outside air (e.g. open windows, do not recirculate cabin air), when weather conditions permit.

4. When the work vehicle allows for distancing of employees, e.g. in a van, establish procedures to maximize separation between employees during travel, e.g. setting occupancy limits, sitting in alternate seats.

F. When multiple employees are occupying a vehicle for work purposes, employers shall:

1. ~~the employers shall e~~ Ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry. Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons.⁹

AJ: [With regard to the above phrase "Ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry."]

I am not sure that there are any standards currently that require respirators when traveling in a vehicle or mobile equipment. Maybe in an ambulance. I think 99% of the time a face covering would be okay. This is really confusing.

Department Response: To address the question, as an example, §1910.132, Personal Protective Equipment, "applies" to all employers in general industry. The Department has an FAQ on the subject at §40, FAQ 12, which states in part:

All federal OSHA identical standards and regulations enforced by VOSH in General Industry (29 CFR Part 1910) apply to general industry employers like the trucking industry, except where otherwise exempted by §4(b)(1) of the OSH Act of 1970. Two such standards are the Personal Protective Equipment (PPE) (1910.132[1]) and Respiratory Protection (1910.134[2]) standards. COVID-19 is a respiratory disease that spreads easily through airborne transmission between persons in contact with each other inside six feet, so the PPE and Respirator Standards are considered applicable.

While the ETS contains specific requirements for an employer to determine the level of exposure risk to the SARS-CoV-2 virus at its workplace (very high, high, medium, or lower risk), generally the determination in most workplace settings outside of healthcare and emergency response will result in either a medium or lower risk classification depending on whether employees are required to work inside six feet of other persons (employees, customers, etc.) or not.

Employers must first implement engineering, administrative, and work practice controls to eliminate or reduce the frequency of contact with others inside of six feet to the extent feasible. Where it is not feasible to eliminate contact with others inside of six feet, medium risk employers must determine what level of personal protective

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html>

equipment (PPE) must be provided and worn as the last line of protection for employees against the virus. This is done through conducting a hazard assessment to determine personal protective equipment (PPE) requirements for employees. 16VAC25-220-60.D (medium risk).

AJ: [With regard to the above phrase “employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons] I think this is enough. May add, unless transporting a known or suspected Covid-19 case.

2. Provide access to fresh air ventilation (e.g., open windows, do not recirculate cabin air).

3. Where physical distancing cannot be maintained, establish procedures to maximize separation between employees during travel.

~~G. Employers shall also ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency.~~

DEPARTMENT COMMENT: After discussions with legal counsel, the Department is recommending removal of the above language. In addition, the language is considered redundant in light of Executive Order 72, Order of Public Health Emergency, Commonsense Surge Restrictions, Certain Temporary Restrictions Due to Novel Coronavirus (COVID-19), adopted on December 14, 2020, which provides as follows:

IV. ADDITIONAL PROVISIONS

A. Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19”

Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

AJ: Does [the below section] mean that persons exposed to silica in their job can wear a face covering? This is really confusing and was confusing in the ERS.

Department Response: No. The ETS and the Draft Final Standard only apply to workplace exposures involving employee exposure to SARS-CoV-2 and COVID-19. It is the position of the Department that this standard cannot override existing VOSH/OSHA standards and regulations applicable to other occupational hazards, such as exposure to silica. In the instance of silica, employers must comply with VOSH standards applicable to hazards associated with occupational exposure to silica without any consideration to the provisions of this standard.

HG. Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements **from employees or other persons**, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry. **In such situations, and until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings.**

AMENDMENT – CM

16VAC25-220-40.H, Mandatory requirements for all employers.

H. When it is necessary for employees solely exposed to lower risk hazards or job tasks to have brief contact with others inside **six feet close contact** (e.g., passing another person in a hallway that does not allow physical distancing of **six feet close contact**), a face covering is required.

Department Response: The Department does not support the proposed amendment.

H. When it is necessary for employees solely exposed to lower risk hazards or job tasks to have brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet), a face covering is required.

AMENDMENT – TP

16VAC25-220-40.I, Mandatory requirements for all employers.

I. Each employer must ensure that all individuals who are not considered an employee (patrons, customers, etc.) at the workplace or other premises subject to the employer's control wear a face covering.

Department Response: The Department does not support this NEW language. Under current Executive Orders, VDH is charged with addressing complaints about non-employees failing to wear face coverings. If VDH cannot resolve the issue successfully with the employer it will coordinate a joint enforcement effort with VOSH/DOLI. If VOSH receives such a complaint currently, it refers the individual to VDH. VOSH does not have the resources to handle these types of complaints at the initial stage of filing.

I. When required by this standard, face coverings shall be worn over the wearer's nose and mouth and extend under the chin.¹⁰

IJ. Nothing in this standard shall require the use of a respirator, surgical/medical procedure mask, or face covering by any employee for whom doing so would be contrary to the employee's health or safety because of a medical condition; however, nothing in this standard shall negate an employer's obligations to comply with personal protective equipment and respiratory protection standards applicable to its industry.

¹⁰ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html>

1. Although face shields are not considered a substitute for face coverings as a method of source control and not used as a replacement for face coverings among people without medical contraindications, face shields may provide some level of protection against contact with respiratory droplets. In situations where a face covering cannot be worn due to medical contraindications, employers shall provide and employees shall wear either:¹¹

a. A face shield that wraps around the sides of the wearer's face and extends below the chin; or

b. A hooded face shield; and

c. To the extent feasible, employees wearing face shields in accordance with this subsection shall observe physical distancing requirements in this standard.

2. Face shield wearers shall wash their hands before and after removing the face shield and avoid touching their eyes, nose and mouth when removing it.

3. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.

4. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.

AJ: [With regard to use of the term "contraindication" in the phrase "In situations where a face covering cannot be worn due to medical contraindications, employers shall provide and employees shall wear...."] Can we find another word? Do most people understand this?

¹¹ *Id.*

JK. Requests to the Department for religious waivers from the required use of respirators, surgical/medical procedure masks, or face coverings will be handled in accordance with the requirements of applicable federal and state law, standards, regulations and the U.S. and Virginia Constitutions, after Department consultation with the Office of the Attorney General.

KL. Sanitation and disinfecting.

1. In addition to the requirements contained in this standard, employers shall comply with the VOSH sanitation standard applicable to its industry.

2. Employees that interact with customers, the general public, contractors, and other persons shall be provided with and immediately use supplies to clean and disinfectant surfaces contacted during the interaction where there is the potential for exposure to the SARS-CoV-2 virus by themselves or other employees.

AMENDMENT – AJ

16VAC25-220-40.L.3, Mandatory requirements for all employers. Sanitation and Disinfecting.

3. In addition to the requirements contained in this standard, employers shall comply with the VOSH hazard communication standard applicable to the employers' industry for cleaning and disinfecting materials and hand sanitizers, and have safety data sheets available.

3. In addition to the requirements contained in this standard, employers shall comply with the VOSH hazard communication standard applicable to the employers' industry for cleaning and disinfecting materials and hand sanitizers.

4. Areas in the place of employment where employees or other persons known or suspected to be infected with the SARS-CoV-2 virus ~~employees or other persons~~ accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas. Where feasible, a period of 24 hours will be observed prior to cleaning and disinfecting. This requirement shall not apply if the areas in question have been unoccupied for seven or more days.

5. All common spaces, including bathrooms (including port-a-johns, privies, etc.)¹², frequently touched surfaces, and doors, shall at a minimum be cleaned and disinfected at least once during or at the end of ~~each~~ the shift. Where multiple shifts are employed, such spaces shall be cleaned and disinfected no less than once every 12 hours. All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another.

¹² See DOLI Frequently Asked Questions (FAQ), §40, FAQ 13, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

AMENDMENT – AJ

16VAC25-220-40.L.5, Mandatory requirements for all employers.

AJ: [In referenced to the above sentence: “All shared tools, equipment, workspaces, and vehicles shall be cleaned and disinfected prior to transfer from one employee to another.”] I would split this up to a separate bullet because it is a different topic.

Department Response: The Department supports the proposed amendment to separate out the above sentence as subdivision 6. and renumber the following sections accordingly.

6. Employers shall ensure that cleaning and disinfecting products are readily available to employees to accomplish the required cleaning and disinfecting. In addition, employers shall ensure use of only disinfecting chemicals and products indicated in the Environmental Protection Agency (EPA) List N for use against SARS-CoV-2.

7. Employers shall ensure that the manufacturer’s instructions for use of all disinfecting chemicals and products are complied with (e.g., concentration, application method, contact time, PPE, etc.).

AMENDMENT – CM

16VAC25-220-40.L.8, Mandatory requirements for all employers.

8. Employees shall have easy, frequent access and permission to use soap and water, and hand sanitizer where feasible, for the duration of work. Employees assigned to a work station where job tasks require frequent interaction inside ~~six feet~~ close contact with other persons shall be provided with hand sanitizer where feasible at the employees work station.

Department Response: The Department does not support the proposed amendment.

8. Employees shall have easy, frequent access and permission to use soap and water, and hand sanitizer where feasible, for the duration of work. Employees assigned to a work station where job tasks require frequent interaction inside six feet with other persons shall be provided with hand sanitizer where feasible at the employees work station.

AMENDMENT – AJ

16VAC25-220-40.L.9, Mandatory requirements for all employers.

9. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a ~~work-site~~ client and customer location and shall have transportation....

Department Response: The Department does not support the amendment in its current form as mobile work crews also work at locations other than those of a client or customer. If the Board member wishes to include client and customer locations, then the Department recommends the following language:

9. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a work site, client or customer location and shall have transportation....

9. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a work site and shall have transportation immediately available to nearby toilet facilities and handwashing facilities that meet the requirements of VOSH laws, standards, and regulations dealing with sanitation. Hand sanitizers required for use to protect against SARS-CoV-2 are flammable, and use and storage in hot environments can result in a hazard.

AMENDMENT – AJ

16VAC25-220-40.L.10, Mandatory requirements for all employers.

10.... employers shall ensure that protective measures are put in place to prevent cross-contamination between tasks, areas, and personnel.

910. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower as presenting potential exposure risk for purposes of application of the requirements of this standard. In situations other than emergencies, **the employers** shall ensure that protective measures are put in place to prevent cross-contamination.

EM. Unless otherwise provided in this standard, when engineering, work practice, and administrative controls are not feasible or do not provide sufficient protection, employers shall provide personal protective equipment to their employees and ensure the equipment's proper use in accordance with VOSH laws, standards, and regulations applicable to personal protective equipment, including respiratory protection equipment.

16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk.

A. The requirements in this section for employers with hazards or job tasks classified as very high or high exposure risk apply in addition to requirements contained in 16VAC25-220-40, 16VAC25-220-70, and 16VAC25-220-80.

B. Engineering controls.

1. Employers shall ensure that appropriate air-handling systems under their control:

a. Are installed and maintained in accordance with the USBC and manufacturer's instructions in healthcare facilities and other places of employment treating, caring for, or housing persons with known or suspected to be infected with the SARS-CoV-2 virus; and

~~b. Comply with minimum American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a), which covers both outdoor and total air ventilation in healthcare facilities. Based on risk assessments or owner project requirements, designers of new and existing facilities can go beyond the minimum requirements of these standards.~~

b. Where feasible and within the design parameters of the system, are utilized as follows:¹³

i. (1) Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open);

¹³ <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>

In ground transportation settings, use natural ventilation ~~(i.e., opening windows if possible and safe to do so)~~ to increase outdoor air dilution of inside air in a manner that will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission to employees, and when environmental conditions and transportation safety and health requirements allow;

Department Response: Comment 89008 states “due to the shape of transit vehicles, interior air travels from back to front while a vehicle is in motion. That is, the air – and any virus that it contains – travels directly toward the driver. If the driver’s window is open, this back-to-front airflow grows even stronger. The best way to ensure that the driver benefits from increased outside air is to keep the driver’s and passengers’ windows closed while opening the vehicle’s rear hatch, adjusting the driver’s air vents to blow fresh outside air (or modifying the vents to do so if the vehicle is not equipped with this feature), and operating the vents on high. These steps help to reverse the airflow within the vehicle so that fresh air travels toward the driver, and potentially contaminated air travels to the back of the vehicle and out the rear hatch. The attached ATU factsheet, entitled “Safe Service Now – Covid-19 Bus Airflows and Solutions” provides further information. This guidance should be incorporated into Section 16 VAC 25-220-60(B)(1)(b)(ii) – or, at the very least, the reference to open windows must be removed from that section.”

The above language change deletes the reference to opening windows and provides a performance oriented goal of mitigating the spread of the virus inside the vehicle.

##(2) In ground transportation settings, use natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of inside air when environmental conditions and transportation safety and health requirements allow;

##(3) Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;

iv(4) Increase air filtration to as high as possible in a manner that will still enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;

v(5) Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;

vi(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

vii(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

viii(8) If the system's design can accommodate such an adjustment and is allowed by the air handler manufacturer's installation instructions and listing, improve central air filtration to MERV-13 and seal edges of the filter to limit bypass;¹⁴and

ix(9) Check filters to ensure they are within service life and appropriately installed.

c. Comply with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards.

¹⁴ <https://www.ashrae.org/technical-resources/filtration-disinfection#iso>

2. For employers not covered by subdivision 1 of this subsection, ensure that air-handling systems where installed and under their control are appropriate to address the SARS-CoV-2 virus and COVID-19 disease related hazards and job tasks that occur at the workplace:
 - a. Are maintained in accordance with the manufacturer's instructions; and
 - b. Comply with subdivisions 1 b and 1 c of this subsection.
3. Hospitalized patients with known or suspected to be infected with the SARS-CoV-2 virus, where feasible and available, shall be placed in an airborne infection isolation room (AIIRs).
4. Employers shall use AIIRs rooms when available for performing aerosol-generating procedures on patients with known or suspected to be infected with the SARS-CoV-2 virus.
5. For postmortem activities, employers shall use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of persons known or suspected to be infected with the SARS-CoV-2 virus persons at the time of their death.
6. Employers shall use special precautions associated with Biosafety Level 3 (BSL-3), as defined by the U.S. Department of Health and Human Services Publication No. (CDC) 21-1112 "Biosafety in Microbiological and Biomedical Laboratories" (Dec. 2009), which is hereby incorporated by reference, when handling specimens from patients or persons known or suspected to be infected with the SARS-CoV-2 virus patients or persons.

Diagnostic laboratories that conduct routine medical testing and environmental specimen testing for COVID-19 are not required to operate at BSL-3.¹⁵

7. To the extent feasible, employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.

C. Administrative and work practice controls.

1. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.

2. In healthcare facilities, ~~an~~ employers shall follow existing guidelines and facility standards of practice for identifying and isolating infected persons and for protecting employees.

3. ~~An~~ Employers shall limit non-employee access to the place of employment or restrict access to only certain workplace areas to reduce the risk of exposure. An employer's compliance with occupancy limits contained in any applicable Virginia executive order or order of public health emergency will constitute compliance with the requirements of this paragraph.

4. ~~An~~ Employers shall post signs requesting patients and family members to immediately report ~~signs and/ or~~ symptoms of respiratory illness on arrival at the healthcare facility and use disposable face coverings.

¹⁵ See Frequently Asked Question (FAQ) §50, FAQ 3, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

AJ: [With reference to the above phrase “and use disposable face coverings.”] Why disposable?

Department Response: 16VAC25-220-50 applies to workplace settings with hazards and job tasks classified as very high or high, often in a healthcare setting where infection control procedures call for disposable items.

5. An employer shall offer enhanced medical monitoring of employees during COVID-19 outbreaks.

~~6. An employer shall provide all employees with job-specific education and training on preventing transmission of COVID-19, including initial and routine and refresher training in accordance with 16VAC25-220-80.~~

~~7. To the extent feasible, an employer shall ensure that psychological and behavioral support is available to address employee stress at no cost to the employee.~~

DEPARTMENT NOTE: The above language was accidentally deleted from the December 10, 2020 Revised Proposed Standard when the Word document was converted to PDF.

~~7. In health care settings, an employer shall provide alcohol-based hand sanitizers containing at least 60% ethanol or 70% isopropanol to employees at fixed work sites and to emergency responders and other personnel for decontamination in the field when working away from fixed work sites.~~

~~8. Employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus non-employees to contain respiratory secretions until the non-~~

employees are able to leave the site (i.e., for medical evaluation and care or to return home).

AMENDMENT – CM

16VAC25-220-50.C.9.c and .d, Requirements for hazards or job tasks classified as very high or high exposure risk.

c. Increase physical distancing between employees at the worksite to ~~six feet~~ close contact.

d. Increase physical distancing between employees and other persons to ~~six feet~~ close contact.

Department Response: The Department does not support the proposed amendment.

10-9. Where feasible, employers shall:

- a. Implement flexible worksites (e.g., telework).
- b. Implement flexible work hours (e.g., staggered shifts).
- c. Increase physical distancing between employees at the worksite to six feet.
- d. Increase physical distancing between employees and other persons to six feet.

e. Implement flexible meeting and travel options (e.g., use telephone or video conferencing instead of in person meetings; postpone non-essential travel or events; etc.).

f. Deliver services remotely (e.g. phone, video, internet, etc.).

g. Deliver products through curbside pick-up.

D. Personal protective equipment (PPE).

1. Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132), shall comply with the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection:

a. The Employer shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). The Employer shall provide for employee and employee representative involvement in the assessment process.

b. If such hazards or job tasks are present or likely to be present, the employers shall:

(1)(1) Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment;

(2)(2) Communicate selection decisions to each affected employee; and

~~(3iii)~~(3) Select PPE that properly fits each affected employee.

2. The e Employers shall verify that the required SARS-CoV-2 virus and COVID-19 disease workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date of the hazard assessment; and the document as a certification of hazard assessment.

3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915, 16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.

AMENDMENT – TP

16VAC25-220-50.D.4 Requirements for hazards or job tasks classified as very high or high exposure risk.

~~4. Employers shall implement a respiratory protection program in accordance with 16VAC25-90-1910.134 (b) through (d) (except (d)(1)(iii)), and (f) through (m), that covers each employee required to use a respirator.~~

TP: This is outdated/incorrect respiratory protection standard language.

4. The e Employers shall implement a respiratory protection program in accordance with 16VAC25-90-1910.134 (b) through (d) (except (d)(1)(iii)), and (f) through (m), that covers each employee required to use a respirator.

AMENDMENT – CM

16VAC25-220-50.D.5, Requirements for hazards or job tasks classified as very high or high exposure risk.

5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside ~~six feet~~ close contact of patients or other persons known to be or suspected of being infected with SARS-CoV-2.

Department Response: The Department does not support the proposed amendment.

5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. ~~Where indicated by the hazard assessment and equipment selection requirements in subsection D of this section, such employees shall also be provided with and wear a surgical/medical procedure mask. Gowns shall be large enough to cover the areas requiring protection~~ the correct size to assure protection.

E. Employee training shall be provided in accordance with the requirements of 16VAC25-220-80 of this standard.

16VAC25-220-60. Requirements for hazards or job tasks classified at medium exposure risk.

A. The requirements in this section for employers with hazards or job tasks classified as medium exposure risk apply in addition to requirements contained in 16VAC25-220-40, 16VAC25-70, and 16VAC25-80.

B. Engineering controls.

1. Employers shall ensure that air-handling systems under their control where installed are appropriate to address the SARS-CoV-2 virus and COVID-19 disease related hazards and job tasks that occur at the workplace and:

a. Are maintained in accordance with the manufacturer's instructions; and

b. Comply with minimum American National Standards Institute (ANSI)/American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) Standards 62.1 and 62.2 (ASHRAE 2019a, 2019b), which include requirements for outdoor air ventilation in most residential and nonresidential spaces, and ANSI/ASHRAE/ASHE Standard 170 (ASHRAE 2017a), which covers both outdoor and total air ventilation in healthcare facilities. Based on risk assessments or owner project requirements, designers of new and existing facilities can go beyond the minimum requirements of these standards.

b. Where feasible and within the design parameters of the system, are utilized as follows:¹⁶

(1) Increase total airflow supply to occupied spaces provided that a greater hazard is not created (e.g., airflow that is increased too much may make doors harder to open or may blow doors open);

In ground transportation settings, use natural ventilation ~~(i.e., opening windows if possible and safe to do so)~~ to increase outdoor air dilution of inside air in a manner that will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission to employees, and when environmental conditions and transportation safety and health requirements allow;

Department Response: Comment 89008 states “due to the shape of transit vehicles, interior air travels from back to front while a vehicle is in motion. That is, the air – and any virus that it contains – travels directly toward the driver. If the driver’s window is open, this back-to-front airflow grows even stronger. The best way to ensure that the driver benefits from increased outside air is to keep the driver’s and passengers’ windows closed while opening the vehicle’s rear hatch, adjusting the driver’s air vents to blow fresh outside air (or modifying the vents to do so if the vehicle is not equipped with this feature), and operating the vents on high. These steps help to reverse the airflow within the vehicle so that fresh air travels toward the driver, and potentially contaminated air travels to the back of the vehicle and out the rear hatch. The attached ATU factsheet, entitled “Safe Service Now – Covid-19 Bus Airflows and Solutions” provides further information. This guidance should be incorporated into Section 16 VAC 25-220-60(B)(1)(b)(ii) – or, at the very least, the reference to open windows must be removed from that section.”

The above language change deletes the reference to opening windows and provides a performance oriented goal of mitigating the spread of the virus inside the vehicle.

¹⁶ <https://www.cdc.gov/coronavirus/2019-ncov/community/office-buildings.html>

ii(2) In ground transportation settings, use natural ventilation (i.e., opening windows if possible and safe to do so) to increase outdoor air dilution of inside air when environmental conditions and transportation safety and health requirements allow;

iii(3) Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass;

iv(4) Increase air filtration to as high as possible in a manner that will still enable the system to provide airflow rates as the system design requires. Ensure compliance with higher filtration values is allowed by the air handler manufacturer's installation instructions and listing;

v(5) Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials;

vi(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

vii(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

viii(8) If the system's design can accommodate such an adjustment and is allowed by the air handler manufacturer's installation instructions and listing, improve central air filtration to MERV-13 and seal edges of the filter to limit bypass;¹⁷and

¹⁷ <https://www.ashrae.org/technical-resources/filtration-disinfection#iso>

~~ix~~(9) Check filters to ensure they are within service life and appropriately installed.

c. Comply with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards.

2. Where feasible, employers shall Install physical barriers (e.g., such as clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission.

AMENDMENT – CM

16VAC25-220-60.C.1.e and f, Requirements for hazards or job tasks classified as medium exposure risk.

e. Increase physical distancing between employees at the worksite to ~~six feet~~ close contact.

f. Increase physical distancing between employees and other persons, including customers, to ~~six feet~~ close contact (e.g., drive-through physical barriers) where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission, etc.

Department Response: The Department does not support the proposed amendment.

C. Administrative and work practice controls.

1. To the extent feasible, employers shall implement the following administrative and work practice controls:

- a. Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19.
- b. Provide face coverings to non-employees suspected to be infected with SARS-CoV-2 non-employees to contain respiratory secretions until the non-employees are able to leave the site (i.e., for medical evaluation and care or to return home).
- c. Implement flexible worksites (e.g., telework).
- d. Implement flexible work hours (e.g., staggered shifts).
- e. Increase physical distancing between employees at the worksite to six feet.
- f. Increase physical distancing between employees and other persons, including customers, to six feet (e.g., drive-through physical barriers) where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission, etc.

DEPARTMENT NOTE: This provision moved to 16VAC25-220-60.A.2 as it is an engineering control. Comment 85910.

~~g. To the extent feasible, install physical barriers (e.g., such as clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission.~~

~~h-g.~~ Implement flexible meeting and travel options (e.g., using telephone or video conferencing instead of in person meetings; postponing non-essential travel or events; etc.).

ih. Deliver services remotely (e.g. phone, video, internet, etc.).

ji. Deliver products through curbside pick-up or delivery.

kj. ~~Require e-E~~ Employers ~~to shall~~ provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.

kk. ~~Require e-E~~ Employers ~~to shall~~ provide and require employees in customer or other person facing jobs to wear face coverings.

D. Personal protective equipment.

1. Employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132) shall comply with the following requirements for a SARS-CoV-2 virus and COVID-19 disease-related hazard assessment and personal protective equipment selection:

a. ~~The e-E~~ Employers shall assess the workplace to determine if SARS-CoV-2 or COVID-19 hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE). ~~The e-E~~ Employers shall provide for employee and employee representative involvement in the assessment process. If such hazards or job tasks are present or likely to be present, ~~the employers~~ shall:

i. Except as otherwise required in the standard, select and have each affected employee use the types of PPE that will protect the affected employee from the

SARS-CoV-2 virus or COVID-19 disease hazards identified in the hazard assessment;

ii. Communicate selection decisions to each affected employee; and

iii. Select PPE that properly fits each affected employee.

2. The employer shall verify that the required SARS-CoV-2 virus and COVID-19 disease workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date of the hazard assessment; and the document as a certification of hazard assessment.

3. Unless specifically addressed by an industry specific standard applicable to the employer and providing for PPE protections to employees from the SARS-COV-2 virus or COVID-19 disease (e.g., 16VAC25-175-1926, 16VAC25-190-1928, 16VAC25-100-1915, 16VAC25-120-1917, or 16VAC25-130-1918), the requirements of 16VAC25-90-1910.132 (General requirements) and 16VAC25-90-1910.134 (Respiratory protection) shall apply to all employers for that purpose.

4. PPE ensembles for employees in the medium exposure risk category will vary by work task, the results of the employer's hazard assessment, and the types of exposures employees have on the job.

AMENDMENT – AJ

16VAC25-220-60.D.5, Requirements for hazards or job tasks classified at medium exposure risk.

Where employees are required to wear respiratory protection for a hazard other than COVID-19 such as silica or asbestos, substituting a surgical mask or face covering is not appropriate. The employer must make reasonable efforts to acquire and use other types of respirators that offer the same or higher protection than the filtering facepiece respirator. This may include an N100 disposable respirator, a nondisposable elastomeric cartridge respirator, or a tight-fitting or loose fitting powered air purifying respirator when disposable N95s are not available.

AJ: I am still very concerned about the early provision that employers don't have to provide PPE if it is not available on commercially feasible terms if they show good faith. In particular, I am referring to respiratory protection. What I see in the field is that masons and concrete workers are wearing face coverings rather than respirators. I do not think this is appropriate. OSHA guidance language is not so generous. I am suggesting that we insert the following language in 60.D.4 or 5 to at least clarify that this is not acceptable and that you can't just say they don't have an N95 or it costs too much.... You can certainly see why switching to a more expensive respirator could fall into your "commercially reasonable terms," particularly if this term is not defined.

Department Response: The Department does not believe the amendment is necessary in its current form and may cause confusion. The ETS and the Draft Final Standard only apply to workplace exposures involving employee exposure to SARS-CoV-2 and COVID-19. It is the position of the Department that this standard cannot override existing VOSH/OSHA standards and regulations applicable to other occupational hazards, such as exposure to silica. In the instance of silica, employers must comply with VOSH standards applicable to hazards associated with occupational exposure to silica without any consideration to the provisions of this standard.

16VAC25-220-70. Infectious disease preparedness and response plan.

A. Employers with hazards or job tasks classified as:

1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan;
2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.

B. The plan and training requirements tied to the plan shall only apply to those employees classified as very high, high, and medium covered by this section.

C. Employers shall designate a person to be responsible for implementing their plan. The plan shall:

1. Identify the name or title of the person responsible for administering the plan. This person shall be knowledgeable in infection control principles and practices as the principles and practices apply to the facility, service, or operation.
2. Provide for employee involvement in development and implementation of the plan.
3. Consider and address the level of SARS-CoV-2 virus and COVID-19 disease risk associated with various places of employment, the hazards employees are exposed to at those sites, and job tasks employees perform at those sites. Such considerations shall include:

- a. Where, how, and to what sources of the SARS-CoV-2 virus or COVID-19 disease might employees be exposed at work, including:

i. (1) The general public, customers, other employees, patients, and other persons;

ii. (2) Persons known or suspected to be infected with the SARS-CoV-2 virus persons or those at particularly high risk of COVID-19 infection (e.g., local, state, national, and international travelers who have visited locations with ongoing COVID-19 community transmission and healthcare employees who have had unprotected exposures to persons known or suspected to be infected with SARS-CoV-2 virus persons); and

iii. (3) Situations where employees work more than one job with different employers and encounter hazards or engage in job tasks that present a very high, high, or medium level of exposure risk; and

iv. Situations where employees work during higher risk activities involving potentially large numbers of people or enclosed work areas such as at large social gatherings, weddings, funerals, parties, restaurants, bars, hotels, sporting events, concerts, parades, movie theaters, rest stops, airports, bus stations, train stations, cruise ships, river boats, airplanes, etc.¹⁸

AJ: [In reference to the below phrase “b. To the extent permitted by law, including HIPAA, employees’ individual risk factors for severe disease.”] This is not a sentence.

Department Response: The below phrase has to be read in conjunction with 16VAC25-220-70.C.3 which starts “Such considerations shall include: b. To the

¹⁸ <https://www.vdh.virginia.gov/coronavirus/coronavirus/travel-to-areas-with-widespread-ongoing-community-spread/>

<https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>

extent permitted by law, including HIPAA, employees' individual risk factors for severe disease.

b. To the extent permitted by law, including HIPAA, employees' individual risk factors **for severe disease**. For example, people of any age with one or more of the following conditions are at increased risk of severe illness from COVID-19: chronic kidney disease; COPD (chronic obstructive pulmonary disease); immunocompromised state (weakened immune system) from solid organ transplant; obesity (body mass index or BMI of **430**¹⁹ or higher); serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; sickle cell disease; or type 2 diabetes mellitus). Also, for example, people with one or more of the following conditions might be at an increased risk for severe illness from COVID-19: asthma (moderate-to-severe); cerebrovascular disease (affects blood vessels and blood supply to the brain); cystic fibrosis; hypertension or high blood pressure; immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines; neurologic conditions, such as dementia; liver disease; pregnancy; pulmonary fibrosis (having damaged or scarred lung tissues); smoking; thalassemia (a type of blood disorder); type 1 diabetes mellitus; etc.). **The risk for severe illness from COVID-19 also increases with age.**²⁰

¹⁹ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

²⁰ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>

- c. Engineering, administrative, work practice, and personal protective equipment controls necessary to address those risks.
4. Consider and address contingency plans for situations that may arise as a result of outbreaks and impact employee safety and health, such as:
- a. Increased rates of employee absenteeism (an understaffed business can be at greater risk for accidents),²¹
 - b. The need for physical distancing, staggered work shifts, downsizing operations, delivering services remotely, and other exposure-reducing workplace control measures such as elimination and substitution, engineering controls, administrative and work practice controls, and personal protective equipment; (e.g., respirators, surgical/medical procedure masks, etc.);
 - c. Options for conducting essential operations in a safe and healthy manner with a reduced workforce, including cross-training employees across different jobs in order to continue operations or deliver surge services; and
 - d. Interrupted supply chains or delayed deliveries of safety and health related products and services essential to business operations.

²¹ <https://smallbusiness.chron.com/absenteeism-affect-safety-workplace-62089.html>

AMENDMENT – AJ

16VAC25-220-70.C.5.c, Infectious disease preparedness and response plan.

c. Establish policies and procedures for managing and educating visitors to the procedures at the place of employment.

5. Identify basic infection prevention measures to be implemented:

a. Promote frequent and thorough hand washing, including by providing employees, customers, visitors, the general public, and other persons to the place of employment with a place to wash their hands. If soap and running water are not immediately available, provide hand sanitizers.

b. Maintain regular housekeeping practices, including routine cleaning and disinfecting of surfaces, equipment, and other elements of the work environment.

c. Establish policies and procedures for managing and educating visitors to the place of employment.

6. Provide for the prompt identification and isolation of employees known or suspected to be infected with the SARS-CoV-2 virus employees away from work, including procedures for employees to report when they are experiencing signs and/or symptoms of COVID-19.

7. Address infectious disease preparedness and response with outside businesses, including, but not limited to, subcontractors who enter the place of employment,

businesses that provide ~~or~~ contract or temporary employees to the employer, and other persons accessing the place of employment to comply with the requirements of this standard and the employer's plan.

8. Identify the mandatory and non-mandatory recommendations in any CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard, as provided for in 16VAC25-220-10 G 1 and G 2.

~~9. Ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency related to the SARS-CoV-2 virus or COVID-19 disease.~~

16VAC25-220-80. Training.

A. Employers with hazards or job tasks classified as very high, high, or medium exposure risk at a place of employment shall provide training on the hazards and characteristics of the SARS-CoV-2 virus and COVID-19 disease to all employees working at the place of employment regardless of employee risk classification. The training program shall enable each employee to recognize the hazards of the SARS-CoV-2 virus and signs and symptoms of COVID-19 disease and shall train each employee in the procedures to be followed in order to minimize these hazards.

B. The training required under subsection A shall include:

1. The requirements of this standard;

AMENDMENT – AJ

16VAC25-220-80.B.2 Training.

2. The mandatory and non-mandatory ~~recommendations~~ provisions in any applicable CDC guidelines....

2. The mandatory and non-mandatory recommendations provisions in any CDC guidelines or State Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this standard as provided for in section 16VAC25-220-10 EG 1 and EG 2;

3. The characteristics and methods of transmission of the SARS-CoV-2 virus;

4. The signs and symptoms of the COVID-19 disease;

5. Risk factors of for severe COVID-19 illness with including underlying health conditions and advancing age;

6. Awareness of the ability of persons pre-symptomatically and asymptomatically infected with SARS-CoV-2 COVID-19 persons to transmit the SARS-CoV-2 virus;

7. Safe and healthy work practices, including but not limited to, physical distancing, the wearing of face coverings; disinfection procedures, disinfecting frequency, ventilation, noncontact methods of greeting, etc.;

8. Personal protective equipment (PPE):

a. When PPE is required;

- b. What PPE is required;
- c. How to properly don, doff, adjust, and wear PPE;
- d. The limitations of PPE;
- e. The proper care, maintenance, useful life, and disposal of PPE; and
- f. Strategies to extend PPE usage during periods of limited supply; and

AMENDMENT – TT

16VAC25-220-80.B.8.f, TRAINING.

(f) Strategies to extend PPE usage during periods when supplies are not available and no other options are available for protection, as long as the extended use of the PPE does not pose any increased risk of exposure. The training to extend PPE usage shall include the conditions of extended PPE use, inspection criteria of the PPE to determine whether it can or cannot be used for an extended period, and safe storage requirements for PPE used for an extended period.

f.g. Heat-related illness prevention including the signs and symptoms of heat-related illness associated with the use of COVID-19 PPE and face coverings;

9. The anti-discrimination provisions in 16VAC25-220-90; and

10. The employer's Infectious Disease Preparedness and Response Plan, where applicable.

AMENDMENT – AJ

16VAC25-220-80.C, Training.

<p>C. Employers covered by 16VAC25-220-50 shall verify compliance with 16VAC25-220-80 A by preparing a written certification record for those employees exposed to hazards or job tasks classified as very high, high, or medium exposure risk levels.</p>
<p>AJ: I missed this in the ETS that it only applied to very high and high not medium. So they do not have to keep any training records? That is silly and it should apply to all in required to train in accordance to section 80A.</p>
<p>Department Response: The Department does not support the amendment.</p>

C. Employers covered by 16VAC25-220-50 shall verify compliance with 16VAC25-220-80 A by preparing a written certification record for those employees exposed to hazards or job tasks classified as very high, high, or medium exposure risk levels.

1. The written certification record shall contain:

a. The name or other unique identifier of the employee trained,

b. The trained employee's physical or electronic signature,

c. The date of the training, and

d. ~~t~~The name of the person who conducted the training, or for computer-based training, the name of the person or entity that prepared the training materials.

2. A physical or electronic signature is not necessary if other documentation of training completion can be provided (e.g., electronic certification through a training system; security precautions that enable the employer to demonstrate that training was accessed by passwords and usernames unique to each employee, etc.).

AJ: [With regard to 16VAC220-80.D.3 below] These provisions are not significantly different from the provisions of the ETS so employers who complied with the ETS in August should not have to prove that the training was adequate. This is a punishment for those who actually complied with the ETS.

3. If ~~the~~ an employer relies on training conducted by another employer or completed prior to the effective date of this standard, the certification record shall indicate the date the employer determined the prior training was adequate rather than the date of actual training.

D4. The latest training or retraining certification shall be maintained.

E. When the an employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required by 16VAC25-220-80 A, the employer shall retrain each such employee. Circumstances where retraining is required include, but are not limited to, situations where:

1. Changes in the workplace, SARS-CoV-2 virus or COVID-19 disease hazards exposed to, or job tasks performed render previous training obsolete;
2. Changes are made to the employer's Infectious Disease Preparedness and Response Plan; or
3. Inadequacies in an affected employee's knowledge or use of workplace control measures indicate that the employee has not retained the requisite understanding or skill.

F. Employers with hazards or job tasks classified at lower risk shall provide written or oral information to employees exposed to such hazards or engaged in such job tasks on the hazards and characteristics of SARS-COV-2 and the symptoms of COVID-19 and measures to minimize exposure. The Department of Labor and Industry shall develop an information sheet containing information on the items listed in subsection G, which an employer may utilize to comply with this subsection.

G. The information required under subsection F shall include at a minimum:

1. The requirements of this standard;
2. The characteristics and methods of transmission of the SARS-CoV-2 virus;
3. The signs and symptoms of the COVID-19 disease;
4. The ability of persons, pre-symptomatically and asymptomatically infected with SARS-CoV-2 COVID-19 persons to transmit the SARS-CoV-2 virus;

5. Safe and healthy work practices and control measures, including but not limited to, physical distancing, the benefits of wearing face coverings, sanitation and disinfection practices; and

6. The anti-discrimination provisions of this standard in 16VAC25-220-90.

16VAC25-220-90. Discrimination against an employee for exercising rights under this standard is prohibited.

A. No person shall discharge or in any way discriminate against an employee because the employee has exercised rights under the safety and health provisions of this standard, Title 40.1 of the Code of Virginia, and implementing regulations under 16VAC25-60-110 for themselves or others.

AMENDMENT: AJ

16VAC25-220-90.B, Discrimination against an employee for exercising rights under this standard is prohibited.

AJ: [With regard to the above sentence “No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees.] I am concerned that this may affect the employer’s ability to prevent employees from wearing face coverings that are political, sexist, racist, or obscene. I have clients who have experienced these problems.

Department Response: The Department recommends the following revised language:

In situations where face coverings are not provided by the employer, ~~no~~ no person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering that meets the requirements of this standard, provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees. Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings.

B. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own personal protective equipment, including but not limited to a respirator, face shield, gown, or gloves, or face covering if such equipment is not provided by the employer, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. No person shall discharge or in any way discriminate against an employee who voluntarily provides and wears the employee's own face covering,

provided that the face covering does not create a greater hazard to the employee or create a serious hazard for other employees.

AMENDMENT: CM

16VAC25-220-90.C, Discrimination against an employee for exercising rights under this standard is prohibited.

C. No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer's agent, other employees, or a government agency, ~~or to the public such as through print, online, social, or any other media.~~

Department Response: The Department does not support the proposed amendment.

The current language reflects current case law on the topic.

C. No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer's agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

AMENDMENT: CM

16VAC25-220-90.D, Discrimination against an employee for exercising rights under this standard is prohibited.

D. Nothing in this standard shall limit an employee from refusing to do work or enter a location that ~~the employee feels~~ is unsafe. ~~However, employees should familiarize themselves with The requirements of 16VAC25-60-110, which contains~~ provide the applicable requirements concerning discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of injury or death.

D. Nothing in this standard shall limit an employee from refusing to do work or enter a location that the employee feels is unsafe. However, employees should familiarize themselves with 16VAC25-60-110, which contains the requirements concerning discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of injury or death.



COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

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January 10, 2021

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM
DRAFT FINAL PERMANENT STANDARD FOR INFECTIOUS DISEASE PREVENTION
OF THE SARS-COV-2 WHICH CAUSES COVID-19,
16VAC25-220

DEPARTMENT STANDARD RESPONSES TO ISSUES RAISED
BY PUBLIC COMMENTERS

Background

The Department received 238 written comments through the Virginia Regulatory Townhall for the 30 day written comment period from December 10, 2020 to January 9, 2021.

There were 21 written comments sent directly to the Department during the 30 day written comment period, although a number of those were also posted by the Commenter on the Virginia Regulatory Townhall.

There were 24 oral comments received during the public hearing on January 5, 2020.

Broadly speaking, the comments can be divided into those who supported the standard and those who opposed the standard. A standard Department response was developed for the following categories:

“Supports”	Comment 87825 (see page 3)
“Opposed with no substantive comments”	Comment 87834 (see page 14)

For each of the above, the Department’s response is provided once in detail and then thereafter a reference back to the initial Department response was provided (e.g. SEE DEPARTMENT RESPONSE TO COMMENT 87825)

COMMENTS POSTED ON THE VIRGINIA REGULATORY TOWNHALL

87810 Kris Manning 12/14/2020 kmanning23@gmail.com

Reporting requirements for 2 or more cases at a worksite (page 24) Item d. indicates that an employer must report two or more confirmed cases of COVID-19 to the VA Dept of Health within 24 hours of becoming aware of such cases, but there is no duration provided. Meaning, are these two cases within a 24-hour period, a week, a 14-day period, a year? Please provide clarity on a duration.

"DOLI is recommending to the Board the following revision to 16VAC25-220-40.B.8.d [notification to VDH of positive cases] in the final standard:

d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp;" (Emphasis added).

87811 Kris Manning 12/14/2020 kmanning23@gmail.com

Termination of the standard Based upon our interpretation of the standard, it appears that only the employer's classification of risk exposure would determine when (if ever) the requirements of this standard would no longer apply. Is the intent to have workers within the same industry or even across industries to act differently (relative to masks, socially distancing, etc.) based upon every employer's interpretation. It would seem prudent to have an end date of this legislation that could be extended as applicable based upon the state (or county) COVID-19 numbers. As written, some workers could be in masks forever. Please clarify

The Revised Proposed Standard, 16VAC25-220-40.B, provides that:

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

The Standard also provides in 16VAC25-220-10.D.1 provides in part:

D. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard.

While employers are required to conduct the risk assessment, that determination is subject to review by the VOSH program as to whether the assessment was conducted in a reasonable fashion in accordance with the requirements of the standard.

Some commenters were under the impression that the Standard was being proposed as legislation to the General Assembly. That is incorrect. The Standard is being considered for adoption by the Virginia Safety and Health Codes Board pursuant to Va. Code §40.1-22(6a) and would be enforced by the Department of Labor and Industry's (DOLI) Virginia Occupational Safety and Health (VOSH) Program.

DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

87825 Melanie Smith 2020/12/16 19:47:59 melscofam@gmail.com

Protect Workers Thank you for proposing this permanent standard to protect Virginia's workers. Please adopt the proposed permanent standard before the temporary standard ends.

The Department agrees with the Commenter's position that a permanent standard is needed.

The VOSH program has clear statutory and regulatory jurisdiction over workplace safety and health issues in the Commonwealth, including the potential for spread of infectious diseases among employees and employers, and when those employees and employers are potentially exposed to other persons who may be carriers of the infectious diseases (patients, customers, independent contractors, etc.).

While the Virginia Department of Health (VDH) has some statutory and regulatory responsibilities in certain industries (restaurant permitting, temporary labor camp permitting, nursing home licensing, etc.), its primary focus is public safety, customer safety and patient safety. VDH has very limited and in some cases no enforcement options when it comes to requiring many of Virginia's industries to limit the spread of SARS-CoV-2 among employees and employers in the workplace.

In such cases where VDH does intervene in a workplace setting that does not fall under its jurisdiction, it will attempt to obtain the employer's agreement with Governor's Executive Orders, but it does not attempt to obtain the employer's agreement to comply with VOSH laws, standards, and regulations, such as VOSH's COVID-19 ETS or other applicable VOSH standards and regulations (e.g., personal protective equipment, respiratory protective equipment, etc.).

In cases where either an employer refuses to comply with Governor's Executive Orders or VDH suspects potential violations of VOSH laws, standards and regulations, it will make a referral to VOSH for either an informal investigation or an onsite inspection. Accordingly, it is neither legal nor appropriate from a policy standpoint for VOSH to cede jurisdiction to VDH to handle all COVID-19 issues.

The states of Virginia, Washington, Michigan, Oregon and California have adopted COVID-19 related workplace safety and health regulations.

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. Please note that DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The new language in 16VAC25-220.C requires the Board to make a "determination" of whether there is continued need for the standard. The Department has identified three "determination" options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

With regard to the phrase "notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to," the intent of the language is to give the Board the maximum amount of flexibility to "notice" the Board meeting within 14 days even if the Board may not actually meet within 14 days

There is substantial scientific evidence and infection, hospitalization and death statistics that support the conclusion that SARS-CoV-2 presents a danger to employees in the workplace.

It is the Department's position that the danger posed to employees and employers by the SARS-CoV-2 virus and COVID-19 disease are necessary and appropriate to regulate after the expiration of the current COVID-19 Emergency Temporary Standard (ETS) on January 26, 2021. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. It is well recognized that one or more vaccines will not be widely available to the public and employees until well after January 26, 2021.

The Department also believes that the Standard will ultimately help businesses to grow and bring customers back when those customers see that employers are providing employees with appropriate protections required by the Standard from SARS-CoV-2. If customers don't feel safe because employees don't feel safe, it will be hard for a business to prosper in a situation where there is ongoing community spread.

With regard to any conflicts identified between Governor's Executive Orders and the standard would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

The Department is recommending an expanded time for employee training from 30 days to 60 days in response to employer concerns expressed during multiple public comment opportunities about the ability to develop and provide effective training to management personnel and employees in 30 days. The Department does not believe the request is unreasonable in light of the unprecedented nature of the pandemic and the need for employers to modify orientation and training materials for new hires and retraining materials for current employees. In addition, new businesses are being opened on a regular basis and should be afforded a sufficient time to develop and provide training. The Department does not intend to change its recommendation in response to the comment.

The VOSH Program follows OSHA's April 3, 2020 Memorandum entitled "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" which "outlines enforcement discretion to permit the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer's recommended shelf life (sometimes referred to as "expired")."

The VOSH Program also follows OSHA's April 24, 2020 Memorandum entitled "Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic."

The standard does not roll protections by allowing "face coverings" when respirators are needed in certain circumstances. 16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase “no enforcement action” to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, “if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms.” The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

At the request of VDH, the Department proposed changing the COVID-19 case reporting requirement threshold from one case to two cases so that it aligned with current statutory/regulatory/procedural VDH reporting requirements. The lower reporting threshold was negatively impacting VDH’s ability to effectively and efficiently use its limited employee resources and caused some confusion in the regulated community. The Department does not intend to change its recommendation in response to the comment.

The Department acknowledges that all of its VOSH laws, standards and regulations can serve to place compliance burdens on employers and employees, particularly in the small business sector. The Department also believes that employers that embrace providing sound and comprehensive workplace safety and health protections can make their business more efficient and profitable through such benefits as reduced injuries, illnesses and fatalities, reduced workers’ compensation costs, reduced insurance costs, improvements in morale and innovation, and increased productivity.

Review of all COVID-19 related inspections under the Emergency Temporary Standard is conducted centrally by the Department with both a programmatic and legal review prior to a decision to issue or not issue violations/penalties to assure consistent enforcement across the Commonwealth. The Department does not anticipate any significant increase in litigation with regard to the Emergency Temporary Standard or any permanent standard.

The Department strongly encourages Virginia’s small business owners to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

In addition, free Outreach, Training, and Educational materials to assure compliance with COVID-19 requirements can be found at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA."

The proposed permanent standard has been subject to the following notice and comment procedures. The Virginia Safety and Health Codes Board held a 60 day written comment period for the Proposed Permanent Standard, with the comment period running from August 27, 2020 to September 25, 2020. The Board held a Public Hearing on September 30, 2020. A revised draft of the Proposed Permanent Standard was published on December 10, 2020 with an additional 30 day comment period (from December 10, 2020 to January 9, 2021) prior to any Board action. A public hearing was held on January 5, 2021. An economic impact analysis/cost analysis will be prepared and posted no later than January 11, 2021. A draft final standard with changes recommended by DOLI in response to all comments received to date was posted on January 4, 2021, with any final changes recommended by DOLI to be posted by January 11, 2021. A meeting of the Board to consider for adoption a final standard is scheduled for January 12, 2021 with possible continuation dates of January 13, 2021 and January 19, 2021.

Economic Impact Analysis.

An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04 will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.

The Department does not intend to recommend that the Safety and Health Codes Board hold an additional comment period solely for the purpose of comment on the EIA.

Many of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in various Governor's Executive Orders, including most recently Executive Order 72. To the extent that a requirement is included in both Executive Orders and the standard, the Department does not consider the standard to impose any new cost burden on a covered locality.

In addition, many of the costs associated with dealing with workplace hazards associated with COVID-19 are the result of requirements contained in current federal OSHA or VOSH unique standards and regulations already applicable to local governments, and therefore the Department does not considered them to be new costs associated with adoption of the standard.

Following are federal OSHA identical and state unique standards and regulations applicable in the Construction Industry, Agriculture Industry, Maritime Industry (public sector employment only as OSHA retains jurisdiction over private sector employment in Virginia), and General Industry ("General Industry" covers all employers not otherwise classified as Construction, Agriculture, or Maritime) that can be used in certain situations to address COVID-19 hazards in the workplace:

General Industry

- 1910.132, Personal Protective Equipment in General Industry (including workplace assessment)
- 1910.133, Eye and Face Protection in General Industry
- 1910.134, Respiratory Protection in General Industry
- 1910.138, Hand Protection
- 1910.141, Sanitation in General Industry (including handwashing facilities)
- 1910.1030, Bloodborne pathogens in General Industry

- 1910.1450, Occupational exposure to hazardous chemicals in laboratories in General Industry

Construction Industry

- 1926.95, Criteria for personal protective equipment in Construction
- 1926.102, Eye and Face Protection in Construction
- 1926.103, Respiratory Protection in Construction
- 16VAC25-160, Sanitation in Construction (including handwashing facilities)

Agriculture

- 16VAC25-190, Field Sanitation (including handwashing facilities) in Agriculture

Public Sector Maritime

- 1915.152, Shipyard Employment (Personal Protective Equipment)
- 1915.153, Shipyard Employment (Eye and Face Protection)
- 1915.154, Shipyard Employment (Respiratory Protection)
- 1915.157, Shipyard Employment (Hand and Body Protection)
- 1917.127, Marine Terminal Operations (Sanitation)
- 1917.92 and 1917.1(a)(2)(x), Marine Terminal Operations (Respiratory Protection, 1910.134)
- 1917.91, Marine Terminal Operations (Eye and Face Protection)
- 1917.95, Marine Terminal Operations (PPE, Other Protective Measures)
- 1918.95, Longshoring (Sanitation)
- 1918.102, Longshoring (Respiratory Protection)
- 1918.101, Longshoring (Eye and Face Protection)

Multiple Industries

- 16VAC25-220, Emergency Temporary Standard in General Industry, Construction, Agriculture and Public Sector Maritime
- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture and Public Sector Maritime
- 1910.142, Temporary Labor Camps (including handwashing facilities) in Agriculture and General Industry
- 1910.1020, Access to employee exposure and medical records in General Industry, Construction, and Public Sector Maritime (excludes Agriculture)
- 1910.1200, Hazard Communication in General Industry, Construction, Agriculture and Public Sector Maritime

• 16VAC25-60-120 (General Industry), 16VAC25-60-130 (Construction Industry), 16VAC25-60-140 (Agriculture), and 16VAC25-60-150 (Public Sector Maritime), Manufacturer's specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment (can be used to apply to operation and maintenance of air handling systems in accordance with manufacturer's instructions)

In addition, Va. Code §40.1-51.1.A, provides that:

“ A. It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.”

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer’s requirements, requirements of the Centers for Disease Control (CDC), or an employer’s safety and health rules.

To the extent that the general duty clause could be used by the Department to address COVID-19 workplace hazards to the same extent as and in the same manner as the standard were the standard not in effect, the Department does not consider any of the costs associated with such use of the clause to be new costs associated with adoption of the standard.

The Department acknowledges that, as it predicted back in June and July of this year in its presentations to the Safety and Health Codes Board, that the COVID-19 pandemic could get much worse before it got better, which was a major reason for recommending adoption of an ETS. The Department notes the following statistics which are also highlighted in the January 4, 2021 Briefing Package for the Board beginning on page 36:

As of December 22, 2020, Virginia ranked 45th in state rankings for total cases per 100K. The Virginia border states of Tennessee, Kentucky, North Carolina, Maryland, and West Virginia, none of which has an ETS, rank higher than Virginia:

7 - Tennessee

29 - Kentucky

39 - North Carolina

42 - Maryland

43 - West Virginia

45 – Virginia

As of December 26, 2020, Virginia ranked 30th in state rankings for average daily cases per 100K in last seven days. The Virginia border states of Tennessee, Kentucky, North Carolina, and West Virginia, none of which has an ETS, rank higher than Virginia. The only border state that outperformed Virginia in this metric was Maryland:

1 - Tennessee

6 - West Virginia

19 - North Carolina

25 - Kentucky

30 - Virginia

39 – Maryland

The Department is not suggesting that the ETS is the sole reason for Virginia's significantly better performance on key COVID-19 indicators than many other states. There are many factors that go into such an evaluation, not the least of which is the impact of Governor's Executive Orders and the commitment of Virginia's citizens, employers and employees to follow safe and health practices and implementing sound mitigation strategies.

While VOSH is charged with assuring the protection of Virginia employees from occupational safety and health hazards, it has a long history of working cooperatively with employers to achieve that protection. It also has the legal authority to enforce applicable laws, standards, regulations and executive orders in situations where employers decide they do not want to take advantage of a cooperative working relationship.

COVID-19 related employee complaints received by the VOSH program that are within VOSH's jurisdiction are being addressed with employers. In an abundance of caution, at the beginning of the COVID-19 outbreak in Virginia the Department decided to modify its normal complaint processing procedures for both the safety and health of the employees at the work sites and its VOSH compliance officers by trying to limit exposure to the virus as much as possible while carrying out statutory enforcement mandates.

Rather than conducting a combination of onsite inspections and informal investigations as is the case under normal situations, COVID-19 complaints were initially handled through the VOSH program's complaint investigation process, which involves contacting the employer by phone, fax, email, or letter.

VOSH informed the employer of the complaint allegation and required a written response concerning the validity of the complaint allegation, any safety and health measures taken to date to protect employees against potential COVID-19 related hazards, and any measures to be taken in response to valid complaint allegations.

Employers were required to post a copy of VOSH's correspondence where it would be readily accessible for review by employees; and provide a copy of the correspondence and the employer's response to a representative of any recognized union or safety committee at the facility. Complainants were provided a copy of the employer's response.

Depending on the specific facts of the employee's alleged complaint, an employer's failure to respond or inadequate response could result in additional contact by the VOSH program with the employer, a referral to local law enforcement officials, an onsite VOSH inspection, or other enforcement options available to the VOSH program.

COVID-19 "Inspections"

- Can result in violations and substantial penalties
- Inspections are opened for COVID-19 related employee deaths
- Inspections may be opened for COVID-19 related hospitalizations or handled through an investigation

- Inspection files with proposed violations will be reviewed by Headquarters and receive a legal review before a decision to issue or not issue is made

Since February, 2020, the Virginia Workers' Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020 in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has received 1,537 employee complaints and referrals from other government agencies (over 800 complaints since the effective date of the ETS). It has received notifications of 30 COVID-19 related employee deaths and 61 employee hospitalizations. To date, VOSH has opened 103 inspections, a number of which resulted from employers not taking advantage of either working cooperatively with the Virginia Department of Health, or not taking advantage of VOSH's informal investigation process, which does not result in citations and penalties, provided the employer provides a satisfactory response.

Of the first 94 inspections conducted by VOSH, 43 remained under investigation as of January 4, 2021, 25 were closed with no violations issued, and 26 resulted in the issuance of violations (29 serious and 29 other-than-serious violations) and a total of \$226,780.00 in penalties.

87826 H-R-Living Wage Campaign 2020/12/16 19:53:25 rsanders97@verizon.net

Make Temporary Standards Permanent I believe that the temporary standards should be made permanent for workers. They should be given every consideration when it comes to Personal Protection Equipment in order to continue to carry-out their essential worker status.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87827 Pamela Tetro NP, UVA Geriatrics Services 2020/12/16 21:08:02 wingspan15@yahoo.com

Safety standard for workers Dear powers that be, in order to be a more compassionate and caring people; Virginia needs to adapt worker safety standards during times of the pandemic and also permanently; Beyond the pandemic. There also needs to be sick day pay permanently established in the state of Virginia and pandemic pay standards. We need to be thoughtful about this current pandemic and those in the future. it is only right. If you think it's wrong, think about the impact of decreasing diseases in your own home/Community and reduction of your own illness risk.

Do the right thing. Pamela

SEE DEPARTMENT RESPONSE TO COMMENT 87825

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at:
<https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

The Consolidated Appropriations Act (CAA 2021) was signed into law on December 27, 2020. “The CAA 2021 allows FFCRA-covered employers to voluntarily extend two types of emergency paid leaves through March 31, 2021 that were originally mandated between April 1, 2020 and December 31, 2020 by the Families First Coronavirus Response Act (FFCRA). These FFCRA leaves are Emergency Paid Sick Leave (EPSL) and Emergency Family and Medical Leave (EFMLA).

The FFCRA provided up to 10 days of EPSL, with varying levels of pay, for any of six COVID-19 qualifying reasons between April 1, 2020 and December 31, 2020. Carryover of unused EPSL into 2021 was not allowed under the FFCRA—at least not as originally written.

The CAA 2021, however, amends the carryover provision of EPSL. Employers may now voluntarily choose to permit the carryover of unused 2020 EPSL into the first quarter of 2021. If they do, EPSL tax credits associated with this paid leave can be taken through March 31, 2021. The tax credits are an incentive for FFCRA-covered employers to choose to carryover unused EPSL.

It is important to note that the CAA 2021 does not provide employees with additional EPSL. Employees who emptied their EPSL tank of 10 days in 2020 have nothing to carry over into the first quarter of 2021 should their employers decide to allow EPSL carryover. The CAA 2021 merely extends the tax credit available to private employers under the FFCRA, and does not create new EPSL leave.

<https://www.jdsupra.com/legalnews/extension-of-emergency-ffcra-leaves-21991/>

87828 Anonymous 2020/12/16 21:14:27 pjonese19@icloud.com

Human Rights Day working can represent slavery when we disrespect those whose jobs are so important to us!!

SEE DEPARTMENT RESPONSE TO COMMENT 87825

The Department has no response to the Commenter's political commentary.

87829 Grace Risetto 2020/12/16 21:20:21 gracerisetto@yahoo.com

permanent safety standards to protect Virginia’s workers against COVID & support Paid Sick Days. Thank you for proposing this permanent standard to protect Virginia's workers.

Please adopt the proposed permanent standard before the temporary standard ends. Please support and adopt the passage of a Paid Sick Day standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87830 Jennie Waering 2020/12/17 0:26:08 Jwaering1102@gmail.com

Please protect Virginia's workers Thank you for proposing this permanent standard to protect Virginia's workers. I am writing to support the permanent safety standard for Virginia's workers. The proposed permanent standard builds on the temporary standard, incorporating the latest information about the virus. Please adopt the proposed permanent standard before the temporary standard ends. Thank you, Jennie Waering, J.D.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87831 Wayne S Teel 2020/12/17 5:11:23 teelws@jmu.edu

worker safety Covid-19 is a wake up call telling us that we do not have any adequate response to a broad health care emergency. Much of it was due to having inadequate worker safety standards in place that employers were required to follow. Employers naturally cut costs often at the expense of workers. Workers need regulatory protection or they become vulnerable if accepted epidemiological standards are not followed. Therefore we need to mandate that the standards developed with learning from Covid-19 are followed in future events. I strongly encourage you to work with the CDC (under Biden, not Trump) and develop these worker safety standard to keep workers safe during pandemics.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87832 Kathleen Temple 2020/12/17 5:37:58 templekj@comcast.net

To protect workers I am grateful to Governor Northam and the Department of Labor and Industries (DOLI) staff, led by Ray Davenport, for their fine work on the critical standard which provides health and safety workplace regulations to protect employees against COVID-19. The proposed permanent standard builds on the temporary standard, incorporating the latest information about the virus. The Commonwealth of Virginia will be stronger when the regulations to protect employees are made permanent.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87833 Maria Clymer Kurtz 2020/12/17 7:05:17 mariacllymerkurtz@gmail.com

adopt permanent safety standard for Virginia workers A permanent standard to protect Virginia's workers must be adopted as soon as possible. This critical measure will slow the spread of COVID-19 and help our economy continue to rebound. Please adopt the proposed permanent standard before the temporary standard ends. Thank you.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

Emergency Temporary Standard, Infectious Disease Prevention, SARS-CoV-2 Virus That Causes COVID-19/P It is my opinion the Virginia ETS, although well-intentioned, was borne of panic, and no other state I am aware of promulgated similar standards. The recent increase in COVID-19 cases in Virginia is reportedly a result of social gatherings over the Thanksgiving holiday and less likely workplace exposures; indicative of behavior outside the workplace. I do not think it is the place of the DOL to address public health issues manifesting outside the workplace, much less citing employers for health issues brought into the workplace by employees who unknowingly are carriers of an infectious disease. The Virginia Department Of Health and localities are better suited, better equipped and have the professional resources necessary to deliver solutions. Lastly, it appearing that there is a "light at the end of the tunnel" with the introduction of vaccines that will hopefully end the pandemic. Accordingly, I do not think implementing a permanent standard is appropriate or necessary. Students of the VOSH Occupational Safety And Health Standards will find numerous respiratory and sanitation standards already in place.

The VOSH program has clear statutory and regulatory jurisdiction over workplace safety and health issues in the Commonwealth, including the potential for spread of infectious diseases among employees and employers, and when those employees and employers are potentially exposed to other persons who may be carriers of the infectious diseases (patients, customers, independent contractors, etc.).

There is substantial scientific evidence and infection, hospitalization and death statistics that support the conclusion that SARS-CoV-2 presents a danger to employees in the workplace.

It is the Department's position that the danger posed to employees and employers by the SARS-CoV-2 virus and COVID-19 disease are necessary and appropriate to regulate after the expiration of the current COVID-19 Emergency Temporary Standard (ETS) on January 26, 2021. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. It is well recognized that one or more vaccines will not be widely available to the public and employees until well after January 26, 2021.

It is the Department's position that the ETS has been and a Final Standard will be an important enforcement tool to reduce or eliminate the spread of the virus in the workplace and assures that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections.

The Department also believes that the Standard will ultimately help businesses to grow and bring customers back when those customers see that employers are providing employees with appropriate protections required by the Standard from SARS-CoV-2. If customers don't feel safe because employees don't feel safe, it will be hard for a business to prosper in a situation where there is ongoing community spread.

While the Virginia Department of Health (VDH) has some statutory and regulatory responsibilities in certain industries (restaurant permitting, temporary labor camp permitting, nursing home licensing, etc.), its primary focus is public safety, customer safety and patient safety. VDH has very limited and in some cases no enforcement options when it comes to requiring many of Virginia's industries to limit the spread of SARS-CoV-2 among employees and employers in the workplace.

In such cases where VDH does intervene in a workplace setting that does not fall under its jurisdiction, it will attempt to obtain the employer's agreement with Governor's Executive Orders, but it does not attempt to obtain the employer's agreement to comply with VOSH laws, standards, and regulations, such as VOSH's COVID-19 ETS or other applicable VOSH standards and regulations (e.g., personal protective equipment, respiratory protective equipment, etc.).

In cases where either an employer refuses to comply with Governor's Executive Orders or VDH suspects potential violations of VOSH laws, standards and regulations, it will make a referral to VOSH for either an informal investigation or an onsite inspection. Accordingly, it is neither legal nor appropriate from a policy standpoint for VOSH to cede jurisdiction to VDH to handle all COVID-19 issues.

The states of Virginia, Washington, Michigan, Oregon and California have adopted COVID-19 related workplace safety and health regulations.

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. Please note that DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The new language in 16VAC25-220.C requires the Board to make a "determination" of whether there is continued need for the standard. The Department has identified three "determination" options:

- That there is no continued need for the standard;
- That there is a continued need for the standard with no changes; and
- That there is a continued need for a revised standard.

Regardless of the determination, the Department and Board will provide notice and comment opportunities on any changes to or revocation of the standard.

With regard to the phrase "notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to," the intent of the language is to give the Board the maximum amount of flexibility to "notice" the Board meeting within 14 days even if the Board may not actually meet within 14 days

The Department notes that the Standard provides flexibility to business through 16VAC25-220-10.E which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation

contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.”

The Standard does not cover other infectious diseases like influenza, tuberculosis, etc.

The Department is recommending removal of the following provisions from the standard:

16VAC25-220-10.F: This standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency.

16VAC25-220-40.G: Employers shall also ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency.

16VAC25-220-70.C.9: Ensure compliance with mandatory requirements of any applicable Virginia executive order or order of public health emergency related to the SARS-CoV-2 virus or COVID-19 disease.

After discussions with legal counsel, the Department is recommending removal of the above language.

In addition, the language is considered redundant in light of Executive Order 72, Order of Public Health Emergency, Commonsense Surge Restrictions, Certain Temporary Restrictions Due to Novel Coronavirus (COVID-19), adopted on December 14, 2020, which provides as follows:

IV. ADDITIONAL PROVISIONS

A. Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19”

Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

With regard to any conflicts identified between Governor's Executive Orders and the standard would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

Use of testing for return to work decisions: 16VAC25-220-40.B.4 provides that “Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an “alternative diagnosis.” <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as “Suspected to be infected with SARS-CoV-2 virus”), but if the test comes back negative, we want to rule out COVID-19 as the

diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

At the request of VDH, the Department proposed changing the COVID-19 case reporting requirement threshold from one case to two cases so that it aligned with current statutory/regulatory/procedural VDH reporting requirements. The lower reporting threshold was negatively impacting VDH's ability to effectively and efficiently use its limited employee resources and caused some confusion in the regulated community. DOLI is recommending to the Board the following revision to 16VAC25-220-40.B.8.d [notification to VDH of positive cases] in the final standard:

"d. The Virginia Department of Health during a declaration of an emergency by the Governor pursuant to § 44-146.17. Every employer as defined by § 40.1-2 of the Code of Virginia shall report to the Virginia Department of Health (VDH) when the worksite has had two or more confirmed cases of COVID-19 of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period. Employers shall make such a report in a manner specified by VDH, including name, date of birth, and contact information of each case, within 24 hours of becoming aware of such cases. Employers shall continue to report all cases until the local health department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above. The following employers are exempt from this provision because of separate outbreak reporting requirements contained in 12VAC5-90-90: any residential or day program, service, or facility

licensed or operated by any agency of the Commonwealth, school, child care center, or summer camp;” (Emphasis added).

Impact of Vaccines. “Community immunity [or herd immunity]: A situation in which a sufficient proportion of a population is immune to an infectious disease (through vaccination and/or prior illness) to make its spread from person to person unlikely. Current estimates for achieving community immunity in the U.S. range from 70% to 90%. There are over 329,000,000 people living in the United States, which means that between 230,000,000 and 296,000,000 people would have to develop immunity through either infection or vaccination. Vaccine manufacturing and deployment will take many months to reach the necessary number of people.

According to the CDC, “The protection someone gains from having an infection (called natural immunity) varies depending on the disease, and it varies from person to person. Since this virus is new, we don’t know how long natural immunity might last. Current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection. Regarding vaccination, we won’t know how long immunity lasts until we have a vaccine and more data on how well it works.”

Virus mutations are also a known concern: “A new, highly contagious coronavirus variant that was first identified in Britain has reached the United States, officials in Colorado confirmed Tuesday, reporting the first known U.S. case of the strain more than two weeks after it was discovered — a worrying development as Covid-19 infections and deaths climb nationwide.

....

Researchers believe this new coronavirus variant — which U.K. officials disclosed earlier this month — is about 56% more contagious than other versions of the virus, an alarming figure even though it doesn’t appear to lead to deadlier infections. As of last week, the variant was already responsible for the majority of London’s Covid-19 infections, and officials have partly blamed it for a recent spike in U.K. Covid-19 cases that has forced much of the country back into strict lockdowns. Dozens of countries have banned or restricted travel from the United Kingdom in response, including the United States, which began requiring all U.K. travelers to show a negative coronavirus test before flying to the U.S. this week.

....

Most infectious disease experts aren’t surprised to see the new variant arrive in the United States. Last week, Dr. Anthony Fauci told ABC News it’s “certainly possible” the mutation was already present in the country. But experts fear a more transmissible form of Covid-19 could make controlling the virus’ spread even more difficult, adding to an already-dire surge in cases throughout the United States.” (Emphasis added).

As of December 29, 2020, the CDC says: “While experts learn more about the protection that COVID-19 vaccines provide under real-life conditions, it will be important for everyone to continue using all the tools available to us to help stop this pandemic, like covering your mouth and nose with a mask, washing hands often, and staying at least 6 feet away from others. Together, COVID-19 vaccination and following CDC’s recommendations for how to protect yourself and others will offer the best protection from getting and spreading COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before deciding to change recommendations on steps everyone should take to slow the spread of the virus that causes COVID-19. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.

....

There is not enough information currently available to say if or when CDC will stop recommending that people wear masks and avoid close contact with others to help prevent the spread of the virus that causes COVID-19. Experts need to understand more about the protection that COVID-19 vaccines provide before making that decision. Other factors, including how many people get vaccinated and how the virus is spreading in communities, will also affect this decision.”

The VOSH Program follows OSHA’s April 3, 2020 Memorandum entitled “Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic” which “outlines enforcement discretion to permit the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer’s recommended shelf life (sometimes referred to as “expired”).”

The VOSH Program also follows OSHA’s April 24, 2020 Memorandum entitled “Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic.”

The Department acknowledges that all of its VOSH laws, standards and regulations can serve to place compliance burdens on employers and employees, particularly in the small business sector. The Department also believes that employers that embrace providing sound and comprehensive workplace safety and health protections can make their business more efficient and profitable through such benefits as reduced injuries, illnesses and fatalities, reduced workers’ compensation costs, reduced insurance costs, improvements in morale and innovation, and increased productivity.

Review of all COVID-19 related inspections under the Emergency Temporary Standard is conducted centrally by the Department with both a programmatic and legal review prior to a decision to issue or not issue violations/penalties to assure consistent enforcement across the Commonwealth. The Department does not anticipate any significant increase in litigation with regard to the Emergency Temporary Standard or any permanent standard.

The Department strongly encourages Virginia’s small business owners to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

In addition, free Outreach, Training, and Educational materials to assure compliance with COVID-19 requirements can be found at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA.”

The proposed permanent standard has been subject to the following notice and comment procedures. The Virginia Safety and Health Codes Board held a 60 day written comment period for the Proposed Permanent Standard, with the comment period running from August 27, 2020 to September 25, 2020. The Board held a

Public Hearing on September 30, 2020. A revised draft of the Proposed Permanent Standard was published on December 10, 2020 with an additional 30 day comment period (from December 10, 2020 to January 9, 2021) prior to any Board action. A public hearing was held on January 5, 2021. An economic impact analysis/cost analysis will be prepared and posted no later than January 11, 2021. A draft final standard with changes recommended by DOLI in response to all comments received to date was posted on January 4, 2021, with any final changes recommended by DOLI to be posted by January 11, 2021. A meeting of the Board to consider for adoption a final standard is scheduled for January 12, 2021 with possible continuation dates of January 13, 2021 and January 19, 2021.

Economic Impact Analysis.

An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04 will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.

The Department does not intend to recommend that the Safety and Health Codes Board hold an additional comment period solely for the purpose of comment on the EIA.

Many of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in various Governor's Executive Orders, including most recently Executive Order 72. To the extent that a requirement is included in both Executive Orders and the standard, the Department does not consider the standard to impose any new cost burden on a covered locality.

In addition, many of the costs associated with dealing with workplace hazards associated with COVID-19 are the result of requirements contained in current federal OSHA or VOSH unique standards and regulations already applicable to local governments, and therefore the Department does not consider them to be new costs associated with adoption of the standard.

Following are federal OSHA identical and state unique standards and regulations applicable in the Construction Industry, Agriculture Industry, Maritime Industry (public sector employment only as OSHA retains jurisdiction over private sector employment in Virginia), and General Industry ("General Industry" covers all employers not otherwise classified as Construction, Agriculture, or Maritime) that can be used in certain situations to address COVID-19 hazards in the workplace:

General Industry

- 1910.132, Personal Protective Equipment in General Industry (including workplace assessment)
- 1910.133, Eye and Face Protection in General Industry
- 1910.134, Respiratory Protection in General Industry
- 1910.138, Hand Protection
- 1910.141, Sanitation in General Industry (including handwashing facilities)
- 1910.1030, Bloodborne pathogens in General Industry
- 1910.1450, Occupational exposure to hazardous chemicals in laboratories in General Industry

Construction Industry

- 1926.95, Criteria for personal protective equipment in Construction

- 1926.102, Eye and Face Protection in Construction

- 1926.103, Respiratory Protection in Construction

- 16VAC25-160, Sanitation in Construction (including handwashing facilities)

Agriculture

- 16VAC25-190, Field Sanitation (including handwashing facilities) in Agriculture

Public Sector Maritime

- 1915.152, Shipyard Employment (Personal Protective Equipment)

- 1915.153, Shipyard Employment (Eye and Face Protection)

- 1915.154, Shipyard Employment (Respiratory Protection)

- 1915.157, Shipyard Employment (Hand and Body Protection)

- 1917.127, Marine Terminal Operations (Sanitation)

- 1917.92 and 1917.1(a)(2)(x), Marine Terminal Operations (Respiratory Protection, 1910.134)

- 1917.91, Marine Terminal Operations (Eye and Face Protection)

- 1917.95, Marine Terminal Operations (PPE, Other Protective Measures)

- 1918.95, Longshoring (Sanitation)

- 1918.102, Longshoring (Respiratory Protection)

- 1918.101, Longshoring (Eye and Face Protection)

Multiple Industries

- 16VAC25-220, Emergency Temporary Standard in General Industry, Construction, Agriculture and Public Sector Maritime

- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture and Public Sector Maritime

- 1910.142, Temporary Labor Camps (including handwashing facilities) in Agriculture and General Industry

- 1910.1020, Access to employee exposure and medical records in General Industry, Construction, and Public Sector Maritime (excludes Agriculture)

- 1910.1200, Hazard Communication in General Industry, Construction, Agriculture and Public Sector Maritime

- 16VAC25-60-120 (General Industry), 16VAC25-60-130 (Construction Industry), 16VAC25-60-140 (Agriculture), and 16VAC25-60-150 (Public Sector Maritime), Manufacturer's specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles,

tools, materials and equipment (can be used to apply to operation and maintenance of air handling systems in accordance with manufacturer's instructions)

In addition, Va. Code §40.1-51.1.A, provides that:

“ A. It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.”

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer's requirements, requirements of the Centers for Disease Control (CDC), or an employer's safety and health rules.

To the extent that the general duty clause could be used by the Department to address COVID-19 workplace hazards to the same extent as and in the same manner as the standard were the standard not in effect, the Department does not consider any of the costs associated with such use of the clause to be new costs associated with adoption of the standard.

The Department acknowledges that, as it predicted back in June and July of this year in its presentations to the Safety and Health Codes Board, that the COVID-19 pandemic could get much worse before it got better, which was a major reason for recommending adoption of an ETS. The Department notes the following statistics which are also highlighted in the January 4, 2021 Briefing Package for the Board beginning on page 36:

As of December 22, 2020, Virginia ranked 45th in state rankings for total cases per 100K. The Virginia border states of Tennessee, Kentucky, North Carolina, Maryland, and West Virginia, none of which has an ETS, rank higher than Virginia:

7 - Tennessee

29 - Kentucky

39 - North Carolina

42 - Maryland

43 - West Virginia

45 – Virginia

As of December 26, 2020, Virginia ranked 30th in state rankings for average daily cases per 100K in last seven days. The Virginia border states of Tennessee, Kentucky, North Carolina, and West Virginia, none of which has an ETS, rank higher than Virginia. The only border state that outperformed Virginia in this metric was Maryland:

1 - Tennessee

6 - West Virginia

19 - North Carolina

25 - Kentucky

30 - Virginia

39 – Maryland

The Department is not suggesting that the ETS is the sole reason for Virginia's significantly better performance on key COVID-19 indicators than many other states. There are many factors that go into such an evaluation, not the least of which is the impact of Governor's Executive Orders and the commitment of Virginia's citizens, employers and employees to follow safe and health practices and implementing sound mitigation strategies.

While VOSH is charged with assuring the protection of Virginia employees from occupational safety and health hazards, it has a long history of working cooperatively with employers to achieve that protection. It also has the legal authority to enforce applicable laws, standards, regulations and executive orders in situations where employers decide they do not want to take advantage of a cooperative working relationship.

COVID-19 related employee complaints received by the VOSH program that are within VOSH's jurisdiction are being addressed with employers. In an abundance of caution, at the beginning of the COVID-19 outbreak in Virginia the Department decided to modify its normal complaint processing procedures for both the safety and health of the employees at the work sites and its VOSH compliance officers by trying to limit exposure to the virus as much as possible while carrying out statutory enforcement mandates.

Rather than conducting a combination of onsite inspections and informal investigations as is the case under normal situations, COVID-19 complaints were initially handled through the VOSH program's complaint investigation process, which involves contacting the employer by phone, fax, email, or letter.

VOSH informed the employer of the complaint allegation and required a written response concerning the validity of the complaint allegation, any safety and health measures taken to date to protect employees against potential COVID-19 related hazards, and any measures to be taken in response to valid complaint allegations.

Employers were required to post a copy of VOSH's correspondence where it would be readily accessible for review by employees; and provide a copy of the correspondence and the employer's response to a representative of any recognized union or safety committee at the facility. Complainants were provided a copy of the employer's response.

Depending on the specific facts of the employee's alleged complaint, an employer's failure to respond or inadequate response could result in additional contact by the VOSH program with the employer, a referral to local law enforcement officials, an onsite VOSH inspection, or other enforcement options available to the VOSH program.

COVID-19 "Inspections"

- Can result in violations and substantial penalties
- Inspections are opened for COVID-19 related employee deaths
- Inspections may be opened for COVID-19 related hospitalizations or handled through an investigation
- Inspection files with proposed violations will be reviewed by Headquarters and receive a legal review before a decision to issue or not issue is made

As of January 1, 2021, the pandemic 341,199 deaths have been attributed to COVID-19 in the U.S. and 5,117 in Virginia.

Since February, 2020, the Virginia Workers' Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020 in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings. In accordance with prioritization procedures, VOSH may conduct either informal investigations or inspections in response notifications received under 16VAC25-220-40.8.

Through January 1, 2021, VOSH has received 1,537 employee complaints and referrals from other government agencies. It has received notifications of 30 COVID-19 related employee deaths and 61 employee hospitalizations. To date, VOSH has opened 103 inspections, a number of which resulted from employers not taking advantage of either working cooperatively with the Virginia Department of Health, or not taking advantage of VOSH's informal investigation process, which does not result in citations and penalties, provided the employer provides a satisfactory response.

Of the first 94 inspections conducted by VOSH, 43 remained under investigation as of January 4, 2021, 25 were closed with no violations issued, and 26 resulted in the issuance of violations (29 serious and 29 other-than-serious violations) and a total of \$226,780.00 in penalties.

87835 Eric C. Anspaugh 2020/12/17 7:48:44 eanspaugh@yahoo.com

ETS The Emergency Temporary Standard must be reinstated until we are safely beyond the Covid-19 pandemic.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87836 anonymous 2020/12/17 8:13:31

Temperature Checks are NOT effective "During cold weather, by the time employees reach an entrance door, their forehead has been cooled too far to get an accurate temperature. I have seen the same issue when I have gone to appointments such as the doctor and dentist. This issue has been going on for many weeks and when the weather is cold, I believe we are misleading employees by making them think we are checking temps.

I know there are no perfect answers to the mess we are in, but for sure during cold weather "temps checks" are a clear waste of resources.

I am confident that the above information can be quickly confirmed by surveying ten companies.

The Department notes the Commenter's concern about the accuracy of forehead temperature checks in cold weather.

Although it is a generally accepted practice, the Standard does not specifically require that employers check the temperatures of employees. 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or

symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

87837 Elizabeth Myers 2020/12/17 8:21:07 elmyers52@gmail.com

Make Permanent the Emergency Temp. Stndrds (ETS) mandating health and safety workplace regulations

Thank you for proposing this permanent standard to protect Virginia's workers. Please adopt the proposed permanent standard before the temporary standard ends.

Keeping workers safe enables our businesses to get back on their feet and the economy to rebound more quickly. Virginia is for lovers and healthy workers! - Elizabeth MMyers

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87838 Donna Wilkers 2020/12/17 8:24:29 dcwilkers@msn.com

COVID-19 Protection for Virginia Workers I am writing as a concerned citizen regarding the safety of Virginia workers. We MUST continue requirements for employers to protect our workers against COVID-19. The distribution of vaccines does give us hope but we still have many months to go before we can all feel a measure of safety.

I am asking that Virginia's Safety and Health Codes Board adopt a standard (not an extension) for COVID-19 protections to continue.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87839 Lucretia McCulley 2020/12/17 8:43:34 glennamac77@gmail.com

Permanent Standard for Virginia workers Please pass the permanent standard for workers in Virginia. With COVID and other future health challenges and possible pandemics, all employees in Virginia deserve to be protected during a pandemic

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87840 Noel Beck 2020/12/17 8:43:48 noel.beck@keolisna.com

No Permanent Standard While the intent was good, the Emergency Temporary Standard was obsolete before it was released. When you have emerging information on a new disease, you cannot put concrete values in a document that you do not intend to update regularly. The Emergency Temporary Standard was a failure because it was not updated with new information as the CDC released it to the general public. In many cases, the ETS conflicted with CDC guidelines and even the Virginia Department of Health's guidelines - who were following CDC guidelines. In order for a new standard to be successful, it would need to be a living document that is reviewed and updated frequently. Because Virginia is unwilling to put forth the effort to make a relevant

standard, the better practice would be to require companies to follow CDC/VDH guidelines and / or create an electronic standard that has links to CDC guidelines.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's assertion that the Emergency Temporary Standard (ETS) was obsolete before it was released and a failure. While one or two provisions based on CDC guidance changed after the adoption date of the ETS, the ETS allowed employers who complied with the revised CDC guidance to do so without being in violation of the ETS.

It is the Department's position that the ETS has been an important enforcement tool to reduce or eliminate the spread of the virus in the workplace and assures that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections.

87841 Tonya Osinkosky 2020/12/17 9:03:22 Oshenkovski@hotmail.com

Make standards permanent! The COVID protection standards are saving lives. Please make them permanent! Workers need to be able to go to work feeling safe

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87842 Jonathan Fuller, Virginia Annual Conference of the United Methodist Church 2020/12/17 9:03:42
jonathanfuller@vaumc.org

Safety Standards Thank you for proposing this permanent standard to protect Virginia's workers. Please adopt this proposed standard prior to the temporary standard's expiration on January 27, 2021. The pandemic has exposed deep, systemic inequities in our employment and labor structures, and the basic protections this standard will offer will benefit our Commonwealth and our workers, especially those deemed essential for the continued functioning of our lives. I am grateful for the efforts put forward so far to prioritize worker safety over corporate profits, and hope this proposal will cross the finish line in time

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87843 Sonia Quinonez 2020/12/17 9:22:01 sonia.jmq@gmail.com

adopt the proposed permanent standard Please adopt the proposed permanent standard before the temporary standard ends. Worker safety is not just an issue during the pandemic. The pandemic opened our eyes and we cannot go back to the previous situation - we must learn from this experience. Please make mandated health and safety workplace regulations permanent before the temporary standard expires.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87844 John Gregoire 2020/12/17 9:22:40 johngregoire185@hotmail.com

Continuing Health & Safety Workplace Co-Vid 19 Regulations Permanent I believe it is appropriate and wise to make the health and safety workplace regulations protecting employees against the CoVid-19 virus permanent. Although the news regarding new vaccines is exciting, the reality is it will take at least 9-12 months to work out the logistics and get everyone vaccinated

During this time it is only prudent to make sure the regulations remain in place to protect employees and their employers safe. Businesses will benefit since productivity will be maintained contributing to the overall financial health of the company.

It also protects customers since they come in contact with employees, especially retail businesses. So the benefits extend to everyone in the community.

Thank you

John Gregoire

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87845 Lawrence Miller2020/12/17 10:54:02 millerlauriew@gmail.com

Safety for workers in the CO-Vid environment Please adopt permanent standards for the ETS. It runs out in January and as we all know the virus is still raging; Workers need this protection to continue.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87846 marcia a marsh 2020/12/17 11:07:27 marciawrightmarsh@gmail.com

ETS regulations Let's make this permanent - we'll be dealing with pandemics beyond COVID-19. We are all wiser now and employers need to adjust

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87847 Anonymous 2020/12/17 12:58:37

Unreasonable and Burdensome to Employees and Employers The proposed 2020 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19 (December 10, 2020), in its current revision, is unreasonable and causes undue burden on employees and employers. This is immediately evident by the elimination of the test-based and time-based return to work options.

The proposed standard requires employees known or to be infected with the SARS-CoV2 virus; not return to work until certain criteria are met, one of those criteria being a minimum of 10 days away from onset of

symptoms. Unfortunately, COVID-19 virus signs and symptoms are consistent with several other common illness or conditions; Flu, common Cold, sinus infections, migraine, allergies, food poisoning, etc.). This standard now eliminates the opportunity for an employee to prove they do not have COVID-19 and allow them return to work. In fact, the entire standard fails to mention any use of COVID-19 testing for the benefit of employees or employers, even though it is free and widely available throughout the Commonwealth. The burden on an employer to cover the costs for every employee, for every illness, and for almost two weeks will create a serious financial challenge. Employees, in an effort to protect their livelihood, will not report illnesses. The non-reporting of illnesses will create an even greater issue than that of the COVID-19 virus itself. This standard will create a culture of non-reporting and fear, and this will create an unsafe work environment. The next burden this standard inflicts is the elimination of the option for employers to provide surgical/ medical procedure masks. On page 29, and other locations, the standard gives the impression that PPE for medical providers and first responders is still not readily available. As a first responder I do not agree with that impression. Requiring employer to provide only face coverings is yet another obstacle for employers to overcome and is unnecessary. This proposed standard is a lot of seemingly good ideas and good intentions but does not appear to have one ounce of genuine understanding of current situation within the Commonwealth and has unrealistic expectations for employers. People and business are struggling. Implementing this standard as-is will create more problems than it solves. Making this a permanent standard is even more absurd.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Commenter is incorrect in stating that "This standard now eliminates the opportunity for an employee to prove they do not have COVID-19 and allow them return to work." 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis:"

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical

contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an “alternative diagnosis”, and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn’t infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

<https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

87848 Stephen Craig, CHEMetrics 2020/12/17 13:56:07 scraig@chemetrics.com

Incorporate OSHA text instead of reference by footnote The newly added definition for "Minimal occupational contact" located in 16VAC25-220-30 includes a footnote reference to OSHA's Hazard Recognition web page. The hyperlink referenced in the footnote on page 16 of the draft standard does not direct the user to the correct location. I believe the correct reference is https://www.osha.gov/coronavirus/hazards#risk_classification

The OSHA web page includes a section with heading "Lower Exposure Risk" in which 5 examples of minimal occupational contact are provided. These examples are more helpful in forming an understanding of the limits and extents of the definition than are the current words in the proposed standard.

In the interests of consistency and best assisting the regulated community in proper risk classification, I suggest the five bullet point examples in the OSHA guidance be directly inserted into the definition in the proposed standard instead of simply being referenced by footnote."

Both hyperlinks referenced by the Commenter contain the same language:

Lower Exposure Risk (Caution)

Jobs that do not require contact with people known to be, or suspected of being, infected with SARS-CoV-2. Workers in this category have minimal occupational contact with the public and other coworkers. Examples include:

Remote workers (i.e., those working from home during the pandemic).

Office workers who do not have frequent close contact with coworkers, customers, or the public.

Manufacturing and industrial facility workers who do not have frequent close contact with coworkers, customers, or the public.

Healthcare workers providing only telemedicine services.

Long-distance truck drivers.

(Emphasis added.)

The Department does not intend to recommend any changes to the definition to "minimal occupational contact." It already contains several examples pulled from the list above, so further examples are not needed."

87849 Peg P Butner 2020/12/17 14:17:15 peg.butner@gmail.com

Permanent safety standard Thank you for proposing this permanent standard to protect Virginia's workers. Please adopt the proposed permanent standard before the temporary standard ends.

It's extremely important for workers to have legal protection and safe working conditions.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87850 Lucile A Wright 2020/12/17 15:05:20 lubruwright@gmail.com

safety concerns We must provide safety measures for all workers during the pandemic and extending on while people are being vaccinated. In order to protect worker's health and maintain our economy, we cannot allow people to work in unsafe conditions

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87851 Sheila Stone 2020/12/17 16:44:47 sheila.stone9@gmail.com

extend covid workplace protections. I'm a nurse. As a nurse who had to quit working because of inadequate PPE supplies, I know that curbing the spread of COVID 19 is essential. The more we prevent, the less we have to pay in treatment costs, and nurses are among those costs. I have been a single mom, sole support, working in jobs without any benefits since I moved to Virginia in 1989 and I know very well how people go to work sick because they can't afford not to. This includes health care aides. If employers were going to provide benefits to part time and shift workers because it is the right thing to do, this would have happened a long time ago. I am convinced that it will never happen without legislation, and that the benefits of enforcement outweigh the costs. Part time workers hold up my own industry (health care) and hold up many other essential industries as well.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87852 Business 2020/12/17 17:11:10

dress code... If an employee continues to wear a political face covering and tries to cite this regulation as to why I can't fire him/her for doing so when political statements are not permitted in business attire, this will become a highly litigious situation.

The Department does not believe this Standard interferes with an employer's abilities to set workplace rules regarding the content of statements, designs, pictures, etc. on face covering or any form of personal protective equipment or respirator required to provided and worn under VOSH laws, standards or regulations.

However, the Department is recommending the following language addition to 16VAC25-220-90.B: "Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings."

87853 Evan Brown, UCWVA 2020/12/17 20:09:13 evan.brown103@gmail.com

Safety and Health We commend the Department of Labor and Industries (DOLI) staff and the Safety and Health Codes Board (Board) for developing and approving emergency temporary standards in the wake of COVID-19. In particular, we thank DOLI and the Board for prioritizing physical distancing, which is one of the best ways to prevent person to person spread. We also strongly support requiring employers to provide greater transparency and communication when someone in the workplace has been infected with COVID-19, while still complying with the Americans with Disabilities Act and other applicable Virginia laws and regulations. Finally, we appreciate both the strong sanitation requirements applying to workplaces and the standards that ensure access to basic sanitation needs for workers, as well as the anti-retaliation provisions. The proposed Permanent Standard for Infectious Disease Prevention for COVID-19 would maintain important protections for working people and communities in Virginia and provide continuity with the emergency temporary standards, thereby reducing the challenges employers and employees would face from changing standards. Thank you for considering these comments. We urge you to do what is right to protect Virginias workers and adopt the proposed Permanent Standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87854 Jason Yarashes, Legal Aid Justice Center 2020/12/17 20:11:30 jasony@justice4all.org

Adopt the Proposed Permanent Standard for Infectious Disease Prevention for COVID-19 We commend the Department of Labor and Industries (DOLI) staff and the Safety and Health Codes Board (Board) for developing and approving emergency temporary standards in the wake of COVID-19.

In particular, we thank DOLI and the Board for prioritizing physical distancing, which is one of the best ways to prevent person to person spread. We also strongly support requiring employers to provide greater transparency and communication when someone in the workplace has been infected with COVID-19, while still complying with the Americans with Disabilities Act and other applicable Virginia laws and regulations. Finally, we appreciate both the strong sanitation requirements applying to workplaces and the standards that ensure access to basic sanitation needs for workers, as well as the anti-retaliation provisions.

The proposed Permanent Standard for Infectious Disease Prevention for COVID-19 would maintain important protections for working people and communities in Virginia and provide continuity with the emergency temporary standards, thereby reducing the challenges employers and employees would face from changing standards.

Thank you for considering these comments. We urge you to do what is right to protect Virginia's workers and adopt the proposed Permanent Standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87855 Evelyn Ruffin 2020/12/17 20:28:27 randyruffin@aol.com

Permanent Health and Safety Standard "Given the fact that Covid - 19 will almost certainly be with us well past March, the proposed deadline for the extension of the health and safety standard for workers, and widespread immunity brought about by the vaccine will take many months, I very much favor that a permanent health and safety standard for workers be adopted.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87856 Ann Klotz 2020/12/18 6:27:48 jasnc5@gmail.com

Permanent health and safety standard "A permanent standard for health and safety for Virginia workers will make Virginia a more welcome place to be employed. Healthy workers are more productive, and assure greater health protection to their coworkers and to public with which they engage.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87857 Concerned, Irritated Citizen 2020/12/18 10:51:31

so here's a few thoughts Do you think you could also pass some laws to make people stop doing irresponsible things when they aren't at work? You know, the 16 hours a day that folks aren't being paid?

Seems like there is an awful big chunk of an employee's day that their place of employment has no control over... and yet the employer is the one subject to citation should too many employees get sick

We have mask mandates, curfews and limits on social gatherings... and who is enforcing that? I don't mean who is supposed to enforce it, I want to know who is actually enforcing that? They're great ideas and people oughta follow them.

But at least in my town, no one is enforcing these rules. Customers do whatever they want and employees keep their mouths shut because their crummy minimum wage job isn't worth getting screamed at or assaulted by some hoaxter hillbilly crying about his rights like Abraham Lincoln just freed his slaves.

That guy (we've all seen that guy plenty of times in 2020) gets to walk around proud as a peacock like he's in control of his own destiny and nobody can tell him what to do, while businesses are trying to keep their employees and customers safe and not go broke trying.

And who gets cited? The business is cited because the Commonwealth isn't standing up to the individual people outright defying the law.

Yes, workers need to be protected and some standard should be in place... but can we level the playing field a little? Seems like an awful lot of pressure to put on people trying to make ends meet when half of the population equates mask-wearing with forced sterilization or concentration camp branding.

When I go to 7-11 and see 5 people mouth-breathing all over the coffee makers despite the employees wearing masks and standing behind plexi-glass partitions, I don't blame the 7-11. I blame the entitled self-absorbed citizens that can't fathom the slightest inconvenience in their lives, and I blame the government that tells the 7-11 that it's their job to risk their lives arguing with people who don't care about public safety. People who would love to rally their like-minded brethren into boycotting, vandalizing or publicly shaming people who had the audacity to try to enforce rules that even police wouldn't enforce.

Meanwhile we have businesses trying to figure out if their HVAC system is up to snuff so they can avoid citations while Customer Karen McRightWing is deliberately coughing on the employees.

"Well that business should call the police and that customer will be treated as a trespasser," says everyone who still believe the business fault And to some extent, they're right. Those people need to be addressed.

But when there are law enforcement officers around the country and in this state outright saying they won't enforce mandates... when public enforcement is a coin toss... why would any business think the law will be on their side; Why would they assume anything more than this pandemic is terrible and their government has abandoned them?

I'd love to dream that this will all be moot in a few months, but some of these same people aren't going to get a vaccine because they think it'll give them autism and lower their credit score, or that it's just playing into whatever "the other side" wants them to do. Nothing like acting only in spite.

There is a level of personal accountability that simply has not been addressed and all the standards in the world, with all the threats of investigation and citation by the various regulatory authorities, all shooting from the hip with the best intentions in this unprecedented time, aren't going to change the fact that individual people will continue to do individually foolish and careless things at the expense of others until they are held accountable for their actions more so than the establishments they frequent and put in jeopardy.

Oh, and thanks for the online portal to report COVID-19 cases. That makes life easier.

The Department recognizes and understands the frustrations expressed by the Commenter about the unwillingness of some people to wear face coverings; however, please note that some people do have legitimate health concerns with wearing face coverings that are excused from having to wear them.

The Standard does not address the rights or protections of the general public, and more specifically, it does not contain a face covering mandate for the general public. That issue is the purview of the Virginia Department of Health and Governor's Executive Orders (e.g., Executive Order 72). VDH has legal authority under Executive Order 72 to enforce requirements (e.g., face covering mandates, curfews and limits on social gatherings) contained in that order. [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-(COVID-19).pdf)

VDH also has an online complaint form that can be filled out by anyone to report violations of EO 72. <https://redcap.vdh.virginia.gov/redcap/surveys/?s=Y4P9H7DTWA>

While the Virginia Department of Health (VDH) has some statutory and regulatory responsibilities in certain industries (restaurant permitting, temporary labor camp permitting, nursing home licensing, etc.), its primary focus is public safety, customer safety and patient safety. VDH has very limited and in some cases no enforcement options when it comes to requiring many of Virginia's industries to limit the spread of SARS-CoV-2 among employees and employers in the workplace.

In such cases where VDH does intervene in a workplace setting that does not fall under its jurisdiction, it will attempt to obtain the employer's agreement with Governor's Executive Orders, but it does not attempt to obtain the employer's agreement to comply with VOSH laws, standards, and regulations, such as VOSH's COVID-19 ETS or other applicable VOSH standards and regulations (e.g., personal protective equipment, respiratory protective equipment, etc.).

In cases where either an employer refuses to comply with Governor's Executive Orders or VDH suspects potential violations of VOSH laws, standards and regulations, it will make a referral to VOSH for either an informal investigation or an onsite inspection. Accordingly, it is neither legal nor appropriate from a policy standpoint for VOSH to cede jurisdiction to VDH to handle all COVID-19 issues.

87858 Luis Velez Ayala, AFSCME Member and Arlington County Employee 2020/12/18 17:02:54

Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th! My name is Luis Velez Ayala. I am a frontline public employee in Arlington County. My father's career in public service showed me how dignifying contributing to our community can be. When the pandemic hit, everything changed. However, when the Emergency Temporary Standard took effect everything became streamlined and has protected me, my coworkers, our families and ultimately our community. With two essential workers in my six-person household, it is tremendously important that heightened workplace health and safety measures continue.

I have worked as a Service Technician Trainee at Arlington County's Water, Sewer, and Streets Division for seven months. Prior to that, I worked seven months part-time at Parks and Rec and also worked two stints with the Solid Waste Department during leaf season, which runs from November 1st to Christmas Day.

At the Streets Division, we are responsible for maintenance on sidewalks and perform general concrete repair. I work as part of a five man crew in close quarters, and that makes it difficult to socially distance. However, due to safety requirements under the emergency temporary standard, we have been provided with source control in the form of face masks. The county is also having us utilize a symptom checker to ensure that we are not coming in to work if we are symptomatic or have been potentially exposed to COVID-19. We have also started driving to job sites separately, where we previously traveled four people in a work vehicle. My crew is also having the supervisor clock folks in and out, to enable compliance with social distancing and to limit the number of hands touching the time clock. The department has those who can teleworking in order to reduce the number of personnel in the building.

The emergency temporary standard has kept us safe. Keeping us safe means keeping our families safe. I don't want to bring any disease or illness home to my loved ones. I support a permanent standard so that we can continue the workplace practices that have been necessary to keep us safe. I urge the Board to adopt the permanent standard and make it and all provisions take immediate effect on January 27, 2021.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87859 Luis Velez Torres, AFSCME Member and Arlington County Employee 2020/12/18 17:05:31 Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th! Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th!

Hello, my name is Luis Velez Torres. I have been honored to serve the public both in Puerto Rico and here in Virginia. I am proud of my son for also continuing our family's legacy in public service, but when the pandemic hit, my thoughts turned immediately to the safety of my family and community. With the VOSH Workplace standards being made permanent, we will have a sense of protection against this dangerous virus that continues to pose a threat to public health.

I have been employed with Arlington County for nearly three years and I currently work as a Construction Management Specialist. I previously worked as a Senior Service Technician in the county's Water, Sewer, and Streets Division.

As a service technician, I was responsible for establishing new water services and repairing water main breaks and leaks. When addressing water main breaks, it was challenging, if not impossible, to adequately socially distance. Placing and riveting a new section of pipe required at least two people working very close to one another. On occasion, we would also be approached by members of the public, who were – thankfully – generally mindful of wearing masks. Masks work as source control and their use should continue.

Related to my current position as a Construction Management Specialist, my employer has urged us to do our reports at home and hold all meetings virtually, reducing risk of exposure. These practices are informed by the current emergency temporary standard and just like the use of masks and social distancing, should continue.

As a person who works in an essential position, I believe that for us to continue doing our jobs and provide the services the public needs, we need the peace of mind that comes with knowing that there are rules in place that enable us to keep not only our coworkers safe, but our loved ones as well. The emergency temporary standard has been effective in reducing the spread of COVID-19 and has led to greater awareness among personnel as to their rights during this pandemic. Furthermore, the standards are holding our management accountable and protecting the broader community. I urge the board take the necessary steps to make the VOSH temporary standard permanent and to make the effective date for a permanent standard and all provisions January 27th, 2021 to avoid any lapse in protection.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87860 Lois Sandy 2020/12/19 12:32:22 ljsandy@gmail.com

Health and Safety Standards in the Workplace- "Health and Safety Standards in the Workplace-

Now is the time to permanently put in place the high standards we've had to live by for 9 months, anyway! Businesses implement safety measures, like wiping surfaces between customers, keeping safe distances with seating assignments and in lines, washing hands diligently, and wearing masks. These and other practices make sense and have been shown to significantly help to protect us all from contagious diseases. I support all reasonable safety measures and hope they become habits, as much as possible. We may control COVID 19 today, but know there will be others in the future to combat.

Though we don't want over-regulation, we need to adapt in order to assure our health and safety.

Thank you, Lois Sandy

Charlottesville, VA

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87861 Beverly Wood 2020/12/19 15:27:28 beverly@thewoodhome.net

Emergency Temporary Standard - permanent? "Emergency Temporary Standard - permanent?"

The temporary standard enacted in late July 2020 was helpful in making workplaces open for business while protecting employees. The six-month standard needs to continue! Vaccines may be on their way but not fast enough and with enough uncertainty that herd immunity is not right around the corner. Thinking even longer-term, these standards are also useful for other airborne, communicable diseases. There are provisions for situations of unattainable and cost-prohibitive PPE to protect business owners from unwarranted litigation but does make them accountable for non-pandemic care for their employees health. Please consider making this (or something very like it) a permanent standard that will improve community health even after COVID is under control.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87863 Jennifer Davis Sensenig, Community Mennonite Church 2020/12/20 10:12:47
jennifer.davis.sensenig@cmcva.org

Permanent Safety and Health Standard "Permanent Safety and Health Standard

Dear Board Members, Thank you for proposing this permanent standard to protect Virginia's workers. As a local pastor in a congregation that relates to many immigrant workers, I see the very real need to adopt the proposed permanent standard before the temporary standard ends. Our Shenandoah Valley poultry workers are especially vulnerable in the plants where they work and these permanent protections will improve their quality of life and public health.

Employers have a moral responsibility to protect their workers from COVID-19 and without these standards we cannot assume that employers will do all they can to protect workers.

Thank you for your consideration.

Sincerely,

Rev. Jennifer Davis Sensenig

Community Mennonite Church

Harrisonburg, VA 22801

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87866 Virginia Diamond, Northern Virginia Labor Federation 2020/12/21 8:44:36
viriniadiamond24@gmail.com

Strongly support making standard permanent Strongly support making standard permanent

Thank you to the Safety and Health Codes Board and the Department of Labor and Industry for adopting the emergency standard in the wake of COVID-19. I strongly urge you to make this standard permanent. The standards help to ensure that employers incorporate social distancing and transparency, and they prohibit retaliation against workers who assert their right to a safe workplace.

Please make this standard permanent to protect Virginia's workers

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87868 Carol Summerlyn 2020/12/21 14:28:13 csummerlyn2@verizon.net

COVID safety standards "COVID safety standards

Workers should not risk life or health by merely going to work. No worker should be exposed to the virus. Temporary standards should be made permanent.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87869 Tom Cleer 2020/12/21 14:40:04 cleernalc@aol.com

Permanent COVID standard Permanent COVID standard

Virginia must stay committed to its workforce and protect them from COVID-19 with a strong, permanent COVID-19 OSHA standard.

This pandemic is far from over. Even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue to be needed.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87870 Mark Snell-Cook 2020/12/21 15:15:16 markesnell@gmail.com

Ongoing workplace protections "Ongoing workplace protections

this pandemic has shown the need for worker and workplace protections to ensure viable standards are consistent across the Commonwealth of Virginia.

The temporary

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87871 Deborah Talley 2020/12/21 17:37:41 dtalley37@gmail.com

We need Permanent work standards to protect our coworkers, our families, and ourselves. Covid case's "We need Permanent work standards to protect our coworkers, our families, and ourselves. Covid case's

We need Permanent Standards.Covid cases. We are losing lived one's every second. Please make thus mandatory.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87874 Chris Lester UMWA 2020/12/22 9:04:35 chris242112@aol.com

PROTECT ALL WORKERS "PROTECT ALL WORKERS

The safety standards that were set for Virginias workers must remain in place until this virus is eradicated.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87876 Stephen Craig 2020/12/22 15:38:02 scraig@chemetrics.com

face covering vs surgical mask differences are arbitrary "The definitions of face covering and surgical mask in the proposed standard apparently aim to categorically disqualify, for reason unclear, use of surgical masks as face coverings. As an unintended result, the terminology has potential to increase employee risk, eliminate highly effective face covering options and thereby trigger a rush to buy compliant face coverings which may result in inadequate availability.

Consider the following.

Face coverings are readily available which are made of ultra-thin, two ply fabric. These products are targeted at the consumer who values comfort over all else.

Surgical masks are readily available which are made of 3 LAYERS of meltblown polypropylene FABRIC. This material is in fact WASHABLE and BREATHABLE. When properly fitted, such masks provide SNUG FIT WITHOUT GAPS. By these metrics, such surgical masks satisfy the face covering definition in the standard. if not for their dispenser box bearing the label "surgical mask".

Comparing the efficacy of the two types of product described above would likely find the "face covering" desperately inferior to the "surgical mask".

If DOLI is interested in requiring face coverings to have specified characteristics, then those specifications should be clear, unambiguous and without subjectivity. As the language stands now, although well intended, it risks forcing employers to abandon effective masks for less effective face coverings. That's not sensible.

The Commenter is mistaken that the Standard disqualifies the use of surgical masks in favor of face coverings. Surgical masks are a form of personal protective equipment permitted under the standard. All employers in general industry (i.e., all companies not in construction, agriculture or maritime) are covered by the federal

OSHA identical standard 1910.132, Personal Protective Equipment, and that standard requires covered employers in 1910.132(d):

1910.132(d)

Hazard assessment and equipment selection.

1910.132(d)(1)

The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE) [SUCH AS SURGICAL MASKS OR RESPIRATORS FOR POTENTIAL COVID-19 EXPOSURE]. If such hazards are present, or likely to be present, the employer shall:

1910.132(d)(1)(i)

Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

1910.132(d)(1)(ii)

Communicate selection decisions to each affected employee; and,

1910.132(d)(1)(iii)

Select PPE that properly fits each affected employee.

Note: Non-mandatory appendix B contains an example of procedures that would comply with the requirement for a hazard assessment.

1910.132(d)(2)

The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

Requirements similar to 1910.132(d) also apply to employers in construction, agriculture and public sector maritime (federal OSHA has jurisdiction over private sector maritime) by virtue of 16VAC25-220-50.D and 16VAC25-220-60.D.

In addition, 16VAC25-220-50.D.5 (very high and high risk) specifically provides:

"5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection."

Also, 16VAC220-60.C.1.j (medium risk) provides:

j. Employers shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has

determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.

87877 Reginald Bryan Fitts 2020/12/22 18:14:18 reginaldfitts@cox.net

Support personal safety standards I pray that the state of Virginia will maintain all safety standards for state and government employees during the covet19 and ensure that all personal receive the vaccine when it becomes available. Myself and my fellow employees hope that health and safety standards will be continually up held during the covet19 crisis.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87885 Carl 2020/12/23 14:21:22 gilmore.67@hotmail.com

Covid19 "Covid19

Make the Emergency temporary standards full time the state should do all they can to protect the workers

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87890 Chad Conley United Steelworkers District 8 2020/12/23 18:32:26 cconley@usw.org

Protective Standard Protective Standard. Establishing a permanent Protective Standard is necessary to protect workers from conditions that allow COVID-19 and other infectious diseases to spread easily. Workers are on the frontlines fighting this illness, we need to support them.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87893 Joel Geiss, USW Local 8-00002 2020/12/23 20:38:46 joel_geiss04@outlook.com

Making Emergency Temporary Standards Permanent. Making Emergency Temporary Standards Permanent

This pandemic is far from over. Even with vaccines, it will take a long time to build immunity in the population, and strong workplace safety protections will continue to be needed. I support the state's commitment and need to ensure strong protections that workers have now under the emergency standard remain in place in the permanent standard. The ETS is a strong standard and should be made permanent and is needed by all workers.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87896 Bruce Burton 2020/12/27 14:12:30 Bruce_Burton@outlook.com

To Make Permanent Virginia's COVID-19 Temporary OSHA Standard To Make Permanent Virginia's COVID-19 Temporary OSHA Standard

I write in support of making Virginia's current temporary COVID-19 OSHA standard permanent. It is clear that approximately 10 months into the worst health crisis since the 1918 influenza pandemic that Virginia's workers continue to need protection and making the standard permanent will provide this necessary continuity. In addition, making the standard permanent will provide workers with a good degree of preparedness for the next pandemic when it occurs; and it will. Reasonable people may disagree on the timing, but there will be another pandemic in the future.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87899 Richard Haehn 2020/12/28 8:12:58 richie.haehn@gmail.com

Threshold for Application of Standard "Threshold for Application of Standard

I understand the need to extend COVID-19 protections for workers at this time, however there needs to be a threshold (i.e. number of cases/100,000 people, or the like) as to when this standard is enforceable. If the language in this standard remains unchanged, employers will be shouldered with a burden of training their employees and providing additional PPE that, for all intents and purposes, will be unnecessary once we make it through this pandemic.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

87901 George Farenthold / American Income Life Insurance Company 2020/12/28 14:01:23
gefarenthold@aiflife.com

Marketing Specialist Marketing Specialist

To Virginia State Officials:

Making the COVID-19 safety standards is not only a good idea it is forward looking and important for the safety of all Virginians, workers in Virginia (like me), travelers and all people who are susceptible to this horrible virus.

Please do make these new temporary standards permanent. It is what will make Virginia safe for all and will put you in the forefront of safety standards among all other states.

Sincerely,

George

George Farenthold

Marketing Specialist/Licensed Virginia Insurance Professional

4501 Connecticut Ave. NW, Apt. 102

Washington, DC 20008

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87903 Mark Bryant 2020/12/30 11:46:55 markbryant108@gmail.com

Opposed to making the ETS permanent I oppose the proposed Permanent Standard in its entirety. It is overly burdensome, costly, unconstitutional, and simply unnecessary for what has turned into a much less impactful pandemic than originally feared. I strongly urge the DOLI and Governor Northam to let the Emergency Temporary Standard expire and to not replace it with a Permanent Standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's assertion that the pandemic is much less impactful than originally feared. As of January 1, 2021, the pandemic 341,199 deaths have been attributed to COVID-19 in the U.S. and 5,117 in Virginia.

Since February, 2020, the Virginia Workers' Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020 in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has received 1,537 employee complaints and referrals from other government agencies. It has received notifications of 30 COVID-19 related employee deaths and 61 employee hospitalizations.

87912 Sarah Koolsbergen 1/1/2021 17:27 skcabbages@gmail.com

Make the ETS Permanent and Include Mandatory SARS-CoV-2 Testing of All Workers in Virginia Happy new year.

I urge VOSH and the Department of Labor and Industry to make the current Emergency Temporary Standard permanent to prevent the spread of SARS-CoV-2 in Virginia during the COVID-19 pandemic. All workers in Virginia should be protected throughout this public health crisis. In addition, I urge VOSH and the DOLI to require all employers to test all workers frequently (e.g., using rapid tests) as an additional public-health tool to reduce the spread of COVID-19 throughout the state of Virginia. Too many people are dying daily. Virginia must protect all workers, their families, their friends, and their surrounding communities.

I have included links to three articles about the importance of rapid testing during the COVID-19 pandemic.

Thank you,

Sarah Koolsbergen, daughter of an elder mother who requires the continuous support of health care, home care, and personal care workers in Virginia

<https://www.harvardmagazine.com/2020/08/covid-19-test-for-public-health>

<https://www.wgbh.org/news/national-news/2020/11/23/harvard-epidemiologist-10-20-million-rapid-at-home-tests-per-day-would-be-enough-to-stop-the-outbreaks-across-the-united-states>

<https://time.com/5912705/covid-19-stop-spread-christmas/>

SEE DEPARTMENT RESPONSE TO COMMENT 87825

While the Department acknowledges the Commenter's request to require rapid testing, it does not plan to recommend to the Safety and Health Codes Board that such a requirement be added to the standard. As noted in the articles referenced by the Commenter, there are issues about widespread availability of the testing materials and costs associated with obtaining them in sufficient supply to conduct daily workplace testing, that are best suited to be addressed at the federal government level rather than at the state level.

87913 Ben Ragsdale 1/1/2021 18:13 benragsdale@verizon.net

New Permanent Health and Safety Standards for Virginia's Workers The Emergency Temporary Standard which you adopted in the summer of 2020 was a singular act of public responsibility. Thank you.

We must continue the vigilance. Please adopt the proposed permanent standard before the temporary standard ends.

And, to members of the Virginia Safety and Health Codes Board, thank you again for your year-round public service, your compassion, and your wisdom.

Ben Ragsdale, Jr.

Richmond, Va.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87930 Fred Millar 2021/04/01 11:54:18 fmillarfoe@gmail.com

ETS standard "Please make permanent the ETS standard.

Thank you. Fred Millar

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87931 Joe Fekete 2021/04/01 11:56:17 joefek@gmail.com

Keep it extended! Virginia must stay committed to its workforce and protect them from COVID-19 with a strong, permanent COVID-19 OSHA standard. We support the state's commitment, and need to ensure strong protections that workers have now under the emergency standard remain in place in the permanent standard. This pandemic is far from over. Even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue to be needed. The permanent standard is necessary to protect working people in Virginia.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87932 Lawrence 2021/04/01 11:59:23 LCHager@gmail.com

Regarding recent Emergency Temporary Standards (ETS) I was pleased to see that VA passed an emergency; version of a Temporary Standards for worker/workplace protection/safety. I hope this can be made permanent in the first meetings of the legislature in 21. Thank you-L C Hager, in Falls Church

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87933 Keri 2021/04/01 12:09:10 kshanks@afcio.org

Temporary Safety Measures "Hello, I would like very much to ask that you consider making the Temporary Workplace Standards permanent. Workers lives should not be bargaining chips!

Thank you, Keri

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87934 Eric Jones local 2069 alternate committeemen 2021/04/01 12:12:18

Fmla approval hours We need to lower the fmla worked approval hours from 1250 to around 1000 hours worked to accommodate some of the individuals seeking their fmla as they are falling short of the federal guidelines of the 1250 worked hours due to being absent from work due to many facilities being shut down or laid off due to covid 19. This 1250 hours worked rule is seriously hindering these individuals from receiving the care they need and giving the care their loved ones need as well. We need to act fast to accommodate these individuals because we are seriously hindering these people's lives and their ability to juggle work without absence charges and their fmla right and the care their entitled to and deserve. Best wishes Eric Jones local 2069

SEE DEPARTMENT RESPONSE TO COMMENT 87825

Neither the Department nor the Virginia Safety and Health Codes Board have jurisdiction over Family and Medical Leave Act (FMLA) legal requirements."

87935 Sally Diaz-Wells 2021/04/01 12:31:48 sdiazwells@olqpva.org

permanent workplace health and safety standard Please make these safety standards permanent. There is no reason to temp fate or drop our guard. We know that this will happen again even if it is not as deadly, it would help us to be ready in the future.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87936 Lynn Kearney 2021/04/01 12:37:22 jalee@verizon.net

Question of Life and Death Frontline and other workers meeting the public on a regular basis are risking their lives and the lives of their families to make the economy work for those of us who can work from home or are retired. How can we not provide the strongest worker protections? What is profit when compared to a single human life.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87937 Sarah Jacobson, UNITE HERE Local 23 2021/04/01 12:38:42 sjacobson@unitehere.org

Extend the Emergency Temporary Standards I have moved to Washington State during the pandemic, but I was in Virginia at the time the Emergency Temporary Standards were being debated. As the representative of a union with thousands of front-line food service and hospitality workers who were facing the risk of infection every time they went to work, I am glad for the temporary standards that were passed. I am sure they saved lives. This pandemic has been an extremely difficult time for front line workers. I have attended too many zoom funerals of people who were infected in their workplace. Now, especially with the mutating virus, workplace protections are even more vital to prevent infection, illness and death. Virginia played an important leadership role in our country at a time when the federal government failed to provide consistent standards or create any protections for workers. Workers in this country need these protections until the pandemic is completely over

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87946 Vance Ayres 2021/04/01 13:35:34 vayres@iuec.org

Make worker safety permanent including new standards! As a life long resident of 54 years of Virginia and a representative of working folks I am proud to say Virginia was the first to pass and implement the Emergency Temporary Standards that mandated health and safety workplace regulations to protect workers against COVID 19. This terrible pandemic has taken a toll on many workers including myself as my 83 year old mother somehow contracted the COVID 19 virus before Christmas and has been quarantining since and as of now is in very bad shape and will be lucky to survive. This happened with restricted social interactions and while following COVID 19 CDC rules like going to the grocery store. I also have a 2 college daughters that have had to have multiple COVID tests done and one older daughter that all work in the food industry that interact with the public everyday and they need all the required protections and public requirements as possible to try to keep them safe.

So, in conclusion I would say the least we need to do in Virginia is to extend the Emergency Temporary Standards to make them permanent to protect the workers that have constant interaction with the public just as a result of them performing their jobs everyday. I hope that the folks making this decision have the fortitude, intelligence, common sense and passion for working folks risking their lives everyday to keep society functioning.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87947 Susan Bruns 2021/04/01 13:36:56 srbruns@hotmail.com

Make emergency temporary standards permanent Please make these temporary standards to protect our workers permanent. We need to protect our most vulnerable, our workers from the devastation this pandemic has caused in disruption of job security, job safety and personal health and well being. Please act to ensure these standards will stay in place and continue to help our workers Susan Bruns

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87949 Jenny Toth 2021/04/01 14:18:19 jtoth@hburgchc.org

Return to Work Guidance The elimination of the test-based strategy as part of the return to work guidance has the potential to significantly impact the staffing of our organization. If employees with a known exposure, positive test of symptoms must adhere to:

At least 24 hours of being fever-free without the use of fever reducing medications;" AND

Improvement of symptoms associated with COVID-19 including cough and shortness of breath; AND

At least 10 days have passed since symptoms first appeared.

This has the opportunity to create a situation where an employee who would otherwise be able to return to work based on a negative test and meeting the first two criteria being unable to do so for 10 days. The impact to our staff's income could be significant if they must miss this much work unnecessarily.

I would recommend providing alternative return to work guidance that incorporates a test-based option, and is geared toward individuals in a healthcare setting who work in appropriate PPE throughout the course of their day.

The Commenter is incorrect in stating that "The elimination of the test-based strategy as part of the return to work guidance has the potential to significantly impact the staffing of our organization."

First, The Standard does not address the issue of "quarantine". "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does address the issue of "isolation".

"Isolation" is the separation of people with COVID-19 from others. People in isolation need to stay home and separate themselves from others in the home as much as possible. Requirements for returning to work from isolation is covered by the ETS in 16VAC25-220-40.C. However, please note that in lieu of complying with

16VAC25-220-40.C, employers may comply with recently updated CDC guidelines (see §40 FAQ 18, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>).

Second, 16VAC25-220-40.B.4 provides that “Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an “alternative diagnosis:”

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as “Suspected to be infected with SARS-CoV-2 virus”), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term “Suspected to be infected with SARS-CoV-2 virus” as:

“a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza).”

If an employee HAS HAD “close contact” with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define “close contact” as meaning “you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an “alternative diagnosis”, and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn’t infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

<https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

87953 Julie Hunter 2021/04/01 14:39:55 jhunter@va-aflcio.org

Make the standard permanent "Now more than ever, Virginia must stay committed to protecting its workforce with a strong, permanent COVID-19 OSHA standard.

Every day we are reminded that this pandemic is far from over. My stepson works in a restaurant that has had two positive covid cases in the last 2 months. Thankfully, the ETS lays out a process that protects employees and their rights to a safe workplace. With 5000+ cases every day and community spread evident throughout the Commonwealth, there should be no question about whether to make this standard permanent or not. Even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue to be needed.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87954 Eastern Virginia Labor Federation 2021/04/01 14:46:17 clcunion@aol.com

ETS Standard We support the state's commitment and need to ensure strong protections that workers have now under the emergency standard REMAIN IN PLACE in the permanent standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87956 Elizabeth Konold 2021/04/01 15:14:50 konold@gmail.com

Protect Virginia's workforce by making COVID-19 OSHA protections permanent! With the December 31, 2020 expiration of the Families First Coronavirus Relief Act, Virginia's hardworking men and women have no protection from being forced into work after having been exposed to or infected with COVID-19.

We all watched with great shame the actions of Tyson plant managers in Iowa, who placed bets on how many of their employees would become infected with COVID. is this what we want to see happening in Virginia? As COVID-19 infections spike and the vaccine remains several months away for most people, it is critical that we take steps to mitigate risks for workplace exposure now and in the future. The virus has already taken on a second, more infectious form, and the CDC acknowledges that this is unlikely to be the last such zoonotic virus which evolves to infect humans. Unfortunately, pandemics aren't going away anytime soon. We need robust, permanent OSHA protections AND enforcement to protect the health and safety of all Virginians while preventing another economic disaster.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87957 Donna Davis 2021/04/01 15:32:51 davis.donna55@gmail.com

VA ETS The VA ETS needs to be made permanent to protect our workers. It's the ethical and compassionate thing to do. As citizens of VA we should value our workforce enough to care about them being protected against this pandemic (and any future such events) so that they can carry out their work without fear of the work causing them the danger of illness (or even death.)

Donna L Davis

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87958 Laura Rotenberry 2021/04/01 15:50:10 otisandlaura@gmail.com

csr Working from home is safer.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87959 Eugene Kelly 2021/04/01 15:59:03 ewkelly626@gmail.com

Emergency Temporary Standards - Make Permanent I join with the Virginia AFL-CIO to urge that Emergency Temporary Standards be made permanent: The ETS is a strong standard and should be made permanent The standard is effective when employers implement the protections. Standard is based off scientific information, long-standing occupational practices, and health &a safety recommendations. Key components are based off current OSHA standards and familiar to employers and workers. Face coverings are clearly defined and help control the spread of droplet transmission Thank you.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

87960 Sue Sargeant 2021/04/01 16:17:04 sgt_1976@yahoo.com

Safety for Students, Teachers/Staff in Public Schools Not one person has ever experienced a global pandemic: There's no safe way 'in person' at this time in the viciousness of COVID19 because we're still in 'baseline' data rather than intervention and replication. We're guinea pigs because It's opinion v. fact. Interpretation, Ideology, v. Science. Keep Virginia's public school folks SAFE by doing what Supt. Kamras in Richmond is modeling for this Commonwealth: 100% Distance Learning/DL, including virtual, learning packets and parent coaching. Even for those students with the most significant of Autism and the most 'medically fragile' with intellectual disabilities. They are not even being provided equal educational opportunities as per their general Ed peers to engage in data-driven DL to prove progress or regression, or stabilization/maintenance. All students can learn in DL. As public school educators, sure, we want 'in person'. but #OnlyWhenItsSafeFORALL.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88076 Lou Spencer 2021/01/05 5:28:36 jspencer@local5plumbers.org

Please make ETS Permanent Please make ETS Standards Permanent!

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88085 Mark Flowers 2021/01/05 6:12:39 mflowrs@gmail.com

Covid 19 Permanent Standard to protect Virginia workers Virginia must stay committed to its workforce and protect them from Covid 19 with a Permanent Covid 19 OSHA Standard. The permanent Standard is necessary to protect working people in Virginia.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88221 Anita Snyder 2021/01/05 10:37:35 asnyder@nps.k12.va.us

Keep us Safe I am the Family Engagement Specialist at OCEANAIR Elementary School in Norfolk ,Virginia. I work a five day work week in person and in the field. Home visits are in my job title; to provide parents and students with Zoom, Attendance, Transportation and Technical issues. Our cafeteria staff are on the frontline daily with providing our students with nutritional food and snacks. Oceanair's custodial staff are charged with the Biggest job of maintaining a COVID- 19 free work environment. We must Stay Committed to keep EVERYONE safe. We must Maintain and Continue to have procedures and policies in place to PROTECT.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88250 Wendy 2021/01/05 11:20:35 wendy.kaylor@yahoo.com

Just some thoughts Removing the test based return to work option will likely cause a hardship to both employees (FFCRA sick pay is no longer mandatory) and employers.

Many businesses have suffered and cannot continue to front money, wait on a tax credit, and maintain some level of financial stability

Employees will be less likely to tell their employer they have symptoms since they will be put out (likely unpaid) for at least 10 days.

Temperature checks do not work so employers have to rely on the employees being honest and reporting if they are experiencing symptoms.

It is unclear what to do if your employee has been exposed to someone who has tested positive.

2 positive cases in what time frame constitutes and outbreak?

Business owners, managers, Human Resource professionals, and the like are NOT healthcare professionals, but we are being put in a position to make decisions as such everyday that effect every single person around an employee who may have allergies, strep, the common cold, the flu, or COVID-19. Doctor's are not treating patients like they were a year ago so many who are sick go without answers.

I absolutely agree that we must protect our employees, but they must take responsibility in that too. We can't control what they do outside of work or what information they report to us, but we will still be held accountable for it. Changes and updates to this need to be announced in a manner that is more widespread than the website and Richmond newspaper. You will have many who know nothing about this because they don't check the website regularly or get the Richmond paper.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's assertion " Removing the test based return to work option will likely cause a hardship to both employees (FFCRA sick pay is no longer mandatory) and employers." 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis." <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

§40. FAQ 30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

The Department acknowledges that all of its VOSH laws, standards and regulations can serve to place compliance burdens on employers and employees, particularly in the small business sector. The Department also believes that employers that embrace providing sound and comprehensive workplace safety and health protections can make their business more efficient and profitable through such benefits as reduced injuries,

illnesses and fatalities, reduced workers' compensation costs, reduced insurance costs, improvements in morale and innovation, and increased productivity.

The Department strongly encourages Virginia's small business owners to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at: <https://www.doli.virginia.gov/vosh-programs/consultation/>

In addition, free Outreach, Training, and Educational materials to assure compliance with COVID-19 requirements can be found at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

Although it is a generally accepted practice, the Standard does not specifically require that employers check the temperatures of employees. 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

The Standard does not address the issue of "quarantine". "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does address the issue of "isolation".

"Isolation" is the separation of people with COVID-19 from others. People in isolation need to stay home and separate themselves from others in the home as much as possible. Requirements for returning to work from isolation is covered by the ETS in 16VAC25-220-40.C. However, please note that in lieu of complying with 16VAC25-220-40.C, employers may comply with recently updated CDC guidelines (see §40 FAQ 18, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>).

With regard to the issue of "what to do if your employee has been exposed to someone who has tested positive," § 40, FAQs 25, 26, 27, 28 and 29 explain VDH's role in contact tracing and quarantine situations, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>: SEE ANSWER TO COMMENT 88554 ABOVE.

With regard to screening of personnel, 16VAC25-220-50.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19." Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19." OSHA provides guidance on screening employees in the construction industry that can be used by non-medical personnel at: <https://www.osha.gov/SLTC/covid-19/construction.html>.

While the Department constantly strives to improve information dissemination about its programs, and will continue to look for new ways to do so, it feels that there was widespread notice to the business community and the general public about the adoption of the Emergency Temporary Standard and the Draft final standard through print, television, and social media.

88458 UFCW LOCAL400 2021/01/05 19:09:25 Lisa54321@gmail.com

Help Workers with COVID19 RELIEF . Workers are getting sick everyday from other People spreading COVID19 because a lot of them were traveling doing the Holidays bringing back COVID19 back to Virginia not

knowing they are caring the Term on them which then infecting Workers. Please pass the Law to keep Long term Protection for Workers on the Frontlines trying to do their Jobs with Safety Protections. Thank you

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88522 Carla Okouchi 2021/01/05 23:44:40 carla.okouchi@gmail.com

Covid-19 Emergency Temporary Standard As a Virginian, to be the first state to pass such an outstanding Covid-19 Emergency Temporary Standard makes me very proud of our Governor and the Safety and Health Codes Board. This must become a permanent OSHA standard if Virginia is truly committed to its workforce and stopping the spread of SARS-Cov-2. As a public school employee, I know this standard greatly influenced how our districts have been preparing for a safe return to schools for in-person learning. We are in the midst of a global pandemic with a virus that continues to mutate spreading more rapidly throughout our communities. A permanent standard is necessary to protect all working people in Virginia from infectious diseases

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88554 Neiman C Young, King George County, VA 2021/01/06 9:24:22 neiman_young@yahoo.com

In Opposition to the Permanency of the VOSH Emergency Standards In Opposition to the Permanency of the VOSH Emergency Standards

On behalf of the King George County Board of Supervisors, I am writing to express our strong opposition to the Virginia Occupational Safety and Health (VOSH) Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19. VOSH's attempt to establish emergency orders as permanent policy undermines the Commonwealth's legislative process and illegally affords a regulatory agency the ability to step outside of their authority (or lack thereof) to craft statutory policy.

In addition, the VOSH standard places both employers and employees at risk. First, it includes no prohibition on barring employees from coming to work after close contact with an individual who has tested positive for COVID-19; nor does it afford an employer the ability to install testing based return-to-work policies. Second, the permanency of the VOSH policy will deny agencies the benefit of adjusting their operating procedures to meet ever evolving CDC guidance; this rigidity will compromise an organization's ability to take advantage of scientific discovery and recommendations regarding a novel disease. Finally, the Proposed Permanent Standard lacks "safe harbor" protections for employers that follow current CDC guidance in their attempt to maintain a safe workplace.

We ask that you reconsider this matter and afford agencies the ability to establish local policy that reflects the ground truth of each organization. This cookie cutter approach to combating the COVID-19 disease undermines our ability to safeguard the health and welfare of our employees and the community.

Respectfully, NEIMAN C. YOUNG, PhD, County Administrator, King George County, 10459 Courthouse Drive, Suite 200, King George, VA 22485, 540.775.9181, nyoung@co.kinggeorge.state.va.us

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's assertion that there is anything "illegal" about a state agency adopting a standard or regulation pursuant to a statute passed by the General Assembly and signed into law by the Governor (Va. Code §40.1-22(6a)) to address a situation it clearly has jurisdiction over (occupational safety and health in the workplace per Va. Code §40.1-2).

The Commenter is correct that the standard does not contain a prohibition on barring employees from coming to work after close contact with an individual who has tested positive for COVID-19. That was done intentionally as VDH has jurisdiction over such situations. Section 40, FAQs 25, 26, 27, 28 and 29 explain VDH's role in contact tracing and quarantine situations, <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>:

§40, FAQ 25. What is the difference between “isolation” and “quarantine”?

“Isolation” is the separation of people with COVID-19 from others. People in isolation need to stay home and separate themselves from others in the home as much as possible. Requirements for returning to work from isolation is covered by the ETS in 16VAC25-220-40.C. However, please note that in lieu of complying with 16VAC25-220-40.C, employers may comply with recently updated CDC guidelines (see §40 FAQ 18).

“Quarantine” is separation of people who were in “close contact” with a person with COVID-19 from others. People in quarantine should stay home as much as possible, limit their contact with other people, and monitor their health closely in case they become ill.

“Close contact” means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.

Requirements for returning to work from “quarantine” is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29).

§40, FAQ 26. When can an employee filling an essential critical infrastructure role (except for education sector workers) return to work after close contact with a person with COVID-19?

Close contacts of a known COVID-19 case who are not experiencing symptoms should be quarantined at home until 14 days have passed since last contact with the COVID-19 case or, if contact is ongoing (such as living together in a household), 14 days after the COVID-19 patient has been released from isolation, which may result in exclusion for up to 24 days.

NOTE: If the employee is a household contact of a person with COVID-19 and the employee is able to have complete separation from the ill person (meaning no contact, no time together in the same room, no sharing of any spaces, such as the same bathroom or bedroom), the employee may follow the timeline for non-household contact.

However, it may be necessary for personnel filling essential critical infrastructure roles (except for education sector workers) who are asymptomatic contacts to remain in the workplace in order to provide essential services, if the business cannot operate without them. These situations should be reviewed with the local health department on a case-by-case basis, with home quarantine being the preferred method of addressing close contacts. If the employee develops symptoms of COVID-19 or tests positive for SARS-CoV-2, exclusion guidance

for employees suspected or confirmed to have COVID-19 should be followed. If the employee tests negative during the quarantine period, they must continue to quarantine for the full 14 days.

If a business is unable to operate without the critical infrastructure employee, the employee (except for education sector workers, who should follow the public health quarantine guidance for non-essential workers listed in FAQ 27 and outlined here) may return to work (not undergo quarantine) as long as:

- Employers pre-screen the employee (temperature checks)
- Employers conduct regular monitoring of employee
- Employee wears a face mask at all times for 14 days after last close contact
- Employee maintains 6 feet of physical distance from all persons outside their household
- Employer ensures work space is routinely cleaned and disinfected

However, anyone who has been exposed through close contact with someone with COVID-19 does NOT need to stay home when the exposed person:

- developed COVID-19 illness within the previous 3 months,
- has recovered, and
- remains without COVID-19 symptoms (for example, cough, shortness of breath)

§40, FAQ 27. When can an employee NOT filling an essential critical infrastructure role return to work after close contact with a person with COVID-19?

Close contacts of a known COVID-19 case who are not experiencing symptoms should be quarantined at home until 14 days have passed since last contact with the COVID-19 case or, if contact is ongoing (such as living together in a household), 14 days after the COVID-19 patient has been released from isolation, which may result in exclusion for up to 24 days.

NOTE: If the employee is a household contact of a person with COVID-19 and the employee is able to have complete separation from the ill person (meaning no contact, no time together in the same room, no sharing of any spaces, such as the same bathroom or bedroom), the employee may follow the timeline for non-household contact.

If the employee develops symptoms of COVID-19 or tests positive for SARS-CoV-2, exclusion guidance for employees suspected or confirmed to have COVID-19 should be followed. If the employee tests negative during the quarantine period, they must continue to quarantine for the full 14 days.

However, anyone who has been exposed through close contact with someone with COVID-19 does NOT need to stay home when the exposed person:

- developed COVID-19 illness within the previous 3 months,
- has recovered, and
- remains without COVID-19 symptoms (for example, cough, shortness of breath)

Further details are available [here](#).

§40, FAQ 28. Can employers require employees who were close contacts of a COVID-19 case to return to work sooner than 14 days after the close contact?

Employers must follow appropriate quarantine requirements discussed in FAQs 26 and 27 for employees who were close contacts of a COVID-19 case before allowing such employees to return to work.

§40, FAQ 29. Can an employee's negative test for SARS-CoV-2 after close contact with a COVID-19 case release an employee from quarantine?

No. It is possible for an employee to test negative for SARS-CoV-2 after the close contact and still develop symptoms of COVID-19 up to 14 days after the close contact. Employers and employees must follow appropriate quarantine requirements discussed in FAQs 26 and 27 for employees who were close contacts of a COVID-19 case before allowing such employees to return to work.

§40, FAQ 30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

The Commenter is incorrect in stating that the standard does not "afford an employer the ability to install testing based return-to-work policies." 16VAC25-220-30.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis", <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>:

§40, FAQ 30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

With regard to change CDC guidelines, the Department notes that the Standard provides flexibility to business through 16VAC25-220-10.E which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2

and COVID19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.”

The Commenter is incorrect that the standard does not include "safe harbor" language - see above 16VAC25-220-10.E. The Standard is clear that employer's wishing to take advantage of 16VAC25-220-10.E must comply with both mandatory and non-mandatory provisions in the specific CDC guidelines, and those provisions must provide equivalent or greater protection than provided by a provision of the Standard.

The Department does not plan to recommend that 16VAC25-220-10.E be returned to its original language. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.G assures such protections.

88592 Destiny LeVere 2021/01/06 11:12:58 dlevere@va-afcio.org

Permanent Standards Are What We Need Virginia must stay committed to its workforce and protect our workers and our communities from COVID-19 with a strong, COVID-19 OSHA standard.

This pandemic is far from over. Even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue to be needed.

I personally have known 3 people who have contracted the virus while on the job/at their workplaces, and have passed away because they were not supplied the proper PPE by their employers, who couldn't take the proper time off necessary to recuperate, so the added stress exacerbated the horrible effects of the virus, and because of it, they are no longer able to be a part of working for Virginia and our families are without them.

We don't know how long this pandemic will last nor if something else like this will ever happen again, but what we do know, is that it is better to be prepared ahead of time, than to wait until the bad thing happens and trying to fix it.

The permanent standard is necessary to protect working people in Virginia. A thriving and healthy working class is what it takes to beat back the virus, and what will be necessary to build back our economy once we come out on the other side of the pandemic.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88649 Barry DuVal, Virginia Chamber of Commerce 2021/01/06 16:02:42 e.rison@vachamber.com

RE: DOLI solicitation of public comments regarding the adoption of a permanent standard Dear
Commissioner Davenport and Members of the Safety and Health Codes Board,

The health and safety of our workforce and customers continue to be the top priority for businesses in the commonwealth during the ongoing pandemic. Thank you for taking into consideration some of our previously stated concerns regarding the emergency temporary standard and working with the business community and other stakeholders on this important topic.

Although we support clear and consistent workplace health protection protocols and the proposed permanent standard addresses some of the business communities' concerns; we remain concerned about the impact that making the emergency temporary standard permanent might have on businesses. We continue to believe that the regulation needs to allow for maximum flexibility for businesses to respond to outbreaks and, more importantly, businesses that follow these regulations need legal protections from frivolous lawsuits. If the board decides to make the standard permanent, we encourage you to allow the permanent standard to sunset once the pandemic state of emergency is rescinded.

Lastly, we continue to believe that enforcement of these provisions should be handled with understanding and leniency. Virginia businesses, many of which have been devastated by the economic impact of this pandemic, are working hard to remain safely operational for their workforce and customers; however, the shifting regulatory landscape continues to be a significant challenge, especially for Virginia's small businesses. As the Board considers making these standards permanent, it is our hope that they will refrain from over enforcement and not penalize businesses that have given a good faith effort in following these complicated rules that continue to change.

Thank you for your consideration.

Best regards,

Barry E. DuVal, President and CEO

Virginia Chamber of Commerce

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88699 Kerri Ross 2021/01/07 10:12:43 kross@cwa2201.org

Standards Standards. We need this to be a permanent standard. We have no idea when this pandemic will end. We would then have a procedure in place to deal with situations that could come up. All workers in Virginia need to have this protection.

Thanks

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88702 Joanne Carpenter/CHEMetrics, Inc. 2021/01/07 11:06:02 jcarpen465@aol.com

Permanent Draft does not address Return to Work guidelines for asymptomatic employees Permanent Draft does not address Return to Work guidelines for asymptomatic employees

As far as I can tell, the proposed Permanent Standard revised text for Return to Work policy on pg 26 only addresses symptomatic employees known or suspected to be infected with the SARS-CoV2 virus. Unlike the Temporary Standard, no guidance is given for asymptomatic employees, (which is what we deal with most often). There are 6 hits for the search term "asymptomatic", so the condition is acknowledged in the Draft Permanent Standard.

Here's how the Temporary Standard handled Return to Work for asymptomatic employees, (pg 18)

The employer shall develop and implement policies and procedures for known to be infected with SARS-CoV-2 asymptomatic employees to return to work using either a time-based or test-based strategy depending on local healthcare and testing circumstances. While an employer may rely on other reasonable options, a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the time based strategy requirements in §16VAC25-220-40.B.2.a will constitute compliance with the requirements of §16VAC25-220-40.B.

It is baffling why the Return to Work section of the Permanent Standard is exclusively tied to symptomatic cases. In our organization, we have been fortunate thus far with a very low (+) case rate over the 10 month period. We attribute this to our employees who have been forthcoming in reporting possible Covid exposures. Of course these cases involve waiting (keeping the employee home) until until the +/- status is established for the suspect case and then prescribing stay a home directives from that point. Furthermore, employees who do test (+) may be allowed to return to work too soon if they have a mild case and are asymptomatic.

By not providing guidance for asymptomatic employees, a business will be more apt to allow an asymptomatic employee (under various scenarios) back into the workplace prematurely.

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

88707 Reg Tanner (Merck) 2021/01/07 11:43:23 REG.TANNER@MERCK.COM

Merck Elkton Facility Comments"Merck Elkton Facility Comments

As a fundamental overarching comment, Merck opposes the adoption of the current 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19. Merck believes that a more appropriate approach is to continue with a Temporary Standard with a suitable extension process with defined end dates. This could be accomplished with six-month renewals of a Temporary Standard (allowing for updates as necessary) with reevaluation of applicability and necessity at the end of each six-month term.

Comments on specific text are below.

In Section 16VAC25-220-30 Definitions;

The definition of Face Covering has been updated to include only washable fabric masks. Merck's pharmaceutical operations are regulated by the Food and Drug Administration (FDA) which does not permit the use of washable fabric masks in many of our manufacturing areas. The use of fabric masks has the potential to introduce fibers into sterile production areas and can be a mechanism for the transmission of contaminate microorganisms to pharmaceutical product. Rather, Merck's Elkton Facility uses disposable sterile masks, consistent with FDA requirements. These disposable sterile masks visually look like a Surgical/Medical Procedure

Mask but are not FDA approved (as referenced in the definition of Surgical/Medical Procedure Mask in Section 16VAC25-220-30 Definitions). These disposable sterile masks are considered Face Coverings by Merck, and as such are designated as Face Coverings in our COVID specific Hazard Assessments. The new proposed language in the definition of Face Covering appears to exclude the approach Merck has taken for Face Coverings in its pharmaceutical production areas. This is a significant issue that requires clarification. Our recommendation is to address the words “washable” and “fabric” to allow appropriate flexibility to use these disposable sterile masks as Face Coverings while meeting FDA manufacturing requirements. Importantly, utilizing FDA approved Surgical/Medical Procedure Masks as face coverings under the Virginia regulations would unnecessarily remove them from the inventories for hospital use. Merck does not believe this is an appropriate allocation of these critical resources. As such Merck is requesting that the definition be clarified such that disposable masks, that are not necessarily FDA approved Surgical/Medical Procedure Masks, are designated as an acceptable form of Face Covering.

In Sections 16VAC25-220-40 Mandatory Requirements for all Employers

Section 16VAC25-220-40 B.8 the new language regarding employer reporting of COVID positive cases “present at the place of employment within 2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test)” is now inconsistent with the language in the subsections that follow, i.e., Sections 16VAC25-220-40 B.8.d. & e. These sections (Sections 16VAC25-220-40 B.8.d. & e) still contain the language “present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period.” This requirement requires clarification such that the new language in Section 16VAC25-220-40 B.8 is clearly applicable in Sections 16VAC25-220-40 B.8.d. & e.

Sections 16VAC25-220-40 B.8.d. & e.; The 24 - hour reporting requirement for VDH and DOLI requires modification. The private personal information necessary for this reporting requires coordination between three groups within Merck: Health Services, Human Resources, and Environmental Health & Safety. It is not feasible to staff these three functions 24 hours per day/7 days per week. This makes reporting over weekends and holiday periods extremely challenging. It is not clear that VDH or DOLI are using this information in any way that necessitates reporting within 24 hours. Merck believes that reporting by the “next business day” will alleviate an unnecessary reporting burden, protect personal information that should not be handled by individuals outside the groups listed above, and provide VDH and DOLI with the necessary information in an appropriate period of time.

Section 16VAC25-220-40 B.8.d.; The term “Declared Emergency” requires definition. Who implements and communicates a “Declared Emergency” in the future? A clear definition and defined process is needed.

Sections 16VAC25-220-40 B.8.e.; Unlike subsection d above, there appears to be no end to this reporting requirement or reimplementation based on necessity. At a minimum, the same language in subsection d needs to be included in subsection e so it is not an “in perpetuity” requirement.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

If the commenter's place of business uses surgical/medical procedure mask consistent with Food and Drug Administration (FDA) guidance, it will be in compliance with the standard. Surgical/medical procedure masks are defined in the standard are regulated by the FDA, and are a form of personal protective equipment permitted under the standard.

16VAC25-220-30:

"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).

With regard to 24 hour reporting requirements in 16VAC25-220-40.8, such requirements are consistent with other reporting requirements in statute. See Va. Code §40.1-51.1.D. Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings. In accordance with prioritization procedures, VOSH may conduct either informal investigations or inspections in response notifications received under 16VAC25-220-40.8.

88717 CharlesCraddock CWA Local 2201 2021/01/07 12:53:44 ccraddock@cwa2201.org

Permanent Standard Needed This permanent standard is critical to the pursuit of ending this pandemic. Workers in Virginia need this protection in place to systematically prioritize the health and safety of employees and their families over irresponsible employer actions that ultimately fuel the spread of this virus and its often tragic outcome.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88718 Jesse Hemphill 2021/01/07 12:56:39 jhemphill@commonwealthlodging.com

Permanent Standards are Unnecessary The adopted Emergency Temporary Standard related to COVID-19 was a thoughtful gesture, but is burdensome on already struggling organizations and will stretch governmental departments even further than they currently are to monitor, enforce and educate. The temporary standards were quickly outdated with the ever changing environment experienced in 2021 and have now become obsolete with the roll out of vaccines and improved treatments. Unnecessary mandates create further hardships to an economy trying to recuperate from a devastating blow.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88752 Theodore L. Voorhees, County of Orange
tvoorhees@orangecountyva.gov

2021/01/07 17:28:56

Permanent Rule on Infectious Disease Standard "https://orangecountyvagov-my.sharepoint.com/:w:/g/personal/tvoorhees_orangecountyva_gov/EZep3ig8oFVMkeemDOZoQBsBDMqeWXzSD1z3aXboVwxnLg?e=UzvgNr

I still think this language is problematic. If the employee is known to be infected, then it is fine. But if they are only "suspected" this does not work to provide a way to rule out SARS-CoV2 in favor of some other common respiratory illness, such as flu, cold or sinus infection. Suspected symptoms overlap between a possible SARS-CoV2 infection and numerous other illnesses.

I believe that one of the challenges to using a test-based strategy is that some tests will come back negative for asymptomatic people or people who are early in the disease lifecycle. To account for this, rather than 24 hours fever-free and 10 full days since symptoms first appeared, I would propose that DOLI add an additional test-based option similar to the following:

(iv) As an alternative to meeting all three conditions, an employee may return to work upon receiving a negative PCR test result following a period of at least 24 hours fever-free without the use of fever-reducing medications, or a medical diagnosis from a licensed healthcare provider of a different illness with overlapping symptoms.

As I complete this email, I am thinking that the way out of this is to simply change the diagnosis if a test-based strategy is used. I suppose once someone gets a PCR test that is negative, he/she could possibly no longer be suspected of having SARS-CoV2 in the first place, but the regulation does not make this clear since it lumps test-based and symptom-based strategies together.

Theodore L. Voorhees Orange County Administrator

The current requirements for return to work are consistent with CDC and VDH requirements. The Department does not intend to recommend any changes in response to the Commenter's suggestion.

In addition, 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis." <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

“a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza).”

If an employee HAS HAD “close contact” with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define “close contact” as meaning “you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you.”

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NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn’t infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

88753 Coleman S Lyttle Sr The Lyttle Companies 2021/01/07 17:32:28 clyttle@lyttleco.com

permanent covid standards we oppose any adoption of permanent covid 19 workplace safety standards and strongly suggest that after covid restrictions are lifted employers / contractors / small businesses be subject to current health standards that exist with OSHA / VOSHA. Any implement of permanent covid standards once the restrictions are lifted would be extremely cost prohibitive and unnecessary for our industry.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88754 Bryan Bumgardner, Fortiline Waterworks 2021/01/07 17:58:21
bryan.bumgardner@fortiline.com

Strongly Oppose Adopting a Permanent Standard Strongly Oppose Adopting a Permanent Standard

Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary

health situation. I remain committed to the health and safety of my coworkers, employees and customers and I thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88756 Smith-Midland Corporation 2021/01/07 18:33:37

Strongly Oppose the Permanent Standard Dear Members of the Safety and Health Code Board, First, thank you for your time and effort in helping control the spread of Covid-19 in our beloved State of Virginia. I think the temporary standards have helped a lot. As an employer at Smith-Midland Corporation, a precast concrete manufacturer that produces essential products for infrastructure needs in Virginia, I strongly oppose a Permanent Standard for Infectious Disease Prevention. The proposed standard has no specified end date and is based on a temporary standard for a temporary health crisis. There are now two vaccines distributed to Virginia which will soon wipe out Covid-19. A permanent standard will be burdensome and costly to our business (in both time and money) and provides no flexibility to adapt for a time (hopefully soon) when Covid-19 is no longer a threat. Again, I STRONGLY OPPOSE the adoption of a Permanent Standard, with no expiration, for what is a temporary health crisis.

We will remain, as always, committed to the health and safety of our employees. I appreciate you giving me the opportunity to publicly comment. Sincerely, Matthew Smith, Smith-Midland Corp.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88757 Concrete Precast Structures Inc. 2021/01/07 18:39:27 mimicoles@cox.net

Strongly oppose the permanent standard We strongly oppose the permanent standard

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88760 Gene McGee 2021/01/07 18:59:22 Gene.McGee@rinkerpipe.com

Strongly Oppose Adopting a Permanent Standard "Members of the Safety and Health Code Board, As an employer in the precast concrete industry, we produce essential products to support the infrastructure needs of the Commonwealth. I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. As a critical part of the construction industry, we are an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor’s COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the “Low” and “Medium” categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my employees, co-workers, and customers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88764 Cristy Robinson 2021/01/07 19:29:16 cristy@ctpurcellinc.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88765 Shane Sweat 2021/01/07 20:02:01 shanesweat@brucehowardcontracting.com

Strongly oppose adopting a permanent standard Members of the Safety and Health Code Board, As a project manager in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. This permanent standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88787 David Driskill Rish Equipment 2021/01/08 5:56:45 ddriskill@rish.com

Opposition to Adopting Permanent Infectious Disease Standards "As a territory manager in the construction machinery industry, I strongly oppose adopting a permanent standard to address infectious disease issues. These measures while necessary during the first and only pandemic we have faced in our lifetime are not necessary or appropriate as a permanent standard. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with 95% efficacy and several more candidates are nearing the end of their trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I am committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment David Driskill

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88789 Troy Dow 2021/01/08 6:33:17 Troy.Dow@Mastec.com

Strongly Oppose Adopting a Permanent Standard "As an employer of over 500 individuals in the utility construction industry, in the state of Virginia I am strongly opposed to making this standard permanent. My objections are listed below.

- Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.
- Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.
- The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.
- The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.
- What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?
- The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88793 Diana Lopezarenas 2021/01/08 7:06:58 diana_k09@hotmail.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88795 Michael Willis 2021/01/08 7:38:01 mjwillis56.mw@gmail.com

Adopting Permanent Standard For Infectious Disease PreventionAs an employee (Operations Manager) in the heavy construction industry, I oppose adopting a permanent standard for Infectious Disease Prevention: SARS-CoV-2 Virus that causes Covid-19, 16VAC25-220. The proposed permanent standard has no specific end date and is based on a temporary standard for a temporary health crisis for which there are now two vaccines distributed in Virginia with over 90% efficiency and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to public comment. Thanks, Michael Willis

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88796 Holly Porter, Delmarva Chicken Association 2021/01/08 7:49:19 porter@dcachicken.com

Strongly Oppose Permanent Standard Regulations Thank you for the opportunity to comment on the adoption of a permanent standard pertaining to COVID-19. The Delmarva Chicken Association is the 1,600-member trade association representing the chicken growers, companies and allied businesses in Delaware, the Eastern Shore of Maryland and the Eastern Shore of Virginia. In particular, we have two chicken company members in Accomack county that employ thousands of Virginia residents and contract with more than 60 growers. Our comments reflect the views of DCA and do not constitute a statement of admission on behalf of individual members of DCA. To be clear, employee health and safety has been the number one priority of the Delmarva chicken companies, followed closely by providing an abundant food supply during this crisis. And the

efforts that have been made have worked – prior to any regulations, emergency or permanent, being implemented. According to data shared by the Virginia Department of Health (VDH), about 90 percent of cases among poultry and meat processing workers occurred in April and May, with a dramatic decline after that, even as Virginia cases have and continue to increase. This can clearly be due to the industry’s implementation of OSHA, CDC and VDH guidance – not regulations. DCA continues to have many of the same concerns with the permanent standard as we did with the emergency temporary standards and urges the Virginia Department of Labor and Industry (DOLI) not to promulgate the proposed permanent standard because the regulations are not necessary and will not allow for flexibility as more is learned about this virus. Virginia should not be making permanent regulations that are specific to a temporary virus – which we all believe COVID is. Our specific concerns with the latest proposed regulations include: A static regulation is inappropriate given the ever-changing science and understanding of not only COVID-19, but the vaccine that is now being administered. There seems to be no sunset for this permanent standard, which is concerning as we have said many times, this pandemic is temporary.

The proposed permanent standard that was published for the 30 day public comment changed the day before the public hearing, making it very difficult to know which draft will be voted upon by the Virginia Safety & Health Codes Board next week – this makes the public process feel less than genuine.

The economic impact analysis that is required for all regulations to deterring the costs to small businesses will not be provided until the day before the Board meeting. This is unacceptable for both the Board members as well as the regulated small business. VOSH already has the ability under OSHA general duty clause to cite a business that fails to take actions to protect its workers from COVID-19, as recommended by OSHA or CDC. Both the United States Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) have issued guidance, updated with regularity as new information is learned about the disease, to employers regarding preventative actions that can be taken to protect worker health and safety and mitigate against transmission of the disease at workplaces. DCA would urge DOLI to not adopt a permanent standard and at most, consider a sunset method that allows any on-going COVID-19 regulatory standards to expire immediately when the state’s emergency order has ended. This makes the most sense rather than setting a precedent of a permanent standard on a temporary issue.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88804 Aaron Myers - Allan Myers VA, Inc. 2021/01/08 8:40:35 aaron.myers@allanmyers.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to

current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment. Sincerely, Aaron T. Myers Executive Vice President Allan Myers VA, Inc.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88814 Shannon Hayes, Director of Human Resources 2021/01/08 9:25:51 shannon.hayes@timmons.com

Strongly Oppose Adopting Permanent Standard Members of the Safety and Health Code Board,

As a Human Resources Director in the AEC industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Low and Medium categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88817 Darrin Brown - McClung Logan Equipment, Inc. 2021/01/08 9:30:42 dbrown@mcclung-logan.com

Strongly Oppose Adopting Permanent Standard While the lengths to which we go each day to protect ourselves and our customers is completely necessary at this time, it is far from necessary to make them permanent requirements. Please, let's use some common sense. Respectfully, Darrin Brown - President

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88820 Daniel Rickmond, P.E., BHCI 2021/01/08 9:36:21 DanielRickmond@brucehowardcontracting.com

In Opposition of the Proposed Permanent Standard "After reading and reviewing the Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that causes COVID-19 (16VAC25-220) I stand in strong opposition to its adoption. I offer the following comments and observations as specific examples of my opposition. The permanent standard has no mechanism for ending these requirements. With vaccines now becoming available a permanent standard is unnecessary. It would be more sensible to simply extend the temporary standard in reasonable intervals to react appropriately to the changing situation. The reporting requirements place an undue burden on employers and have vague outlines. The 24-hour reporting requirement does not define a period in which the 2 identified employees were found to be sick, i.e., if employee A is found to have been exposed to COVID-19 on February 1st and employee B is found to have been exposed on May 15th, does the employer still have to report to the VDH under this requirement? The reporting requirements create a health risk for employees. Under these requirements it is a reasonable assumption that some employees will be less likely to tell their employer that they have symptoms or have been exposed to COVID-19 since they will be out of work for a minimum of 10 days.

The scientific data does not support that there is an immediate danger to employees categorized as low and medium risk. Workers such as those in the construction industry who work outside in unconfined spaces, do not interact with the public, and often work alone on individual pieces of equipment. This type of employee represents a wide portion of Virginia's work force and should not be subjected to the same requirements as those employees who must meet and interact with the public daily.

As a Professional Engineer working in the construction industry, I have found that the current CDC and OSHA guidelines are more than sufficient regulations for my industry.

Thank you for the opportunity to comment. Sincerely,
Daniel T. Rickmond, P.E Director of Engineering Bruce Howard Contracting, Inc.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88823 Eric Moore 2021/01/08 9:42:53

Permanent Standard for Infectious Disease Prevention Members of the Safety and Health Code Board, As a Director of Safety in the heavy construction industry, I strongly oppose a "Permanent" Standard for Infectious Disease Prevention;Sars-CoV-2 Virus that causes COVID-19. The current proposed standard has no specified end date and is based on the temporary standard. This standard is not only taxing and a burden for cost to smaller businesses, but also can cause a greater hazard to working conditions in the summer when our product is already 350 degrees. I'm strongly opposed to the current standard with no expiration for what seems to be

more than likely a temporary health situation with the forecast of a vaccine. I remain and will always look out for the Safety and wellbeing of my employees, and thank you for listening.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88825 Mike Van Sickel 2021/01/08 9:50:00 vansickelm@branscome.com

STRONGLY OPPOSED to the adoption of a Permanent Standard As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88826 Stacy Fossum 2021/01/08 9:52:15 stacy.fossum74@gmail.com

Strongly Oppose Adopting a Permanent Standard As a Benefits Manager in the AEC industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Medium categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88830 Barbara Jones 2021/01/08 10:07:26 sagle@ctpurcellinc.com

STRONGLY OPPOSE ADOPTING A PERMANENT STANDARD Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am **STRONGLY OPPOSED** to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88831 Michael H 2021/01/08 10:10:02 harrierm@branscome.com

Strongly Oppose Adopting Permanent Standard for Infectious Disease Prevention: As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88832 Anonymous 2021/01/08 10:10:42 tup@ctpurcellinc.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88833 Charles Purcell 2021/01/08 10:11:09 tup@ctpurcellinc.com

Strongly Oppose Adopting a Permanent Standard "Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an

Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88835 S J Purcell 2021/01/08 10:11:54 bsjre@hotmail.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88836 John Jones 2021/01/08 10:12:17 jejonesjr33@gmail.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88837 Carter Purcell/ ATC 2021/01/08 10:13:28 cap32012@hotmail.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent

standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88838 Edith Duke 2021/01/08 10:14:18 addison_purcell@icloud.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88840 David Redford 2021/01/08 10:18:28 dave.redford@lbh2o.com

Strongly Oppose Adopting a Permanent Standard As a Sales Manager for the Heavy Construction industry, I STRONGLY OPPOSE adopting a Permanent Standard for Infectious Disease Prevention: SARS-Cov-2 Virus that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specific end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment. David Redford

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88841 Erica T 2021/01/08 10:18:44 etester@branscome.com

STRONGLY OPPOSED to the adoption of a Permanent Standard STRONGLY OPPOSED to the adoption of a Permanent Standard. As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis, for which there are now 2 vaccines distributed to Virginia, with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard, specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88842 Charles Crabbe 2021/01/08 10:19:51 crabbe@ctpurcellinc.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-

19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88844 Kate Bates, Arlington Chamber of Commerce 2021/01/08 10:21:04 kbates@arlingtonchamber.org

Arlington Chamber Opposition to Making ETS Permanent Dear Commissioner Davenport and Members of the Safety and Health Codes Board,

As we enter the second calendar year of the coronavirus pandemic, the Arlington Chamber of Commerce's paramount priority remains our workforce and customer's health and safety. We also recognize that the prolonged economic dislocation caused by the pandemic has created more urgency for government to collaborate with and to support businesses to rebuild economic activity and to preserve jobs in Virginia. We encourage the Board not to enact the Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19. Notwithstanding the revisions to address some of the business community's concerns, we believe that proposed permanent standard does not minimize disruption and cost in meeting the regulation's health and safety goals. If the Board does enact the permanent standard, we encourage that it sunset once the pandemic state of emergency is lifted. In proceeding, we continue to believe that businesses should have flexibility to apply practices that work best for achieving health and safety in their circumstances. The shifting regulatory landscape continues to be a challenge for our businesses recovery, especially for our small businesses. We encourage the Board not to penalize businesses that have given a good faith effort in following these complex and evolving rules. We thank you for your consideration of these comments. Kate Bates President & CEO

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88845 T. Smith 2021/01/08 10:21:13 hr@ctpurcellinc.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance.

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SEE DEPARTMENT RESPONSE TO COMMENT 87834

88846 Ray B 2021/01/08 10:23:08 ray@ctpurcellinc.com

Please DO NOT adopt the permanent standard Members of the Safety and Health Code Board, >As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no

expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88847 Chris Jones 2021/01/08 10:24:09 tee_purcell@icloud.com

Please DO NOT adopt the permanent standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% efficacy. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance. The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation. Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary. The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginias. The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88848 Brian F Bortell 2021/01/08 10:25:49 brian.bortell@timmons.com

Strongly Oppose Adopting a Permanent Standard "Members of the Safety and Health Code Board,

As an employee and employer in the Engineering and construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with

several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Medium categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers; employees and thank you for the opportunity to publicly comment. Brian

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88849 Timmons Group 2021/01/08 10:26:49 brian.bortell@timmons.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee and employer in the Engineering and construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Low and Medium categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time

and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers & employees and thank you for the opportunity to publicly comment. Brian

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88850 Mary Starr, Branscome 2021/01/08 10:26:52 mstarr@branscome.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board,

As an employee in the heavy construction industry, I oppose adopting a permanent standard for infectious disease preventions: SAWS-CoV-2 Virus that causes COVID-19, 16VAC25-220. The proposed permanent standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science innovation. I am STRONGLY OPPOSED to the adoption of a permanent standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88851 Ashley Smith 2021/01/08 10:27:43 asmith@smithmidland.com

STRONGLY OPPOSED to the adoption of a Permanent Standard January 8, 2021

Members of the Safety and Health Code Board, I am Ashley Smith, President and CEO of Smith-Midland Corporation, a manufacturer of quality precast concrete products headquartered in Midland, Fauquier County, VA. We produce essential products to support the infrastructure needs of the Commonwealth. I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specific end date and is based on a temporary standard for a temporary health crisis for which there is now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my employees, and thank you for the opportunity to publicly comment. Very Respectfully, Ashley B. Smith

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88853 Austin Frederick, McClung-Logan Equipment Co. 2021/01/08 10:36:17 afrederick@mcclung-logan.com

Strongly Oppose Adopting a Permanent Standard We go to extremes to protect our team members and customers, but to adopt this as a permanent standard is preposterous. Let's use our heads and put together a common-sense approach. Austin Frederick - Vice President

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88855 Jake martin 2021/01/08 10:36:35 Jacob.martin1089@gmail.com

Strongly Disagree with adopting the new legislation As a business owner I strongly disagree with the proposed legislation. It will make business more difficult and in the long run will hurt the general working public.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88858 Charlotte Brody, RN for the BlueGreen Alliance 2021/01/08 10:42:30 cbrody@bluegreenalliance.org

The BlueGreen Alliance supports a Permanent COVID Standard On behalf of the 13 national unions and environmental organizations that make up the BlueGreen Alliance, thank you for the hard work and dedication that has gone into the promulgation of the emergency temporary standard and the proposed revised permanent standard to protect Virginia's workers from COVID-19. The BlueGreen Alliance's mission is to align the interests of labor unions and environmental organizations to provide common sense climate and environmental solutions that create family-sustaining jobs, build a fair and thriving economy and protect the health of workers and communities. We support the proposed standard because we believe that it is an important step towards ending this tragic pandemic and making Virginia's workers, communities and economy healthier and stronger over time. The data show the extent of the COVID tragedy and the need for a permanent standard According to data from the Virginia Departments of Health, in the last nine months, more than nine times more Virginians have been diagnosed with COVID than the recent average year of Virginians diagnosed with all types of cancer If only 4 percent of the COVID deaths are workplace related in Virginia, the total is already greater than the number of job-related deaths of workers in the Commonwealth in any of the last five years. The New York Times calculates that the number of cases in Virginia have gone up 21% in the last 14 days. And we haven't yet witnessed the expected increase because of Christmas and New Year's gatherings. Virginia needs a permanent standard so these important state OSHA protections don't expire before the COVID pandemic does. The commenters who are questioning the need for a permanent standard may not understand that. Maybe they also don't understand that once the pandemic is over, the permanent standard could be amended to become an infectious disease standard with appropriate changes or it could be repealed. And maybe they don't understand that the issuance of a federal emergency temporary standard in the upcoming Biden Administration will still take some time before it can be enforced. Maybe they don't understand that even if the initial transmission is at a private gathering, the workplace can be the way the virus dramatically. Or that death is not the only long term impact of being infected by COVID. Or maybe they don't understand that the absence of strong workplace COVID data is not the same as the absence of harm. None of these misunderstandings or the misinformation that these critiques are based on should prevent the promulgation of a permanent Virginia standard. We second the concerns stated by our colleagues from ATU, VA AFL-CIO, UFCW and SEIU. In addition, there is one sentence in the proposed January 4 version of the proposed final standard that we suggest could be made more clear. On page 22, number B2 under Mandatory requirements for all

employers, it reads: Employers shall inform employees of the methods of and encourage employees self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure. Is this sentence meant to require employers to inform employees of the methods of self monitoring? Or is it meant to ensure that employees know the methods of reporting to their employers if they do have COVID signs or symptoms. This is an important provision and we encourage the sentence to be rewritten to clarify its meaning. Again, thank you for all that you're doing for the health and safety of Virginians inside and outside of the workplace.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

With regard to 16VAC25-220-40.B.2:

2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs or symptoms of an illness.

The Department interprets the above language to mean that employers must inform employees of the methods to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs or symptoms of an illness.

The Department does not intend to recommend any language change to this section.

88859 Lucy Lahocki 2021/01/08 10:43:21 Lucy.Lahocki@outlook.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment. Lucy Lahocki

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88861 Jason Dunlavey 2021/01/08 10:46:21

STRONGLY OPPOSED to adopting a Permanent Standard As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88863 Marc Denis 2021/01/08 10:49:29 rwarden@branscome.com

Vehemently opposed As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88864 Anonymous 2021/01/08 10:50:19

strongly opposeAs an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88866 Steve Martin 2021/01/08 10:51:20 Jacob.martin1089@gmail.com

Strongly disagree with adopting the new legislation Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Low and Medium categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88867 Mike Carroll 2021/01/08 10:52:54

STRONGLY OPPOSED As an employee in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88872 Petrina Jones Wroblewski, Columbia Gas of Virginia 2021/01/08 11:04:04
pjoneswroblewski@nisource.com

Comments on Proposed Permanent Standard Relative to COVID-19 On behalf of Columbia Gas of Virginia, we request your consideration of the following recommendations:

COMMENTS

Proposed Permanent Standard for Infectious Disease Prevention, SARS-CoV-2 Virus That Causes COVID-19

NiSource/Columbia Gas of Virginia is a party interested in the promulgation of the referenced Standard/Regulation and offers the following as public comment:

Comment 1 [Page 24, 16 VAC25-220-40B.8.d.]

The term "outbreak" is not defined and, as such, is open to different interpretations. For instance, is an outbreak when the worksite experiences two or more confirmed cases of COVID-19? If so, during what time frame? A 5-day period? A 10-day period? A 14-day period? The term "outbreak" should be defined in the Proposed Permanent Standard, particularly given that the Standard uses the term in multiple places. See, e.g., 16 VAC25-220-40B.8.d., 16 VAC25-220-50B.8.c.5, 16 VAC25-220-70C.4.

Also, when will the Local Health Department close an "outbreak"? When there have been no new cases for a period of 10 days or 14 days? In the same vein, how will the Local Health Department put the employer on notice that it deems the "outbreak" closed? Via written notice to the employer? Other means? It is important to address this issue because the Local Health Department's practice has not been to issue any formal notice that an "outbreak" is closed.

The Permanent Proposed Standard should define when and how the Local Health Department will close an "outbreak." This will ensure that employers are clear on when the Local Health Department has closed an outbreak, thus terminating the employer's obligation to report every confirmed case of COVID-19 to the Local Health Department amidst an "outbreak." See 16 VAC25-220-40B.8.d. ("Employers shall continue to report all cases until the Local Health Department has closed the outbreak. After the outbreak is closed, subsequent identification of two or more confirmed cases of COVID-19 during a declared emergency shall be reported, as above.").

Comment 2 [Page 26, 16 VAC25-220-40C.1.]

The language added under Comment 56 to the Proposed Permanent Standard lacks specificity. It starts by saying “a limited number of employees with severe illness may produce replication-competent virus beyond 10 days”, and that this “may warrant extending duration of isolation up to 20 days after symptom onset.” It also states employees who are “severely immunocompromised may require testing to determine when they can return to work.” Further, employers are instructed to “consider consult[ing] with infection control experts” regarding whether to require testing for “severely immunocompromised” employees before they return to work.

The Proposed Permanent Standard should be clear that the language added under Comment 56 is aspirational and recommended only to the extent feasible, or omit the language altogether, given that the requirements, as drafted, are arguably preempted, at least in part, by federal anti-discrimination laws.

If the language from Comment 56 is to remain and is meant to impose requirements on employers, the language needs to be clarified. For example, how would an employer know of an employee’s severe illness, let alone a severe illness that produced replication-competent virus beyond 10 days? And even if the employer had such knowledge, how is it to determine whether an isolation period of more than 10, and up to 20, days is warranted? If the language from Comment 56 is to remain, it should make clear that employers are not obliged to assess the severity of an employee’s COVID-19 illness, or impose an isolation period of more than 10 days, unless they have (a) actual knowledge of a severe COVID-19 illness from the employee’s medical provider and (b) evidence from the employee’s medical provider that an isolation period of more than 10 days is required due to the presence of replication-competent virus.

Likewise, if the language from Comment 56 is to remain, it should make clear that employers are not obliged to require that severely immunocompromised employees who test positive for COVID-19 receive a negative COVID-19 test prior to their return to work, unless the employee’s medical provider submits evidence that the employee is severely immunocompromised as defined in the PPS and should receive testing before returning to work.

Comment 3 [Page 28, 16 VAC25-220-40F.2.]

The Proposed Permanent Standard states that employers must provide and require that employees wear face coverings while occupying a work vehicle with other employees or persons. It also states that employers should provide access to “fresh air ventilation (e.g., open windows, do not recirculate cabin air).” Based on these instructions and the use of the non-inclusive “e.g.” or “for example”, it seems employers may satisfy their obligation to provide fresh air ventilation to employees riding together in a vehicle simply by (1) requiring the use of facial coverings and (2) not recirculating cabin air within the vehicle, particularly where it is not safe or feasible to open windows due to inclement weather. The Standard should be clarified by addressing whether or not that is true.

Comment 4 [Pages 41 and 51]

The Proposed Permanent Standard omits the heading for 16 VAC25-220-60 before subsection A at the top of page 41. Similarly, the Proposed Permanent Standard also omits the heading for 16 VAC25-220-80 before subsection A at the bottom of page 50. The headings should be the same as the Temporary Standard.

The Department refers the Commenter to VDH for its definition of "outbreak" (it is the Department's understanding that the number of cases to constitute an outbreak is two). The Commenter is also referred to VDH on what their procedures are for closing an outbreak. DOLI has no control over VDH laws, standards, regulations, policies and procedures.

With regard to 16VAC25-220-40.C.1, the phrase "consider consultation with infection control experts" means that the employer should consider contacting VDH or other medical professionals about the specific situation.

With regard to 16VAC25-220-40.F.2, the Commenter is correct that employers may satisfy their obligation to provide fresh air ventilation to employees riding together in a vehicle simply by (1) requiring the use of facial coverings and (2) not recirculating cabin air within the vehicle, particularly where it is not safe or feasible to open windows due to inclement weather. The Department does not intend to recommend any change to the language in the section as it considers the language to be clear as written.

With regard to the headings for 16VAC25-220-60 and -80, they were inadvertently omitted during the process of changing the Word document to a PDF. The corrections have been made.

88875 Hayley Evans 2021/01/08 11:10:13 hevans@wmjordan.com

Strongly Opposed As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the Low and Medium categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88883 Wilmer Waldrop 2021/01/08 12:20:14 wilmer@hotmail.com

OPPOSE!!!! Please DO NOT adopt the permanent standard "Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth of Virginia. The health and safety of all employees is a top priority of our company. A culture of safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance.

The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation.

Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary.

The permanent standard, if adopted, should sunset on the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia.

The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88884 Alesia Clarke 2021/01/08 12:21:51 aclarke88@yahoo.com

Oppose - Strongly Oppose Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is

based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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SEE DEPARTMENT RESPONSE TO COMMENT 87834

88886 Lamont Ingrid 2021/01/08 12:22:47 lingrid@gmail.com

I oppose! Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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safety is a primary operating principle. We quickly implemented the CDC and OSHA COVID-19 guidelines as soon as they were published and are in compliance.

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Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary.

The permanent standard, if adopted, should sunset on the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

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I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations. I need my job and these regulations will cause more layoffs for businesses.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88888 Atticus Smith 2021/01/08 12:23:41 atticusmoney@gmail.com

Oppose!!! Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88890 Ester Mason 2021/01/08 12:25:42 esterlmason@hotmail.com

DO NOT Make the standard permanent "Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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The permanent standard, if adopted, should sunset on the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia.

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The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88892 Carolyn Ruth 2021/01/08 12:29:27 cruth74@yahoo.com

oppose I strongly oppose making this standard permanent. As a supervisor I cannot get people to comply with these regulations. I just want to be able to do my job and my employer does a wonderful job with providing what we need to do safety but i don't think i can continue to argue with people about complying. most cases are not coming from the workplace - they are coming from people gathering and not being safe. Please do not make this go on any longer and burden me as a supervisor and the company i work for. Carolyn.

EE DEPARTMENT RESPONSE TO COMMENT 87834

"

88897 Tim Nester 2021/01/08 12:33:39 timgnester@gmail.com

do not extend into a permanent standard Please do not make this a permanent standard - this is costing families, businesses and our economy with these regulations. the standard is not well written, very rushed and does allow businesses to operate in a way in which they can reward employees and increase wages. You are hurting everyone by making the standard permanent - without businesses there are not jobs. I want more jobs for our state, not less.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88899 Jeremy Gerondal 2021/01/08 12:36:40 jgerondal@branscome.com

STRONGLY OPPOSED to the adoption of a Permanent Standard "As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

The standard, if adopted, should sunset upon the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88900 Scott Claud 2021/01/08 12:36:42 scottc@colony paving.com

I strongly oppose. I strongly oppose

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88907 Melvin L. Carter, Sr. United Auto Workers - Virginia CAP Council 2021/01/08 12:42:39
melcartersr2@aol.com

Workers Safety "On behalf of myself and the United Auto workers, these have been some very stressful months for the Front Line workers, Essential and Non Essential workers, their Families and Friends. The stress of leaving the safety of your home to go to work, thinking you may not return or what condition or illnesses they may endure. As a Union Leader we not only have the safety of our members to be concerned about, the families of those members are our responsibilities as well, to make sure we offer them Safety and Protection to do their jobs. The stress of dealing with the lost of Income, Mounting Unpaid Bills, School closings , Home and Car payments and the rise in everyday Cost of living has been overwhelming.; I've had several Family members, Friends and workers that have had to endure the painful death of love ones along with all the other stress and hurt. We feel that all the workers of Virginia deserve the utmost importance and respect when it comes to their safety, working conditions and health on their jobs. We encourage you to give this matter your undivided attention and support. Virginia has progressed so much over the last several years, and part of that is due to the Trained and Skilled Workforce, it's time to show our workers that the State of Virginia cares about them.

Respectfully,

Melvin Carter, Pres.

VA UAW CAP Council

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88925 Brandon Kim 2021/01/08 12:52:45 bkim@branscome.com

Strongly oppose

Strongly oppose

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88929 Joseph E. Liesfeld, III 2021/01/08 12:57:23 jliesfeld@liesfeld.com

Strongly Opposed to Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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The proposed permanent standard is burdensome at a minimum, quickly obsolete, difficult to enforce, costly in time and money and lacks flexibility to adapt to current science and innovation.

Construction already works under CDC and OSHA guidelines. Placing additional regulations are duplicative and unnecessary.

The permanent standard, if adopted, should sunset on the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia.

The data has not shown a direct or immediate danger for those workers whose tasks fall into the "Low" or "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88930 Trey Woody, Branch Civil, Inc. 2021/01/08 12:57:34 trey.woody@branchcivil.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines (and more forthcoming) to Virginia with over 90% effectiveness.

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The permanent standard, if adopted, should sunset on the expiration of the Governor COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

It is unclear to us, what metrics, scientific data, or criteria the Safety and Health Codes Board would use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginia.

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The standard has been and is currently costly in time and money and if it becomes permanent will be burdensome, obsolete, difficult to enforce and continue to be costly in terms of time and money. It also lacks flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed, as always, to the health and safety of my employees and thank you for the opportunity to provide public feedback. Please do not continue to hurt our business and other businesses with these regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88936 Trey Woody 2021/01/08 12:59:48 jbwoody3@gmail.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board,

I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation; I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

Sincerely

Trey

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88948 Leigh Musselman 2021/01/08 13:15:23 lmusselman@branscome.com

Strongly Oppose As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88953 Trenton Clark, Virginia Asphalt Association 2021/01/08 13:18:04 tclark@vaasphalt.com

Opposition to Adopting Permanent Standard Members of the Safety and Health Code Board,

As President of the Virginia Asphalt Association, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation; I and our Association are STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

We remain committed to the health and safety of our members employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88954 Maureen Miller 2021/01/08 13:18:21 maureen.miller@ingevity.com

Clarification Needed on Reporting Requirements I am also in agreement with previous commenters who are opposed to making this a permanent standard. Should this become a permanent standard, it would be beneficial to provide additional clarification on reporting requirements for VDH with 2 or more cases and VDL for 3 or more cases in the workplace; Reporting cases to VDH and/or VDL should only be required when workplace transmission of the virus has been established during contact tracing. Employees confirmed cases of COVID-19 that are attributable to exposures outside of the workplace, where contact tracing establishes no other employees have been in routine close contact in the workplace, should not be reportable. These are cases which are not the result of, or cause of, outbreaks in the workplace and therefore should not be reportable. Thank you for your consideration of this feedback.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department notes that 16VAC25-220-10.H. provides:

"Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease."

The Department does not intend to make the Commenter's suggested change that would require employers to conduct contact tracing in order to determine whether an employee's positive COVID-19 test was the result of exposure at work or outside of work, as that would add a significant new compliance burden for employers. VDH already has responsibility to conduct contact tracing and the expertise and resources to do so.

88962 American Federation of Teachers Virginia 2021/01/08 13:31:13 tfinck-haynes@fcft.org

Support: COVID Permanent Standard On behalf of American Federation of Teachers, Virginia and our thousands of members that work diligently in our public schools to provide quality education to our students, we strongly urge you to make the emergency standard permanent (ETS). The ETS expires on January 26th, but COVID-19 is far from over. It is critical that the Safety and Health Codes Board and Department of Labor and Industry finalize the permanent COVID-19 safety standard to ensure strong protections remain for Virginian workers. We appreciate your leadership on this issue to date and want to ensure that as Virginia students and staff return to school, they are healthy and safe indefinitely.

Some schools across Virginia are open for face-to-face instruction. As of December 2020, the Virginia Department of Education notes that 9 school districts are 100% in person and 71 districts are partially in person.^[i] This means that currently, 80 of the 132 school districts in Virginia have some component of staff and students in buildings. Across the state, there have been hundreds of cases of COVID-19 in Virginia schools, including COVID-19 outbreaks as defined by the Virginia Department of Health. We expect these numbers to increase as educators return to in person classes. The permanent standard is necessary to protect our school community as we return to in person learning.

We want nothing more than for students and staff to be in school buildings for face-to-face learning, but we must reopen school buildings safely with proper science-based safeguards in place for our school staff, students and families. While the COVID-19 vaccine appears to be on the horizon for school staff, even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue

to be needed to prevent the spread of the virus. It is critical that school districts have one clear, consistent standard in place that protects all school staff, from our teachers to our custodians to our bus drivers to food service workers and instructional support staff. Every single staff member and student in Virginia deserves to be protected from COVID-19 at work. Standards at each school should not change due to federal inaction or political pressure.

As schools across the country try to reopen, we unfortunately have seen what happens when strong health and safety measures such as physical distancing, proper PPE, training, and reporting of infections are not in place. The science is clear. Schools are high risk settings for spread of COVID-19. The Virginia ETS must be made permanent, so we maintain a strong worker protection standard in Virginia to protect Virginia students and school employees. A permanent ETS is critical because it helps ensure school districts outline for employees a clear written plan for how to control COVID-19 workplace exposures using a hierarchy of controls. The standard includes strong training provisions, reporting and notification requirements, and protections against discrimination. These aspects of the standard are essential for employees creating safe environments for students. Currently, the proposed standard has delayed effective dates for essential requirements that are already in place, such as the training requirements. This would create a gap in coverage for key provisions of the rule that will be harmful to workers including school employees. Due to this, we believe it is critical that the standard go immediately into effect for continued coverage of training and other protections.

It is critical that a permanent ETS include language that provide ventilation requirements that ensure airborne transmission is addressed. The proposed standard updates the ventilation requirements to list specific measures to improve ventilation and maintains references to ASHRAE standards, the respected source of indoor air quality standards. These requirements will help to ensure that employers take appropriate specific measures to improve ventilation to keep our school buildings safe. The permanent ETS must also require that workplace outbreaks are reported to government agencies and made publicly available to help identify and slow the spread. This update must apply to outbreak notifications to the VDH and VOSH, which include K-12 school outbreaks. This is a critical aspect that must be incorporated to keep students, staff and families informed and safe in our school community.

In addition, the standard must ensure that adequate respiratory protection is provided to workers when necessary. The standard cannot rollback or weaken protections in the current rule. Further, face coverings must not be allowed in place of respiratory protection. We are concerned that the Virginia Department of Health has proposed changes to the rule to allow face coverings when respirators are actually needed to protect many workers from this virus. Reducing needed protections because of any shortages in supplies must not be in the rule itself and should be handled through enforcement discretion, as the agency always has. Face coverings protect others from the person wearing them and are not a replacement for strong respiratory protection that many workers need. This is especially important for our school employees, who work with vulnerable student populations that by the nature of their job, are not able to necessarily wear specific face coverings.

It is critical that workers, including school employees, are trained on how to properly use PPE. The proposal contains a new requirement to train workers on how to extend the use of PPE. Reusing single use PPE in the workplace is dangerous and places everyone at risk. This provision must be removed.

Instead, workers must be trained on how to properly use PPE and on what makes this equipment the most effective. Any extended use during critical, actual shortages should be handled through enforcement discretion and not the final rule. This proposed provision lowers the bar for everyone and is harmful.

It is vital that the standard addresses all return to work situations. The return to work provisions have been updated to be consistent with current CDC guidance. However, guidance for how to return workers with asymptomatic COVID-19 is unclear. Asymptomatic individuals with COVID-19 are still a major source of workplace exposure and protective requirements must be included to ensure they do not return until they can no longer infect coworkers or students.

The permanent standard will help decrease the spread of COVID-19 in our schools and help limit community transmission. Each workplace and school district are different across Virginia and this standard is important because each workplace will be able to implement a tailored program of control practices that will help keep everyone safe. This is particularly important for staff in our schools who, by the nature of their job, cannot be 6 feet from their students (for example those who work with students that have certain disabilities, speech pathologists, etc), or their students cannot wear face-coverings in the classroom. Having a permanent standard that establishes strong health and safety practices will help isolate and control the spread of COVID-19.

The temporary standard was the first step we needed to help make our schools safer – now we need to make sure it is permanent because COVID-19 is not going away. We need a strong, comprehensive, and enforceable standard with no loopholes for employers that outlines clear requirements based on sound science and proven successful practices. We urge the Virginia Department of Labor and Industry to move forward with the permanent standard rulemaking right away to protect teachers, support staff, students, and our families. Our schools are open now and our school community needs these protections permanently.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

88970 Bruce Howard 2021/01/08 13:39:18 brucehoward@brucehowardcontracting.com

Strongly Oppose Permanent Standard for Infectious Disease Prevention.

I strongly oppose the permanent implementation of this standard. We have always supplied our employees with cleaning materials for personal and use for equipment and work areas and have led by example to set a standard and image (Cleanliness is next to Godliness) for others to see and judge. To place this standard as a permanent standard enforced by the state is far outside what is or should be allowed under our Constitution and brings to question how many in the Private vs Government sector have been infected while on the job?

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88972 Tom Glasheen, Colony Construction 2021/01/08 13:41:31 tomg@colonypaving.com

Strongly Oppose With over forty years in the construction industry, I strongly oppose adopting a permanent Standard for Infectious Disease Prevention. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now vaccines in distribution to all Virginias with well over 90% efficacy and there remains potential for many more vaccines to be available in the near short term.

The standard, if adopted Should End upon the expiration/termination of the Governor's COVID-19 State of Emergency. There is no scientific justification or need of such standard which was specifically introduced in response to the existing health crisis.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88973 Brian Conrad 2021/01/08 13:42:45 bconrad@leehypaving.com

STRONGLY OPPOSE ADOPTING A PERMANENT STANDARD Members of the Safety and Health Code Board,

As an employee and executive officer of my organization, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARs-CoV-2 that causes COVID-19, 12VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary health crisis for which there are now 2 vaccines with over 90% efficacy.

Construction is an essential business performing critical infrastructure work that keeps society moving in the Commonwealth.

The health and safety of our employees is our company's top priority. We responded to the pandemic by implementing CDC and OSHA COVID-19 guidelines as soon as they were published and in compliance.

The construction industry already operates under CDC and OSHA guidelines. Placing additional regulations are unnecessary and duplicative.

The permanent standard, if adopted, should sunset on the expiration of the Governor's COVID-19 State of Emergency. There is no scientific or logical justification for the continuance of a standard that was drafted in response to an Executive Order the COVID-19 State of Emergency.

The data has not shown, a direct or immediate danger to our workers who fall into the "Low" and "Medium" risk categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for industries regulated by OSHA.

The standard has been costly in time, money and resources and will become burdensome if it becomes permanent. The standard lacks flexibility to adapt to science and innovation.

I AM STRONGLY OPPOSED to the adoption of a permanent standard with no expiration date that is geared towards a temporary health situation.

Our organization stands committed to the safety our employees and do not want to see this regulation continue to hurt businesses throughout the Commonwealth.

Thank you for the opportunity to provide public feedback.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88978 Virginia Retail Federation 2021/01/08 13:49:18 kbaker@virginiaretailfederation.com

Oppose "Dear Board Members:

Thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. We are commenting on behalf of Virginia Retail Federation. Virginia Retail Federation is the statewide retail association advocating on behalf of retailers large and small across the Commonwealth. Our members will be directly impacted by the attempt to implement "one size fits all" COVID-19 Regulations on businesses throughout Virginia.

Our members oppose the adoption of a Permanent Standard by The Virginia Safety and Health Codes Board. We assert that adopting 16VAC25-220 as permanent regulations is overly burdensome, unnecessary, and violates existing law. The science and understanding of COVID-19 is continuously changing. Therefore, the CDC and OSHA guidelines are frequently updated to reflect this. If the Emergency Temporary Standard were to become permanent, it would continue to require businesses to comply with outdated regulations.

In addition, the proposed permanent standard does not contain a true sunset date. Rather, all it does is reiterate the Board's authority to come back at a later date to determine the necessity of a continued permanent standard after the Governor's State of Emergency is lifted. The Board was clear during its July deliberations; the temporary nature of this pandemic requires that any regulations put in place related to COVID-19 must sunset with the Governor's State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic.

VRF also takes issue with the fact that there is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis.

Permanent regulations would be overly burdensome, costly, and confusing for businesses. Especially in light of overlapping regulations and guidance with the "Safer at Home" guidance, Executive Order 72, and the proposed rule. Businesses are already incurring expensive costs to comply with the ETS. These include hiring consultants and attorneys, taking workers out of production to do additional training, and much more.

Virginia Retail Federation strongly urges the board not to adopt a permanent standard for a temporary issue, and not to approve any amendments to the Regulations that would incorporate other infectious diseases. There is no one-size-fits-all plan to combat a wide variety of infectious illnesses.

We recommend that the Board reject the Regulations, provide additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88987 Philip F. Abraham, Old Dominion Highway Contractors Association
pabraham@vectrecorp.com

2021/01/08 14:01:44

Opposition to Proposed Permanent Standard On behalf of the Old Dominion Highway Contractors Association (ODHCA), I am writing to express opposition to the proposed Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. ODHCA represents highway contractors from across the Commonwealth. Our workers are our most important resource and our members have made worker safety a top priority during the COVID-19 crisis while we continue to meet the infrastructure needs of the Commonwealth. Our members are particularly concerned that the proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. It makes no sense to continue indefinitely a standard that was adopted to respond to a specific disease, COVID-19. Continuing these standards after the pandemic has been contained and the Executive Order is lifted will impose unnecessary burdens on both businesses and their employees for little if any health benefit. If you proceed to make the standards permanent, please make sure to include a specific sunset date tied to the control of the virus and the lifting of the Governor's Executive Order. Thank you for consideration of these comments.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88990 Dennis Edwards 2021/01/08 14:07:35 daedwardsjr@gmail.com

Oppose permanent regulation "The following questions should be considered by board members before attempting to enact a permanent standard.

Where is the proof that Virginia's workers are in grave danger? (hard data)

Where is the data that show the ETS was effective in reducing the spread of COVID-19?

Where is the data that shows the effectiveness of VOSH enforcement of the ETS?

Where is the data that shows the effectiveness of the VOSH Consultation Program in regard to COVID-19?

Where is the economic impact analysis?

Without this information the board would be negligent in enacting a permanent standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Also see the Department's Briefing Package at: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf>

88993 Melissa Dunham 2021/01/08 14:10:37 mdunham@branscome.com

STRONGLY OPPOSED to adopting a Permanent Standard. Members of the Safety and Health Code Board,

As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society

moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers and employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88994 Jeff Whitmire, Virginia Golf Course Superintendents Association 2021/01/08 14:11:29
rbohannon@huntonAK.com

Comments re: 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention. On behalf of the Virginia Golf Course Superintendents Association (VGCSA), I write in response to 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19. Our member golf course superintendents professionally maintain green spaces across the Commonwealth that provide recreation and wildlife habitats. Golf is also a significant driver of tourism, with the sport accounting for \$2.5 billion in positive economic impact in Virginia.

We believe making these standards permanent is unnecessary, as most industries have already worked diligently to comply with the emergency temporary standard (ETS) established in July, and have implemented additional best practices and guidance from the Centers for Disease Control (CDC), the Occupational Safety and Health Administration (OSHA), as well as national trade groups.

Golf has provided a much-needed outlet during the pandemic, with the average golf course providing 150 acres of open land, which allows for socially distant recreation. Most courses have fortunately remained open in Virginia throughout the year, and have enjoyed strong player participation. In order to sustain these venues safely, golf course superintendents have utilized tactics and best practices from the Golf Course Superintendents Association of America (GCSAA), which are based upon CDC and OSHA guidance, and are then applied to the tasks required for golf course maintenance. Several examples of changes instituted to keep workers safe include limiting the sharing of tools (or sanitizing tools between uses when sharing is necessary), allowing one employee per golf cart, and removing touchable surfaces such as bunker rakes and water coolers.

The proposed permanent standard does not include an end date. Thankfully, vaccine distribution is occurring and those most at risk are starting to receive inoculation. We fully understand that it will be some time before the majority of Americans are treated, but it is clear we are getting closer to that goal each day. As such, we believe it is critical to include an end date for this standard. As written currently, the proposed permanent standard would require a meeting of the Virginia Safety and Health Codes Board to determine whether there is a

continued need for the standard. Providing employers with more certainty as vaccination ramps up would be a better path forward. We know much more about the virus than we did when the ETS was developed, and now have several vaccines approved.

We are fortunate that this situation is temporary. While every industry in the Commonwealth has found ways to adjust to the challenges the pandemic has created, we have largely risen to those challenges. Some proponents have suggested that this standard should apply to other infectious diseases. We strongly believe that any standard that is adopted should focus solely on COVID-19. We cannot begin to assume what protocols may be necessary for any future infectious diseases, so if the Board is going to create a permanent standard, it should be limited in scope.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

88997 Zachary Adams 2021/01/08 14:14:21 adamsz@vt.edu

Comments on the Proposed Standard for COVID-19 dated 12-10-2020 16VAC25-220-30. Definitions

"Medium" exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees"

Define 'more than minimal'. This should mirror the CDC definition of 'close contact'. Per revised CDC guidance, a person trained and fitted to an appropriate respirator may not be deemed to be a 'close contact', so an exception should be provided. Also, per CDC, "Several COVID-19 investigations recently highlighted by CDC provide convincing data adding to the evidence for the prevention effectiveness of masking for individuals with high risk exposures", which reinforces that face coverings alone, or even respirators that have not been fitted, provide a high level of protection for both the wearer and other persons in proximity. See <https://www.vdh.virginia.gov/coronavirus/frequently-asked-questions/disease-prevention/>

"Lower" exposure risk hazards, (...) "through the implementation of engineering, administrative and work practice controls, such as, but not limited to: 1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time);

What is the scientific basis for this requirement? In many stores and other venues, ceiling heights are 10' to as much as 30' or more above the floor, which would make this impractical and would serve no valid purpose. Also, installation of such large barriers may impede air circulation and actually create pocket of stagnation that would elevate the exposure risk. Further, in any sprinkled building this would likely obstruct sprinkler flow, which would be a violation of the Fire Code. If the barrier prevents the direct transmission of droplets between one person and another, would this emulate the protection provided by a face covering and physical distancing, which would mean a smaller barrier may well be sufficient?

"Employee use of face coverings for contact inside six feet of coworkers, customers, or other persons is not an acceptable administrative or work practice control to achieve minimal occupational contact."

The CDC definition of 'close contact' should be considered in defining 'minimal occupational contact'. Also, CDC guidance indicates that coverings can protect both the wearer and those in proximity from the spread of SARS-

CoV-2. As noted here, <https://www.cdc.gov/coronavirus/2019-ncov/more/masking-science-sars-cov2.html>, “Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger) but they can also block the exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns which increase in number with the volume of speech and specific types of phonation. Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles and limit the forward spread of those that are not captured. Upwards of 80% blockage has been achieved in human experiments that have measured blocking of all respiratory droplets, with cloth masks in some studies performing on par with surgical masks as barriers for source control.” Also, per CDC, “Several COVID-19 investigations recently highlighted by CDC provide convincing data adding to the evidence for the prevention effectiveness of masking for individuals with high risk exposures”, which reinforces that face coverings alone, or even respirators that have not been fitted, provide a high level of protection for both the wearer and other persons in proximity. See <https://www.vdh.virginia.gov/coronavirus/frequently-asked-questions/disease-prevention/> See also <https://doi.org/10.1016/j.eml.2020.100924> as well as <http://jv.colostate.edu/masktesting/>.

“Face covering” (...) A face covering is (...) not considered a form of personal protective equipment or respiratory protection equipment under VOSH laws, rules, regulations, and standards.”

CDC guidance indicates that coverings can protect both the wearer and those in proximity from the spread of SARS-CoV-2. As noted here, <https://www.cdc.gov/coronavirus/2019-ncov/more/masking-science-sars-cov2.html>, “Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger) but they can also block the exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns ; which increase in number with the volume of speech and specific types of phonation. Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles and limit the forward spread of those that are not captured. Upwards of 80% blockage has been achieved in human experiments that have measured blocking of all respiratory droplets, with cloth masks in some studies performing on par with surgical masks as barriers for source control.” See also <https://doi.org/10.1016/j.eml.2020.100924> as well as <http://jv.colostate.edu/masktesting/>.

While there is limited evidence that infection can occur from exposure to infectious aerosols under very specific circumstances, the overwhelming evidence is that the main route of infection is from virus-laden droplets, likely because droplets contain a higher number of viable SARS-CoV-2 virus than aerosols. According to Taylor Engineering, “Masks have been shown by experimental and modeling studies (Leung et al, Hao et al, Aydin et al, Booth et el, Davies et al, Goyle et al) and by epidemiological studies (Howard et al, Gupta) to be the most effective measure and also the only measure that appears to be necessary to control the outbreak.” Face coverings are not respirators, but there should be a greater recognition of the benefits wearing a face covering alone provides in mitigating risk, including when people are working in closer proximity.

“Minimal occupational contact” means no or very limited, brief, and infrequent contact (...)

Definitions should align with the CDC definition of ‘close contact’, since that is the guiding principle for when a person is at risk for infection based on exposure to an infected person.

“Physical distancing” Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall constitutes one form physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others

If, as demonstrated by research, the primary risk of exposure is through droplets and not aerosols, if the barrier is sufficiently large to interrupt the transmission of infectious droplets from one person into the breathing zone of another, would this not be sufficient to assure 'physical distancing'? Why would a cubicle wall not be sufficient, provided face coverings were worn when standing if ones' face would be above the cubicle wall?

16VAC25-220-40. Mandatory requirements for all employers.

Subsection B(8)e, "The Virginia Department of Labor and Industry within 24 hours of the discovery of three or more of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus during that 14-day time period."

For employers with large numbers of employees, this could result in imposing a requirement that VDLI be notified every two weeks or even more frequently, which is incredibly burdensome. What is the value of serial reporting by an employer to VDLI, especially when B(8)d requires reporting to VDH when the worksite has had two or more confirmed cases of COVID-19? VDH would be the responsible agency for responding to and investigating any outbreaks that have occurred, not VDLI. Recommend requiring only an initial report to VDLI, not on-going reporting.

Subsections F and G state, "until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings."

As outlined above, there is ample research, and community-based evidence, which demonstrate that simple face coverings are effective in limiting the spread of SAR-CoV-2 virus even when physical distances cannot be maintained at all times. In combination with ventilation (F2), is it reasonable to stipulate that respirators be provided when available when this introduces all of the other requirements of 29 CFR 1910.134 (e.g., medical clearance, fit testing, establishment of a respiratory protection program) and where there are no established exposure limits for SARS-CoV-2?

Subsection L(4), Sanitation and disinfecting, states, "Areas in the place of employment where known or suspected to be infected with the SARS-CoV-2 virus employees or other persons accessed or worked shall be cleaned and disinfected prior to allowing other employees access to the areas."

The presumption should be that 'suspected to be infected' persons are present in the workplace every day, and there will be a time interval between when the person is either diagnosed or becomes symptomatic and during which they were present in the workplace. Imposing a requirement to disinfect now that the employee 'knows' of a case is disingenuous at best and provides no tangible benefit—employees have already been exposed to potential fomites. Subsection E(1)c imposes a requirement that employees clean and disinfect the immediate area in which they were located prior to leaving. Section L(5) and L(6) impose requirements that high touch surfaces and shared tools and equipment be routinely cleaned and disinfected. Is this not sufficient? Further, the CDC states, "It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads".

16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk and 16VAC-25-220-60. Requirements for hazards or job tasks classified as medium exposure risk.

Subsection B(1): The changes that are suggested in this section will require engineering evaluations be performed, require substantial work effort, may jeopardize the operation of the HVAC, increase operational costs, and provide little if any tangible benefit. At best, this section should require the employee assure ventilation systems are working 'optimally as designed'. Source control (e.g. the wearing of face coverings) should be the emphasis of this standard, not imposing expensive modifications to or evaluations of ventilation systems. See Taylor Engineering for a review of how ventilation systems are not an optimal choice for controlling exposure to SARS-CoV-2 virus.

Subsection B(1)(b)(i), "Increase total airflow supply to occupied spaces (...)"

What does 'increase total airflow' even mean? There is substantial evidence that source control (face coverings) should be the primary control for COVID-19, and research indicates that increasing 'airflow' may provide little tangible benefit while greatly increasing operational costs.

Subsection B(1)(b)(iv), "Increase air filtration to as high as possible".

To my knowledge, there is very little evidence to-date of a COVID infection occurring as a result of the virus being transmitted as an aerosol through an air handling system. While this may seem like a good idea, what is the scientific basis for imposing this requirement? Further, determining what level of filtration an HVAC system can accommodate requires an engineering evaluation, which imposes a substantial financial burden on the employee where there is little evidence that increasing ventilation rates and filtration are beneficial. Again, source control (masking) should be the primary emphasis. See Taylor Engineering.

Subsection B(1)(b)(v), "Generate clean-to-less-clean air movements by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers and adjusting zone supply and exhaust flow rates to establish measurable pressure differentials.

While this may seem like a good idea, there is limited evidence of infection by aerosols, which this subsection seeks to address at great cost to the employer. If the primary route of infection is through droplets, the emphasis should be on source control.

Subsection B(6) of 16VAC25-220-50

Please reconcile the language in this section to conform to the VDLI FAQ and related interpretation which indicates that certain tasks, including laboratory tests and specimen handling, may be conducted at BSL-2.

16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk and 16VAC-25-220-60. Requirements for hazards or job tasks classified as medium exposure risk.

Subsections D. Personal protective equipment (PPE). 1(a) "Employers shall assess the workplace to determine if SARS-CoV-2 virus or COVID-19 disease hazards or job tasks are present or are likely to be present that necessitate the use of personal protective equipment (PPE)."

General comment: There are situations (intubation and other aerosol-generating procedures, close contact with a known infected person, etc.) where the use of respiratory protection is an obvious, common sense precaution. In the absence of an occupational exposure limit for SARS-CoV-2 virus, however, and knowing that there are factors which increase ones' risk of infection, serious disease or even death, it is difficult to quantify or perform a hazard assessment to determine when respiratory protection would be necessary. This draft standard states, "when engineering, work practice, and administrative controls are not feasible or do not provide sufficient

protection, employers shall provide personal protective equipment to their employees". "Do not provide sufficient protection' is a very nebulous requirement when our understanding of this virus and ways to mitigate exposure are evolving. What level of risk of infection is acceptable? If ventilation and the use of face coverings theoretically reduce the risk to less than 1%, is that sufficient or would respiratory protection be required to reduce the risk even further?" "A definition is provided for in the standard: "Minimal occupational contact" means no or very limited, brief, and infrequent contact with employees or other persons at the place of employment. 197Examples include, but are not limited to, remote work (i.e., those working from home); employees with no more than brief contact with others inside six feet (e.g., passing another person in a hallway that does not allow physical distancing of six feet); healthcare employees providing only telemedicine services; a long distance truck driver.

The language referenced by the Commenter (1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time)) is one of a number of possible mitigation strategies that an employer can implement depending on the feasibility of doing so.

With regard to the Commenter's references to "close contact," the Department does not intend to incorporate the phrase as defined by the CDC into the standard. The CDC defines "close contact" as "Close contact" means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does not address the issue of "quarantine."

Requirements for returning to work from "quarantine" is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

With regard to face covering issues, the Department has recommended changes to the definition to reflect updated CDC guidance on their effectiveness:

"Face covering" means an item made of two or more layers of washable, breathable fabric that fits snugly against the sides of the face without any gaps, completely covering the nose and mouth and fitting securely under the chin. Neck gaiters made of two or more layers of washable, breathable fabric, or folded to make two such layers are considered acceptable face coverings. Face coverings shall not have exhalation valves or vents, which allow virus particles to escape, and shall not be made of material that makes it hard to breathe, such as vinyl.

However, it also needs to be noted (see the definition) that "A face covering is not a surgical/medical procedure mask or respirator. A face covering is not subject to testing and approval by a state or government agency, so it is not considered a form of personal protective equipment or respiratory protection equipment under VOSH laws, rules, regulations, and standards.

89004 Jonathan Williams, Virginia Ready Mixed Concrete Association 2021/01/08 14:27:10
jonathan.williams@easterassociates.com

Opposition to Permanent Standards The ready mixed concrete industry produces essential products that support the infrastructure needs of the Commonwealth. While our industry is committed to the health and safety of our employees, VRMCA opposes adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, as we feel that the standard is overly burdensome, costly in both time and money, and lacks the flexibility to adapt to future advances in science and medicine.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89008 Laura Karr, Amalgamated Transit Union 2021/01/08 14:44:15 lkarr@atu.org

Approve the Revised Proposed Permanent Covid-19 Standard to Protect Virginia Workers BEFORE THE
VIRGINIA SAFETY AND HEALTH CODES BOARD

16 VAC 25-220

Revised Proposed Permanent Standard

Infectious Disease Prevention:

SARS-CoV-2 Virus that Causes Covid-19

Comments in Support of the Revised Proposed Permanent Standard by the

Amalgamated Transit Union

International President John Costa

The Amalgamated Transit Union (the "ATU") submits the following Comments in strong support of the revised proposed permanent standard regarding infectious disease prevention and the SARS-CoV-2 virus that causes Covid-19 that is under consideration by the Virginia Safety and Health Codes Board (the "Board"). As the labor union representing bus, rail, and paratransit workers employed throughout Virginia, the ATU comes to the Board to present the pressing and immediate safety concerns of its Virginia members – just as the ATU did in October 2020 with regard to the proposed permanent standard concerning SARS-CoV-2.

The ATU supports the revised proposed permanent standard as an essential and urgently needed corollary to Virginia's emergency temporary standard regarding SARS-CoV-2 and Covid-19. The emergency temporary standard has provided Virginia ATU members with substantially enhanced workplace protections in the areas of social distancing, information sharing with employers regarding SARS-CoV-2 and Covid-19, personal protective

equipment (“PPE”), and sanitation, among others. However, the SARS-CoV-2 pandemic persists, as does the risk that ATU members will become infected and suffer severe health consequences – or even death.

While effective vaccines have arrived in Virginia, public health experts agree that it will be well into 2021 before essential workers like ATU members have universal access to them. It will be even longer before population-level immunity occurs, if it ever does. In the near term, experts predict that infection rates will increase. Meanwhile, the ETS will expire on January 26, 2021, leaving ATU members – and all working Virginians, along with their families and communities – unprotected unless this Board acts immediately to approve the revised proposed permanent standard.

The ATU stands with its labor movement allies, as represented by the AFL-CIO, in supporting the revised proposed permanent standard for the reasons that the AFL-CIO lists in its own comments to the Board. Further, the ATU would like to highlight the following:

The ATU urges the adoption of the proposed ventilation rules that focus on outcomes, not on third-party standards that do not work for all workplaces. The initial proposal for the permanent standard directed employers overseeing medium-risk worksites, like transit vehicles, to install air-handling systems that are consistent with certain standards developed by the American National Standards Institute (“ANSI”) and the American Society of Heating, Refrigerating and Air-Conditioning Engineers (“ASHRAE”). As the ATU stated in its comments regarding the initial proposal, these standards are designed for buildings – not for vehicles – and they do not ensure adequate ventilation for confined, mobile workspaces. The ATU called for an outcome-focused reimagining of ventilation rules for medium-risk worksites, along with a requirement for employers controlling such sites to ensure that their ventilation systems are equipped with air filters rated MERV-13 or higher.

In a positive development, the revised proposed permanent standard now includes just these types of rules. Section 16 VAC 25-220-60(B)(1) directs employers to maintain ventilation systems, increase clean airflow and outside air, limit filter bypass, and ensure the highest filtration levels that their ventilation systems can provide – up to and including MERV-13, where possible. While an employer still must abide by ASHRAE standards inasmuch as they apply to the worksites that the employer controls, it is clear that the revised proposed permanent standard shifts the emphasis of its ventilation rules to the specific ventilation outcomes that help to protect workers from SARS-CoV-2. By focusing employers’ attention and VOSH’s enforcement on outcomes instead of on third-party rules that do not apply to and are not protective in all workplaces, the revised proposed permanent standard offers substantial and effective protection to ATU members and other medium-risk workers. These important modifications to the initial proposal must be preserved.

However, additional ventilation improvements are necessary to keep transit workers safe. The revised proposed permanent standard recognizes, in Section 16 VAC 25-220-60(B)(1)(b)(ii), that ground transportation poses unique ventilation challenges and that transit workers have correspondingly unique needs when it comes to the ventilation changes that are necessary to protect them from SARS-CoV-2. As the revised proposal notes, these changes include increasing the flow of outside air into transit vehicles. The revised proposal suggests that employers open vehicle windows to increase outside airflow.

Far from protecting transit workers, however, the directive to open windows actually puts them at increased risk of infection. The ATU’s extensive research into transit vehicle safety, developed over more than a century of representing transit workers, reveals that due to the shape of transit vehicles, interior air travels from back to front while a vehicle is in motion. That is, the air – and any virus that it contains – travels directly toward the driver. If the driver’s window is open, this back-to-front airflow grows even stronger. The best way to ensure

that the driver benefits from increased outside air is to keep the driver's and passengers' windows closed while opening the vehicle's rear hatch, adjusting the driver's air vents to blow fresh outside air (or modifying the vents to do so if the vehicle is not equipped with this feature), and operating the vents on high. These steps help to reverse the airflow within the vehicle so that fresh air travels toward the driver, and potentially contaminated air travels to the back of the vehicle and out the rear hatch. The attached ATU factsheet, entitled "Safe Service Now – Covid-19 Bus Airflows and Solutions" provides further information. This guidance should be incorporated into Section 16 VAC 25-220-60(B)(1)(b)(ii) – or, at the very least, the reference to open windows must be removed from that section.

Additionally, the applicability of Section 16 VAC 25-220-40(F)(2) should be expanded to cover not only workers who travel in shared vehicles but also those whose job duties include transporting members of the public. This section provides that when multiple workers travel together, the employer should not recirculate air within the vehicle cabin. However, Section 16 VAC 25-220-60(B)(1) does not include eliminating air recirculation among the steps that employers controlling medium-risk worksites must take to protect workers from SARS-CoV-2.

As the attached factsheet shows, ending air recirculation is vital to virus protection. Further, there is no rational basis upon which to offer workers greater protection in this regard when they ride in a vehicle together than when they ride with members of the public. This is especially true in light of the failure of the revised proposed permanent standard to direct employers to require members of the public to wear face coverings when entering worksites (like transit vehicles), while Section 16 VAC 25-220-40(F)(1) requires workers to cover their faces when they ride together. It is clear that employers must be required to eliminate air recirculation in all vehicles transporting workers, regardless of whether the vehicle in question provides transportation for groups of workers or transit for the general public.

In order to protect transit workers effectively, Virginia's permanent standard regarding SARS-CoV-2 also must include these additional measures. Please see the ATU's comments regarding the initial proposed permanent standard for further details.

- Require employers to install UV-C lights in vehicle and building ventilation systems whenever such lights would mitigate the spread of SARS-CoV-2.
- Require employers to install physical barriers to protect workers who must share a confined space with members of the public.
- Require transit employers to limit vehicle capacities to twenty-five percent of the ordinary maximum and to create passenger-free "buffer zones" between drivers and occupants, with an exception for passengers who need to use accessible seating near the driver.
- Require transit employers to utilize rear-door boarding, with an exception for passengers who need to use accessibility equipment attached to the front door of the transit vehicle.
- Require employers to place a vehicle out of service, and to clean and disinfect it thoroughly while providing proper PPE to the workers completing these tasks, whenever the vehicle has been used by any individual who subsequently tests positive for Covid-19.
- Direct employers to require that members of the public wear masks or face coverings whenever they visit worksites.

- Require employers controlling medium-risk worksites to use every effort to procure N-95 masks and to provide them to workers.
- Increase social distancing directives to a distance greater than six feet in order to account for the airborne spread of SARS-CoV-2.
- Increase opportunities for workers and their representatives to participate in hazard assessment and safety planning processes.
- Expand medical removal provisions to cover workers who know that they have been exposed to SARS-CoV-2 and those who reasonably believe themselves to have been exposed.
- Require employers to maintain workers' pay, benefits, and seniority when workers must be absent due to Covid-19 diagnosis or symptoms, or due to SARS-CoV-2 exposure or suspected exposure.
- Clarify employers' contract tracing responsibility to explain that when a worker tests positive for Covid-19, the employer must determine the worker's contacts at the worksite in order to identify and notify those who might have been exposed.
- Require employers to collect reports of suspected Covid-19 cases, known exposures, and suspected exposures within the workforce; to determine these potentially infected workers' contacts at the worksite; and to notify the contacts of their potential exposure.
- Require employers to give workers paid time and appropriate PPE with which to complete the cleaning and disinfection tasks mandated by the revised proposed permanent standard.

The emergency temporary standard has provided essential SARS-CoV-2 protections to ATU members in Virginia since the standard's promulgation. Yet ATU members continue to contract and die from Covid-19, and the emergency temporary standard will remain in effect only for eighteen more days. Just as the pandemic persists, so must Virginians' workplace protections. The ATU therefore urges this Board to adopt a permanent standard that both preserves the vital safeguards of the emergency temporary standard and incorporates the improvements discussed above, so that transit workers can continue to provide their essential services while staying as safe as possible from SARS-CoV-2.

For further information, please contact ATU Associate General Counsel Laura Karr at lkarr@atu.org or (240) 461-7199.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

With regard to the Commenter's remarks about 16VAC25-220-50.B.1.b.(2) and -60.B.1.b(2), the Department is proposing a language change: "...use natural ventilation to increase outdoor air dilution of inside air in a manner that will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission to employees, and when environmental conditions and transportation safety and health requirements allow...."

The Department does not intend to change the Standard's provisions dealing with installation of physical barriers as it is appropriate to consider feasibility (both technological and economic) when selecting mitigation strategies, whether on a mass transit vehicle or a fixed worksite.

The issue of N-95 respirators raised by the Commenter is appropriate to address during the personal protective equipment (PPE) hazard assessment process required in General Industry under 1910.132.

The Department does not intend to recommend the addition to the standard of medical removal protections or guaranteed compensation requirements for employees who are away from work due to COVID-19 issues.

The Department does not intend to recommend any additional employee involvement language to the Standard. Such involvement is currently required in 16VAC25-220-50.D.1.a, 16VAC25-220-60.D.1.a, and 16VAC25-220-70.C.2.

The Department does not intend to recommend adding requirements that employers be required to provide pay for cleaning activities by employees. Payment of wage issues fall under Va. Code §40.1-29, <https://law.lis.virginia.gov/vacode/40.1-29/>, and not within the enabling statutes of the VOSH program.

Face covering requirements for the general public are contained in Governor's Executive Order 72. The standard does not contain a face covering mandate for the general public.

The Department notes that 16VAC25-220-10.H. provides: "Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease."

VDH already has responsibility to conduct contact tracing and the expertise and resources to do so.

89012 Gordon Penick 2021/01/08 14:46:27 gordonpenick@leehypaving.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board,

As an employee/employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the “Low” and “Medium” categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89015 Timmons Group 2021/01/08 14:48:46 chris.dodson@timmons.com

Opposition to Adopting a Permanent ‘Infectious Disease’ Standard In our capacity as a long-time member of the VA construction industry, we wish to register our strong opposition to VOSH adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16 VAC25-220.

The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential industry performing critical infrastructure work keeping our society moving in and around the Commonwealth. Health and safety for all of our employees is part of our Company value system and culture. We have implemented and complied with CDC, VOSH ETS and OSHA COVID-19 guidelines for construction since they were published and remain in compliance.

Construction activity already operates under CDC, VOSH and OSHA Covid prevention guidelines. We believe additional regulations are duplicative and unnecessary.

The proposed permanent standard is burdensome, will become quickly obsolete, difficult to enforce, costly in time, money and resources, and lacks flexibility to adapt to current and emerging science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor’s COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

We ask you: what metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, who is a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The health data on Covid has not shown a direct and immediate danger for those workers whose tasks fall into the “Low” and “Medium” categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for industries regulated by VOSH.

We are therefore STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health emergency.

Our Company remains sincerely committed to the health and safety of our employees through continued compliance with Best Practices, CDC, VOSH and OSHA requirements.

Thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89018 Anonymous 2021/01/08 14:54:54 J.Chapman@yahoo.com

Strongly Disagree As employee in the heavy construction industry, I oppose adopting a permanent standard for infectious disease prevention for Covid-19. The proposed permanent standard has no specific end date and is based on a temporary health crisis. With 2-vaccines being distributed in Virginia with 90% efficacy and with more being vaccines being developed and near the end of their trials and do not see the benefit of a permanent standard.

In the construction industry the permanent standard will be burdensome and difficult to enforce. I am STRONGLY OPPOSED to adopting a Permanent Standard with no expiration.

I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89020 David Horton, Virginia Paving Company 2021/01/08 14:57:19 david.horton@eurovia.us

Strongly Oppose adopting a Permanent Standard Members of the Safety and Health Code Board,

As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89022 Bud Webb 2021/01/08 15:00:25 bud@webbdevelopmentllc.com

Strongly Opposed to Permanent Standard As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89023 Ken Olsen 2021/01/08 15:04:08 ken.olsen@slurrypavers.com

Reject the proposed emergency regulation

As a safety professional in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89026 Greg Roberts 2021/01/08 15:08:50 greg.roberts@slurrypavers.com

Mandating new rules I do not agree with more regulation

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89028 Jonathan Newell 2021/01/08 15:10:39

Opposition to Permanent Standard Members of the Safety and Health Code Board,

I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is

our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89035 Ken Garrison C/O HCCA 2021/01/08 15:26:27 kgarrison@hcca.net

Strongly Opposed to making the COVID-19 Standard Permanent "Members of the Safety and Health Code Board:

As an Executive in the Heavy Construction industry, I strongly oppose adopting a Permanent Standard for the Infectious Disease Prevention: SARS-COV-2 virus that causes COVID-19. The proposed standard has no specified end date is based on a temporary standard for emergency health crisis for which there are two vaccines now be distributed to Virginia with over 90% efficacy with several more candidates now in trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to science and innovation. I am STRONGLY OPPOSED to the Adoption of a Permanent Standard., with no expiration date for what is a temporary health situation.

Construction is an essential business and our members have safely continued to provide essential infrastructure work during the pandemic.

Construction is under CDC and OSHA guidelines,. Additional regulations are duplicative and costly.

The data has not shown a direct and immediate danger for those workers whose task fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30. These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

I remain committed to the health and safety of all Virginians.

Thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89038 Anonymous 2021/01/08 15:28:39 kkolda@branscome.com

Strongly oppose I strongly oppose the continuation beyond the sunset date of the state of emergency for the safety standards. With vaccines in place the need is no longer there to continue.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89040 Gordon Dixon 2021/01/08 15:29:49 gordon@vtca.org

Proposed Permanent Standard for Infectious Disease Prevention" One behalf of the Virginia Transportation Construction Alliance (VTCA), we are pleased to submit comments related to the proposed permanent Standard for Infectious Disease Prevention. The health and safety of our members workforce continue to be the top priority. Most firms have strict policies in place to telework whenever possible and not to travel unnecessarily to in-person meetings. We have learned a significant amount about working with the omnipresent threat of COVID-19, and have the following suggestions to offer based on our experiences.

We support efforts for the Governor's Emergency Declaration. Temporary standards enable the board and the construction industry flexibility to respond and adjust to outbreaks.

We oppose making the temporary standard permanent. Science and health are evolving around treatment and prevention to COVID-19. What some in the health community thought were viable solutions 10 months ago now appear to not be the best solution and, in some cases, have made individual situations worse. We suggest you keep the standards temporary and adjust those standards until science can better predict outcomes.

If a permanent standard is enacted, it should only relate to the current public health crisis related to COVID-19. All companies have enacted new protocols in the last ten months and have updated and revised those protocols within the last six months based on guidance from public health officials. This has required many employees without any medical training to become de facto health officers to determine if employees may be infected. Since teleworking is not an option in most transportation construction jobs, companies utilize the best information they have – most of which is required to be reported by the employee – to determine an employee's fitness to work. Expanding this permanent standard any further would create additional, unnecessary challenges for industries such as ours.

Given that our member companies, which have been essential businesses since the onset of the pandemic, have gained valuable experience safely working with the threat of COVID-19 and within the parameters of the standard. We strongly believe adjustments need to be made if a permanent standard is to be created. We

concur with others that the Board should reject the proposed regulations and convene a workgroup of stakeholders to revise and recommend a new set of emergency temporary standard which would expire within 6 months or at the end of the Governor's Emergency Declaration.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89043 Vanessa Patterson, RAMCA 2021/01/08 15:34:46 vanessa.patterson@ramca.info

RAMCA Strongly Opposes Adopting a Permanent Standard Members of the Safety and Health Code Board, The Richmond Area Municipal Contractors Association (RAMCA) represents companies in heavy construction and their associate partners who provide products and services critical to the industry. For 56 years, RAMCA has worked cooperatively on a broad range of important issues relating to the infrastructure needs of the Commonwealth. RAMCA provides a forum designed to improve the business practices and the construction environment in which our employees work. The health and safety of our employees and the community at-large is our highest priority. Promoting a culture of safety is a primary operating principle of our employers. On behalf of RAMCA, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220.

Construction is an essential industry performing critical infrastructure work keeping society moving in the Commonwealth. The industry is heavily regulated under multiple federal and state occupational health and safety programs. RAMCA members immediately implemented and rigorously follow CDC and OSHA Guidelines for COVID-19 in the construction workplace.

The proposed permanent standard has no specified end date. The permanent standard is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines with over 90% efficacy and several additional candidates nearing the end of their trials. Governor Northam on January 6th, 2021 expressed confidence in a consistent supply of over 110,000 doses distributed to Virginia weekly. The Governor projected Virginia would have essential workers and Virginians most vulnerable to COVID-19 (Groups 1A, B, C), vaccinated before summer 2021. At that time, he projected the remaining 40% of the population, would be eligible to receive the vaccine. Considering these factors, there is no logical or scientific justification for the continuance of a standard that was specifically crafted in response to a State of Emergency for COVID-19. Any standard should sunset immediately upon the expiration of the Governor's State of Emergency.

The proposed standard is burdensome and inflexible.

As the science has changed, the current ETS has not, nor does it have the flexibility to do so as either science changes or innovation occurs. As an example, the disinfection standard requirements are based on practices that now may not provide meaningful reduction in transmission. The disinfection standards for tools and equipment are burdensome and time consuming. An hour a day or more is spent by each crew in some cases. Procurement of necessary disinfection items is time consuming, distracts from other job functions, and supply chain issues still impact the ability to obtain disinfectant approved for use against SARS-CoV-2 as defined in 16VAC25-220-30.

The standard requires non-medically trained individuals to be in the health screening business. Daily screenings add another 30 minutes at the start of a shift. Multiply that by every shift of every crew and less work is being accomplished across the Commonwealth. These daily screenings take crew leaders away from performing their

other job duties, impacting overall productivity. RAMCA member companies have generous paid sick leave policies that cover COVID-19 absences and provide employees the choice to stay home with pay if they are exhibiting symptoms of COVID-19 or have had a potential exposure. Employees in heavy construction are not forced to choose between working and staying home.

It has not been proven a “grave danger” exists for ALL workplaces thereby making it necessary to adopt a permanent standard for ALL businesses or industries. Construction job tasks falls into the “Low” and “Medium” (16VAC25-220-30) exposure category. Physical distancing is a natural part of our work environment. The standard uses “Grave” danger to regulate ALL businesses in Virginia, yet the great majority of the tragic deaths in the Commonwealth are citizens over 70 years old, residents of nursing/assisted living facilities or congregant settings, and those with serious comorbidities.

The Board must partner with a wide variety of stakeholders, including the business community to advise and consent on any workplace regulations.

The economic impact of the proposed standard on businesses and entire industries is significant. The Commonwealth will be impacted as the cost of doing business increases due to burdensome and costly proposed standard. The public should be allowed sufficient access to the Economic Impact Statement required by the Small Business Regulatory Act/Small Business Regulatory Enforcement Fairness Act. To date, no EIS has been made available. The public must have the opportunity to comment on the findings prior to a vote to adopt the permanent standard.

The metrics, scientific data, or criteria the board would use to make a determination to continue a permanent standard after the expiration of the COVID-19 State of Emergency should made public. It is critical for the public to see the data that would be used to continue a standard for a disease the Governor, a physician, no longer views as an emergency, and the Commissioner of Health has determined no longer presents a public health emergency in the Commonwealth.

COVID-19 is a unique disease and should not be used to expand workplace regulations to include other infectious diseases. No amendment or attempt to include other flus, viruses, cold or other communicable diseases in any permanent standard should be considered. There is no one-size fits all plan to combat a wide variety of infectious illnesses. No one knows what the future holds. If there is a next pandemic, the transmission method cannot be accurately predicted and therefore regulations cannot be adopted for the unknown.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. On behalf of RAMCA, I am strongly opposed to the adoption of a Permanent Standard for what is a temporary health emergency.

The construction industry remains committed to the safety of our workers and the citizens of the Commonwealth. I welcome the opportunity to work with all stakeholders to develop any necessary policies regarding the health and safety of workers in the construction industry.

Thank you for the opportunity to publicly comment." "SEE DEPARTMENT RESPONSE TO COMMENT 87834

Screening of employees is a widely recognized and effective strategy to mitigate the spread of the virus in the workplace. 16VAC25-220-60.C.1 provides that "Prior to the commencement of each work shift, prescreening or surveying shall be required to verify each covered employee does not have signs or symptoms of COVID-19."

Employers are provided the flexibility to determine what form of prescreening they will use to determine that "each covered employee does not have signs or symptoms of COVID-19."

OSHA provides guidance on screening employees in the construction industry that can be used by non-medical personnel at: <https://www.osha.gov/SLTC/covid-19/construction.html>

The Department does not intend to recommend any changes to screening requirements in the standard.

89045 KICKIN ASPHALT PAVING & EXCAVATING 2021/01/08 15:38:58 MTRAIL@KICKINASPHALT.NET

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board,

As an employee/employer (you can use your title like foreman, crew leader, etc.) in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89060 David A. White, Superior Paving Corp. 2021/01/08 15:55:02 davidwhite@superiorpaving.net

Strongly Oppose Adopting a Permanent Standard As an employer in the heavy construction and paving industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that causes COVID-19. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89061 Warren Howard 2021/01/08 15:55:19 warren.howard@mersino.com

Strongly disagree Members of the Safety and Health Code Board,

As a Branch Manager in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89063 Tom Locher/Safety Manager 2021/01/08 15:59:58 tlocher@dalholding.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board,

As a Safety Manager in the heavy construction industry, strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials.

Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89068 Steven Chambers 2021/01/08 16:04:00 johndoe23112@yahoo.com

For Adopting a Permanent Standard I am strongly for a permanent standard. It was because of that standard that my company started to take our safety seriously. It is one thing to put out memos we care about our

employees but it is something totally different to show it over profit. I wish we didn't have to mandate for some to do the right thing unfortunately we still do. If everyone always did the right thing the Virginia & Federal code would not be so many pages.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89073 Chemung Contracting / Cedar Mountain Stone 2021/01/08 16:11:53 edalrymple@dalholding.com

Strongly Oppose adopting a Permanent Standard As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation.

The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment, Edward C. Dalrymple, Jr. President Cedar Mountain Stone / Chemung Contracting

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89076 SEIU Virginia 512 2021/01/08 16:19:13 michelle.v.starr@seiuva.org

Public Comment on Jan 4, 2021 Proposed Perm. Standard for Infectious Disease Prevention for COVID-19.

On behalf of our hard-working members, we are in strong support of the Proposed Permanent Standard for Infectious Disease Prevention for COVID-19, which would make these essential standards a permanent protection for workers in Virginia. There is no way out of this pandemic without a permanent standard to

protect workers, our families, and our communities across the commonwealth. Without a permanent standard, we will not be able to protect those on the job, or get those who are without work back on the job. We have the following recommendation to strengthen the standards: The state is proposing delayed effective dates for some elements, such as training. This would (wrongfully) cause a lapse in coverage for workers since these protections are already required under the emergency standard. The rule must go into effect immediately. The Virginia Department of Health has proposed changes to the rule to allow face coverings when respirators are actually needed to address the airborne nature of this highly contagious virus. Reducing needed protections because of any shortages in supplies must not be in the rule itself and should be handled through enforcement discretion, as the agency always has. Face coverings must be allowed only for protecting others from the person wearing them, and not in place of adequate respiratory protection that many workers need when working close to other people for long periods of time.

There is a new requirement to train workers on how to extend the use of PPE. Reusing single use PPE in the workplace is dangerous and places everyone at risk. This provision must be removed. Instead, workers must be trained on how to properly use PPE and on what makes them effective. Any extended use during critical, actual shortages should be done in limited and extreme circumstances and handled through enforcement discretion and not the final rule. This proposed provision lowers the bar for everyone and is harmful.

The return-to-work provisions have been updated to be consistent with current CDC guidance. However, guidance for how to return workers with asymptomatic COVID-19 is unclear and must be addressed. The ETS is a strong, comprehensive standard that sets clear requirements based on longstanding practices and current science, and should be made permanent while implementing the changes we outlined above. We urge you to do what is right to protect Virginia's workers and adopt the proposed January 4, 2021 Permanent Standard with our recommended changes. In Solidarity,

David Broder, President SEIU Virginia 512

SEE DEPARTMENT RESPONSE TO COMMENT 87825

SEE DEPARTMENT RESPONSE TO COMMENT 10008

SEE DEPARTMENT RESPONSE TO COMMENT 20012

89077 Cannon Moss, Virginia Railroad Association 2021/01/08 16:22:03 rbohannon@huntonAK.com

Comments re: 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention

The Virginia Railroad Association (“VRA”) respectfully submits these comments to the Virginia Department of Labor and Industry’s (the “Department’s”) Revised Proposed Permanent Standard for Infectious Disease Prevention: SARS CoV-2 Virus That Causes COVID-19, 16VAC25-220, dated January 4, 2021 (the “Revised Proposed Permanent Standard”). VRA renews the concerns expressed in its comments dated September 25, 2020 (the “Initial Comments”) to the Department’s earlier Proposed Permanent Standard dated July 24, 2020 (the “Original Proposed Permanent Standard”), which have not been addressed in the Revised Proposed Permanent Standard. As VRA pointed out in its Initial Comments, the Federal Railroad Administration (the “FRA”) has issued a Safety Advisory encouraging railroads to follow federal recommendations and guidance related to COVID-19, including guidance issued by the Centers for Disease Control and Prevention (the “CDC”). 85 FR 20,335 (April 10, 2020). The railroad members of VRA are following the CDC’s COVID-19 guidance in

Virginia and throughout their systems in other states to keep their workers safe. VRA further noted that their members who are following CDC guidance will not necessarily be in compliance with the Original Proposed Permanent Standard for those activities covered by Virginia's health and safety laws.[1] That is because the Department proposed to deem an employer following CDC guidance to be compliant with the Original Proposed Permanent Standard "provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard." 16VAC25-220-10(G.1) (Emphasis added). VRA expressed its concern that its members will not necessarily know whether following a particular CDC recommendation will provide an equivalent or greater level of protection than the Original Proposed Permanent Standard, putting railroads who are trying to figure out whose standard to follow – the CDC's or the Department's – in the difficult position of having to guess. While the Original Proposed Permanent Standard did allow that following CDC guidance is considered to be "evidence of good faith in any enforcement proceeding," VRA's members have no assurance that such evidence will be sufficient to avoid an adverse finding, a fine, or a civil judgment. VRA's recommendation was to add a sentence to Section G.1 allowing railroads and others engaged in interstate commerce to freely follow CDC's COVID-19 guidance without fear of being deemed to have violated the Department's standard. This would have allowed railroad operators in Virginia to confidently follow a single standard across their entire interstate networks to keep their workforces safe. In response to VRA's Original Comments, the Department claims VRA is concerned that "Virginia's unique COVID-19 standard would present compliance burdens for its members because it differs from federal OSHA requirements that apply in states covered by federal OSHA jurisdiction." Department Response to Written and Oral Comments dated November 4, 2020, p. 395. The Department goes on to dismiss this concern, noting that it already has promulgated nine other occupational health standards unique to Virginia. *Id.* Concluding that one more unique standard would therefore not be overly burdensome, the Department declined to make VRA's suggested changes to Section G.1.

But the Department missed the point of the Initial Comments. The concern was not that the Department's standards might be different from federal OSHA standards, but that they may be different from the CDC guidance the railroads are already following pursuant to a Safety Advisory issued by the industry safety regulator, the FRA. Where the Department's standards and the CDC's are different, the railroads will have to choose which one to follow. Section G.1 did not give railroads clear direction on how to make that choice. Not only does this create a compliance burden, it puts railroads at risk for the consequences of making what may turn out to have been the "wrong" decision. Although in the revised version of former Section G.1 (now Section E), the Department is directed to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines," it is unclear how such consultations will aid VRA or its members in determining whether following CDC's COVID guidelines falls within the safe harbor provision. The Department has established no timelines for making such determinations, no clear process for making those determinations known to the regulated community, and no clear guidance on what the precise subject matter of those determinations will be. By giving Virginia's railroads a clear path to continue to follow the single set of COVID-19 safety standards issued by CDC and as advised by FRA, the Department can avoid the ambiguities created by establishing a competing set of standards. Following federal standards is especially appropriate for industries, like railroads, that are engaged in interstate commerce.

For these reasons, VRA renews its request that the Department adopt the revisions to the CDC safe harbor provision set forth in VRA's Initial Comments.

[1] As noted in VRA's Initial Comments, many activities performed by railroads are not subject to Virginia's occupational safety and health laws because they are outside the jurisdiction of the federal Occupational Safety and Health Act of 1970. See 16VAC25-60-20(2) and FRA Policy Statement, 43 FR 10,583 (March 14, 1978). Any

such activities are not subject to regulation by the Department and are therefore beyond the scope of these comments.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department does not plan to recommend that 16VAC25-220-10.E be changed as suggested by the Commenter. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.E assures such protections. The Commenter has provided no substantive reasons while railroad employees and employers and the hazards and job tasks they are exposed to are substantially different from every other covered entity such that it would justify different treatment under the standard.

As noted by the Commenter, the Department is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines " The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

89078 Virginia Business Coalition 2021/01/08 16:23:06 nicole.riley@nfib.org

VA Business Coalition Opposes Permanent Standard "Dear Safety and Health Codes Board Members On behalf of the Business Coalition ("Coalition") which is comprised of 33 leading business associations across the Commonwealth, we thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations"). The Business Coalition is committed to protecting employees, contractors, suppliers, and communities from COVID-19 infection. Our members are already heavily regulated under multiple federal and state occupational health and safety programs. Coalition members are interested in a uniform and coordinated approach to Federally delegated health and safety regulations. As such, our members participate in national trade groups, and have worked to develop best management practices and implemented a hierarchy of controls to protect their workforce from COVID-19 infections as proscribed by all Federal regulatory agencies. Accordingly, the Coalition is uniquely positioned to participate in the public process associated with the development of the Regulations. I. Summation of Business Coalition's Comments Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements. The Virginia Safety and Health Codes Board should not adopt a Permanent Standard. The Coalition asserts that adopting 16VAC25-220 as permanent regulations is overly burdensome, unnecessary, and violates existing law. The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect this. If the ETS were to become permanent, it would continue to require businesses to comply with outdated regulations.

Now is not the time to impose a permanent standard. Why adopt a permanent standard when we're beginning to see the rollout of vaccinations? There is no sunset date for the Standard The proposed permanent standard does not contain a true sunset date. Rather, all it does is reiterate the Board's authority to come back at a later date to determine the necessity of a continued permanent standard after the Governor's State of Emergency is lifted. The Board was clear during its July deliberations; the temporary nature of this pandemic requires any

regulations put in place related to COVID-19 should be sunset with the Governor's State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic. There is no economic impact analysis to determine cost to small businesses. There is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis.

The Standard is burdensome for businesses to comply with Permanent regulations would be overly burdensome, costly and confusing especially in light of overlapping regulations and guidance with the "Safer at Home" guidance, Executive Order 72, and the proposed rule. Businesses are already incurring expensive costs to comply with the ETS from hiring consultants and attorneys, taking workers out of production to do additional training, etc.

The Board has not proven a "grave danger for ALL workplaces necessitating a permanent regulation It is unreasonable to apply a "one size fits all" approach to COVID-19 regulations to all employers and employees. The Board's determination of "grave danger" in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities. The "grave danger" determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk).VDOLI also cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and yet infections have been reduced entirely by employer compliance with CDC guidance, OSHA guidance, and Governor's Executive Orders – not the COVID-19 ETS. Therefore, the Board cannot simply assume and apply its prior "grave danger" determination and COVID-19 ETS efficacy as the basis for permanent regulations. Further, since 46 other states have neither a COVID-19 ETS or permanent regulation, the Board has not proven the necessity for such a permanent regulation. Regulations should not be expanded to other infectious diseases Infectious diseases are not all the same. Therefore, the Board should not expand these regulations to other infectious diseases. We have no idea what protocols will be necessary to mitigate the risks of future diseases, so it doesn't make sense to create a permanent standard for all infectious diseases. If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it must include these important provisions: The sunset clause whereby the Regulations will expire with the Governor's State of Emergency. Amend § 10G to the agency's original language with clarification on providing "safe harbor" for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance. Eliminate requirements for physical separation of employees at low and medium risk businesses by a permanent, solid floor to ceiling wall. Higher risk businesses have more flexibility to use smaller temporary barriers like Plexiglas sneeze guards. Eliminate all human resource policies from the Regulations such sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. These policies exceed the Board's authority as it relates to workplace hazards. Amend common space sanitation requirements. Requiring common spaces to be cleaned and disinfected at the end of each shift" is impractical for 24/7 operations with multiple and overlapping shifts. The Regulations should be amended to provide for a time-based alternative such as every 8, 12, or 24 hours

exempting FDA regulated facilities. Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations. Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level. Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague. Eliminate the conflicts and overlaps between the "Safer at Home" guidance, Executive Order 72, and the proposed rule. The regulation should govern, and this should be explicitly stated in the permanent regulation. Otherwise, the regulation must be inadequate to protect worker safety. II. Recommendations As such, the Coalition respectfully requests that the Virginia Safety and Health Codes Board withdraw its "Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220." Instead, if the Board can demonstrate a necessity to pursue regulation, it should do the following: The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires. III. Conclusion It is unreasonable to apply one-size-fits-all COVID-19 Regulations to all employers and employees. It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify guidance and Executive Orders as a reasonable replacement. Further, it is confusing why the Board would pursue permanent regulations that are in conflict with previously issued Executive Orders. Therefore, it is the Coalition's recommendation that the Board reject the Regulations, provides additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires.

Sincerely, VIRGINIA BUSINESS COALITION

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees that the Standard is a "one size fits all" regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines." The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

The language referenced by the Commenter (1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time)) is one of a number of possible mitigation strategies that an employer can implement depending on the feasibility of doing so.

89079 D DOUGLAS TAIT 2021/01/08 16:23:40 dtait@wcsprattinc.com

Strongly Oppose Adopting a Permanent Standard **Members of the Safety and Health Code Board** As an employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment. Sincerely, D. Douglas Tait President W. C. Spratt, Inc.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89082 Anonymous 2021/01/08 16:29:11 sherryt@branscome.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89083 Susan Arnold, Insight, LLC 2021/01/08 16:31:01 sarnold@insightdmv.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employer in the heavy construction industry, I oppose adopting a Permanent Standard for Infections Disease Prevention:SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary Standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 96% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no exception, for what is a temporary health situation. I remain committed to the health and safety of my employees and thank you for the opportunity to publicly comment. Susan Arnold | Principal, Insight, LLC

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89084 Dennis Clarken 2021/01/08 16:36:35 dclarken@hwphillips.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As vendor in the heavy construction industry, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates are nearing the end of their trials. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation.

I remain committed to the health and safety of my coworkers and fellow members and thank you for the opportunity to publicly comment. Regards: Dennis Clarken

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89085 Dennis Showalter 2021/01/08 16:39:00 dshowalter@insightdmv.com

Strongly Oppose Adopting a Permanent Standard "Members of the Safety and Health Code Board, As an employer in the construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-COVID-19, 16VAC25-220. The proposed permanent standard has no end date and is based on a temporary health crisis for which there are now 2 vaccines being distributed in Virginia with over 90% efficacy and more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work that keeps things moving in the Commonwealth. The health and safety of all employees is the top priority of our company and safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under the CDC and OSHA guidelines; additional regulations are unnecessary.

The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money and does not adapt to current science and innovation.

If anything is adopted, it should have a sunset provision that ends with the Governor's state of emergency. There is not a logical or scientific reason to continue a standard that was specifically written in response to a state of emergency. The data has not shown direct or immediate danger for workers in the "low" and "medium" categories as defined in 16VAC25-220-30. These categories should be removed from the permanent standard, since those industries are regulated by OSHA.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money and does not allow flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a permanent standard with no expiration. Sincerely, Dennis Showalter President / Owner Insight, LLC

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89089 John M. Blankenship, Concrete Pipe & Precast, LLC 2021/01/08 16:46:07
jblankenship@concretepandp.com

Emergency Temporary Standard Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 I strongly oppose making the Emergency Temporary Standard Infection Disease Prevention SARS-CoV-2 Virus That Causes COVID-19 a permanent standard. This standard will no longer be needed in the near future and should not be made a permanent standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89090 Robert Hollingsworth 2021/01/08 16:49:04 rhollingsworth@districtcouncil20.org AFSCME District Council 20 Strongly Supports the Proposed Permanent Standard Dear Safety and Health Codes Board The

American Federation of State, County and Municipal Employees (AFSCME) District Council 20 strongly supports the permanent standard for Infectious Diseases Prevention: SARS-CoV-2 the Virus that Causes COVID-19. The Commonwealth of Virginia has proposed a strong, comprehensive permanent standard to protect workers from the SARS-CoV-2 virus. We strongly urge the Safety and Health Codes Boards and Department of Labor and Industry (DOLI) to adopt the proposed permanent standard with several recommended improvements and to remain vigilant in protecting workers in Virginia. AFSCME District Council 20 members are on the front lines, keeping our communities running in Virginia. They and other public service workers are hard at work providing emergency services, health care, transportation, sanitation, public safety and other essential services. Many of these workers come in contact with people who are or may be infected by the SARS-CoV-2 virus, thereby endangering themselves and their families. They need adequate and enforceable worker protections to do their jobs safely. Even with vaccines starting to become available, the pandemic is far from over, and workplace controls are needed to mitigate SARS-CoV-2 exposure. The proposed permanent standard ensures that employers identify how workers could be exposed to COVID-19 in the workplace and have a written plan to control those risks using the hierarchy of controls. The standard also includes strong training provisions, reporting and notification requirements and protections against discrimination. AFSCME District Council 20 supports the added ventilation provisions in the proposed permanent standard. Since SARS-CoV-2 is an airborne transmissible virus, proper ventilation and increased supply of fresh air are vital to reduce spread indoors. The ventilation requirements reference the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards, which will ensure that airborne transmission is addressed in workplaces. We also support the modification of the return-to-work criteria since workers who experience severe illness may need to be removed from work for an extended period of time. However, the provisions for return-to-work criteria fail to address asymptomatic individuals with COVID-19. Asymptomatic individuals with COVID-19 are a major source of workplace exposure and protective provisions must be included to ensure they do not return until they can no longer infect others. Therefore, workers with COVID-19 exposures should not return to work until: 14 days have passed since the worker was exposed to a COVID-19 case and the worker has remained asymptomatic during this time period; or 10 days have passed since the worker was exposed to a COVID-19 case, the worker has remained asymptomatic during this time period, the worker receives a COVID-19 test administered after day five post exposure with a negative COVID-19 test result, and the following conditions are met: No clinical evidence of COVID-19 has been observed by daily symptom monitoring during the entirety of quarantine up to the time at which quarantine is discontinued, and Daily symptom monitoring continues for 14 days after exposure, and Workers should be advised that if any symptoms develop, they should immediately report them to the employer and isolate. In the proposed standard, the Board has changed the employer reporting requirement to the Virginia Department of Health (VDH) compared to what is required under the emergency temporary standard (ETS). If adopted the proposed permanent standard will require employers to report every instance of outbreaks of two or more employees. AFSCME District Council 20 recommends that the reporting requirements to DOLI be consistent with those of the VDH. That is, employers should be required to report to DOLI within 24 hours of the discovery of two or more of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus, instead of DOLI's current practice under the ETS of requiring reporting for the discover of three or more such employees. AFSCME District Council 20 strongly opposes the delayed effective date of March 26, 2021. Employers have already been complying with the ETS requirements. The extended effective date is an oversight that can cause a lapse in worker protections. Since the ETS will remain in effect only through January 26, 2021, we recommend the permanent standard requirements take immediate effect on January 27, 2021 so that there is no gap in coverage and to avoid confusion within the regulated community. The Board should add language in the standard to clarify the

definition of a face covering. A face covering can provide a means for source control, reducing the spread of virus from the wearer to others, but it is not intended to protect the wearer. A typical example of source control for COVID-19 is to use a mask or face covering to limit the spread of respiratory droplets and aerosols from the wearer to others. Face coverings, however, are not a replacement for strong respiratory protection that workers need when working close to other people for a long period of time. The Board must reject efforts to weaken worker protections based on respirator availability. VDH has proposed changes to the rule to allow face coverings when respirators are needed. In contrast to a face covering, a respirator protects the worker by filtering out virus particles in the air. Using face coverings instead of respirators substantially increases the risk that workers will be exposed to SARS-CoV-2. Reducing needed protections because of any shortages in supplies must not be in the rule and should be handled through enforcement discretion, as the agency always has. We note that NIOSH recently issued new approval holders and several of those respirator manufacturers report they have respirators in stock for employers to purchase. The permanent standard will help protect Virginia's workers, their families and the communities they serve. AFSCME District Council 20 urges the Board take immediate action to adopt and enforce the proposed permanent standard. We appreciate the opportunity to provide these comments. If you have any questions, please feel free to contact me. Sincerely, Robert Hollingsworth Interim Executive Director AFSCME District Council 20

SEE DEPARTMENT RESPONSE TO COMMENT 87825

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHER WORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

With regard to the Commenter's request to change employer reporting requirements to DOLI from 3 to 2, VOSH does not support such a change because it does not have the resources to deal with a notification requirement lowered from three to two. "Three" was chosen because of the previous long time requirement for employers to report catastrophic events where three or more employees were hospitalized.

The Department is proposing an effective date for the Standard of January 27, 2021 and an effective date for the training and Infectious Disease Preparedness and Response Plan of March 26, 2021.

With regard to the issue of face coverings versus respirators, 16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms." The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

All employers in general industry (i.e., all companies not in construction, agriculture or maritime) are covered by the federal OSHA identical standard 1910.132, Personal Protective Equipment, and that standard requires covered employers in 1910.132(d):

1910.132(d)

Hazard assessment and equipment selection.

1910.132(d)(1)

The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment (PPE) [SUCH AS SURGICAL MASKS OR RESPIRATORS FOR POTENTIAL COVID-19 EXPOSURE]. If such hazards are present, or likely to be present, the employer shall:

1910.132(d)(1)(i)

Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment;

1910.132(d)(1)(ii)

Communicate selection decisions to each affected employee; and,

1910.132(d)(1)(iii)

Select PPE that properly fits each affected employee.

Note: Non-mandatory appendix B contains an example of procedures that would comply with the requirement for a hazard assessment.

1910.132(d)(2)

The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment.

Requirements similar to 1910.132(d) also apply to employers in construction, agriculture and public sector maritime (federal OSHA has jurisdiction over private sector maritime) by virtue of 16VAC25-220-50.D and 16VAC25-220-60.D.

In addition, 16VAC25-220-50.D.5 (very high and high risk) specifically provides:

"5. Unless contraindicated by a hazard assessment and equipment selection requirements in subdivision 1 of this subsection, employees classified as very high or high exposure risk shall be provided with and wear gloves, a gown, a face shield or goggles, and a respirator when in contact with or inside six feet of patients or other persons known to be or suspected of being infected with SARS-CoV-2. Gowns shall be the correct size to assure protection."

Also, 16VAC220-60.C.1.j (medium risk) provides:

j. Employers shall provide and require employees to wear face coverings who, because of job tasks, cannot feasibly practice physical distancing from another employee or other person if the hazard assessment has determined that personal protective equipment, such as respirators or surgical/medical procedure masks, was not required for the job task.

89091 Annette Kirby 2021/01/08 16:50:00 wthanet@cox.net

Totally opposed to the adoption of a permanent Standard Infectious Disease Prevention I am a private citizen living in Bath Co. Virginia. I feel that now, after almost year of wearing masks this practice has to end. The masks do not prevent the disease from the person wearing the mask to get it. In fact, the masks have been found to cause other health issues such as difficulty breathing, coughing etc. As soon as the vaccine is more widely spread all of the prevention tactics should end and we should return to our normal lives as before.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89094 Robert Melvin, Virginia Restaurant, Lodging & Travel Association 2021/01/08 17:05:57
robert@vrlta.org

VRLTA Comments re Adoption of Proposed Permanent Standard related to COVID-19 "On behalf of the Virginia Restaurant, Lodging & Travel Association, we would like to take a moment to impart our organization's comments regarding the Virginia Department of Labor and Industry's (VDOLI) intent to adopt the emergency regulation for preventing COVID-19 in places of employment as a permanent standard. While we appreciate some of our concerns were taken into consideration and included in this final version of the proposed permanent COVID-19 standard, we want to highlight the public safety measures being taken by the hospitality and tourism industry and why the proposed COVID-19 permanent standard should not be adopted, nor applied to restaurants, campgrounds, attractions, of lodging providers. Hospitality and tourism related businesses have been working diligently to comply with COVID-19 related requirements from the Governor's Executive Orders (EO), Virginia Department of Health (VDH), Virginia Department of Labor and Industry (VDOLI) and applicable federal requirements. In fact, the hospitality and tourism industry has strived to protect the public and their staff throughout this public health epidemic. The American Hotel & Lodging Association created the Safe Stay program, and the National Restaurant Association developed the Serve Safe Dining Commitment/ COVID-19

trainings. Major hotel brands, including Marriott, Hilton, and others also have implemented rigorous cleaning protocols as well. These lessons were created in accordance with the guidance issued by public health authorities, including the U.S. Centers for Disease Control. Regrettably, VDOLI has failed to accept these hospitality industry specific education programs even after much encouragement from our industry to get these recognized as satisfying training and safety criteria of the ETS. Our organization and industry supports clearly defined and predictable measures to address health and safety concerns related to COVID-19; however, we believe that adopting a permanent standard when the science and our knowledge of the virus are frequently changing and have been since the start of the pandemic will hinder the ability of our industry to adequately respond in a changing public health landscape on the issue. The ETS was approved ostensibly to provide a means of ensuring employees and the public were protected during the temporary COVID-19 emergency; however, your agency is now seriously considering establishing these as permanent standards. As we are seeing, COVID-19 vaccines and treatments have been developed and are now being deployed to the public. Therefore, it's misguided to establish these requirements as a permanent standard that will be perennial. As a result, hospitality and tourism businesses will need to comply with these onerous regulations even after we have vaccinated our citizens against this virus.

As you may be aware, hospitality related businesses have been one of the most heavily impacted by COVID-19. These businesses have already been absorbing huge costs just to comply with existing requirements from VDH, EOs, CDC, and national trainings. Making the VDOLI standard permanent will place these businesses in a more precarious situation. We currently anticipate that almost 25% of restaurants in Virginia will permanently close, and these regulations will increase the rate of permanent closures. Therefore, we believe that it's imprudent to transition the ETS to a permanent standard, but should your agency move forward with making these standards permanent here are our suggestions: Exempt hotels, restaurants, and campgrounds that train their staff in either the American Hotel & Lodging Association (AHLA) Stay Safe, national hotel brand trainings and guidance, National Restaurant Association (NRA) Serve Safe Dining Commitment, or National Association of RV Parks and Campgrounds (ARVC) Re-Opening RV Parks and Campgrounds procedures and follow necessary protocols included in these respective programs. Sunset the regulation when the Governor's State of Emergency concludes for COVID-19. We remain of the belief that hospitality related businesses that follow national health and safety procedures from AHLA, NRA, and ARVC should be exempt from the VDOLI regulations as these procedures were developed in accordance with CDC guidelines. For these reasons, we strongly believe that the best approach is to not adopt the ETS as a permanent regulation. However, if you do promulgate them, we believe the adjustments outlined above will provide the means to address the public health issues pertinent to mitigating transmission of COVID-19. Eric Terry & Robert Melvin

SEE DEPARTMENT RESPONSE TO COMMENT 87834

With regard to the Commenter's request for an industry exemption (exempt hotels, restaurants, and campgrounds that train their staff in either the American Hotel & Lodging Association (AHLA) Stay Safe, national hotel brand trainings and guidance, National Restaurant Association (NRA) Serve Safe Dining Commitment, or National Association of RV Parks and Campgrounds (ARVC) Re-Opening RV Parks and Campgrounds procedures and follow necessary protocols included in these respective programs), it is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Commenter has provided no substantive reasons while the employees and employers it represents and the hazards and job tasks they are

exposed to are substantially different from every other covered entity such that it would justify different treatment under the standard.

89097 Virginia Manufacturers Association 2021/01/08 17:07:10 thefuture@vamanufacturers.com

Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus The VMA has filed comments in opposition to the proposed permanent standard for infectious disease prevention: SARS-CoV-2 virus via a document filed with Princy Doss, VDOLI, due to the size of document.

SEE DEPARTMENT RESPONSE TO COMMENT 10012

89103 Nicole Riley - NFIB 2021/01/08 17:15:15 nicole.riley@nfib.org

Small Businesses Oppose a Permanent Standard Dear Members of the Virginia Safety and Health Codes Board: On behalf of the Virginia small business members of the National Federation of Independent Business (NFIB), we are submitting the following comments related to your intent to adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (otherwise further to as “the Regulations”). Our organization represents approximately 6000 small businesses and 60,000 employees across a broad swath of industries from manufacturing, retail, restaurants, agricultural and forestry companies, healthcare, construction, to professional services. As we enter the 44th week of Virginia’s State of Emergency related to containing the spread of COVID-19, safety for their employees and customers has been the top priority for Virginia’s many small business owners. Yet small business owners have faced intense stress as their businesses were ordered to close or operate in an extremely limited capacity. The economic turmoil suffered by small businesses during the global pandemic has only somewhat abated as Virginia has gradually reopened. Many small business owners have watched helplessly as their revenue slowed to a trickle or dried up entirely. According to NFIB’s 14th Small Business Covid-19 Survey which was released on December 11th, 2020, One-in-four (25%) of small business owners report that they will have to close their doors if current economic conditions do not improve over the next six months, up from 20% a month ago. Sales levels are still 50% or less than they were pre-crisis for one-in-five (20%) small businesses with another 29% at sales levels of 51%-75% of pre-crisis. Even those small businesses that received a PPP loan, 22% of them have or anticipate having to lay off employees in the next six months, a slight increase from one month ago when it was 19%. And about half (53%) of borrowers anticipate needing additional financial support over the next 12 months, about the same as last month. Despite these challenging times, small businesses quickly adapted and implemented protocols to protect their employees and customers from exposure to the coronavirus by following the guidance issued from the CDC, OSHA, and the Governor’s executive orders. Now Virginia small business owners are doing their best to comply with the Emergency Temporary Standard (ETS). The last thing business owners need as they rebuild their businesses during this critical time is a permanent one-size-fits-all government regulation. Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements. Therefore, NFIB requests the Virginia Safety and Health Codes Board REJECTS a Permanent Standard for several reasons. First, adopting 16VAC25-220 as permanent regulations will be overly burdensome for small businesses. The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect this. If the ETS were to become permanent, it would

continue to require businesses to comply with outdated regulations. Now is not the time to impose a permanent standard. More importantly, why adopt a permanent standard when we're beginning to see the rollout of vaccinations? Second, there is no sunset date for the Standard. The proposed permanent standard does not contain a true sunset date. The Board was clear during its July deliberations; the temporary nature of this pandemic requires any regulations put in place related to COVID-19 should be sunset with the Governor's State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic. Third, there is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis. Fourth, the Board has not proven a "grave danger for ALL workplaces necessitating a permanent regulation. It is unreasonable to apply a "one size fits all" approach to COVID-19 regulations to all employers and employees. The Board's determination of "grave danger" in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities. The "grave danger" determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk). Therefore, the Board cannot simply assume and apply its prior "grave danger" determination nor has the Board proven the necessity for such a permanent regulation. If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it must include these important provisions: The sunset clause whereby the Regulations will expire with the Governor's State of Emergency. The specific recommendations from the Business Coalition to ensure the implementation and enforcement of any Permanent Standard is reasonable, fair, and attainable. Here are several of NFIB's priorities for amendments to any Permanent Standard Amend § 10G to the agency's original language with clarification on providing "safe harbor" for employers who follow CDC and OSHA guidance. Eliminate requirements for physical separation of employees at low and medium risk businesses by a permanent, solid floor to ceiling wall. Eliminate all human resource policies from the Regulations such sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. Amend common space sanitation requirements. Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. Increase the amount of time employers must train their employees. The current timetable is unachievable. Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Revise requirements related to transportation of employees who travel in the same vehicle. Eliminate the conflicts and overlaps between the "Safer at Home" guidance, Executive Order 72, and the proposed rule. Reject any amendments to the Regulations that would incorporate other infectious diseases. Therefore, NFIB recommends the Board withdraws its "Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220." Instead NFIB encourages the Board, upon a determination that it's a necessity to pursue regulations, it should do the following: The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that

expires within 6 months of adoption or when the State of Emergency expires. Conclusion. It is unreasonable to impose one-size-fits-all COVID-19 regulations on all employers when they reduce a business' flexibility to quickly alter workplace procedures to remain safe during the ever-changing circumstances of this pandemic especially when each industry has its own needs. By approving a Permanent Standard, the Commonwealth is freezing current scientific understanding into place which is unnecessary and poses more risk for our businesses and workers. It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify guidance and Executive Orders as a reasonable replacement. Further, it is confusing why the Board would pursue permanent regulations that are in conflict with previously issued Executive Orders and in light of the beginnings of vaccine availability. Therefore, it is NFIB's recommendation that the Board reject the Regulations, provide additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires. We hope the Board will see fit to give Virginia's small businesses an opportunity to rebuild their businesses, restore their customer base and rehire their employees without imposing additional costly regulations. Nicole Riley, Virginia State Director

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees that the Standard is a "one size fits all" regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines." The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

The language referenced by the Commenter (1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time)) is one of a number of possible mitigation strategies that an employer can implement depending on the feasibility of doing so.

Opposed to permanent VOSH emergency standard "On behalf of the King George County Service Authority Board of Directors, I am writing to express that we strongly oppose the proposed VOSH Permanent Standard for Infectious Disease Prevention of the SARS-Cov-2 Virus that causes COVID-19. VOSH should not move to adopt a permanent policy as it goes beyond the original temporary standard being that the current pandemic is a fluid situation that requires real time evaluation and adjustments. The permanent standard proposal being implemented by a regulatory agency would usurp the Commonwealth of Virginia's legislative process.

Furthermore, the VOSH standards being proposed, place both employers and employees at risk. First, it includes no prohibition on barring employees from coming to work after close contact with an individual who has tested positive for COVID-19; nor does it allow an employer to install testing based return-to-work policies. Second, several of its provisions relating to return-to-work and close contact do not allow employers to benefit from continually evolving CDC guidance. Third, it includes whistleblower protections for employees who report concerns to the news media or social media, which may invalidate some employers' media policies. Finally, the Proposed Permanent Standard lacks "safe harbor" protections for employers that protect employees by following CDC guidance.

We strongly request for you to reconsider this proposal and its implementation and allow agencies the ability to establish policy. Respectfully, Jonathon Weakley General Manager, King George County Service Authority

SEE DEPARTMENT RESPONSE TO COMMENT 87834

With regard to return to work issues for employees who have had close contact with a positive COVID-19 person, the CDC defines "close contact" as "Close contact" means you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

Close contact is used by the CDC and VDH for contact tracing purposes. The standard provides in 16VAC25-220-10.H:

H. Nothing in the standard shall be construed to require employers to conduct contact tracing of the SARS-CoV-2 virus or COVID-19 disease.

Close contact is also used for quarantine purposes. "Quarantine" is separation of people who were in "close contact" with a person with COVID-19 from others. The Standard does not address the issue of "quarantine."

Requirements for returning to work from "quarantine" is NOT covered by the ETS. Instead, Virginia Department of Health (VDH) guidelines apply (see §40, FAQs 26, 27, 28, 29, 30). <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

VDH has responsibility for quarantine issues by statute and regulation.

The Department does not intend to recommend any change to 16VAC25-220-90.C as it is the position of the Department that it reflects the current state of case law on the subject.

Pursuant to Va. Code §40.1-51.2:1, employees are protected from discrimination when they engage in activities protected by Title 40.1 of the Code of Virginia (“because the employee has filed a safety or health complaint or has testified or otherwise acted to exercise rights under the safety and health provisions of this title for themselves or others.”).

Whether an employee engaged in a “protected activity” under Title 40.1 is very fact specific, but can include occupational safety and health information shared by an employee about their employer on a social media or other public platform in certain situations.

16VAC25-220-90.C provides that:

No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer’s agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

If an employee raises an unsubstantiated COVID-19 related claim or makes a false COVID-19 related claim against their employer through print, online, social, or any other media, such an act by an employee would not be considered “reasonable” under the ETS and disciplinary action taken against the employee in accordance with the employer’s human resource policies would not be considered “discrimination” under the ETS/ER or Va. Code §40.1-51.2:1.

89112 William E Cifers, Manager Asphalt Emulsion Industries, LLC 2021/01/08 17:30:30
ecifers@asphalt-emulsion.com

Strongly Oppose Adopting Permanent Standard "Members of the Safety and Health Code Board, As an employee/employer in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor’s COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to the Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

The data has not shown a direct and immediate danger for those workers whose tasks fall into the “Low” and “Medium” categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent

Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers/employees and feel that this is an example of government overreach. Thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89113 Carter Machinery co inc 2021/01/08 17:34:59 Paul_casanave@cartermachinery.com

Strongly oppose the new health standards We are in a temporary situation, to impose these kind of standards on workplace is the death of America. Retail is already going to self checkout, if you are looking to put people and personal touch out of work, then go ahead. But people like to deal with people In the construction industry employees are not going to put up with this muzzling, and control. You will bring a mutiny and rebellion among the people. I will be the one of the first.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89122 Jon Lawson 2021/01/08 18:05:13 vindicatedenvironmental@gmail.com

Important Comments and Request for Clarifications/Data To begin, the Virginia Department of Labor and Industry (DOLI) should be a trusted resource in this pandemic. However, DOLI has failed to seize an important opportunity to help employers and employees of the Commonwealth navigate the new challenges brought upon us by COVID-19. Instead of spending resources assisting industry and employees with helpful guidance and best practices, the focus of DOLI has been to draft restrictions and place such standards in stone for a situation that has continually proved itself to be too fluid to warrant such action. The evidence is clear, the DOLI website COVID-19 Resources page was last updated March 15, 2020 and the outreach material did not come available until July 27, 2020. The update and dissemination of resources should be the goal of DOLI in this pandemic, not the drafting of permanent regulations to address a hopefully temporary pandemic. On 1/4/2021, the Proposed Permanent Standard was revised to a Final Draft, the changes were substantial enough to extend the comment period. The comments made below are referencing page numbers and sections from the original proposal. Case in point, the 1/4/2021 document added a stipulation for Employers to provide psychological and behavioral support for employee stress at no cost to employees, while it is commented as an omission, that is a substantial change from original document and needs to be properly discussed. For a proposed permanent standard that has the reach to impact all of Virginia's workforce, please faithfully follow the Virginia Administrative Process Act as Board Members previously agreed. With so many changes in our understanding of this disease, it is not prudent to set a permanent standard, if action is required an extension of the current emergency temporary standard should be explored. There should also be research/data made available about the spread at workplaces in Virginia and then determine the need for additional action. Page 4 - Former Section F - The disagreements in terms between this standard and ever-evolving Executive Order 72 (and previous EOs) need to be rectified to reduce confusion. Page 21 - #4 - the symptoms of COVID-19 overlap many other illnesses and allergies, automatically designating employees with symptoms as "suspected to be infected with SARS-CoV-2 virus" should be reevaluated. Page 24 - d. This section is confusing without a timeframe related to the initial

outbreak (two or more confirmed cases of COVID-19). Page 31 - #4 - a scientific explanation of why general industry observing 24-hours prior to cleaning and disinfecting should accompany this statement. This feels like it is included only for medical/hospital settings but is included for all employers. Page 38 - #5 - This statement is too vague for standard, could be misinterpreted, more detail on what would be required from an employer is needed. Page 48 - b. - The employers burden to balance HIPAA, anti-discrimination laws, and this infectious disease control plan on an individual basis is overbearing. Age, obesity, and pre-existing conditions are not to be discriminated against yet this could cause someone not to be able to work/perform their job duties due to pregnancy or smoker status. Putting the burden on employers in these decisions is a severe misstep. Thank you for considering these comments.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

With regard to the Commenter's reference to the addition to the January 4, 2021 Draft Final Standard of a stipulation for Employers to provide psychological and behavioral support for employee stress at no cost to employees, that requirement is in the current ETS, and as noted by the Commenter was accidentally deleted during the conversion of a Word document to a PDF. The language was also contained in the original proposed standard of July 27, 2020.

89129 Marlon Tillerson, AFSCME Member and Arlington County Employee 2021/01/08 18:26:10
marlontillerson26@gmail.com

Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th! My name is Marlon Tillerson. I have been employed at Arlington County for 11 years. I currently work at the Water, Sewer, and Streets Division as a Master Technician. We repair broken catch basins, sanitary and storm lines, and manhole covers, as well as assist with snow removal. The work is hazardous, even more so with the pandemic. I want to do everything I can to keep not just myself and my coworkers, but also my wife and three kids safe. That is why, with AFSCME VA members, I support making the COVID-19 Emergency Temporary Standard permanent. I work as part of a four-person crew, though I often work as part of a group of as many as nine people. When setting cinder blocks, repairing catch basins, running saws, or operating a backhoe, it is necessary that we work within 6 feet of one another. We are provided masks, gloves, and hand sanitizer to curb the spread of COVID-19. The crews don't have enough vehicles for all nine of us to ride alone and narrow streets don't always allow the space needed to park all those cars. This makes personal protective equipment even more important. The COVID-19 cases are currently spiking in my department and I would like to see steps taken to further prioritize safety. One thing that comes to mind is returning to the practice of having an alternative work schedule in which personnel work one week on and have one week off. Less people on shift means less people in the building. We need a permanent health and safety standard to keep us safe. The temporary standard has required employers to give heightened priority to health and safety. I worry that the elimination of this standard would mean that conditions in our workplace could be rolled back, putting us at greater jeopardy of contracting COVID-19 and bringing it back home to our families. I urge the Board to enact the permanent standard and make it and all provisions take immediate effect on January 27, 2021.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

Reject a Permanent Standard "Thank you for the opportunity to comment on the Board's intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. These comments are provided on behalf of the Virginia Trucking Association (VTA). As background, the VTA is the statewide association of trucking companies, private fleet operators, industry suppliers, and other firms that support safe and successful trucking operations. Our membership includes family-owned and corporate trucking businesses engaged in the transport of goods and services throughout the Commonwealth of Virginia and the United States. The VTA membership includes companies that are headquartered in Virginia as well as companies headquartered in other states that have locations in Virginia and/or operate commercial vehicle in and through the Commonwealth. Throughout the COVID-19 pandemic, the trucking industry has continued to operate as an essential service, providing critical transportation of the essential goods and services needed to sustain the population and the economy. Professional truck drivers are the heroes who have kept moving to ensure everyone has the goods they need to get through these challenging times. Their jobs have now taken on an even greater importance as distribution of COVID-19 vaccines begins across the country. The trucking industry has been able to continue operating by making commonsense adjustments to its operations, both on the road and within its shops and offices necessary to continue daily operations. Safety and Human Resources professionals within the trucking industry have spent countless hours poring over guidelines and recommendations from medical and industry experts to draft continuation plans that work best for their operations and provide the highest and most practical level of safeguards for their employees to protect them from COVID-19.

Our position on safety has never wavered: Safety is of paramount importance. Since the onset of the COVID-19 pandemic, the VTA's member companies have remained committed to this principle, and as the Commonwealth and our nation begin to enter the recovery phase, the safety and health of their employees will continue to guide their decision-making. Trucking holds the keys to the economic recovery of Virginia and the nation, and as an industry, we are prepared to meet that challenge. However, to meet that challenge, the industry cannot be hindered with burdensome, impractical and unclear regulations such as the current Emergency Temporary Standard (ETS) that is being considered as a permanent standard. Therefore, we respectfully request that Board not adopt the proposed Permanent Standard: Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19. Support of Comments filed by the Virginia Business Coalition. The VTA is a member of the Virginia Business Coalition. We strongly support the comments filed by the Business Coalition and incorporate the concerns and issues they raised as part of these comments filed on behalf of the VTA. The remainder of these comments address issues and concerns about adoption of the proposed permanent standard of particular interest to the trucking industry. Trucking Industry-Related Issues¹. In the definition of "Lower" exposure risk hazards or job tasks, it is stated that "Employee use of face coverings for contact inside six feet of coworkers, customers, or other persons is not an acceptable administrative or work practice control to achieve minimal occupational contact." This provision conflicts with CDC guidance, "What Long-Haul Truck Driver Employers Need to Know about COVID-19" (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking-employers.html>). This guidance recommends that employers of long-haul drivers "Take additional precautions to address risks associated with ride-alongs or team driving (two drivers in the cab on a long-haul run) when they cannot be avoided. For example, wear a cloth mask when sharing the cab with someone outside of your household and 6 feet of distance cannot be maintained. The same conflict exists for CDC guidance, "What Long-Haul Truck Driver Employees Need to Know about COVID-19" (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking-employees.html>). This guidance recommends that truck drivers: • "Wear a cloth mask in public, and at work, even when social

distancing” and • “When team driving or ride-alongs are required, wear a cloth mask when sharing the cab with someone who doesn’t live with you and you can’t stay 6 feet apart.” If the Board proceeds with adoption of the proposed permanent standard, we recommend that it be amended to allow the wearing of a cloth mask by team truck drivers as an acceptable administrative control to achieve minimal occupational contact, as recommended by the CDC. We also recommend that it be amended to recognize that there is no need to require truck driving teams of husbands and wives, or others who live in the same household to wear a face covering mask while occupying the same truck cab.² We commend DOLI staff for including truck drivers in the new definition of “Minimal occupational contact” as recommended in the OSHA Hazard Recognition document cited in the footnote 4. This is a helpful clarification that truck drivers are considered to be working in “lower exposure risk hazards or job tasks.”

Additional Comments If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it:

1. Should not expand the standard to include other infectious diseases. As we have learned with COVID-19, all infectious diseases are not the same. We have no idea what protocols will be necessary to respond to and mitigate future infectious diseases, so it does not make sense to create a permanent standard for all infectious diseases.
2. Adopt a sunset clause whereby the Standard will expire at the same time as the Governor’s State of Emergency.
3. Amend § 10G to revert to the agency’s original language with clarification on providing “safe harbor” for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance. Additionally, as pointed out in our trucking industry-related comments above, we believe there is a conflict between CDC recommendations for truck drivers and their employers and the proposed permanent standard. Conflicts such as this create confusion and uncertainty for employers that hinder their compliance efforts.
4. Eliminate all human resource policies from the Regulations such as sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. These policies exceed the Board’s authority as it relates to workplace hazards.
5. Increase the amount of time allowed for employers to train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. There is increasing demand for freight transportation and a shortage of qualified drivers to meet that demand. We believe trucking employers should have additional time to complete this training to give them flexibility in scheduling time out of the truck for their drivers to minimize disruptions to the supply chain.

Recommendation We join the Business Coalition in respectfully requesting that the Virginia Safety and Health Codes Board withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.” Instead, if the Board can demonstrate a necessity to pursue regulation, it should do the following:

1. The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period.
2. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period.
3. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

Conclusion It is unreasonable to apply these “one size fits all” COVID-19 regulations to all employers and employees, especially an interstate business like trucking with a highly mobile workforce that does not work in brick and mortar facilities. Regulations written to address fixed facilities and businesses are impractical and difficult to comply with for the trucking industry as illustrated in the concerns we have expressed. Safety is of paramount importance to the trucking industry as we continue to provide essential transportation service as we begin to reopen the economy. We will continue to provide the highest and most practical level of safeguards for our employees to protect them from COVID-19 as our economy recovers and freight demand increases. We do not believe that the Board should adopt a permanent standard to address a temporary pandemic. Therefore, we

recommend that the Board reject the Regulations, provide additional public comment on the newly revised January 4th proposal, including the required economic analysis that has not yet been released. Additionally, the Board should convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires. Please contact me if you need any additional information or have any questions regarding these comments or the trucking industry.

Sincerely, P Dale Bennett President & CEO

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Commenter's discussion of lower risk, minimal occupational contact and the issue of face coverings appears inaccurate. As noted, truck drivers (when driving alone) can be considered lower risk. Once another driver is present in the cab of the vehicle and 6 feet of physical distancing cannot be maintained, the drivers will fall under the definition of "medium risk" because they cannot maintain minimal occupational contact. The standard contains additional protections for employees exposed to hazards or job tasks classified as medium risk. As has always been intended by the standard and also consistent with CDC guidance, the wearing of face covering is not a substitute for also practicing physical distancing. <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html>.

The Department respectfully disagrees with the Commenter's assertion that mitigation strategies (referred to by the Commenter as "human resource policies") to prevent the spread of SARS-CoV-2 in the workplace, exceeds the authority of the Board.

The Department does not plan to recommend that 16VAC25-220-10.E be changed as suggested by the Commenter. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.E assures such protections.

89131 Diana Reynoso, City of Alexandria employee 2021/01/08 18:31:42 djreynoso@comcast.net

Strongly Support Adopting Proposed Permanent Standards Hello, my name is Diana Reynoso, and I work at Alexandria's Community and Human Services Department as a Customer Support Engineer 2. One of my duties was to fingerprint potential volunteers to ensure the safety of our most vulnerable citizens while participating in our programs. When fingerprinting we must be less than 6 feet from the person, touching the person's hand to make sure we capture their fingerprints. Although this is no longer my duty, I still worry about my co-workers that have this task which puts them at a higher risk for COVID-19 exposure. We all worry about our health and safety during this difficult time, and even though, I am no longer at a higher risk, I do not want to get exposed with COVID-19, and bring it home to my husband--who does not have paid sick leave. If this happens, he could be without pay for 14 days or longer. The VOSH health and safety training by AFSCME VA and our ongoing effort to make temporary COVID-19 standards permanent is vital to the health and economic well being of my family and me. We need VOSH to make the temporary emergency workplace standard permanent, so it can continue protecting us against exposure by providing clear guidance to employers. We need strong enforcement mechanisms so that employers take these standards seriously. I urge you to continue protecting Virginian workers and our families. I urge the Board to make the permanent standard and all its provisions effective immediately on January 27, 2021. Thank you for making Virginia the first in the nation to enact these temporary emergency standards.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89134 Jerrell Williams, City of Alexandria employee 2021/01/08 18:38:32 jrellwill1991@gmail.com

Strongly Support Adopting Proposed Permanent Standards My name is Jerrell R Williams and I work for the Department of Transportation and Environmental Services as a Refuse Collector. I am a proud member of AFSCME Local 3001 and the public services me and my coworkers do to protect the health, safety, and cleanliness of our community. It is great to see our union step up in support of Virginia's emergency workplace standards addressing the spread of the coronavirus. The VOSH ETS protected Virginia workers in 2020 and must continue to do so in 2021. I join with my fellow members and Virginians in support of making those temporary standards permanent. As a Refuse Collector there are many opportunities to encounter hazardous materials. COVID-19 makes my job even more dangerous. Across the country, we have heard that refuse and sanitation workers face alarming consequences when they lack access to necessary PPE or were not following the correct guidelines and safety procedures. As a father of two small children, I worry about bringing home something that can seriously harm my children. I understand that Virginia's VOSH Emergency Temporary Standard will expire in January. I ask, on behalf of myself and workers worried about our health and safety, that Virginia's Safety and Health Codes Board adopt the permanent workplace standard. We need these protections against the risk of exposure, and employers need continued workplace safety requirements. I urge you to make the permanent standard and all its provisions effective immediately on January 27, 2021. SEE DEPARTMENT RESPONSE TO COMMENT 87825

89139 Heather Greenwell, Virginia Association of Roofing Professionals 2021/01/08 18:43:22

heather@varoofingprofessionals.org Oppose Permanent Standard The Virginia Association of Roofing Professionals (VARP) is the statewide trade organization representing roofing contractors, design professionals, manufacturers, and distributors in the Commonwealth. Our organization is committed to protecting employees and communities from COVID-19 infection. VARP is a member of the Virginia Business Coalition and strongly affirms, supports, and echoes the Business Coalition's position on the Safety and Health Codes Board intent to adopt Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 VARP members are already heavily regulated under multiple federal and state occupational health and safety programs.

As such, our members have worked to develop best management practices and implemented a hierarchy of controls to protect our workforce from COVID-19 infections as proscribed by all Federal regulatory agencies. Therefore, VARP requests the Virginia Safety and Health Codes Board REJECT a Permanent Standard for the following reasons. I. Summation of Business Coalition's Comments Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements. A. The Virginia Safety and Health Codes Board should not adopt a Permanent Standard. The Coalition asserts that adopting 16VAC25-220 as permanent regulations is overly burdensome, unnecessary, and violates existing law. The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect this. If the ETS were to become permanent, it would continue to require businesses to comply with outdated regulations.

Now is not the time to impose a permanent standard. Why adopt a permanent standard when we're beginning to see the rollout of vaccinations? B. There is no sunset date for the Standard. The proposed permanent

standard does not contain a true sunset date. Rather, all it does is reiterate the Board's authority to come back at a later date to determine the necessity of a continued permanent standard after the Governor's State of Emergency is lifted. The Board was clear during its July deliberations; the temporary nature of this pandemic requires any regulations put in place related to COVID-19 should be sunset with the Governor's State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic. C. There is no economic impact analysis to determine cost to small businesses. There is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis. D. The Standard is burdensome for businesses to comply with Permanent regulations would be overly burdensome, costly and confusing especially in light of overlapping regulations and guidance with the "Safer at Home" guidance, Executive Order 72, and the proposed rule. Businesses are already incurring expensive costs to comply with the ETS from hiring consultants and attorneys, taking workers out of production to do additional training, etc. E.

The Board has not proven a "grave danger for ALL workplaces necessitating a permanent regulation. It is unreasonable to apply a "one size fits all" approach to COVID-19 regulations to all employers and employees. The Board's determination of "grave danger" in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities. The "grave danger" determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk). VDOLI also cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and yet infections have been reduced entirely by employer compliance with CDC guidance, OSHA guidance, and Governor's Executive Orders – not the COVID-19 ETS. Therefore, the Board cannot simply assume and apply its prior "grave danger" determination and COVID-19 ETS efficacy as the basis for permanent regulations.

Further, since 46 other states have neither a COVID-19 ETS or permanent regulation, the Board has not proven the necessity for such a permanent regulation. F. Regulations should not be expanded to other infectious diseases. Infectious diseases are not all the same. Therefore, the Board should not expand these regulations to other infectious diseases. We have no idea what protocols will be necessary to mitigate the risks of future diseases, so it doesn't make sense to create a permanent standard for all infectious diseases. G. If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it must include these important provisions: The sunset clause whereby the Regulations will expire with the Governor's State of Emergency. Amend § 10G to the agency's original language with clarification on providing "safe harbor" for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance. Eliminate requirements for physical separation of employees at low and medium risk businesses by a permanent, solid floor to ceiling wall. Higher risk businesses have more flexibility to use smaller temporary barriers like Plexiglas sneeze guards. Eliminate all human resource policies from the Regulations such sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services

or the delivery of products. These policies exceed the Board's authority as it relates to workplace hazards. Amend common space sanitation requirements. Requiring common spaces to be cleaned and disinfected at the end of each shift" is impractical for 24/7 operations with multiple and overlapping shifts.

The Regulations should be amended to provide for a time-based alternative such as every 8, 12, or 24 hours exempting FDA regulated facilities. Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations. Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level. Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague.

Eliminate the conflicts and overlaps between the "Safer at Home" guidance, Executive Order 72, and the proposed rule. The regulation should govern, and this should be explicitly stated in the permanent regulation. Otherwise, the regulation must be inadequate to protect worker safety. II. Recommendations As such, the Coalition respectfully requests that the Virginia Safety and Health Codes Board withdraw its "Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220." Instead, if the Board can demonstrate a necessity to pursue regulation, it should do the following: The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires. III. Conclusion. It is unreasonable to apply one-size-fits-all COVID-19 Regulations to all employers and employees. It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify guidance and Executive Orders as a reasonable replacement. Further, it is confusing why the Board would pursue permanent regulations that are in conflict with previously issued Executive Orders. Therefore, it is the Coalition's recommendation that the Board reject the Regulations, provides additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires. Thank you for your time and consideration in this matter. Should you have any questions or wish to discuss this further, please feel free to contact me.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department disagrees that the Standard is a "one size fits all" regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines." The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

89142 Virginia Education Association 2021/01/08 19:08:26 clee@veanea.org

STRONGLY SUPPORT ADOPTION OF PERMANENT SAFETY STANDARDS FOR COVID-19 "Dear Mr. Withrow: On behalf of the Virginia Education Association and our tens of thousands of school employee members, who work tirelessly to provide quality education to Virginia students, we strongly support making the Emergency Temporary Standards for COVID-19 ("ETS") permanent before they expire on January 26, 2021. In fact, we believe the ETS should be expanded to include all airborne infectious diseases. It is with a heavy heart that we share we have already tragically lost colleagues, friends, and family members to COVID-19 which we believe was contracted while working for Virginia school divisions. Countless school employees have, and are continuing to, battle the illness days, weeks, and months after exposure. COVID-19 is spread in schools. Students and staff share small rooms for hours and hours five days a week. School buildings lack proper ventilation. Social distancing standards, mask requirements, PPE, enhanced ventilation, proper training, notice to employees and the public of exposure to COVID-19 in school buildings are all critically necessary to enable school employees to work safely.

We are proud and pleased Virginia was the first in the nation to adopt the ETS. As COVID-19 cases and positivity rates surge in the Commonwealth, it is more important now than ever to enact permanent safety standards for workplaces. Schools are the life blood of every community. Protecting school employees with permanent safety standards for COVID-19 protects students, their families, and vice versa. Allowing the temporary standards to simply expire would place all Virginians at substantial risk of illness or death. Leaving school employees and students unprotected from COVID-19 would be unacceptable. Permanent COVID-19 safety standards will boost the Virginia economy by providing clear, uniform guidance to local school divisions and government employers. All Virginia employees need and deserve the protection that permanent state COVID-19 safety standards will provide. We urge the Safety and Health Board for the Department of Labor and Industry to protect our members and their students. Sincerely, Catherine A. Lee Virginia Education Association Staff Attorney

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89144 Debra Kozak 2021/01/08 19:21:42 d-kozak@msn.com

PLEASE MAKE THE STANDARD PERMANENT TO PROTECT VA WORKERS "

My name is Debbie Kozak, and I am a Commonwealth of Virginia Employee and a member of the American Federation of State, County & Municipal Employees (AFSCME). I have been working in the mental health field for 36 years and when the COVID-19 pandemic hit, thankfully my agency granted my physician's request to telework. I am living with health conditions that put me at a higher risk of exposure and impact from the coronavirus. Recently, when our workplace began preparing for the implementation of an electronic health records system, I struggled to obtain an accommodation to attend the related training virtually, rather than on-site. That's why we need the standards in place that protect us from having to enter an unsafe work environment to be made permanent. We need strong enforcement mechanisms so that employers in Virginia know that safety of employees and our citizens comes first. What we have seen in health facilities across Virginia and around the country is that there is a higher likelihood of a single infection turning into an outbreak due to the close living quarters for patients and working spaces with staff. Couple that with the dynamics of the risks of exposure from visitors and employees who routinely come in and out of our facilities and back into the community. I am afraid for our staff and their families and especially our patients, and every measure should be taken to protect us. Please make the Emergency Temporary Standard permanent. In doing so there are two minor technical areas to please consider: The permanent standard and its provisions should take immediate effect on January 27, 2021.

The proposed permanent standard extended dates for implementation of training and other measures, even though employers have been complying with the same requirements under the ETS. We want to make sure there is no lapse in health and safety protections and avoid confusion. ? The standard has language that allows the use of face coverings in place of respirators, if not readily available. Face coverings will not provide the adequate protection that workers need if they need to use a respirator. ? ·?? Proposed Permanent Standard below. Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide, and employees shall wear face coverings while occupying a work vehicle with other employees or persons. I strongly oppose the language and it needs to be removed. The Coronavirus continues to ravage communities across the country, and we have had a sense of pride in the Commonwealth of Virginia moving swiftly to protect our workplaces and communities being the first in the nation to enact such protections. Please continue this leadership to make these workplace standards permanent.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89165 Tim K 2021/01/08 20:59:58 tim.klabunde@timmons.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As a Manager in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of

safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance. Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers and thank you for the opportunity to publicly comment.

Tim

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89167 Anonymous 2021/01/08 21:08:45 fsaul@bandscontracting.com

Strongly Oppose Adopting a Permanent Standard Members of the Safety and Health Code Board, As an employee/employer (you can use your title like foreman, crew leader, etc.) in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

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for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment. Respectfully, Frank S

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89172 Frank S 2021/01/08 22:01:17 fsaul@bandscontracting.com

Strongly Oppose Adopting a Permanent Standard "Members of the Safety and Health Code Board, As an employee/employer (you can use your title like foreman, crew leader, etc.) in the heavy construction industry, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. The proposed permanent standard has no specified end date and is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy with several more candidates nearing the end of their trials. Construction is an essential business performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees is the top priority of our company. A culture of safety is our primary operating principle. We implemented the CDC and OSHA COVID-19 guidelines for construction as soon as they were published and are in compliance.

Construction works under CDC and OSHA guidelines. Additional regulations were duplicative and unnecessary. The proposed permanent standard is burdensome, quickly obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. The standard, if adopted, should sunset upon the expiration of the Governor's COVID-19 State of Emergency. There is no logical or scientific justification for the continuance of a standard specifically crafted in response to an Executive Order during the COVID-19 State of Emergency.

What metrics, scientific data, or criteria would the Safety and Health Codes Board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians? The data has not shown a direct and immediate danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks flexibility to adapt to current science and innovation. I am STRONGLY OPPOSED to the adoption of a Permanent Standard, with no expiration, for what is a temporary health situation. I remain committed to the health and safety of my coworkers/employees and thank you for the opportunity to publicly comment. Respectfully, Frank S

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89175 Anthony Pistone 1/8/2021 22:16 a.pistone@live.com

Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th! My name is Anthony Pistone and I am a member of the American Federation of State, County and Municipal Employees (AFSCME). I have served Arlington County in the Water, Sewer, and Streets Division of Environmental Services for 4 years. My primary job responsibility is to operate an asphalt truck as part of a four-person asphalt maintenance (or "pothole") crew to ensure safety on the roads and that residents don't experience damage to their vehicles from potholes. Road construction work is often loud and fast paced, making it hard to be constantly conscientious of social distancing while at a work site. Since the onset of the pandemic, in the interest of being compliant with the Emergency Temporary Standard (ETS), the county has been furnishing us with source control in the form of face masks. While this does not eliminate the risk of exposure to COVID-19 or other communicable illness, it does serve to curb its spread. Altering the past practice of commuting to job sites in full vehicles so that we drive one to a vehicle worked as well. We should return to that practice. These are necessary changes. While the work we do has us out in the community and in close contact with the public, the measures that the county has implemented to comply with the ETS has meant some measure of protection for us. These regulations don't just keep us safe, but our families and communities, as well. We need VOSH to make the emergency temporary standards permanent to protect employees against the risk of exposure. The risk presented by COVID-19 is not over and it is of the utmost importance that employers have clear directives as to what steps must be taken to protect employees and the public. Strong enforcement mechanisms will mean more compliance. Virginia has shown leadership being first in the nation to enact these temporary emergency standards, and the commonwealth can continue to lead by making the standard permanent. As employers have had the last six months to prepare, by complying with temporary requirements under the ETS, I urge you to make the permanent standard and all its provisions effective immediately on January 27, 2021. Anything short of that could lead to a rollback of the conditions we presently need to be safe in our workplaces and could jeopardize not just us, but our families and the communities we serve.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89234 Fred Williams, AFSCME Member and Arlington County Employee 1/9/2021 10:54
wfred63@gmail.com

Please Make the ETS Permanent and have all Provisions Enter Into Effect on January 27th! "My name is Fred Williams and I am a member of the American Federation of State, County and Municipal Employees (AFSCME). I have served Arlington County in the Water, Sewer, and Streets Division of Environmental Services for 5 years. Currently, I work as a Crew Leader supervising the work of two road crews.

I take pride in my work and I want to see the county continue to prioritize our safety. While the work we do has us out in the community and in close contact with the public, the measures that the county has implemented towards compliance with ETS has meant some measure of protection for us. Prior to the pandemic, it was typical practice for road crews to ride out to job sites four people in a vehicle. These conditions would make it impossible to adequately socially distance. In response to the newly implemented VOSH requirements, the county has enacted the practice of having employees ride alone. The impact of that decision has made a world of difference in mitigating risk of potential exposure.

We need VOSH to make the Emergency Temporary Standard permanent to protect employees against the risk of exposure. The risk presented by COVID-19 has not passed and it is of the utmost importance that employers have clear directives as to what steps must be taken to protect employees and the public. Strong enforcement mechanisms will mean more compliance. Virginia has shown leadership in being first in the nation to enact these temporary emergency standards, and they can continue to lead by making the standards permanent. We urge you to protect Virginian workers and our families and enact a permanent standard and requirements to take effect on January 27, 2021.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89236 Vanessa Patterson, Precast Concrete Association of Virginia 1/9/2021 10:59 vanessa@precastva.org

The PCAV STRONGLY OPPOSES adopting a permanent standard "Submitted Electronically: Jay Withrow, Director, Division of Legal Support, ORA, OPPPI, and OWP

The PCAV STRONGLY OPPOSES adopting a permanent standard

Members of the Safety and Health Code Board,

The Precast Concrete Association of Virginia (PCAV) represents companies in the precast concrete industry that produce essential products to support the infrastructure needs of the Commonwealth. On behalf of the PCAV, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220.

The producers of precast concrete products and the associate partners who provide necessary elements used in the manufacturing process, are a critical part of the Construction industry. Construction is an essential industry performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees and the community around us is the top priority of our companies. Promoting a culture of safety is a primary operating principle of our employers. The industry is heavily regulated under multiple federal and state occupational health and safety programs. PCAV members immediately implemented and rigorously follow CDC and OSHA Guidelines for COVID-19 in the construction workplace.

The proposed permanent standard has no specified end date. The permanent standard is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines with over 90% efficacy and several additional candidates nearing the end of their trials. Governor Northam on January 6th, 2021 expressed confidence in a consistent supply of over 110,000 doses distributed to Virginia weekly. The Governor projected Virginia would have essential workers and Virginians most vulnerable to COVID-19 (Groups 1A, B, C), vaccinated before summer 2021. At that time, he projected the remaining 40% of the population, would be eligible to receive the vaccine. Considering these factors, there is no logical or scientific justification for the continuance of a standard that was specifically crafted in response to a State of Emergency for COVID-19. Any standard should sunset immediately upon the expiration of the Governor's State of Emergency.

The proposed standard is burdensome and inflexible.

As the science has changed, the current ETS has not, nor does it have the flexibility to do so as either science changes or innovation occurs. As an example, the disinfection standard requirements are based on practices that now may not provide meaningful reduction in transmission. The disinfection standards for tools and

equipment are burdensome and time consuming. An hour a day or more is spent by employees in some cases. Procurement of necessary disinfection items is time consuming, distracts from other job functions, and supply chain issues still impact the ability to obtain disinfectant approved for use against SARS-CoV-2 as defined in 16VA25-220-30.

The standard requires non-medically trained individuals to be in the health screening business. Daily screenings add another 30 minutes at the start of a shift. Multiply that by every shift of every crew and less work is being accomplished across the Commonwealth. These daily screenings take crew leaders away from performing their other job duties, impacting overall productivity. PAV member companies have generous paid sick leave policies that cover COVID-19 absences and provide employees the choice to stay home with pay if they are exhibiting symptoms of COVID-19 or have had a potential exposure. Employees in heavy construction are not forced to choose between working and staying home.

It has not been proven a "grave danger" exists for ALL workplaces thereby making it necessary to adopt a permanent standard for ALL businesses or industries. Construction job tasks falls into the "Low" and "Medium" (16VAC25-220-30) exposure category. Physical distancing is a natural part of our work environment. The standard uses "Grave" danger to regulate ALL businesses in Virginia, yet the great majority of the tragic deaths in the Commonwealth are citizens over 70 years old, residents of nursing/assisted living facilities or congregant settings, and those with serious comorbidities.

The Board must partner with a wide variety of stakeholders, including the business community to advise and consent on any workplace regulations.

The economic impact of the proposed standard on businesses and entire industries is significant. The Commonwealth will be impacted as the cost of doing business increases due to burdensome and costly proposed standard. The public should be allowed sufficient access to the Economic Impact Statement required by the Small Business Regulatory Act/Small Business Regulatory Enforcement Fairness Act. To date, no EIS has been made available. The public must have the opportunity to comment on the findings prior to a vote to adopt the permanent standard.

The metrics, scientific data, or criteria the board would use to make a determination to continue a permanent standard after the expiration of the COVID-19 State of Emergency should be made public. It is critical for the public to see the data that would be used to continue a standard for a disease the Governor, a physician, no longer views as an emergency, and the Commissioner of Health has determined no longer presents a public health emergency in the Commonwealth.

COVID-19 is a unique disease and should not be used to expand workplace regulations to include other infectious diseases. No amendment or attempt to include other flus, viruses, cold or other communicable diseases in any permanent standard should be considered. There is no one-size fits all plan to combat a wide variety of infectious illnesses. No one knows what the future holds. If there is a next pandemic, the transmission method cannot be accurately predicted and therefore regulations cannot be adopted for the unknown.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. On behalf of the PAV, I am strongly opposed to the adoption of a Permanent Standard for what is a temporary health emergency.

The precast concrete producers and associates as a vital component of the construction industry, remain committed to the safety of our workers and the citizens of the Commonwealth. I welcome the opportunity to

work with all stakeholders to develop any necessary policies regarding the health and safety of workers in the construction industry.

Thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89247 James Hickman 1/9/2021 12:32 jhickman@bandscontracting.com

strongly opposes any permanent standard strongly opposes any permanent standard

The CDC and the VDH will admit that they don't know enough about covid 19.

OSHA want make a strong requirement for workers. OSHA will only make recommendations.

If CDC doesn't completely understand this disease how can one make a permanent conclusion. The studies show that this year is the only year since 2011 that the FLU virus has declined. The CDC report said that the CDC has combined flu, covid19, and pneumonia. Since 2007 on average the state of Va. averages 12 high levels of the flu. {about 4,000 case } this year none.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89250 Erika Yalowitz: AFSCME Local 3001 1/9/2021 13:00 erika.yalowitz@gmail.com

AFSCME SUPPORTS MAKING THE STANDARD PERMANENT IMMEDIATELY "AFSCME SUPPORTS MAKING THE STANDARD PERMANENT IMMEDIATELY

My name is Erika Yalowitz. I am a member of the American Federation of State, County & Municipal Employees (AFSCME) and a frontline public employee, serving as a juvenile court intake officer and probation counselor. I take a deep sense of pride in being there for my clients at some of the most difficult times of their lives, and having the chance to support children in abusive situations and survivors of domestic violence.

I balance my work in public service with being a wife and a mother to my school age child. As a parent, like many of my co-workers, we are concerned about the risk of exposure and bringing this virus home to our families.

We need the Board to make the temporary emergency workplace standard permanent. It must protect employees against the risk of exposure and offer requirements to employers. We need strong enforcement mechanisms so that employers take the Standard's provisions seriously.

Thank you for making Virginia the first in the nation to enact these safety measures. I urge you to continue protecting Virginia's workers and our families.

We also ask that you please make the following minor improvements:

The Board should make the permanent standard and its provisions take immediate effect on January 27, 2021 to prevent a gap in coverage.

The proposed permanent standard language allows the use of face coverings in place of respirators if respirators are not readily available. If respirators are preferable, then workers should not be using face coverings.

Thank you for your steps to protect Virginians" SEE DEPARTMENT RESPONSE TO COMMENT 87825

89254 Alden Blevins, Goochland County Public Schools 1/9/2021 13:18 aldenmbean@gmail.com Please adopt a permanent standard to protect workers throughout the state. "Please adopt a permanent standard to protect workers throughout the state.

As a Virginia public school teacher, I have seen firsthand how desperately rank-and-file workers need these protections. Even with this law in place, many workers are sent into unsafe working conditions that are not compliant with CDC guidelines every day. This is our last line of defense in creating safe working situations that in the end, will protect both our economy (as we will better retain a healthy workforce and keep the supply chain moving) and our workers.

I was retaliated against in my own school division for publicly commenting about the lack of safety precautions, PPE, and adherence to safety guidelines. Without the protections from OSHA, I may have even suffered worse.

I know Virginians who have lost coworkers, friends, family members, and spouses to this virus, many of them whom have been incredibly careful and followed all protocols in and outside of their workplaces. Workers across the VA are still battling the illness days, weeks, and months after exposure.

COVID-19 is spread in work environment, including schools. Social distancing standards, mask requirements, PPE, enhanced ventilation, proper training, notice to employees and the public of exposure to COVID-19 in workplaces are all critically necessary to enable employees to work safely.

I am proud that my homestate was the first in the nation to enact strong worker protections against COVID-19. As COVID-19 cases and positivity rates surge in the Commonwealth, it is more important now than ever to enact permanent safety standards for workplaces.

Allowing the temporary standards to simply expire would place all Virginians at substantial risk of illness or death. Leaving workers in any field unprotected from this real and growing threat, would be inhumane.

Permanent COVID-19 safety standards will ultimately benefit businesses by allowing more workplaces and schools to remain open and well-staffed, as workplaces are held accountable for utilizing evidence-based mitigation strategies. All Virginia employees need and deserve the protection that permanent state COVID-19 safety standards will provide. We urge the Safety and Health Board for the Department of Labor and Industry to protect workers and their families.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89256 Emily Reynolds, Hampton Roads Chamber 1/9/2021 13:48 ehasty@hrchamber.com
Hampton Roads Chamber Opposes Proposal to Adopt Permanent Standard Hampton Roads
Chamber Opposes Proposal to Adopt Permanent Standard. Dear Members of the Virginia Safety and Health
Codes Board:

On behalf of the Hampton Roads Chamber and our members, we are submitting the following comments related to your intent to adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.

The Hampton Roads Chamber is the premier pro-business organization serving over 1,200 members, representing more than 400,000 members of Virginia's workforce. The Chamber supports public policies that strengthen free enterprise and regional collaboration efforts that promote economic development and conditions for businesses to succeed.

The Hampton Roads Chamber is strongly opposed to the Department of Labor and Industry's COVID-19 emergency regulations becoming permanent. Businesses, especially our small businesses, are struggling to survive these hard economic times and regulations only increase the burden on them. In a time where some reports estimate that 20-25% of businesses will shut down permanently, these regulations threaten to drive those numbers even higher.

Despite these challenging times, small businesses quickly adapted and implemented protocols to protect their employees and customers from exposure to the coronavirus by following the guidance issued by the CDC, OSHA, and the Governor's executive orders. Now Virginia's businesses are doing their best to comply with the Emergency Temporary Standard (ETS). The last thing business owners need as they rebuild their businesses during this critical time is a permanent one-size-fits-all government regulation.

Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program and that all parties can work together to satisfy the regulatory requirements. Therefore, the Hampton Roads Chamber believes the board should NOT adopt a permanent standard for the following reasons:

First, the science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect the science. If the Emergency Temporary Standards were to become permanent, it would continue to require businesses to comply with outdated regulations. Adopting these permanent regulations will be overly burdensome for businesses.

Second, the proposed permanent standard does not contain a true sunset date. The expectation is the pandemic will end and when that happens so should any regulations. If the Board intends to move forward with a permanent standard when the Emergency Temporary Standard expires, we expect the Board to stick by its decision, from the July deliberations, to end these regulations at the end of the COVID-19 pandemic.

Third, there is still no economic impact statement prepared to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA). Businesses have had no opportunity to address any findings from that analysis.

While facing devastating economic conditions Virginia's businesses continue to keep the safety and health of their employees as their top priority. It is unreasonable to apply a "one-size fits all" approach to COVID-19 regulations to all employers and employees. We respectfully request that you reject the proposed permanent emergency regulations. Thank you for your time and consideration.

Emily Reynolds, Executive Director of Governmental Affairs, Hampton Roads Chamber

SEE DEPARTMENT RESPONSE TO COMMENT 87834

89262 Tracy Little 1/9/2021 14:24 Tlittlede@gmail.com

Please adopt a permanent standard of wearing masks indoors Please adopt a permanent standard of wearing masks indoors

It is NOT BURDENSOME as others would have you believe to enforce PPE masking standards. It is a SAFETY PRECAUTION to prevent a DEADLY VIRUS that we've only just begun to receive vaccinations for and that has already MUTATED because of people's lax care with masking and social distancing.

This isn't about "freedoms" and anyone who professes as such is a black box idiot.

WEAR A MASK. MAKE IT STANDARD. This isn't about you, it's about everyone else around you. There is an entire world outside of your specific existence and if people took even half a second to care about other people we might actually make progress in reducing the number of infections.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89269 Andrew L 1/9/2021 14:56 andrew.laye@icloud.com

I support masks indoors I support masks indoors

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89271 Angeline 1/9/2021 15:16 angichan777@gmail.com

We are still winning- at having the most corona virus cases world wide Britain and Ontario, Canada black box back down this month and we are still going full throttle on case count. No way should we be laxing on mask protocols. Especially for the safety of essential workers in the service industry who have been caring for us this entire time. SEE DEPARTMENT RESPONSE TO COMMENT 87825

89272 ANDREW WHEELER 1/9/2021 15:25 wheeler.a.t@gmail.com Make it standard, but I've been to many places where owners, employees, and customers alike all basically say 'screw it' and either wear a mask ineffectively (under the nose, or just all the way down the chin exposing nose and mouth) or dont wear them at all. The most common place Ive seen this is WaWa, but i see offenders everywhere. start writing tickets for not wearing masks/wearing them incorrectly. check in on restaurants, gas stations, etc, without warning and fine the business for employees not masked. maybe my view is radical, but we haven't been getting better by letting people ignore the rules without consequence.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

The Department does not have the legal authority to issue violations and penalties to members of the general public or employees, only to employers. See Va. Code §40.1-49.4. VDH has an online complaint system where you can file complaints about customers not wearing face coverings: <https://redcap.vdh.virginia.gov/redcap/surveys/?s=Y4P9H7DTWA>

89273 Moria, Health care worker 1/9/2021 15:28 moriaoden@gmail.com

Make it standard! With the rate cases are increasing, we cannot afford to let mask wearing lapse. Protect yourself and others and make mask wearing a standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89277 Anonymous 1/9/2021 15:50 vickiemauri@comcast.net

Continue indoor face masks I believe wearing of face masks in door should continue for everyone's safety

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89278 Kyle Wendling 1/9/2021 15:57 kyle.p.wendling@gmail.com

Masks Should Be Worn Indoors and Infractions Should Be Enforced Masks have been shown to limit the spread of the disease and are a key tool in mitigating the pandemic. Wearing them indoors should be a standard as long as the pandemic is raging, particularly since transmission is easier indoors than outdoors. In addition, the proper wearing of masks indoors should be enforced. Just saying this is the standard and doing nothing to enforce it is a half-measured response, the type that severely reduces the effectiveness of masks as a means of preventing transmission.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89280 Charles Davis: City of Norfolk General Utilities Maintenance Supervisor 1/9/2021 16:08 Support
for Permanent VOSH Standards "Hello.

My name is Charles Davis and I'm a General Utilities Supervisor and now Inspector in the Norfolk City's Department of Combined Utilities. Our teams ensure that residents have access to clean drinking water, accurate billing and when there is a storm we assist in minimizing flood-water damage to homes.

Since the outbreak of COVID-19, there have been numerous concerns dealing with adequate personal protection equipment and proper social distancing. I've watched office personnel get rearranged to adhere to social distancing practices. In the field, it's not possible due to the nature of work that requires multiple employees to complete complex assignments.

Within the essential functions of my job description, the Standard notes that we are subject to communicable diseases several times a week, as well as physical danger and various fumes and odors daily. As stated in the interview process "This is an Essential Position which means you may be required to work nights, weekends, and rotating shifts, and holidays in response to severe weather events and emergencies."

As a Supervisor, my personal Health and Safety, as well as that of my colleagues who provide daily Essential Public Services, are my priority. We are potentially exposed to COVID-19 in our work environment daily. How would I explain it to workers family if a crew member dies of COVID-19 after exposure at work? We know the seriousness of this pandemic because one of our coworkers has passed away due to Covid-19.? Right now, the

lack of preparation is a major concern for myself and my colleagues. Who knows? As it stands right now, we can be exposed with no proper assessment or quarantine. I feel that the Standard should include following up with workers exposed to COVID-19. The Standard should also include a COVID-19 exposure log and requirements for managing cases. Please help us by making the VOSH infectious disease standard permanent effective January 27th. Support the Front-Line Workers here in the City of Norfolk and across Virginia.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

Request for exposure log and requirements for managing cases.

With regard to exposure logs, the Standard contains a framework for managing cases:

1. Identify cases.

16VAC25-220-40.B.4 provides that “Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza). Such employees shall be designated by the employer as “suspected to be infected with SARS-CoV-2 virus.”

2. Remove from work known cases and those “suspected to be infected with SARS-CoV-2 virus.”

16VAC25-220-40.B.5 provides that “Employers shall not permit employees or other persons known or suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work.”

3. Notify employees and others of known cases.

16VAC25-220-40.B.8 provides “To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive SARS-CoV-2 tests by employees, subcontractors, contract employees, and temporary employees (excluding patients hospitalized on the basis of being known or suspected to be infected with SARS-CoV-2 virus) present at the place of employment within the previous 14 days from the date of positive test....”

4. Provide for return to work.

16VAC25-220-40.C.1 provides that “The employer shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work....”

Federal OSHA’s Recordkeeping regulation contains requirements for employer maintenance of injury and illness logs in part 1904. <https://www.osha.gov/laws-regs/regulations/standardnumber/1904/>. Section 1904 contains recording criteria, <https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.4>. OSHA provides further guidance at: <https://www.osha.gov/memos/2020-05-19/revised-enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19>

The VOSH program is prohibited from requiring or allowing recordkeeping requirements contrary to those set by federal OSHA so that a consistent, statistically reliable national data collection system can be maintained. See 16VAC25-60-190.A.2, <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-60-190>, “2. No variances on record keeping requirements required by the U.S. Department of Labor shall be granted by the commissioner....”

89282 Edward Gadsden AFSCME Virginia 1/9/2021 16:13

Support for Permanent VOSH Standards "My name is Edward Gadsden I'm a Mechanic II with the City of Norfolk Parks and Urban Forestry Department and a leader in our AFSCME VA Fund the Front Lines Committee.

As a City Mechanic in Parks, I am charged with repair, construction, maintenance and in some instances, fabrication of both light and heavy equipment, as well as vehicles used to perform work in our department.

What that means is that having the proper PPE is extremely important.

Not only am I faced with challenges of unsafe and faulty equipment, but depending on the type of equipment and its daily function the work performed poses frequent threats to the Health and Safety of myself and Co-workers.

In our line of work, something as meticulous as a paper cut has the potential to cause great harm. Other risks like contaminants from cleaning Z Turn mower decks where we encounter hypodermic needles and such keeps us on edge quite frequently.

When the COVID-19 Pandemic hit and most recently, we were faced with understaffing due to several of my Co-workers testing positive for COVID, but what made things worst is that because the proper PPE notification guidelines were not met, our shop was closed down which caused a backlog of preventive maintenance, required duty assignments and other tasks.

Not having Permanent VOSH Standards in place costs our City time and money, but more importantly when not adhered to it can costs workers like myself and their families a long life of pain.

Having a Permanent VOSH Standard in place on January 27th would be of great benefit, as using these standards will help corral this PANDEMIC and bring awareness, consistency and structure of carrying PPE at all times, for all employees and addresses the many concerns of Essential Frontline workers across the Commonwealth.

Thank you for your time and consideration.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89283 Janal Floyd- AFSCME Virginia Fund The Front-Lines Committee 1/9/2021 16:18

Support for Permanent VOSH Standards . I am Janal Floyd, a Equipment Operator III with the City of Norfolk Streets Roads and Bridges Division. I am writing you today to express my desire to have the temporary VOSH Standards for proper PPE be made permanent.

Staying safe on the job is very important to me and my fellow crew members. We all work several other jobs, in addition our jobs with the City of Norfolk. We all work full time and are doing so to provide for our families. Right now our Health and Safety are at risk. Appropriate PPE is essential to our safety as well as that of our families and community.

I have a toddler and pregnant wife at home who is due any day now, and carrying any strand of flu or COVID 19 is unacceptable for us. I believe we can continue to depend on you to assist us in this fight. Our safety manager at the City Of Norfolk Division of Streets and Bridges has done a good job with the funds he has been allotted to provide bleach water, spray bottles, disposable and washable mask, sanitizer, sanitizing fogger solutions, and

other essential PPE for our essential duties as needed during this pandemic, but funding and workplace PPE are just part of the need.

The other part is having the temporary Standard become permanent on January 27th. Please consider this request so that we may all feel safe to do our jobs and return home healthy every day.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89284 Jennifer Webb Engineering TechI AFSCME VA Fund The Front Lines Committee 1/9/2021 16:27
Support for Permanent VOSH Standards

My name is Jennifer Webb and I have been in the City of Norfolk Department of Utilities for seven years. I am performing essential frontlines work as an Engineering Technician I.

I am also a single mother of eight school aged children, for whom I am the sole provider and protector.

I worry about the safety and health of my children. In fact, my four-year old daughter is a COVID-19 survivor.

As a mother of children that have underlying health conditions, I worry at work every day that I will bring this virus home to my children.

I support the proposed VOSH permanent standard for infectious disease prevention for COVID-19.

Not properly notifying workers when an employee has tested positive or has been exposed, is a serious concern because this puts me and my children health at risk. I am the bread winner in my household. I honestly do not know what I would do if I contracted this dreaded virus. How would I be able to provide for my household??These are scary times!

Recently, I have had to split my time between transporting my kids back and forth to their doctor appointments and working ten hours days, so this pandemic has brought about serious personal and professional challenges for me.

We also need access to PPE when we cannot properly stay physically distanced from our coworkers.

Right now, during the pandemic, we are riding four and five employees to a vehicle with no shields to protect and/or distance ourselves.

Other Norfolk employees and I, with the support of Health and Safety experts from AFSCME District Council 20 and the AFSCME International, have been advocating to improve VOSH Standards for some time. We recently reached out to several City of Norfolk officials to meet and make suggestions to help further these efforts.

The City of Norfolk, on one occasion provided employees a pack of masks, but once they were no longer useable and out of stock, we were told we were on our own. How could this happen? The standard should include, at minimum a (daily; weekly; monthly; quarterly) mask distribution protocol and COVID-19 exposure log, as well as requirements for managing cases.

I urge you to make the permanent standard and all its provisions effective immediately on January 27, 2021. Please consider my advocacy for a permanent VOSH Standard to protect Front-Line Essential Workers in the City of Norfolk.

Thank you.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89294 Nandan Kenkeremath, Leading Edge Policy And Strategy 1/9/2021 18:36 nandank@comcast.net

Strongly Oppose Process and Substance Of The Proposed Rule "Thank you for the opportunity to comment on the proposed rule. I have separately provided a detailed set of written comments under the name Leading Edge Policy and Strategy, which I assume will be posted on the Department of Labor and Industry (DOLI) website along with other longer written comments.

Government has fundamentally different obligations when it creates law than when that government is just providing information and best practices guidelines. In this case the proposal purports to create law that subjects hundreds of thousands of Virginia businesses to substantial burdens and potential sanctions. Both should be based on evidence and logic. However, enforceable standards must also provide for proportion and flexibility in written language that guidance need not state expressly. Businesses have tailored circumstances and inflexible rules in complex situations do not work. Rules must be proportional with respect to the burdens they impose and the resulting benefits must be clear. This means assessing alternatives and impacts. Standards must be clear. Regulated parties must know what is required of them, so they may act accordingly. Precision in drafting is necessary in the rules so that those enforcing the laws do not act in an arbitrary and discriminatory way. These are fundamental Constitutional standards and DOLI staff proposed rule fails in multiple ways.

First, the proposed rule violates the commitment of the Safety and Health Codes Board (Board) to provide public participation under the Virginia Administrative Process Act (VAPA). VAPA requires that there is an opportunity to comment on a regulatory impact analysis. There has been no such impact assessment provided to comment on. Even were it not for the Board's commitment, it is inadequate not to provide an impact assessment for public comment. Most modelling, particular when there are different and confusing interpretation benefit from public comment.

The proposal itself is uninformed and not based on a regulatory impact assessment. DOLI staff is likely to ignore any assessment and not actually evaluate the proposal based on impacts. The analysis must include a real and complete regulatory flexibility analysis concerning impacts and options for small businesses. It is not reasonable for small businesses to follow all of the provisions of the rules as written.

Second, the Board, DOLI staff, the Health Commissioner, and the Governor have published overlapping, confusing, and conflicting requirements in a series that include Executive Orders, Orders of Public Health Emergency, an associated document styled "Safer at Home" document, the Emergency Temporary Standard (ETS), and now a proposed permanent rule. These provisions overlay existing Virginia rules, rules under the Occupational Safety and Health Act, the Americans with Disabilities Act, and privacy laws. So far, no government official nor commenter from labor unions, to my knowledge, has discussed these overlaps, impacts and resulting confusion. This is the typical government approach of not taking full responsibility and being blind to overlapping actions. All that seems to be in play is that there is a lot of words and whether they clash and how they work seems to have no discussion. This is a failure of the first order and this cannot continue. Clearly, these government officials are responsible for the matrix of rules they are enforcing on Virginia businesses which also adversely impact employees. These officials must lay the provisions down side-by-side to ask why

there are differences and how they work together in explicit terms and with full public comment. This is good government 101.

Indeed, there are numerous conflicts, unworkable constructs, and unclear language in this regulatory matrix of cross-references. Consider the proposed rule draft itself appears to have 20 footnotes that cross-reference websites. The Safer at Home document refers to multiple guidance documents. None of these documents were written in a manner to work as enforceable rules and the result cacophany is worse.

Third, after numerous attempts, the Board should understand that certain areas do not lend themselves to enforceable rule language as opposed to guidance. My longer written comments contain more examples. Here I mention the "suspected" COVID provisions which involve excluding people from a work site if they have any symptom or sign consistent with COVID. Such employees may not return to work potentially for 10 days or longer. The problem is that symptoms of COVID involve a list that includes a cough, a sneeze, runny nose, headache, vomiting or fatigue. Each is independently a symptom. The proposed rule only allows ignoring the symptom if there is an "alternative diagnosis". It is unclear who makes such alternative diagnosis and whether that diagnosis has to provide that something is not COVID or just that there is a good possibility the symptom is consistent with something else. On some things, the Safer at Home documents are better with respect to these concerns. For example, the Safer at Home document requires employers to instruct employees to stay home who are "sick" as opposed to "suspected" It may be wise for people to stay who home who have symptoms but a hard rule would have dramatic consequences and would not work. The COVID-19 screening protocols referred to in the Safer at Home documents for employee self-checks suggest a structure with a check if the symptom "cannot be attributed to another health condition". That is very different language than the "alternative diagnosis construct." Regardless, at this point there is substantial overlap and confusion.

If people may not return to a work site for 10 days after such symptoms are no longer there or until there is a professional diagnosis that rules out COVID, the damage to businesses and employees will be substantial. The scheme means employees lose work and employers lose an employee for a length of time when the issue is not COVID. That time loss can be repeated each time there is a symptom. Such caution may or may not be relevant to certain high-risk settings. However, this approach is not feasible for all employment settings, including in settings that are outside or where distancing is available in the employment setting. Employees may use up their sick leave, they miss important training, projects or job opportunities. Many temporary or contract employees may have no sick leave and no alternative funds--all because an employee has a cold or cough or a headache. The system means that employees will want to be honest about their symptoms with their employees for fear of the losses they may entail.

The Board's prior support for incorporation of the Orders in the ETS was also a problem. Changing that incorporation is good, but unfortunately, both the impermissible infringement on freedoms continue and the arguable threat of DOLI enforcement is in play for the overlapping areas of assembly and association and the distancing rules.

A statewide limitation of the size of assembly is unprecedented. This limitation has uneven application under the Orders. These same restrictions do not now apply to a large meeting of lawyers at a law firm. Crowds are allowed at a Walmart, Lowes, or other large

"essential" store without those restrictions. The numerical limits of 10 persons currently under EO72 and the Safer at Home document apply to businesses in certain circumstances but not in others. Similarly the distancing requirement and the related definitions of who may or may not stand together are set out inconsistently. A

government scheme that prohibits every instance of physical proximity among individuals within six feet of one another, based on nothing more than the government's arbitrary and unilateral classification of their relationship status is an infringement of fundamental rights under the Virginia and U.S. Constitutions. The right of association is both an integral part of the right of assembly and a separate fundamental right. At issue is nothing less than the right of a free people to determine, apart from government rules or coercion, with whom they can sit or stand next to or perhaps a private conversation without distancing.

By penalizing employers for not following the impermissible infringements on Constitutional rights by the Governor, the Health Commissioner, and the Board itself in the ETS, forces employers to participate in an illegal scheme. There should be no government definition of who must distance versus not distance based on relationships which neither the government nor businesses can reasonably assess. In various settings, the ETS would have employers ask customers about their family or household relationships to enforce the distancing requirements. This is not a workable scheme. There is no evidence after many months that this scheme has yielded any benefit other than to threaten all with criminal sanctions. The Board would penalize a wedding venue because a boyfriend and a girlfriend not residing in the same house sat together at a religious service or walked together at a farmer's market. This is obviously absurd, yet the construct that the government can decide who can voluntarily stand together remains in the Orders. The proposed rule does nothing to remove this problem and may or may not simply repeat it.

For the reasons discussed above and in my longer written comments, the Board should not promulgate a permanent standard and not promulgate the current proposal from DOLI staff. The Board should provide or obtain a regulatory impact statement and regulatory impact analysis and provide a 60-day opportunity for public comment. The Board should obtain an evaluation of the implementation of the ETS.

SEE DEPARTMENT RESPONSE TO COMMENT 10019

89300 Anonymous 1/9/2021 18:59 hurtc2@vcu.edu

Support for Permanent Standards The continuation of this standard set in July 2020 should continue. If there was reason to establish this in the middle of 2020, it makes sense to continue it now. Whether they are considered low or medium risk, workers need these extra protections. If it is costly for the employer to follow this standard, then the state should provide support. Our communities should not suffer from the lack of state support. Healthy workplaces equal healthy communities and Virginia can continue to set precedence for other states to follow. There is a reason we have been able to somewhat mitigate the spread of the virus. Please listen to your biggest stakeholders, Virginia's workforce.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89312 USW 8888 1/9/2021 19:37 cspivey@uswa.hrcoxmail.com

Safety for essential workers To Whom It May Concern: I agree that this should be a permanent mandatory standard for all Virginia workers

SEE DEPARTMENT RESPONSE TO COMMENT 87825

Oppose Permanent Standard Thank you for the opportunity to comment on 16 VAC 25-220, the permanent standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19. On behalf of its food retail and wholesale industry members, the Virginia Food Industry Association (VFIA) respectfully requests you oppose the adoption of the Permanent Safety Standard for Infectious Disease Prevention, SARS-CoV-2 / 16VAC25-220.

The VFIA is a nonprofit trade association that serves as an advocate for the retail and wholesale food industries in the Commonwealth of Virginia. Collectively, VFIA's members employ more than 55,000 people at more than 530 retail locations. VFIA shares the department's objective to exercise safety and health precautions in our stores. Throughout the pandemic, VFIA members have safely and effectively maintained in-store sanitization and safety standards. Additionally, VFIA members were the very first to implement innovative safety measures that are now seen as staples across all retail industries.

The current Emergency Temporary Standards, of which is the basis for the proposed permanent safety standard, mandates a one-size-fits-all approach for businesses across Virginia to prevent the spread of SARS-CoV-2. The standard has caused confusion due to conflicting federal and state regulations. VFIA members prioritize keeping customers and employees safe and follow guidelines published by CDC, VDH, and OSHA to help prevent the spread of COVID-19. Conflicting regulations and guidance become more confusing when retail establishments have locations in multiple states. When implementing precautions to keep customers and employees safe, businesses should be allowed to implement current nation-wide guidance. This ensures consistent and clear guidance for all employers to implement throughout their corporate footprint.

Additionally, converting a temporary standard into a permanent standard for a specific virus such as COVID-19, sets a dangerous precedent. Scientist and world health groups say the probability of this virus soon being manageable and even preventable is high. Mandating a permanent standard implies that safeguards such as face masks, social distancing, protective barriers, and daily pre-shift screenings will still be required after the imminent threat of COVID-19 has subsided.

While we take issue with several of the proposed regulations, the following pose the most significant challenges to the grocery industry from a practical standpoint:

§10.F originally stated that this standard shall not conflict with requirements and guidelines applicable to businesses set out in any applicable Virginia executive order or order of public health emergency. With the removal of this provision in its entirety, there is more opportunity for conflicting standards and confusion. We recommend stating that to the extent that guidance conflicts, CDC and/or OSHA guidelines govern, or other similar clarification given the ever-evolving regulations and guidelines in other jurisdictions.

§40.B.8 requires employers to report to the VDH when the worksite has had two or more confirmed cases of COVID-19 and to report all cases until the local health department has closed the outbreak. This reporting then restarts even after the case has been closed by VDH. Currently, businesses are already required to notify the Virginia Department of Labor each time there are three or more positive cases. Requiring employers to make separate and more frequent reports seems duplicative and more burdensome for administrative purposes -- if that is the intent. We recommend this provision be eliminated or revised to mirror the existing reporting requirements to the Virginia Department of Labor, and no more. Alternatively, the reporting issue to the VDH could be addressed through a shared agreement between the agencies, rather than placing the burden on businesses.

§40.C.1 prohibits screened-out employees (whether “known” to be infected or not) from returning to work unless three conditions are met, including that 10-20 days have passed since symptoms first appeared. This last requirement should be eliminated or revised to allow for employees to return sooner when there is sufficient information showing there is little to no risk in the employee’s return to work. A few examples include a voluntary negative COVID-19 test result from the employee, symptom(s) disappearing within hours, or a doctor’s note clearing the employee for work. Please remember that 10-20 days is a lengthy time for an hourly employee to be away from work and potentially unpaid, and a lengthy time for the business to deal with the absence -- if it is unnecessary.

§90.B. prohibits discharge or discrimination against any employee who voluntarily provides and wears their own face covering. Most retail operations have dress codes which place reasonable and nondiscriminatory restrictions on such garments, including acceptable color/pattern for masks and face coverings. These dress codes are essential to professionalism in customer service, as well as Company branding. This discrimination provision should state that if the employee insists on providing his or her own face covering, the employer can still enforce the dress code regarding such mask or face covering without violating this provision.

§60.B. requires that air-handling systems under employer control be handled in accordance with certain standards. The section begins with “Employers shall ensure that air-handling systems under their control where installed in accordance with the . . .,” but is incomplete. This provision should be revised for clarity.

§ 60.B.1.c requires compliance with USBC and applicable referenced American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Standards. It should be clarified that this is in lieu of preceding provisions I-ix, as adherence with both is overly burdensome and confusing.

As raised previously, §60.C. is drafted to address administrative offices, not retail workspaces. The section is prefaced with “To the extent feasible...” -- however, some standards listed are technically “feasible” but not practical or necessary in the grocery store environment. For example, grocery stores are unable to implement flexible worksites and work hours, such as telework. We have similar concerns with the broad use of delivery and curbside pickup, which are currently used in our stores, but cannot be a wholesale replacement for customer shopping. We recommend this provision be revised to either include standards that are practical for retail workplaces such as grocery stores or provide an exception to standards that are not practical or unnecessary in the grocery store environment.

Thank you again for your time in considering the concerns laid out above. Again, I respectfully ask you oppose the adoption of the Permanent Safety Standard for Infectious Disease Prevention, SARS-CoV-2 / 16VAC25-220.

As always, I am happy to discuss any of these further.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees that the Standard is a “one size fits all” regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines." The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

With regard to 16VAC25-220-40.8 notification requirements, the Department has no control over VDH outbreak reporting and resolution procedures which are contained in statute, regulations or policies and procedures applicable to VDH.

With regard to screened out employees, 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza).

In addition, §40, FAQ 30 provides some flexibility for employers to use COVID-19 testing in support of an "alternative diagnosis." <https://www.doli.virginia.gov/conronavirus-covid-19-faqs/>

30. Can you provide some clarification on return to work and diagnosis requirements under the ETS? We want to isolate and test anyone with signs or symptoms of COVID-19 (defined under the ETS as "Suspected to be infected with SARS-CoV-2 virus"), but if the test comes back negative, we want to rule out COVID-19 as the diagnosis and treat the employee like they have a more common and less dangerous illness. The regulation is not clear on this and reads like we can only return them to work after two tests as if the initial presumption was correct.

16VAC25-220-20 defines the term "Suspected to be infected with SARS-CoV-2 virus" as:

"a person who has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2, and no alternative diagnosis has been made (e.g., tested positive for influenza)."

If an employee HAS HAD "close contact" with a COVID-19 case and developed signs or symptoms, but tested negative for SARS-CoV-2, the employee should remain under quarantine for 14 days after last close contact with the COVID-19 case. Although not defined in the ETS, the Virginia Department of Health (VDH) and the CDC define "close contact" as meaning "you were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more; you provided care at home to someone who is sick with COVID-19; you had direct physical contact with the person (hugged or kissed them); you shared eating or drinking utensils; or they sneezed, coughed, or somehow got respiratory droplets on you."

However, if the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

With regard to employee provided face coverings, The Department does not believe this Standard interferes with an employer's abilities to set workplace rules regarding the content of statements, designs, pictures, etc. on face coverings or any form of personal protective equipment or respirator required to provided and worn under VOSH laws, standards or regulations.

However, the Department is recommending the following language addition to 16VAC25-220-90.B: "Nothing in this subsection shall be construed to prohibit an employer from establishing and enforcing legally permissible dress code or similar requirements addressing the exterior appearance of personal protective equipment or face coverings."

The Department does not intend to recommend changes to the air handling provisions referenced by the Commenter, which were reviewed and approved by the Virginia Department of Housing and Community Development.

With regard to the reference to "feasibility," that term as defined in the standard concerns both technical and economic feasibility.

89333 JESSICA E RHODES 2021/01/09 22:40:31 lovetazzy83@yahoo.com

Worksite non compliance contributes to spread Employees and managers at my worksite (healthcare) can not and or will not comply with safety protocols such as masking and social distancing. Cloth masks are not good enough but they can't or won't even wear or enforce that properly. My federal worksite does not report to VDH or any other entity. The lead organizer of our Covid response openly admits she does not think Covid is a big deal and we need to get on with our lives. More employees are onsite daily without being able to social distance than are necessary for the current mission, and the bare minimum of caution is being taken when considering symptoms or exposures. Healthcare workers are not being notified of exposures. Positive patients are lying to get closer to staff. Policies are not shared with staff. The open access to non-necessities around the campus is a concern for the increased spread in the area. Please consider more closures or limitations on gatherings and restricted/limited services. Though we are following CDC guidance the senior leader is following the governor's lead as well. We have experienced more and more infections and death near to us. Disinfection in my campus is a joke. Leaders refuse to communicate with employees that ask questions. Please do something to make a difference. It worked so well before!

SEE DEPARTMENT RESPONSE TO COMMENT 87825

89338 Daren Williams 2021/01/09 23:58:04 ruth_boaz79@hotmail.com

Comment Period Extension Consider extending comment period an extra week since the draft was updated on 1/4/2021 during the comment period.

It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA."

The ETS lapses on January 26, 2021, and Va. Code §40.1-22(6a) provides "he Board by similar publication shall prior to the expiration of six months give notice of the time and date of, and conduct a hearing on, the adoption of a permanent standard."

The Board made clear its intent during the adoption process for the ETS that during any process to adopt a permanent replacement standard it would attempt to substantially comply with the core requirements in the APA within the time constraints of the requirements of Va. Code §40.1-22(6a) by holding a 60 day written comment period and a public hearing along with obtaining an Economic Impact Analysis and holding a meeting to consider a final standard. All four of those conditions have or will be met by January 11, 2021. The Board's meeting to consider adoption of a permanent standard is scheduled for January 12, 2021.

COMMENTS SENT DIRECTLY THE DEPARTMENT

10001 Sam Revenson 12/31/2020 ssrevenson@gmail.com

Public Feedback comments on putting into place a permanent COVID Standard in Virginia at this time. "I would hope that Virginia DOLI goes no further than they already have regarding COVID concerns for the following reasons:

1. The incoming Presidential administration has now indicted its intention of addressing a permanent standard. In this likelihood, DOLI will have to revisit and revise anything additional now. This creates a waste of Virginia DOLI time and resources.
2. By definition, Covid 19 is a specific sickness and is likely temporary in the long term. It is a waste of time and resources to create a non permanent sickness specific standard in permanent form.
3. An alternative could be to extend the existing temporary standard.
4. There are more than enough standards in place already that can be effectively used by Compliance Officers to address any and all concerns. Not the least of which is the General Duty clause. Existing standards have been used for years creating, in essence, case law from which Compliance can use more effectively. Until standards have been in place for some working period they can be more ambiguous in their usage which ultimately triggers additional legal review and considerations. Again, a waste of precious budgetary resources.

I trust every Board member will get a copy of these concerns well before any future Code Board meetings. Please confirm this will and has occurred.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department does not know whether the incoming federal administration will choose to act or not at this time and does not consider the possibility of action as a reason to allow workplace protections to lapse. Should federal OSHA adopt a standard, the Board and Department will follow its normal procedures for reviewing and considering regulations and standards adopted by OSHA.

The Department's Briefing Package on the Draft Final Standard contains background on the use and substantial limitations of the general duty clause:

<https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf>

There are no VOSH or OSHA regulations or standards that would require:

Physical distancing of at least six feet where feasible (also known as Social Distancing)

Disinfection of work areas where known or suspected COVID-19 employees or other persons accessed or worked

Employers to develop policies and procedures for employees to report when they are sick or experiencing symptoms consistent with COVID-19

Employers to, prior to the commencement of each work shift, prescreen of employees and other persons to verify each employee or person is not COVID-19 symptomatic

Employers to prohibit known and suspected COVID-19 employees and other persons from reporting to or being allowed to remain at work or on a job site until cleared for return

Employers to develop and implement policies and procedures for known COVID-19 or suspected COVID-19 employees to return to work using either a symptom-based or test-based strategy depending on local healthcare and testing circumstances

Employers to prohibit COVID-19 positive employees from reporting to or being allowed to remain at work or on a job site until cleared for return to work

Employers to provide employees assigned to work stations and in frequent contact with other persons inside six feet with alcohol based hand sanitizers at their workstations

Employers with hazards or job tasks classified at very high, high, or medium exposure risk to develop a written Infectious Disease Preparedness and Response Plan

10002 Roy Norville 12/31/2020 roy.norville@farmerfocus.com

Comments of Shenandoah Valley Organic Regarding Adoption of Proposed Permanent Standard for COVID for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 "On behalf of the management here at Shenandoah Valley Organic we wish to thank you for your service to our State and to the welfare of this State's workers and Citizens. We wish you a blessed New Year in 2021!

Our recommendations regarding the "Proposed" standard are as follows:

1. The Temporary Standard should remain in effect as a temporary standard. The legislature should vote to extend until the vaccination program has been fully implemented and completed. At that time the reason for the standard will have been relegated to history and the standard will be obsolete because the next infectious disease will be "Novel" in its own right. The State should not make permanent an obsolete policy.
2. We also, oppose the standards intent to disregard CDC guidance.
3. We support the in-depth recommendation that will be presented by the Virginia Poultry Federation of which we are a member company.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes

Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

Some commenters were under the impression that the Standard was being proposed as legislation to the General Assembly. That is incorrect. The Standard is being considered for adoption by the Virginia Safety and Health Codes Board pursuant to Va. Code §40.1-22(6a) and would be enforced by the Department of Labor and Industry's (DOLI) Virginia Occupational Safety and Health (VOSH) Program.

The Department respectfully disagrees with the Commenter's assertion that the standard's intent is to disregard CDC guidance.

The Department notes that the Standard provides flexibility to business through 16VAC25-220-10.E which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard.

10003 R. Mark Bryant, CEO 1/5/2021 mark.bryant@buckinghambranch.com

Proposed Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 "Thank you for the opportunity to comment on the revised proposed Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.

The Buckingham Branch Railroad is a small, privately-owned, family-owned freight railroad that operates 280 miles of track in Virginia. We are also a member of the Virginia Railroad Association which previously submitted comments on our behalf in the first round of public comment on the proposed Permanent Standard. The Buckingham Branch would like to offer these additional comments in response to the recent revised proposed Permanent Standard.

The Buckingham Branch, like most businesses and business associations that have commented, is opposed to the adoption of a Permanent Standard because the Standard is overly burdensome and unnecessary. It is overly burdensome because small essential business such as ours are already operating in a very challenging and uncertain business environment due to the impacts of Covid-19. The additional work and expense created by the regulations in this Standard are crippling. We believe the Permanent Standard is unnecessary because we already have reasonable and effective guidance from the CDC and Virginia Department of Health as well as the Federal Railroad Administration and OSHA. Additionally, like all businesses, we are naturally incentivized to want to eliminate the spread of Covid-19 among our employees primarily because we care about their welfare and the welfare of their families, but also to ensure we have the people we need to operate our business and serve our communities, and to reduce the costs associated with having our people out sick.

Many other commenters from the first round of public comments have already noted the above concerns but they were dismissed. I urge you to please reconsider.

However, if the Board decides to move forward with a Permanent Standard, the Buckingham Branch believes it must include two provisions:

1) A sunset clause that ties expiration of the Permanent Standard with the expiration of the Commonwealth's State of Emergency. We are aware that many other commenters suggested this and the Board responded by noting that it has the authority to amend or repeal the proposed Permanent Standard as workplace hazards from Covid-19 evolve, thus an expiration date is not necessary. Our concern is that, according to many medical experts, Covid-19 will never go away fully and instead continue to circulate as the other coronaviruses do (fortunately with less severe effects). Additionally, the new vaccines will only provide partial protection and not everyone will get the vaccines. This leaves a rationale for the Permanent Standard to be left in place indefinitely on the basis that Covid-19 is still present and a danger, when in fact there may no longer be a significant danger. Thus, we believe it would be best to specify an expiration of the Permanent Standard that is tied to an event (e.g., expiration of the State of Emergency) or a specific date.

2) The Virginia Railroad Association's proposed revision to the Permanent Standard outlined in their letter dated September 25, 2020. The proposed revision would account for the special circumstances that railroads in the Commonwealth face. I will not reproduce the entire argument here but below is the proposed revision to subsection (G.1) of 16VAC25-220-10. The VRA revision suggests adding the text in underline.

G.1. To the extent an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or nonmandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions should be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 and COVID-19 related hazards or job tasks addressed by this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. Anything to the contrary in this section notwithstanding, to the extent that an employer engaged in interstate commerce complies with a recommendation contained in CDC guidance or other federal standards or guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV2 and COVID-19 related hazards or job tasks addressed by this standard, the employer's actions shall be considered in compliance with this standard.

The Board previously responded by declining to make the proposed revision to section G.1. but we at the Buckingham Branch encourage you to reconsider.

Virginia's economy has been devastated by Covid-19. Small businesses, the working class, and the poor have been disproportionately affected. 'While everyone would agree it is necessary to take reasonable precautions with Covid-19, we in the small business community believe that it is vital to remove burdensome and unnecessary regulations on Virginia's businesses so that we can allow our economy regain strength so that all Virginians may benefit and flourish.

"SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's assertion that the standard is unnecessary and overly burdensome. At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

Employers that are able to modify job tasks and mitigate potential exposure to SARS-CoV-2 to the extent that they can classify their employees as lower risk greatly reduce their compliance burden under the Standard. Such employers will not have to comply with the additional requirements contained in 16VAC25-220-60 for medium risk hazards and job tasks; nor will they have to develop an infectious disease preparedness and response plan under 16VAC25-220-70.

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor's COVID-19 State of Emergency and Commissioner of Health's COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The Department does not plan to recommend that 16VAC25-220-10.E be changed as suggested by the Commenter. It is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Standard's language in 16VAC25-220-10.E assures such protections.

10004 Wayne Pryor 1/5/2021

Comments of the Virginia Farm Bureau Federation Regarding Adoption of Revised Proposed Permanent Standard for COVID for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

The Virginia Farm Bureau Federation (VFBF) appreciates the opportunity to provide additional comments on the proposed Permanent Standard for COVID for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.

As we enter 2021, the health and safety of our 35,000 farm family members continues to be our top priority during the ongoing pandemic. We understand and appreciate your intent to establish clear and consistent workplace health protection protocols, however, we remain concerned about the impact many of the provisions of the proposed permanent standard have on the agriculture industry, and farm families, and encourage you to consider revisions and maintain a temporary, rather than permanent, standard.

On at least two previous occasions, VFBF previously urged the Virginia Department of Labor and Industry (DOLI) to not make permanent the Emergency Temporary Standard (ETS). We laid out our reasons for opposing the ETS in detailed comments, and proposed revisions that would make the ETS more workable and effective. We noted that the continuously updated guidance issued by the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) are the most appropriate mechanism to guide prevention measures, and were exceedingly effective in controlling outbreaks and ensuring safety in the agriculture industry when implemented in mid-2020.

Virginia's farmers and agriculture industry have worked together, and have worked with national affiliates to develop best practices, and follow OSHA and CDC guidance to address the COVID-19 pandemic head on and in a manner that protects our farm families, employees, and consumers of our products. Indeed, while the agriculture industry continues to have success in controlling the virus on our operations, we have seen no similar correlation between decreased positivity or control of spread in the general population as a result of the ETS.

Further, this proposed permanent standard has already shown its lack of flexibility and permanence is its greatest weakness. The new edit of the proposed permanent standard was circulated less than 24 hours before the January 5, 2021 public hearing. As of this writing, a new strain of the COVID-19 virus is present in five states, and may impact national standards related to contagion. Multiple vaccines are available with several more in the pipeline, and some states may move to Phase 1b allowing for more citizens to access immunity. How will a permanent standard work to nimbly address this ever-changing landscape?

We have concerns with language that would expand the scope to cover other infectious diseases. The standard, as drafted, contains specific mitigation practices and protocol to the novel coronavirus, as it exists today. Many of those mitigation practices would not prevent the spread of other infectious diseases, let alone the ever-evolving pandemic we are currently grappling with. This is a product of the hasty, and unscientific manner in which the Emergency Temporary Standard was adopted, and reflects the lack of adequate time for public, and professional, input. We owe it to the Commonwealth to have the appropriate tools for future pandemics, rather than using a one-size-fits-all approach.

To-date we have not received any fiscal impact study showing how this proposed permanent standard will impact businesses, and the Commonwealth in general. We need to know what the impact will be on essential industries, like agriculture and food production. How can we possibly make decisions that could impact the food supply chain, food availability, and affordability without the data to first weight the risks and benefits?

VFBF appreciates the opportunity to file these comments. It is our hope that the board will consider our suggestions, and oppose extending these standards on a permanent basis. We place a great deal of trust in the regulations and standards that govern our home state, and trust the Board will prevent an environment of overenforcement and not penalize farm operations that have given a good faith effort in following these ever-changing and complicated rules.

Thank you for your consideration of these comments.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word “permanent” in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The Department notes that the Commenter has not provided any data to support its contention that “the agriculture industry continues to have success in controlling the virus on our operations.”

The Department notes that a recent report by the U.S. Department of Agriculture found (<https://www.agweek.com/business/agriculture/6819831-USDA-report-studies-pandemics-effect-on-rural-America>):

“On the health front, “The rural share of COVID-19 cases and deaths increased markedly during the fall of 2020. Rural areas have 14% of the population but accounted for 27% of COVID-19 deaths during the last three weeks of October 2020,” according to “Rural America at a Glance: 2020 Edition” from the U.S. Department of Agriculture’s Economic Research Service, or ERS.”

Study: More Than 125,000 Farmworkers Have Contracted Covid-19 (<https://www.ewg.org/news-and-analysis/2020/09/study-more-125000-farmworkers-have-contracted-covid-19>):

“TUESDAY, SEPTEMBER 22, 2020

The Covid-19 virus has infected more than 125,000 U.S. farmworkers, according to the latest estimates in an ongoing study by Purdue University.

To arrive at their estimates, researchers applied the county-by-county rate of the infection’s spread to the number of farmworkers and farmers in those counties. As could be expected, the states with the most farmworkers – as estimated by farm labor spending in the U.S. Agricultural Census – top Purdue’s list. Three of the five states with the most farmworkers lead the list of infections. Texas has 15,410 farmworker infections, California has 10,640 and Florida has 6,380.

But after the top states, outliers pop up. The fourth through sixth highest number of farmworker infections are in Iowa (5,680), Tennessee (4,410) and Missouri (3,960). Each of those states ranked much higher in Covid-19 infections than in number of farmworkers.

What could account for the disparity?

Each of those states is notable for having no mandatory protections for farmworkers to fight Covid-19. Missouri and Tennessee have not even developed a set of voluntary guidelines for employers and employees to follow, and Iowa has recommended guidelines but no mandatory rules.”

The Department acknowledges that, as it predicted back in June and July of this year in its presentations to the Safety and Health Codes Board, that the COVID-19 pandemic could get much worse before it got better, which was a major reason for recommending adoption of an ETS. The Department notes the following statistics which are also highlighted in the January 4, 2021 Briefing Package for the Board beginning on page 36 (<https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf>):

As of December 22, 2020, Virginia ranked 45th in state rankings for total cases per 100K. The Virginia border states of Tennessee, Kentucky, North Carolina, Maryland, and West Virginia, none of which has an ETS, rank higher than Virginia:

- 7 - Tennessee
- 29 - Kentucky
- 39 - North Carolina
- 42 - Maryland
- 43 - West Virginia
- 45 – Virginia

As of December 26, 2020, Virginia ranked 30th in state rankings for average daily cases per 100K in last seven days. The Virginia border states of Tennessee, Kentucky, North Carolina, and West Virginia, none of which has an ETS, rank higher than Virginia. The only border state that outperformed Virginia in this metric was Maryland:

- 1 - Tennessee
- 6 - West Virginia
- 19 - North Carolina
- 25 - Kentucky
- 30 - Virginia
- 39 - Maryland

The Department is not suggesting that the ETS is the sole reason for Virginia's significantly better performance on key COVID-19 indicators than many other states. There are many factors that go into such an evaluation, not the least of which is the impact of Governor's Executive Orders and the commitment of Virginia's citizens, employers and employees to follow safe and health practices and implementing sound mitigation strategies.

The Standard does not cover other infectious diseases like influenza, tuberculosis, etc."

10005 Hobey Bauhan 1.8.21 hobey@vapoultry.com>

Comments of the Virginia Poultry Federation Regarding Adoption of

Proposed Permanent Standard for COVID for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

I am writing on behalf of Virginia Poultry Federation (VPF) concerning the referenced matter. VPF is a statewide trade association representing all sectors of the poultry industry. Our comments reflect the views of VPF and do not constitute a statement of admission on behalf of individual members of VPF.

Virginia's largest agricultural sector, the poultry industry contributes about \$13 billion annually to the Virginia economy; supports the livelihood of some 1,100 family farms; and employs more than 15,000 people.

Poultry plants in Virginia were successful in implementing COVID-19 prevention measures well PRIOR to adoption of the Emergency Temporary Standard (ETS), and will continue to make worker safety a top priority. According to data posted by the Virginia Department of Health (VDH), about 90 percent of cases among poultry workers occurred in April and May, with a dramatic decline after that, even as total Virginia cases increased. The data show that the industry's implementation of OSHA, CDC, and VDH guidance was successful. In addition to our successful implementation of protective measures when the pandemic struck last spring, our industry has worked diligently to comply with the ETS.

As you know, VPF previously urged the Virginia Department of Labor and Industry (DOLI) not to promulgate the ETS last summer. We set forth our reasons for opposing the ETS in detailed comments to DOLI. We noted the changing scientific understanding of the novel COVID-19 and contended that guidance issued by the OSHA and CDC, which are updated with regularity, is the most appropriate mechanism to guide prevention measures.

We further contended in our previous comments that Virginia employers have a general duty under the Occupational Safety and Health Act of 1970 to keep their workplaces free from recognized hazards that cause or are likely to cause death or serious physical harm (the general duty clause). 29 U.S.C. § 654(a)(2) (see Va. Code § 40.1-51.1A- "It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees, and to comply with all applicable occupational safety and health rules and regulations promulgated under this title."). Each of these regulations and statutes is clear and enforceable. If a Virginia employer failed to take action to protect its workers from COVID-19, as recommended by OSHA or the CDC, DOLI's Occupational Safety and Health Division (VOSH) could cite the company for violation of the general duty clause or another existing regulation.

These and other viewpoints and facts set forth in our previous comments remain the same, and we reiterate them herein.

Additionally, the proposed permanent standard published for a 30 day public comment period did not contain the language that had been included in the ETS at §16VAC25-220-10. G.1 concerning compliance with CDC guidelines. I was going to ask, what is the purpose of removing this reference? But then suddenly, the day before the public hearing, a new draft emerged containing a version of 10 G.1. Virginia should rely MORE heavily upon and correlate more closely to CDC guidance.

Also, where is the economic impact analysis to determine cost to small businesses? How are impacted stakeholders able to review and comment on this analysis, which has not been released, before the comment period ends this week or before the Board votes next week?

In our view, DOLI should not adopt a permanent standard. Disease pandemics are temporary; regulations addressing them should be as well. If anything, you should consider another temporary standard, especially with the present rollout of vaccines which will likely end the public health emergency this year.

However, whatever you do requires additional time for appropriate deliberation, transparency, and stakeholder input, and it should contain an explicit mechanism to allow it to expire immediately upon the end of the state of emergency.

The process by which DOLI adopted the ETS was flawed and inappropriate because it did not allow for adequate stakeholder input. The result was an ETS with ambiguous and confusing provisions that led to many questions among the regulated community. VPF sought to help our members navigate the new rules by hosting a webinar with subject matter experts and submitting questions to DOLI, some of which remain to be answered.

Adoption of a regulatory program of this magnitude should have involved a regulatory advisory committee and extensive discussions with representatives of impacted businesses. Such is normally the case pursuant to the Administrative Process Act. We understand the ETS was adopted through certain emergency regulatory procedures. However, the ETS was hastily adopted without adequate time for deliberation with stakeholders. We are concerned the same is true of the present rulemaking process.

Please let me know if you have any questions or would like any additional information. Thank you for your consideration of our views.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

10006 Laurie Aldrich 1.8.21 director@vawine.org

Safety and Health Codes Board intent to adopt Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

I am writing you today on behalf of the Virginia Wineries Association to provide comments regarding the proposed Permanent Standard for COVID-19 mitigation. The Virginia Wineries Association (VWA) is a member-based trade association representing the Virginia wine and cider industries, contributing \$1.37 billion to the Virginia economy as last calculated in 2017.

We oppose the standard as an unnecessary, static, and one-size fits all policy that does not allow the industry to adapt to the latest science and guidelines for mitigation. The Northam Administration is currently coordinating an effort to distribute the vaccine for COVID-19. As the vaccine is distributed over the next several months, public safety measures and mitigation strategies are likely to change. This static regulation is not adaptable to these changing recommendations.

In response to COVID, our public-facing farm wineries and cideries have vigorously followed the Governor's Phased Guidelines. This permanent standard is yet another layer of regulation this already heavily regulated industry must follow. It comes from yet another agency that leads to further confusion and endangers the very workers the standard seeks to protect.

In addition, we request that the regulations not encompass other infectious diseases, as not all infectious diseases are transmitted the same or mitigated in the same manner. The Emergency Temporary Standard was

proposed to deal specifically with SARS-COV-2 and the Permanent Standard is largely unchanged in mitigation measures. An expansion of the current Permanent Standard to all future, unspecified diseases violates the purpose for the statute and puts an unspecified burden on businesses with no practical benefit of preventing the spread of disease.

We also request the Board include a provision repealing the standard when the Governor removes the State of Emergency related to COVID-19. The Governor has stated he expects life to be back to a relative normal by mid-summer. If the state of emergency is removed, a permanent standard responding to a temporary threat is nonsensical, and therefore, should sunset when the Governor's State of Emergency expires.

Again, we kindly request the Virginia Safety and Health Codes Board reject the permanent standard given the changing science of SARS-COV-2 and for the previously stated reasons. We appreciate the opportunity to comment and would be happy to answer any questions the Board may have.

" SEE DEPARTMENT RESPONSE TO COMMENT 87834

10007 Tiffany Finck-Haynes 1.8.21 tfinck-haynes@fcft.org Proposed Permanent Standard: Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19 "On behalf of American Federation of Teachers, Virginia and our thousands of members that work diligently in our public schools to provide quality education to our students, we strongly urge you to make the emergency standard permanent (ETS). The ETS expires on January 26th, but COVID-19 is far from over. It is critical that the Safety and Health Codes Board and Department of Labor and Industry finalize the permanent COVID-19 safety standard to ensure strong protections remain for Virginian workers. We appreciate your leadership on this issue to date and want to ensure that as Virginia students and staff return to school, they are healthy and safe indefinitely. Some schools across Virginia are open for face-to-face instruction. As of December 2020, the Virginia Department of Education notes that 9 school districts are 100% in person and 71 districts are partially in person. This means that currently, 80 of the 132 school districts in Virginia have some component of staff and students in buildings. Across the state, there have been hundreds of cases of COVID-19 in Virginia schools, including COVID-19 outbreaks as defined by the Virginia Department of Health. We expect these numbers to increase as educators return to in person classes. The permanent standard is necessary to protect our school community as we return to in person learning. We want nothing more than for students and staff to be in school buildings for face-to-face learning, but we must reopen school buildings safely with proper science-based safeguards in place for our school staff, students and families. While the COVID-19 vaccine appears to be on the horizon for school staff, even with vaccines, it will take a long time to build immunity in the population and strong workplace safety protections will continue to be needed to prevent the spread of the virus. It is critical that school districts have one clear, consistent standard in place that protects all school staff, from our teachers to our custodians to our bus drivers to food service workers and instructional support staff. Every single staff member and student in Virginia deserves to be protected from COVID-19 at work. Standards at each school should not change due to federal inaction or political pressure.

As schools across the country try to reopen, we unfortunately have seen what happens when strong health and safety measures such as physical distancing, proper PPE, training, and reporting of infections are not in place. The science is clear. Schools are high risk settings for spread of COVID-19. The Virginia ETS must be made permanent, so we maintain a strong worker protection standard in Virginia to protect Virginia students and school employees. A permanent ETS is critical because it helps ensure school districts outline for employees a clear written plan for how to control COVID-19 workplace exposures using a hierarchy of controls. The standard includes strong training provisions, reporting and notification requirements, and protections against discrimination. These aspects of the standard are essential for employees creating safe environments for

students. Currently, the proposed standard has delayed effective dates for essential requirements that are already in place, such as the training requirements. This would create a gap in coverage for key provisions of the rule that will be harmful to workers including school employees. Due to this, we believe it is critical that the standard go immediately into effect for continued coverage of training and other protections.

It is critical that a permanent ETS include language that provide ventilation requirements that ensure airborne transmission is addressed. The proposed standard updates the ventilation requirements to list specific measures to improve ventilation and maintains references to ASHRAE standards, the respected source of indoor air quality standards. These requirements will help to ensure that employers take appropriate specific measures to improve ventilation to keep our school buildings safe. The permanent ETS must also require that workplace outbreaks are reported to government agencies and made publicly available to help identify and slow the spread. This update must apply to outbreak notifications to the VDH and VOSH, which include K-12 school outbreaks. This is a critical aspect that must be incorporated to keep students, staff and families informed and safe in our school community.

In addition, the standard must ensure that adequate respiratory protection is provided to workers when necessary. The standard cannot rollback or weaken protections in the current rule. Further, face coverings must not be allowed in place of respiratory protection. We are concerned that the Virginia Department of Health has proposed changes to the rule to allow face coverings when respirators are actually needed to protect many workers from this virus. Reducing needed protections because of any shortages in supplies must not be in the rule itself and should be handled through enforcement discretion, as the agency always has. Face coverings protect others from the person wearing them and are not a replacement for strong respiratory protection that many workers need. This is especially important for our school employees, who work with vulnerable student populations that by the nature of their job, are not able to necessarily wear specific face coverings.

It is critical that workers, including school employees, are trained on how to properly use PPE. The proposal contains a new requirement to train workers on how to extend the use of PPE. Reusing single use PPE in the workplace is dangerous and places everyone at risk. This provision must be removed.

Instead, workers must be trained on how to properly use PPE and on what makes this equipment the most effective. Any extended use during critical, actual shortages should be handled through enforcement discretion and not the final rule. This proposed provision lowers the bar for everyone and is harmful.

It is vital that the standard addresses all return to work situations. The return to work provisions have been updated to be consistent with current CDC guidance. However, guidance for how to return workers with asymptomatic COVID-19 is unclear. Asymptomatic individuals with COVID-19 are still a major source of workplace exposure and protective requirements must be included to ensure they do not return until they can no longer infect coworkers or students.

The permanent standard will help decrease the spread of COVID-19 in our schools and help limit community transmission. Each workplace and school district are different across Virginia and this standard is important because each workplace will be able to implement a tailored program of control practices that will help keep everyone safe. This is particularly important for staff in our schools who, by the nature of their job, cannot be 6 feet from their students (for example those who work with students that have certain disabilities, speech pathologists, etc.), or their students cannot wear face-coverings in the classroom. Having a permanent standard that establishes strong health and safety practices will help isolate and control the spread of COVID-19.

The temporary standard was the first step we needed to help make our schools safer – now we need to make sure it is permanent because COVID-19 is not going away. We need a strong, comprehensive, and enforceable standard with no loopholes for employers that outlines clear requirements based on sound science and proven successful practices. We urge the Virginia Department of Labor and Industry to move forward with the permanent standard rulemaking right away to protect teachers, support staff, students, and our families. Our schools are open now and our school community needs these protections permanently.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

10008 David Broder (email from Michelle V. Starr) 1.8.21 david.broder@seiuva.org

In strong support of the Proposed Permanent Standard for Infectious Disease Prevention for COVID-19, which would make these essential standards a permanent protection for workers in Virginia. On behalf of our hard-working members, we are in strong support of the Proposed Permanent Standard for Infectious Disease Prevention for COVID-19, which would make these essential standards a permanent protection for workers in Virginia.

There is no way out of this pandemic without a permanent standard to protect workers, our families, and our communities across the commonwealth. Without a permanent standard, we will not be able to protect those on the job, or get those who are without work back on the job.

We have the following recommendations to strengthen the standards:

1. The state is proposing delayed effective dates for some elements, such as training. This would (wrongfully) cause a lapse in coverage for workers since these protections are already required under the emergency standard. The rule must go into effect immediately.
2. The Virginia Department of Health has proposed changes to the rule to allow face coverings when respirators are actually needed to address the airborne nature of this highly contagious virus. Reducing needed protections because of any shortages in supplies must not be in the rule itself and should be handled through enforcement discretion, as the agency always has. Face coverings must be allowed only for protecting others from the person wearing them, and not in place of adequate respiratory protection that many workers need when working close to other people for long periods of time.
3. There is a new requirement to train workers on how to extend the use of PPE. Reusing single use PPE in the workplace is dangerous and places everyone at risk. This provision must be removed. Instead, workers must be trained on how to properly use PPE and on what makes them effective. Any extended use during critical, actual shortages should be done in limited and extreme circumstances and handled through enforcement discretion and not the final rule. This proposed provision lowers the bar for everyone and is harmful.

4. The return-to-work provisions have been updated to be consistent with current CDC guidance. However, guidance for how to return workers with asymptomatic COVID-19 is unclear and must be addressed.

The ETS is a strong, comprehensive standard that sets clear requirements based on longstanding practices and current science, and should be made permanent while implementing the changes we outlined above.

We urge you to do what is right to protect Virginia's workers and adopt the proposed Permanent Standard with our recommended changes.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

With regard to face covering issues, 16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms." The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

With regard to the issue of training extended use of PPE and the Commenter's request to have it removed, the proposed language states in 16VAC25-220-80.B.8.f: "Strategies to extend PPE usage during periods of limited supply." The Department does not intend to recommend removal of the proposed language. It is unquestioned that PPE shortages occurred and continue to occur. The language is consistent with current OSHA policy on the issue which VOSH follows: OSHA's April 3, 2020 Memorandum entitled "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" which "outlines enforcement discretion to permit the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer's recommended shelf life (sometimes referred to as "expired")."

The VOSH Program also follows OSHA's April 24, 2020 Memorandum entitled "Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic."

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

10009 Nicole Riley 1.8.21 Nicole.Riley@NFIB.ORG

Comments of the Virginia Business Coalition re: Safety and Health Codes Board intent to adopt Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

On behalf of the Business Coalition ("Coalition") which is comprised of 33 leading business associations across the Commonwealth, we thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations"). The Business Coalition is committed to protecting employees, contractors, suppliers, and communities from COVID-19 infection.

Our members are already heavily regulated under multiple federal and state occupational health and safety programs. Coalition members are interested in a uniform and coordinated approach to Federally delegated health and safety regulations. As such, our members participate in national trade groups, and have worked to develop best management practices and implemented a hierarchy of controls to protect their workforce from COVID-19 infections as proscribed by all Federal regulatory agencies. Accordingly, the Coalition is uniquely positioned to participate in the public process associated with the development of the Regulations.

I. Summation of Business Coalition's Comments

Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements.

A. The Virginia Safety and Health Codes Board should not adopt a Permanent Standard.

The Coalition asserts that adopting 16VAC25-220 as permanent regulations is overly burdensome, unnecessary, and violates existing law. The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA

guidelines are frequently updated to reflect this. If the ETS were to become permanent, it would continue to require businesses to comply with outdated regulations.

Now is not the time to impose a permanent standard. Why adopt a permanent standard when we're beginning to see the rollout of vaccinations?

B. There is no sunset date for the Standard

The proposed permanent standard does not contain a true sunset date. Rather, all it does is reiterate the Board's authority to come back at a later date to determine the necessity of a continued permanent standard after the Governor's State of Emergency is lifted. The Board was clear during its July deliberations; the temporary nature of this pandemic requires any regulations put in place related to COVID-19 should be sunset with the Governor's State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic.

C. There is no economic impact analysis to determine cost to small businesses

There is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis.

D. The Standard is burdensome for businesses to comply with

Permanent regulations would be overly burdensome, costly and confusing especially in light of overlapping regulations and guidance with the "Safer at Home" guidance, Executive Order 72, and the proposed rule. Businesses are already incurring expensive costs to comply with the ETS from hiring consultants and attorneys, taking workers out of production to do additional training, etc.

E. The Board has not proven a "grave danger for ALL workplaces necessitating a permanent regulation

It is unreasonable to apply a "one size fits all" approach to COVID-19 regulations to all employers and employees. The Board's determination of "grave danger" in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities. The "grave danger" determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk).

VDOLI also cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and yet infections have been reduced entirely by employer compliance with CDC guidance, OSHA guidance, and Governor's Executive Orders – not the COVID-19 ETS.

Therefore, the Board cannot simply assume and apply its prior "grave danger" determination and COVID-19 ETS efficacy as the basis for permanent regulations. Further, since 46 other states have neither a COVID-19 ETS or permanent regulation, the Board has not proven the necessity for such a permanent regulation.

F. Regulations should not be expanded to other infectious diseases

Infectious diseases are not all the same. Therefore, the Board should not expand these regulations to other infectious diseases. We have no idea what protocols will be necessary to mitigate the risks of future diseases, so it doesn't make sense to create a permanent standard for all infectious diseases.

G. If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it must include these important provisions:

1. The sunset clause whereby the Regulations will expire with the Governor's State of Emergency.
2. Amend § 10G to the agency's original language with clarification on providing "safe harbor" for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance.
3. Eliminate requirements for physical separation of employees at low and medium risk businesses by a permanent, solid floor to ceiling wall. Higher risk businesses have more flexibility to use smaller temporary barriers like Plexiglas sneeze guards.
4. Eliminate all human resource policies from the Regulations such sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. These policies exceed the Board's authority as it relates to workplace hazards.
5. Amend common space sanitation requirements. Requiring common spaces to be cleaned and disinfected at the end of each shift" is impractical for 24/7 operations with multiple and overlapping shifts. The Regulations should be amended to provide for a time-based alternative such as every 8, 12, or 24 hours exempting FDA regulated facilities.
6. Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations.
7. Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level.
8. Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply.
9. Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency.
10. Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague.
11. Eliminate the conflicts and overlaps between the "Safer at Home" guidance, Executive Order 72, and the proposed rule. The regulation should govern, and this should be explicitly stated in the permanent regulation. Otherwise, the regulation must be inadequate to protect worker safety.

II. Recommendations

As such, the Coalition respectfully requests that the Virginia Safety and Health Codes Board withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.”

Instead, if the Board can demonstrate a necessity to pursue regulation, it should do the following:

1. The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period.
2. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period.
3. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

III. Conclusion

It is unreasonable to apply one-size-fits-all COVID-19 Regulations to all employers and employees. It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify guidance and Executive Orders as a reasonable replacement. Further, it is confusing why the Board would pursue permanent regulations that are in conflict with previously issued Executive Orders.

Therefore, it is the Coalition’s recommendation that the Board reject the Regulations, provides additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department disagrees that the Standard is a “one size fits all” regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer’s compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for “advice and technical aid before making a determination related to compliance with the CDC guidelines.” The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

The language referenced by the Commenter (1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time)) is one of a number of possible mitigation strategies that an employer can implement depending on the feasibility of doing so.

The Department has proposed language changes regarding cleaning between shifts.

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at:

<https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

The Consolidated Appropriations Act (CAA 2021) was signed into law on December 27, 2020. “The CAA 2021 allows FFCRA-covered employers to voluntarily extend two types of emergency paid leaves through March 31, 2021 that were originally mandated between April 1, 2020 and December 31, 2020 by the Families First Coronavirus Response Act (FFCRA). These FFCRA leaves are Emergency Paid Sick Leave (EPSL) and Emergency Family and Medical Leave (EFMLA).

The FFCRA provided up to 10 days of EPSL, with varying levels of pay, for any of six COVID-19 qualifying reasons between April 1, 2020 and December 31, 2020. Carryover of unused EPSL into 2021 was not allowed under the FFCRA—at least not as originally written.

The CAA 2021, however, amends the carryover provision of EPSL. Employers may now voluntarily choose to permit the carryover of unused 2020 EPSL into the first quarter of 2021. If they do, EPSL tax credits associated with this paid leave can be taken through March 31, 2021. The tax credits are an incentive for FFCRA-covered employers to choose to carryover unused EPSL.

It is important to note that the CAA 2021 does not provide employees with additional EPSL. Employees who emptied their EPSL tank of 10 days in 2020 have nothing to carry over into the first quarter of 2021 should their employers decide to allow EPSL carryover. The CAA 2021 merely extends the tax credit available to private employers under the FFCRA, and does not create new EPSL leave.

<https://www.jdsupra.com/legalnews/extension-of-emergency-ffcra-leaves-21991/>

With regard to: 6. Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations. REVISED LANGUAGE HAS BEEN PROPOSED.

With regard to: 7. Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level. The Department does not intend to recommend a change in language. The Department has provided free online plan and training materials.

With regard to: 8. Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. REVISED LANGUAGE HAS BEEN PROPOSED ALLOWING 60 DAYS FOR TRAINING.

With regard to: 9. Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. The Department does not intend to recommend any change to 16VAC25-220-90.C as it is the position of the Department that it reflects the current state of case law on the subject.

With regard to: 10. Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague. REVISED LANGUAGE HAS BEEN PROPOSED

10010 Robert Hollingsworth emailed from Eunice Salcedo 1.8.21 ESalcedo@afscme.org

The American Federation of State, County and Municipal Employees (AFSCME) District Council 20 strongly supports the permanent standard for Infectious Diseases Prevention: SARS-CoV-2 the Virus that Causes COVID-19. The Commonwealth of Virginia has proposed a strong, comprehensive permanent standard to protect workers from the SARS-CoV-2 virus. We strongly urge the Safety and Health Codes Boards and Department of Labor and Industry (DOLI) to adopt the proposed permanent standard with several recommended improvements and to remain vigilant in protecting workers in Virginia.

AFSCME District Council 20 members are on the front lines, keeping our communities running in Virginia. They and other public service workers are hard at work providing emergency services, health care, transportation, sanitation, public safety and other essential services. Many of these workers come in contact with people who are or may be infected by the SARS-CoV-2 virus, thereby endangering themselves and their families. They need adequate and enforceable worker protections to do their jobs safely. Even with vaccines starting to become available, the pandemic is far from over, and workplace controls are needed to mitigate SARS-CoV-2 exposure.

The proposed permanent standard ensures that employers identify workers could be exposed to COVID-19 in the workplace and have a written plan to control those risks using the hierarchy of controls. The standard also includes strong training provisions, reporting and notification requirements and protections against discrimination.

AFSCME District Council 20 supports the added ventilation provisions in the proposed permanent standard. Since SARS-CoV-2 is an airborne transmissible virus, proper ventilation and increased supply of fresh air are vital to reduce spread indoors. The ventilation requirements reference the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) standards, which will ensure that airborne transmission is addressed in workplaces.

We also support the modification of the return-to-work criteria since workers who experience severe illness may need to be removed from work for an extended period of time. However, the provisions for return-to-work criteria fail to address asymptomatic individuals with COVID-19. Asymptomatic individuals with COVID-19 are a major source of workplace exposure and protective provisions must be included to ensure they do not return until they can no longer infect others. Therefore, workers with COVID-19 exposures should not return to work until:

A) 14 days have passed since the worker was exposed to a COVID-19 case and the worker has remained asymptomatic during this time period; or

B) 10 days have passed since the worker was exposed to a COVID-19 case, the worker has remained asymptomatic during this time period, the worker receives a COVID-19 test administered after day five post exposure with a negative COVID-19 test result, and the following conditions are met:

- 1) No clinical evidence of COVID-19 has been observed by daily symptom monitoring during the entirety of quarantine up to the time at which quarantine is discontinued, and
- 2) Daily symptom monitoring continues for 14 days after exposure, and
- 3) Workers should be advised that if any symptoms develop, they should immediately report them to the employer and isolate.

In the proposed standard, the Board has changed the employer reporting requirement to the Virginia Department of Health (VDH) compared to what is required under the emergency temporary standard (ETS). If adopted the proposed permanent standard will require employers to report every instance of outbreaks of two or more employees. AFSCME District Council 20 recommends that the reporting requirements to DOLI be consistent with those of the VDH. That is, employers should be required to report to DOLI within 24 hours of the discovery of two or more of its own employees present at the place of employment within a 14-day period testing positive for SARS-CoV-2 virus, instead of DOLI's current practice under the ETS of requiring reporting for the discovery of three or more such employees.

AFSCME District Council 20 strongly opposes the delayed effective date of March 26, 2021. Employers have already been complying with the ETS requirements. The extended effective date is an oversight that can cause a lapse in worker protections. Since the ETS will remain in effect only through January 26, 2021, we recommend the permanent standard requirements take immediate effect on January 27, 2021 so that there is no gap in coverage and to avoid confusion within the regulated community.

The Board should add language in the standard to clarify the definition of a face covering. A face covering can provide a means for source control, reducing the spread of virus from the wearer to others, but it is not intended to protect the wearer. A typical example of source control for COVID-19 is to use a mask or face covering to limit the spread of respiratory droplets and aerosols from the wearer to others. Face coverings, however, are not a replacement for strong respiratory protection that workers need when working close to other people for a long period of time.

The Board must reject efforts to weaken worker protections based on respirator availability. VDT-I has proposed changes to the rule to allow face coverings when respirators are needed. In contrast to a face covering, a respirator protects the worker by filtering out virus particles in the air. Using face coverings instead of respirators substantially increases the risk that workers will be exposed to SARS-CoV-2. Reducing needed protections because of any shortages in supplies must not be in the rule and should be handled through enforcement discretion, as the agency always has. We note that MOSH recently issued new approval holders and several of those respirator manufacturers report they have respirators in stock for employers to purchase.

The permanent standard will help protect Virginia's workers, their families and the communities they serve. AFSCME District Council 20 urges the Board take immediate action to adopt and enforce the proposed permanent standard. We appreciate the opportunity to provide these comments. If you have any questions, please feel free to contact me.

Adoption of Permanent Standard for Infectious Disease Prevention SARS-CoV-2 Virus that Causes COVID-

19, 16 VAC 25-220" On behalf of the Virginia Restaurant, Lodging & Travel Association, we would like to take a moment to impart our organization's comments regarding the Virginia Department of Labor and Industry's (VDOLI) intent to adopt the emergency regulation for preventing COVID-19 in places of employment as a permanent standard. While we appreciate some of our concerns were taken into consideration and included in this final version of the proposed permanent COVID-19 standard, we want to highlight the public safety measures being taken by the hospitality and tourism industry and why the proposed COVID-19 permanent standard should not be adopted, nor applied to restaurants, campgrounds, attractions, of lodging providers. Hospitality and tourism related businesses have been working diligently to comply with COVID-19 related requirements from the Governor's Executive Orders (EO), Virginia Department of Health (VDH), Virginia Department of Labor and Industry (VDOLI) and applicable federal requirements. In fact, the hospitality and tourism industry has strived to protect the public and their staff throughout this public health epidemic.

The American Hotel & Lodging Association created the Safe Stay program, and the National Restaurant Association developed the ServeSafe Dining Commitment/ COVID-19 trainings. Major hotel brands, including Marriott, Hilton, and others also have implemented rigorous cleaning protocols as well. These lessons were created in accordance with the guidance issued by public health authorities, including the U.S. Centers for Disease Control. Regrettably, VDOLI has failed to accept these hospitality industry specific education programs even after much encouragement from our industry to get these recognized as satisfying training and safety criteria of the ETS. Our organization and industry supports clearly defined and predictable measures to address health and safety concerns related to COVID-19; however, we believe that adopting a permanent standard when the science and our knowledge of the virus are frequently changing and have been since the start of the pandemic will hinder the ability of our industry to adequately respond in a changing public health landscape on the issue. The ETS was approved ostensibly to provide a means of ensuring employees and the public were protected during the temporary COVID-19 emergency; however, your agency is now seriously considering establishing these as permanent standards. As we are seeing, COVID-19 vaccines and treatments have been developed and are now being deployed to the public. Therefore, it's misguided to establish these requirements as a permanent standard that will be perennial. As a result, hospitality and tourism businesses will need to comply with these onerous regulations even after we have vaccinated our citizens against this virus. As you may be aware, hospitality related businesses have been one of the most heavily impacted by COVID-19.

These businesses have already been absorbing huge costs just to comply with existing requirements from VDH, EOs, CDC, and national trainings. Making the VDOLI standard permanent will place these businesses in a more precarious situation. We currently anticipate that almost 25% of restaurants in Virginia will permanently close, and these regulations will increase the rate of permanent closures. Therefore, we believe that it's imprudent to transition the ETS to a permanent standard, but should your agency move forward with making these standards permanent here are our suggestions:

- Exempt hotels, restaurants, and campgrounds that train their staff in either the American Hotel & Lodging Association (AHLA) Stay Safe, national hotel brand trainings and guidance, National Restaurant Association (NRA) ServeSafe Dining Commitment, or National Association of RV Parks and Campgrounds (ARVC) Re-Opening RV Parks and Campgrounds procedures and follow necessary protocols included in these respective programs.
- Sunset the regulation when the Governor's State of Emergency concludes for COVID-19.

We remain of the belief that hospitality related businesses that follow national health and safety procedures from AHLA, NRA, and ARVC should be exempt from the VDOLI regulations as these procedures were developed in accordance with CDC guidelines. For these reasons, we strongly believe that the best approach is to not adopt the ETS as a permanent regulation. However, if you do promulgate them, we believe the adjustments outlined above will provide the means to address the public health issues pertinent to mitigating transmission of COVID-19.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

With regard to the Commenter's request for an industry exemption (exempt hotels, restaurants, and campgrounds that train their staff in either the American Hotel & Lodging Association (AHLA) Stay Safe, national hotel brand trainings and guidance, National Restaurant Association (NRA) ServeSafe Dining Commitment, or National Association of RV Parks and Campgrounds (ARVC) Re-Opening RV Parks and Campgrounds procedures and follow necessary protocols included in these respective programs), it is the Department's position that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections. The Commenter has provided no substantive reasons while the employees and employers it represents and the hazards and job tasks they are exposed to are substantially different from every other covered entity such that it would justify different treatment under the standard.

10012 Brett Vassey bvassey@vamanufacturers.com

Comments of the Virginia Manufacturers Association

VA Department of Labor and Industry, Safety and Health Codes Board ("Board")

Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220"

Thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations"). These comments are provided on behalf of the Virginia Manufacturers Association ("VMA").

Virginia's manufacturing sector includes more than 6,750 manufacturing facilities that employ over 230,000 individuals, contribute \$43 billion to the gross state product, and account for 80% of the Commonwealth's goods exports to the global economy. VMA advocates for science-based, practical health and safety regulations. VMA's members will be directly affected by the Regulations, which apply "one size fits all" COVID-19 Regulations across all business sectors in the Commonwealth.

VMA members are heavily regulated under multiple federal and state occupational health and safety programs, and, as a result, participate actively in the development of Regulations and the implementation of related safety programs. As the delegated occupational health and safety agency in Virginia, the Department of Labor and Industry ("DOLI") is responsible for most, but not all, of those safety programs, and VMA believes that DOLI's regulatory activities should be deliberative, transparent, and consistent with Federal guidance. VMA members are interested in a uniform and coordinated approach to Federally delegated health and safety regulations. As such, our members participate in national trade groups, and have worked to develop best management

practices and implemented hierarchy of controls to protect their workforce from COVID-19 infections as proscribed by all Federal regulatory agencies. VMA Members have also historically addressed and mitigated the potential risks of prior infectious outbreaks, such as H1N1, under existing Federal and State regulation and guidance. Further, VMA and its Members have taken aggressive action in complying with the VA COVID-19 Emergency Temporary Standard (ETS), 16VAC25-220, including but not limited to establishing its own VA COVID-19 ETS compliance training program. Accordingly, the VMA and VMA members are uniquely positioned to participate in the public process associated with the development of the Regulations.

The VMA and its member companies are committed to protecting employees, contractors, suppliers, and communities from COVID-19 infection. We have led the development of industry best-practices, provided ETS compliance training, instituted a COVID-19 Model Action Plan, implemented COVID-19 pandemic protection training, developed a rapid response decontamination service, assisted with increasing testing sites, maintained a COVID-19 Resource Center, commercialized a PPE Sourcing Center, distributed over 4,000 cloth masks from the U.S. Department of Health & Human Services to chemical and allied product essential workers, assisted the Virginia Department of Emergency Management (VDEM) increase domestic supplies, donations and production of PPE (including over 100,000 bottles of hand sanitizer, 1,250 Tyvek® 400 hooded coveralls, and a UV-C sanitation cabinet for public health workers), contributed to the Governor's COVID-19 Business Task Force, and implemented the MFG Makes Virginia Safer Pledge.

The VMA asserts that the proposed permanent Regulations are unnecessary primarily because: 1) The Board cannot demonstrate the validity of the current Emergency Temporary Standard (ETS) on which the proposed permanent Regulations are designed; 2) Vaccinations are already being implemented; and 3) the "General Duty Requirements" of employers along with Federal, State, and Industry guidance is effectively protecting workers. As such, the VMA requests that the Board withdraw its "Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220."

The VMA also requests that the Board do the following: 1) Issue an additional thirty (30) day public comment period on the January 4, 2021 version of the permanent Regulations; 2) Issue a sixty (60) day public comment period on the final Economic Impact Statement and Regulatory Flexibility Analysis; and 3) Convene a working group of stakeholders to develop a new Emergency Temporary Standard (ETS) for the Board's consideration.

However, should the Board proceed with permanent Regulations, the Board should not consider any amendments to the Regulations that would incorporate other infectious diseases and there must be a sunset on the Regulations coincident with the State of Emergency.

VMA COMMENTS

1. Regulations should sunset based upon an event not a date such as the end of the State of Emergency.
2. It is unreasonable to apply "one size fits all" COVID-19 regulations to all employers and employees. The Board's determination of "grave danger" in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent.

VMA Questions:

- What are the verified COVID-19 infections, hospitalizations, and deaths by workplace type (low to very high risk)?

- Why has the Board not directed DOLI to complete an assessment of verified COVID-19 infections, hospitalizations, and deaths by workplace type (low to very high risk) for public comment?
- Why has the Board not revisited its “grave danger” determination for all workplaces?
- Are all the substantial elements of this proposed Regulations, as applied across the scope of every employer in Virginia, necessary under the procedures of Va. Code § 40.1-22(6a)?
- What is the tracing protocol to determine that the workplace was the source of COVID-19 infection?
- Can employers, based on these Regulations, place restrictions on their employees’ interactions outside of work? Since an employer is now responsible for COVID-19 illnesses, regardless of the source of the infection, then would it not be reasonable to enable employers to restrict the activity of their employees outside of work?

3. The Board cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and infections have been reduced entirely by employer compliance with the general duty requirements of § 40.1-51.1 (a) of the Code of Virginia, CDC guidance, OSHA guidance, and Governor’s Executive Orders – not the COVID-19 ETS.

Under the § 40.1-51.1 (a) of the Code of Virginia “general duty” requirements, it states that:

..it shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees..."

Therefore, mandating permanent Regulations built upon the COVID-19 ETS is unsupported especially since empirical evidence has proven that employers have protected employees in 46 other states without a COVID-19 ETS or permanent Regulations.

VMA Questions:

- Why does VOSH have difficulty enforcing Federal OSHA and CDC guidance through the “General Duty” requirements on an employer that willfully violates basic COVID-19 safety guidance?
- Why has the Board not directed DOLI to assess employer compliance with the COVID-19 ETS vs. CDC guidance, OSHA guidance, and Executive Orders to validate or invalidate its regulatory efficacy?
- Why did the Board not convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires?

4. The Board has not complied with the Virginia Administrative Process Act (VAPA). DOLI has proposed this rule without proper legal authority to do so. DOLI has followed and is proposing an illegal process. It violates the commitment of the Board as specifically stated in Section 16VAC25-220-10 of the ETS:

This standard shall not be extended or amended without public participation in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and 16VAC25-60-170.

VAPA defines “agency” to be any authority, instrumentality, officer, board, or other unit of the state government empowered by basic laws to make regulations or decide cases. It is apparent from, Va. Code §40.1-22 that the Virginia Safety and Health Board (Board) is empowered by the basic laws to make regulations in this

case and not DOLI staff. See also definition of “agency” under 16VAC25-11-20. The Board must propose regulations not DOLI staff. The Board may not delegate the authority to propose regulations that satisfy VAPA or to adopt regulations. The Board has exclusive regulatory authority regarding any such standard and the Board did not provide and did not vote on this “proposal” before seeking comment or submitting to the Virginia Registrar. Accordingly, this proposal does not satisfy the requirement that it constitutes the necessary proposal from the Board.¹

DOLI issued a draft permanent Regulations in December 2020 for 30 days of public comments but changed the draft permanent Regulations on January 4, 2021. The public comment period must be reset.

The draft permanent Regulations must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period. Va. Code §2.2-4007.05 styled Submission of proposed regulations to the Registrar states:

The summary; the statement of basis and purpose, substance, and issues; the economic impact analysis; and the agency’s response shall be published in the Virginia Register of Regulations and be available on the Virginia Regulatory Town Hall, together with the notice of opportunity for oral and written submittals on the proposed regulation.

1 Va. Code §40.1-51.1 provides a structure where the State Health Commissioner provides advice, and the Department of Labor and Industry staff provides drafting as proposals for the Board. This structure does not make DOLI the agency with delegated authority for the rules.

It also appears that the Board is violating the requirements of Va. Code §2.2-4007.1 concerning a regulatory flexibility analysis. Under Va. Code §2.2-4007.1(B), the agency proposing a regulation shall prepare a regulatory flexibility analysis in which the agency shall consider utilizing alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small businesses. The agency shall consider, at a minimum, each of the following methods of reducing the effects of the proposed regulations on small businesses:

1. The establishment of less stringent compliance or reporting requirements;
2. The establishment of less stringent schedules or deadlines for compliance or reporting requirements;
3. The consolidation or simplification of compliance or reporting requirements;
4. The establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and
5. The exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

The current process is further in violation of 16VAC-11-50 which requires that the agency shall accept public comments in writing for a minimum of 60 calendar days following the publication of a proposed regulation. The comment period of July 27, 2020 to September 25, 2020 did not qualify both because there was no regulatory impact statement and because the Board did not vote on the ETS as a proposed permanent regulation. Commenters need 60 days to comment on the regulatory impact analysis and the regulatory flexibility analysis.

DOLI seeks to substitute a non-statutory adoption section that conflicts with VAPA on process and effective dates. Proposed 16VAC25-220-20(A) fails on numerous fronts and it is novel to include an adoption process as a

part of a rule since rulemaking is governed by a standard process. First, under proposed 16VAC25-220-20(A)(3) and (4) the Board proposes to have the standard take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia. Under Va. Code §2.2-4013(D) and §2.2-4015(A) the effective date can be no earlier than 30-days after publication of the final regulation in the Register.

VMA Questions:

- Why has the Board not provided an economic impact analysis that will include the effect on small businesses as set out in Va. Code §2.2-4007.04(A)(2)?
- Why has the Board not provided a regulatory flexibility analysis as set out in Va. Code §2.2-4007.1(B)?
- Under what authority can the Board violate 16VAC25-220-20(A), 16VAC25-220-20(A)(3) and (4), §2.2-4013(D), and §2.2-4015(A)?

5. The Board, the Governor and the Health Commissioner must eliminate the conflicts between the Safer at Home document and the Regulations. DOLI is proposing to eliminate the cross-references to the Executive Orders to avoid judicially review of those Orders in the context of the permanent Regulations. Regardless, Executive Order 72 and Order of Public Health Emergency 9 specifically identify the effort to accomplish the same illegal objective. This illustrates the same lack of concern for the confusion caused by a matrix of Regulations on the regulated community. Specifically, under new enforcement sections of EO72, the Governor and the Health Commissioner claim that DOLI can enforce the Orders. In addition, EO72 has a new rule of construction which states:

Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19” Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

Guidelines applicable to businesses refer to the Safer at Home: Phase Three Guidelines for All Business Sectors (“Safer at Home” document). The Safer at Home document has mandatory sections as does EO72, the ETS and the draft Regulations. The combined sections of EO72, the Safer at Home document, and the Regulations are complex, overlapping, and confusing.

6. The Regulations confuse guidance and regulations. Guidance is not regulation. Codifying guidance as regulation bypasses public scrutiny. If any agency or Executive can simply change Regulations by issuing guidance, then the statutory basis for VOSH regulation will cease to exist as will public notice and comment. The VMA objects to including any reference to compliance with the Governor’s Executive Orders in Regulations.

7. Requiring “Low” and “Medium” risk facilities to maintain HVAC systems in accordance with manufacturers’ instructions does not address the potential hazard (if any) as it relates to ventilation. Requiring ASHRAE standards 62.1, 62.2 and 170 should be struck entirely from the ETS and consideration for Regulations. In addition, the language does not account for older facilities, as upgrading the ventilation in those facilities may be infeasible. The VMA also asserts that the Safety and Health Codes Board does not have the authority to require such a physical alteration to all business facilities, especially without a Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA) assessment.

The VMA recommends that the Board adopt the CDC guidelines listed below (where feasible) to adequately address the issue:

- Increase ventilation rates.
- Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.
- Increase outdoor air ventilation, using caution in highly polluted areas. With a lower occupancy level in the building, this increases the effective dilution ventilation per person.
- Disable demand-controlled ventilation (DCV).
- Further open minimum outdoor air dampers (as high as 100%) to reduce or eliminate recirculation. Provide for flexibility to accommodate thermal comfort or humidity needs in cold or hot weather.
- Improve central air filtration to the MERV-13 or the highest compatible with the filter rack, and seal edges of the filter to limit bypass.
- Check filters to ensure they are within service life and appropriately installed.
- Keep systems running longer hours, 24/7 if possible, to enhance air exchanges in the building space.

8. The hand sanitizer definition is imprecise and should be expanded to more than “60% alcohol” because it will result in hazards for certain pharmaceutical manufacturing operations. Clarifications issued by DOLI in its ETS FAQ document should be incorporated into the Regulations.

9. The Regulations’ employee risk assessment review process conflicts with current OSHA Guidance (Guidance on Preparing Workplace for COVID-19, OSHA 3990-03 2020) since it confuses job tasks with employee job classifications.

NOTE: THE COMMENTER IS A PARTY TO A LAWSUIT CHALLENGING THE LEGALITY OF 16VAC25-220 Emporary Standard (ETS) Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 As Adopted by the Safety and Health Codes Board on July 15, 2020. LEGAL ISSUES RAISED BY THE COMMENTER THAT RELATE TO THE ONGOING LITIGATION WILL NOT BE ADDRESSED FOR THAT REASON.

NOTE: TO THE EXTENT THAT THE COMMENTER DISCUSSES THE LEGALITY OF ORDERS OF PUBLIC HEALTH EMERGENCY BY THE HEALTH COMMISSIONER OR EMERGENCY DECLARATIONS AND EXECUTIVE ORDERS OF THE GOVERNOR, THE DEPARTMENT CONSIDERS SUCH COMMENTS TO NOT BE GERMANE TO THIS STANDARD AND PROVIDES NO RESPONSE.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

SEE DEPARTMENT RESPONSE TO COMMENT 20001

With regard to the general duty clause, Va. Code §40.1-51.1.A, provides that:

“ A. It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.”

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer’s requirements, requirements of the Centers for Disease Control (CDC), or an employer’s safety and health rules. In such a situation, because no uninfected employees of the first contractor were exposed to the disease at the worksite, the contractor who created the hazard could not be issued a general duty violation or accompanying monetary penalty.

There is no ability to cite “other-than-serious” general duty violations (“other than serious” violations normally do not carry a monetary penalty) because the statutory language specifies that the hazard be one that is “causing or likely to cause death or serious physical harm.”

In the context of the COVID-19 pandemic, the primary problem with the use of the general duty clause is the inability to use it to enforce any national consensus standard, manufacturer’s requirements, CDC recommendations, or employer safety and health rules which use “should,” “may,” “it is recommended,” and similar non-mandatory language.

It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA.”

A Regulatory Flexibility Analysis is contained in the Department’s Briefing Package for the Board dated January 4, 2021.

Any conflicts identified between Governor’s Executive Orders and the standard would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

In reference to the ASHRAE issue, the Department is recommending language changes that appear to address the concerns of the Commenter.

The Department does intend to recommend changes to the definition of hand sanitizer. Also see DOLI Frequently Asked Questions §40, FAQ 9 and §40, FAQ 17 at: <https://www.doli.virginia.gov/cononavirus-covid-19-faqs/>

10013 Nicole Riley 1.8.21 Nicole.Riley@NFIB.ORG

On behalf of the Virginia small business members of the National Federation of Independent Business (NFIB), we are submitting the following comments related to your intent to adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (otherwise further to as “the

Regulations”). Our organization represents approximately 6000 small businesses and 60,000 employees across a broad swath of industries from manufacturing, retail, restaurants, agricultural and forestry companies, healthcare, construction, to professional services. As we enter the 44th week of Virginia’s State of Emergency related to containing the spread of COVID-19, safety for their employees and customers has been the top priority for Virginia’s many small business owners. Yet small business owners have faced intense stress as their businesses were ordered to close or operate in an extremely limited capacity.

The economic turmoil suffered by small businesses during the global pandemic has only somewhat abated as Virginia has gradually reopened. Many small business owners have watched helplessly as their revenue slowed to a trickle or dried up entirely. According to NFIB’s 14th Small Business Covid-19 Survey which was released on December 11th, 2020, One-in-four (25%) of small business owners report that they will have to close their doors if current economic conditions do not improve over the next six months, up from 20% a month ago. Sales levels are still 50% or less than they were pre-crisis for one-in-five (20%) small businesses with another 29% at sales levels of 51%-75% of pre-crisis. Even those small businesses that received a PPP loan, 22% of them have or anticipate having to lay off employees in the next six months, a slight increase from one month ago when it was 19%. And about half (53%) of borrowers anticipate needing additional financial support over the next 12 months, about the same as last month. Despite these challenging times, small businesses quickly adapted and implemented protocols to protect their employees and customers from exposure to the coronavirus by following the guidance issued from the CDC, OSHA, and the Governor’s executive orders.

Now Virginia small business owners are doing their best to comply with the Emergency Temporary Standard (ETS). The last thing business owners need as they rebuild their businesses during this critical time is a permanent one-size-fits-all government regulation. Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements. Therefore, NFIB requests the Virginia Safety and Health Codes Board REJECTS a Permanent Standard for several reasons. First, adopting 16VAC25-220 as permanent regulations will be overly burdensome for small businesses. The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect this. If the ETS were to become permanent, it would continue to require businesses to comply with outdated regulations. Now is not the time to impose a permanent standard. More importantly, why adopt a permanent standard when we’re beginning to see the rollout of vaccinations?

Second, there is no sunset date for the Standard. The proposed permanent standard does not contain a true sunset date. Rather, all it does is reiterate the Board’s authority to come back at a later date to determine the necessity of a continued permanent standard after the Governor’s State of Emergency is lifted. The Board was clear during its July deliberations; the temporary nature of this pandemic requires any regulations put in place related to COVID-19 should be sunset with the Governor’s State of Emergency order. If the Board intends to move forward with a standard after expiration of the current ETS, we expect the Board to stick by its decision to end these regulations at the end of the COVID-19 pandemic.

Third, there is no economic impact analysis to determine cost to small businesses. There is still no economic impact statement to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act. Because this impact statement was not available at the time written comments were due, businesses have had no opportunity to address any findings from that analysis.

Fourth, the proposed permanent regulations are confusing especially in light of overlapping regulations and guidance with the “Safer at Home” guidance, Executive Order 72, and the proposed rule. Businesses are already incurring expensive costs to comply with the ETS from hiring consultants and attorneys, taking workers out of production to do additional training, etc.

Fifth, the Board has not proven a “grave danger for ALL workplaces necessitating a permanent regulation. It is unreasonable to apply a “one size fits all” approach to COVID-19 regulations to all employers and employees. The Board’s determination of “grave danger” in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities. The “grave danger” determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk).

VDOLI also cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and yet infections have been reduced entirely by employer compliance with CDC guidance, OSHA guidance, and Governor’s Executive Orders – not the COVID-19 ETS.

Therefore, the Board cannot simply assume and apply its prior “grave danger” determination and COVID-19 ETS efficacy as the basis for permanent regulations. Further, since 46 other states have neither a COVID-19 ETS or permanent regulation, the Board has not proven the necessity for such a permanent regulation.

If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it must include these important provisions:

1. The sunset clause whereby the Regulations will expire with the Governor’s State of Emergency.
2. The specific recommendations from the Business Coalition to ensure the implementation and enforcement of any Permanent Standard is reasonable, fair, and attainable. Here are several of NFIB’s priorities for amendments to any Permanent Standard
 - Amend § 10G to the agency’s original language with clarification on providing “safe harbor” for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance.
 - Eliminate requirements for physical separation of employees at low and medium risk businesses by a permanent, solid floor to ceiling wall. Higher risk businesses have more flexibility to use smaller temporary barriers like Plexiglas sneeze guards.
 - Eliminate all human resource policies from the Regulations such sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. These policies exceed the Board’s authority as it relates to workplace hazards.
 - Amend common space sanitation requirements. Requiring common spaces to be cleaned and disinfected at the end of each shift” is impractical for 24/7 operations with multiple and overlapping shifts. The Regulations

should be amended to provide for a time-based alternative such as every 8, 12, or 24 hours exempting FDA regulated facilities.

- Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations.
- Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level.
- Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply.
- Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency.
- Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague.
- Eliminate the conflicts and overlaps between the “Safer at Home” guidance, Executive Order 72, and the proposed rule. The regulation should govern, and this should be explicitly stated in the permanent regulation. Otherwise, the regulation must be inadequate to protect worker safety.
- Reject any amendments to the Regulations that would incorporate other infectious diseases. Infectious diseases are not all the same. Therefore, the Board should not expand these regulations to other infectious diseases. We have no idea what protocols will be necessary to mitigate the risks of future diseases, so it doesn’t make sense to create a permanent standard for all infectious diseases.

Therefore, NFIB recommends the Board withdraws its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.”

Instead NFIB encourages the Board, upon a determination that it’s a necessity to pursue regulations, it should do the following:

1. The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period.
2. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period.
3. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

Conclusion

It is unreasonable to impose one-size-fits-all COVID-19 regulations on all employers when they reduce a business’ flexibility to quickly alter workplace procedures to remain safe during the ever-changing circumstances of this pandemic especially when each industry has its own needs. By approving a Permanent Standard, the Commonwealth is freezing current scientific understanding into place which is unnecessary and poses more risk for our businesses and workers.

It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify guidance and Executive Orders as a reasonable replacement. Further, it is confusing why the Board would pursue permanent regulations that are in conflict with previously issued Executive Orders and in light of the beginnings of vaccine availability.

Therefore, it is NFIB's recommendation that the Board reject the Regulations, provide additional public comment related to the newly revised January 4th proposal and anticipated economic analysis, and convene a workgroup of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

While facing devastating economic conditions Virginia's businesses continue to keep the safety and health of their employees as their top priority as they reopen and increase their business operations. We hope the Board will see fit to give Virginia's small businesses an opportunity to rebuild their businesses, restore their customer base and rehire their employees without imposing additional costly regulations.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department disagrees that the Standard is a "one size fits all" regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer's compliance and cost burdens.

The Department notes that it is recommending a revision to 16VAC25-220-10.E to consult with the State Health Commissioner for "advice and technical aid before making a determination related to compliance with the CDC guidelines." The Commenter is free to contact the Department directly and request an interpretation of the standard: webmaster@doli.virginia.gov

The language referenced by the Commenter (1. Installation of floor to ceiling physical barriers constructed of impermeable material and not subject to unintentional displacement (e.g., such as clear plastic walls at convenience stores behind which only one employee is working at any one time)) is one of a number of possible mitigation strategies that an employer can implement depending on the feasibility of doing so.

The Department has proposed language changes regarding cleaning between shifts.

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at:

<https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

The Consolidated Appropriations Act (CAA 2021) was signed into law on December 27, 2020. “The CAA 2021 allows FFCRA-covered employers to voluntarily extend two types of emergency paid leaves through March 31, 2021 that were originally mandated between April 1, 2020 and December 31, 2020 by the Families First Coronavirus Response Act (FFCRA). These FFCRA leaves are Emergency Paid Sick Leave (EPSL) and Emergency Family and Medical Leave (EFMLA).

The FFCRA provided up to 10 days of EPSL, with varying levels of pay, for any of six COVID-19 qualifying reasons between April 1, 2020 and December 31, 2020. Carryover of unused EPSL into 2021 was not allowed under the FFCRA—at least not as originally written.

The CAA 2021, however, amends the carryover provision of EPSL. Employers may now voluntarily choose to permit the carryover of unused 2020 EPSL into the first quarter of 2021. If they do, EPSL tax credits associated with this paid leave can be taken through March 31, 2021. The tax credits are an incentive for FFCRA-covered employers to choose to carryover unused EPSL.

It is important to note that the CAA 2021 does not provide employees with additional EPSL. Employees who emptied their EPSL tank of 10 days in 2020 have nothing to carry over into the first quarter of 2021 should their employers decide to allow EPSL carryover. The CAA 2021 merely extends the tax credit available to private employers under the FFCRA, and does not create new EPSL leave.

<https://www.jdsupra.com/legalnews/extension-of-emergency-ffcra-leaves-21991/>

With regard to: Eliminate HVAC requirements for medium risk businesses (16VAC25-220-60(B)). Requiring retroactive compliance with a 2019 ASHRAE HVAC standard is premature at best. Any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC) which utilize appropriate industry investigation and recommendations. REVISED LANGUAGE HAS BEEN PROPOSED.

With regard to: Eliminate the requirement that medium risk employers should complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and not necessary at this risk level. The Department does not intend to recommend a change in language. The Department has provided free online plan and training materials.

With regard to: Increase the amount of time employers must train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. REVISED LANGUAGE HAS BEEN PROPOSED ALLOWING 60 DAYS FOR TRAINING.

With regard to: Eliminate language protecting employees who report to news media or social media (16VAC25-220-90). Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. The Department does not intend to recommend any change to 16VAC25-220-90.C as it is the position of the Department that it reflects the current state of case law on the subject.

With regard to: Revise requirements related to transportation of employees who travel in the same vehicle. This standard is impractical and vague. REVISED LANGUAGE HAS BEEN PROPOSED

10014 P. Dale Bennett 1.8.21 dbennett@vatrucking.org

Comments of the Virginia Trucking Association

re: Safety and Health Codes Board intent to adopt Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

Thank you for the opportunity to comment on the Board's intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. These comments are provided on behalf of the Virginia Trucking Association (VTA).

As background, the VTA is the statewide association of trucking companies, private fleet operators, industry suppliers, and other firms that support safe and successful trucking operations. Our membership includes family-owned and corporate trucking businesses engaged in the transport of goods and services throughout the Commonwealth of Virginia and the United States. The VTA membership includes companies that are headquartered in Virginia as well as companies headquartered in other states that have locations in Virginia and/or operate commercial vehicle in and through the Commonwealth.

Throughout the COVID-19 pandemic, the trucking industry has continued to operate as an essential service, providing critical transportation of the essential goods and services needed to sustain the population and the economy. Professional truck drivers are the heroes who have kept moving to ensure everyone has the goods they need to get through these challenging times. Their jobs have now taken on an even greater importance as distribution of COVID-19 vaccines begins across the country.

The trucking industry has been able to continue operating by making commonsense adjustments to its operations, both on the road and within its shops and offices necessary to continue daily operations. Safety and Human Resources professionals within the trucking industry have spent countless hours poring over guidelines and recommendations from medical and industry experts to draft continuation plans that work best for their operations and provide the highest and most practical level of safeguards for their employees to protect them from COVID-19.

Our position on safety has never wavered: Safety is of paramount importance. Since the onset of the COVID-19 pandemic, the VTA's member companies have remained committed to this principle, and as the Commonwealth and our nation begin to enter the recovery phase, the safety and health of their employees will continue to guide their decision-making.

Trucking holds the keys to the economic recovery of Virginia and the nation, and as an industry, we are prepared to meet that challenge. However, to meet that challenge, the industry cannot be hindered with burdensome, impractical and unclear regulations such as the current Emergency Temporary Standard (ETS) that is being considered as a permanent standard.

Therefore, we respectfully request that Board not adopt the proposed Permanent Standard: Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19.

Support of Comments filed by the Virginia Business Coalition.

The VTA is a member of the Virginia Business Coalition. We strongly support the comments filed by the Business Coalition and incorporate the concerns and issues they raised as part of these comments filed on behalf of the VTA. The remainder of these comments address issues and concerns about adoption of the proposed permanent standard of particular interest to the trucking industry.

Trucking Industry-Related Issues

1. In the definition of “Lower” exposure risk hazards or job tasks, it is stated that “Employee use of face coverings for contact inside six feet of coworkers, customers, or other persons is not an acceptable administrative or work practice control to achieve minimal occupational contact.” This provision conflicts with CDC guidance, “What Long-Haul Truck Driver Employers Need to Know about COVID-19” (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking-employers.html>). This guidance recommends that employers of long-haul drivers “Take additional precautions to address risks associated with ride-alongs or team driving (two drivers in the cab on a long-haul run) when they cannot be avoided. For example, wear a cloth mask when sharing the cab with someone outside of your household and 6 feet of distance cannot be maintained.”

The same conflict exists for CDC guidance, “What Long-Haul Truck Driver Employees Need to Know about COVID-19” (<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking-employees.html>). This guidance recommends that truck drivers:

- “Wear a cloth mask in public, and at work, even when social distancing” and
- “When team driving or ride-alongs are required, wear a cloth mask when sharing the cab with someone who doesn’t live with you and you can’t stay 6 feet apart.”

If the Board proceeds with adoption of the proposed permanent standard, we recommend that it be amended to allow the wearing of a cloth mask by team truck drivers as an acceptable administrative control to achieve minimal occupational contact, as recommended by the CDC. We also recommend that it be amended to recognize that there is no need to require truck driving teams of husbands and wives, or others who live in the same household to wear a face covering mask while occupying the same truck cab.

2. We commend DOLI staff for including truck drivers in the new definition of “Minimal occupational contact” as recommended in the OSHA Hazard Recognition document cited in the footnote 4. This is a helpful clarification that truck drivers are considered to be working in “lower exposure risk hazards or job tasks.”

Additional Comments

If the Board can demonstrate the validity and necessity of the current Emergency Temporary Standard (ETS) on which the proposed rule is designed, and proceeds with a Permanent Standard, it:

1. Should not expand the standard to include other infectious diseases. As we have learned with COVID-19, all infectious diseases are not the same. We have no idea what protocols will be necessary to respond to and mitigate future infectious diseases, so it does not make sense to create a permanent standard for all infectious diseases.
2. Adopt a sunset clause whereby the Standard will expire at the same time as the Governor’s State of Emergency.

3. Amend § 10G to revert to the agency’s original language with clarification on providing “safe harbor” for employers who follow CDC and OSHA guidance. It is unclear who determines which version of CDC guidance an employer may reference for purposes of compliance. Additionally, as pointed out in our trucking industry-related comments above, we believe there is a conflict between CDC recommendations for truck drivers and their employers and the proposed permanent standard. Conflicts such as this create confusion and uncertainty for employers that hinder their compliance efforts.

4. Eliminate all human resource policies from the Regulations such as sick leave, telework, flexible worksites, flexible work hours, flexible meeting and travel, the delivery of services or the delivery of products. These policies exceed the Board’s authority as it relates to workplace hazards.

5. Increase the amount of time allowed for employers to train their employees. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply. There is increasing demand for freight transportation and a shortage of qualified drivers to meet that demand. We believe trucking employers should have additional time to complete this training to give them flexibility in scheduling time out of the truck for their drivers to minimize disruptions to the supply chain.

Recommendation

We join the Business Coalition in respectfully requesting that the Virginia Safety and Health Codes Board withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.” Instead, if the Board can demonstrate a necessity to pursue regulation, it should do the following:

1. The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period.
2. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period.
3. Convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

Conclusion

It is unreasonable to apply these “one size fits all” COVID-19 regulations to all employers and employees, especially an interstate business like trucking with a highly mobile workforce that does not work in brick and mortar facilities. Regulations written to address fixed facilities and businesses are impractical and difficult to comply with for the trucking industry as illustrated in the concerns we have expressed.

Safety is of paramount importance to the trucking industry as we continue to provide essential transportation service as we begin to reopen the economy. We will continue to provide the highest and most practical level of safeguards for our employees to protect them from COVID-19 as our economy recovers and freight demand increases.

We do not believe that the Board should adopt a permanent standard to address a temporary pandemic. Therefore, we recommend that the Board reject the Regulations, provide additional public comment on the newly revised January 4th proposal, including the required economic analysis that has not yet been released. Additionally, the Board should convene a workgroup of stakeholders to revise and recommend a second COVID-19 ETS that expires within 6 months of adoption or when the State of Emergency expires.

Please contact me if you need any additional information or have any questions regarding these comments or the trucking industry.

SEE DEPARTMENT RESPONSE TO COMMENT 89130

10015 Kyle Shreve 1.8.21 kyle@va-agribusiness.org

Proposed Permanent Standard for COVID-19 Mitigation [16VAC25-220]

I am writing today on behalf of the Virginia Agribusiness Council to provide comments regarding the proposed Permanent Standard for COVID-19 mitigation. The Council is a member-based trade association representing the agriculture and forestry industries, contributing \$91 billion of economic impact in the Commonwealth.

We continue to oppose the standard as an unnecessary and static policy that does not allow the different industry sectors to adapt to the evolving science surrounding COVID-19. Employers have a general duty to provide for the safety of their employees from workplace hazards and the Council contends the Department has the authority to sanction employers who fail to do so, including those that fail to protect from COVID-19.

The federal guidance surrounding COVID-19 changes regularly and is likely to change more frequently as the Administration continues to distribute and administer the vaccine. Why would the Board create a static regulation that is unable to adapt to these changing recommendations? We do appreciate the inclusion of the new Section 10.F which allows for compliance with the Permanent Standard by implementing measures from the latest CDC publications. This provision was omitted from a previous draft released by the Department and the Council supports its inclusion should the Board move forward with the Permanent Standard.

We renew our request the Board include a provision repealing the standard if the Governor removes the State of Emergency. The Council disagrees with the method included in the draft Permanent Standard restating the Board's current authority to convene and make a determination of necessity within 14 days. If a state of emergency ceases to exist, why would a standard for mitigation of that emergency continue to be necessary? The Board would have to meet at least once to determine whether the Standard continues to be necessary or should be repealed. If the Board determines amendments are required, more time would be needed for proposed revisions to be drafted and reviewed by the public and the Board. Such amendments should be put through the proper comment period and regulatory review and therefore, delay implementation of a revised standard even further.

During this entire process, our agribusinesses would need to continue to comply with a Permanent Standard that is antiquated and no longer relevant to protecting our workforce. The State of Emergency will end, and if it does, why does Virginia need a Permanent Standard to address a workplace hazard that is no longer a hazard? The Standard should include a sunset when the Governor's State of Emergency expires or a specific date over the next year.

The Council is concerned that the Governor's latest Executive Order and Phase III Guidelines conflict with the provisions of the Emergency Temporary Standard, and would continue to conflict with the Permanent Standard if adopted. It is our understanding that any Executive Orders from the Governor would override the Permanent Standard. Why would the Governor not just issue a standing Executive Order to be revoked when the State of Emergency is no longer in effect? This will continue to lead to confusion for the industry as the Governor continues to revise the Phase III Guidelines in the coming months. The Council's agribusiness members which

are public-facing businesses such as farmers markets, farm wineries, and farm breweries and others, have followed the specific provisions governing those businesses contained in the Governor's Phase III Guidelines. These conflicts cause confusion as to which standard they are to be following for compliance and which agency is enforcing those provisions. Our industry has already invested millions of dollars and implemented unprecedented safety measures to protect their workforce and maintain the food supply chain.

All of the different sectors of our industry have developed policies to comply with guidelines from the CDC, U.S. Department of Labor, Virginia Department of Health, Virginia Department of Agriculture and Consumer Services (VDACS) and the changing Executive Orders and the Governor's Phase III Guidelines. Each individual farm, agribusiness, sawmill, papermill, etc. provides multiple services, could process products differently, and be a diversified operation with different types of agricultural production. These conflicts with the Executive Order should be rectified before adoption of the Permanent Standard.

Finally, we are disappointed that we did not have the opportunity to review and comment on the economic impact study the Department committed to providing. To our knowledge, the report has not been made publicly available before the end of the public comment period. More importantly, the Board itself should have adequate time to review the cost benefit analysis of a Permanent Standard that will continue to have a massive impact on every business and employee in the Commonwealth. We urge the Board to delay action on the Permanent Standard until the Board and the public have adequate time to review the economic impact analysis provided by the contracted third party.

We appreciate the opportunity to comment on the proposed Permanent Standard and would be happy to answer any questions the Board may have.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Any conflicts identified between Executive Orders and the ETS would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

10016 Devandra Harsock 1.9.21 devan.cab@gmail.com

I vehemently oppose any and all COVID restrictions placed by our government on the people and our businesses. This ludicrous policy has upended our economy and destroyed our businesses and now you are considering a PERMANENT shutdown policy, partial or otherwise? I have two businesses in York County whose revenues are down 34% in 2020 and am very close to being forced to close them both. Mind you, these businesses bring in tax revenue for the county in the thousands of dollars and haven't been in business for 30 years. SHAME ON YOU. ALL of this for a flu?? Unlawful at best

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Comments on behalf of the Richmond Area Municipal Contractors Association (RAMCA)

VA Department of Labor and Industry, Safety and Health Codes Board

Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes

COVID-19, 16VAC25-220" The Richmond Area Municipal Contractors Association (RAMCA) represents companies in heavy construction and their associate partners who provide products and services critical to the industry. For 56 years, RAMCA has worked cooperatively on a broad range of important issues relating to the infrastructure needs of the Commonwealth. RAMCA provides a forum designed to improve the business practices and the construction environment in which our employees work. The health and safety of our employees and the community at-large is our highest priority. Promoting a culture of safety is a primary operating principle of our employers. On behalf of RAMCA, I strongly oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220.

Construction is an essential industry performing critical infrastructure work keeping society moving in the Commonwealth. The industry is heavily regulated under multiple federal and state occupational health and safety programs. RAMCA members immediately implemented and rigorously follow CDC and OSHA Guidelines for COVID-19 in the construction workplace.

- The proposed permanent standard has no specified end date. The permanent standard is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines with over 90% efficacy and several additional candidates nearing the end of their trials. Governor Northam on January 6th, 2021 expressed confidence in a consistent supply of over 110,000 doses distributed to Virginia weekly. The Governor projected Virginia would have essential workers and Virginians most vulnerable to COVID-19 (Groups 1A, B, C), vaccinated before summer 2021. At that time, he projected the remaining 40% of the population, would be eligible to receive the vaccine. Considering these factors, there is no logical or scientific justification for the continuance of a standard that was specifically crafted in response to a State of Emergency for COVID-19. Any standard should sunset immediately upon the expiration of the Governor's State of Emergency.
- The proposed standard is burdensome and inflexible.

a. As the science has changed, the current ETS has not, nor does it have the flexibility to do so as either science changes or innovation occurs. As an example, the disinfection standard requirements are based on practices that now may not provide meaningful reduction in transmission. The disinfection standards for tools and equipment are burdensome and time consuming. An hour a day or more is spent by each crew in some cases. Procurement of necessary disinfection items is time consuming, distracts from other job functions, and supply chain issues still impact the ability to obtain disinfectant approved for use against SARS-CoV-2 as defined in 16VA25-220-30.

b. The standard requires non-medically trained individuals to be in the health screening business. Daily screenings add another 30 minutes at the start of a shift. Multiply that by every shift of every crew and less work is being accomplished across the Commonwealth. These daily screenings take crew leaders away from performing their other job duties, impacting overall productivity. RAMCA member companies have generous paid sick leave policies that cover COVID-19 absences and provide employees the choice to stay home with pay if they are exhibiting symptoms of COVID-19 or have had a potential exposure. Employees in heavy construction are not forced to choose between working and staying home.

- It has not been proven a “grave danger” exists for ALL workplaces thereby making it necessary to adopt a permanent standard for ALL businesses or industries. Construction job tasks fall into the “Low” and “Medium” (16VAC25-220-30) exposure category. Physical distancing is a natural part of our work environment. The standard uses “Grave” danger to regulate ALL businesses in Virginia, yet the great majority of the tragic deaths in the Commonwealth are over 70 years old, residents of nursing/assisted living facilities or congregant settings, and those with serious comorbidities.
- The Board must partner with a wide variety of stakeholders, including the business community to advise and consent on any workplace regulations.

a. The economic impact of the proposed standard on businesses and entire industries is significant. The Commonwealth will be impacted as the cost of doing business increases due to burdensome and costly proposed standard. The public should be allowed sufficient access to the Economic Impact Statement required by the Small Business Regulatory Act/Small Business Regulatory Enforcement Fairness Act. To date, no EIS has been made available. The public must have the opportunity to comment on the findings prior to a vote to adopt the permanent standard.

b. The metrics, scientific data, or criteria the board would use to make a determination to continue a permanent standard after the expiration of the COVID-19 State of Emergency should made public. It is critical for the public to

see the data that would be used to continue a standard for a disease the Governor, a physician, no longer views as an emergency, and the Commissioner of Health has determined no longer presents a public health emergency in the Commonwealth.

- COVID-19 is a unique disease and should not be used to expand workplace regulations to include other infectious diseases. No amendment or attempt to include other flus, viruses, cold or other communicable diseases in any permanent standard should be considered. There is no one-size fits all plan to combat a wide variety of infectious illnesses. No one knows what the future holds. If there is a next pandemic, the transmission method cannot be accurately predicted and therefore regulations cannot be adopted for the unknown.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. On behalf of RAMCA, I am strongly opposed to the adoption of a Permanent Standard for what is a temporary health emergency.

The construction industry remains committed to the safety of our workers and the citizens of the Commonwealth. I welcome the opportunity to work with all stakeholders to develop any necessary policies regarding the health and safety of workers in the construction industry.

Thank you for the opportunity to publicly comment.

Best Regards,

SEE DEPARTMENT RESPONSE TO COMMENT 87834

SEE DEPARTMENT RESPONSE TO COMMENT 20006

SEE DEPARTMENT RESPONSE TO COMMENT 89043

10018 Vanessa Patterson 1.9.21 vanessa.patterson@ramca.info

Comments on behalf of the Precast Concrete Association of Virginia (PCAV)

VA Department of Labor and Industry, Safety and Health Codes Board

Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes

COVID-19, 16VAC25-220" "The Precast Concrete Association of Virginia (PCAV) represents companies in the precast concrete industry that produce essential products to support the infrastructure needs of the Commonwealth. On behalf of the PCAV, I oppose adopting a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220.

The producers of precast concrete products and the associate partners who provide necessary elements used in the manufacturing process, are a critical part of the Construction industry. Construction is an essential industry performing critical infrastructure work keeping society moving in the Commonwealth. The health and safety of all employees and the community around us is the top priority of our companies. Promoting a culture of safety is a primary operating principle of our employers. The industry is heavily regulated under multiple federal and state occupational health and safety programs. PCAV members immediately implemented and rigorously follow CDC and OSHA Guidelines for COVID-19 in the construction workplace.

- The proposed permanent standard has no specified end date. The permanent standard is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines with over 90% efficacy and several additional candidates nearing the end of their trials. Governor Northam on January 6th, 2021 expressed confidence in a consistent supply of over 110,000 doses distributed to Virginia weekly. The Governor projected Virginia would have essential workers and Virginians most vulnerable to COVID-19 (Groups 1A, B, C), vaccinated before summer 2021. At that time, he projected the remaining 40% of the population, would be eligible to receive the vaccine. Considering these factors, there is no logical or scientific justification for the continuance of a standard that was specifically crafted in response to a State of Emergency for COVID-19. Any standard should sunset immediately upon the expiration of the Governor's State of Emergency.
- The proposed standard is burdensome and inflexible.

☐ As the science has changed, the current ETS has not, nor does it have the flexibility to do so as either science changes or innovation occurs. As an example, the disinfection standard requirements are based on practices that now may not provide meaningful reduction in transmission. The disinfection standards for tools and equipment are burdensome and time consuming. An hour a day or more is spent by employees in some cases. Procurement of necessary disinfection items is time consuming, distracts from other job functions, and supply chain issues still impact the ability to obtain disinfectant approved for use against SARS-CoV-2 as defined in 16VA25-220-30.

☐ The standard requires non-medically trained individuals to be in the health screening business. Daily screenings add another 30 minutes at the start of a shift. Multiply that by every shift of every crew and less work is being accomplished across the Commonwealth. These daily screenings take crew leaders away from performing their other job duties, impacting overall productivity. PCAV member companies have generous paid sick leave policies that cover COVID-19 absences and provide employees the choice to stay home with pay if they are exhibiting symptoms of COVID-19 or have had a potential exposure. Employees in heavy construction are not forced to choose between working and staying home.

- It has not been proven a “grave danger” exists for ALL workplaces thereby making it necessary to adopt a permanent standard for ALL businesses or industries. Construction job tasks falls into the “Low” and “Medium” (16VAC25-220-30) exposure category. Physical distancing is a natural part of our work environment. The standard uses “Grave” danger to regulate ALL businesses in Virginia, yet the great majority of the tragic deaths in the Commonwealth are citizens over 70 years old, residents of nursing/assisted living facilities or congregant settings, and those with serious comorbidities.
- The Board must partner with a wide variety of stakeholders, including the business community to advise and consent on any workplace regulations.

☐ The economic impact of the proposed standard on businesses and entire industries is significant. The Commonwealth will be impacted as the cost of doing business increases due to burdensome and costly proposed standard. The public should be allowed sufficient access to the Economic Impact Statement required by the Small Business Regulatory Act/Small Business Regulatory Enforcement Fairness Act. To date, no EIS has been made available. The public must have the opportunity to comment on the findings prior to a vote to adopt the permanent standard. ☐ The metrics, scientific data, or criteria the board would use to make a determination to continue a permanent standard after the expiration of the COVID-19 State of Emergency should made public. It is critical for the public to see the data that would be used to continue a standard for a disease the Governor, a physician, no longer views as an emergency, and the Commissioner of Health has determined no longer presents a public health emergency in the Commonwealth.

- COVID-19 is a unique disease and should not be used to expand workplace regulations to include other infectious diseases. No amendment or attempt to include other flus, viruses, cold or other communicable diseases in any permanent standard should be considered. There is no one-size fits all plan to combat a wide variety of infectious illnesses. No one knows what the future holds. If there is a next pandemic, the transmission method cannot be accurately predicted and therefore regulations cannot be adopted for the unknown.

The standard is burdensome, obsolete, difficult to enforce, costly in time and money, and lacks the flexibility to adapt to current science and innovation. On behalf of the PCAV, I am strongly opposed to the adoption of a Permanent Standard for what is a temporary health emergency.

The precast concrete producers and associates as a vital component of the construction industry, remain committed to the safety of our workers and the citizens of the Commonwealth. I welcome the opportunity to work with all stakeholders to develop any necessary policies regarding the health and safety of workers in the construction industry.

Thank you for the opportunity to publicly comment.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

SEE DEPARTMENT RESPONSE TO COMMENT 20006

10019 to p.8 Nandan Kenkeremath 1.9.21 nandank@comcast.net

Comments on Proposed VA Department of Labor and Industry, Safety and Health Codes Board

Proposed Permanent Standard Based on Emergency Temporary Standard for Infectious Disease

Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

Thank you for the opportunity to comment on the proposed 16 VAC 25-220, Permanent Standard/Regulation, Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19. I am a concerned citizen and lawyer with extensive background in regulatory law and policy. I have worked on dozens of statutory programs for many years as Senior Counsel to the Energy and Commerce Committee in the U.S. House of Representatives and worked in the Office of General Counsel for the U.S. Environmental Protection Agency. I have substantial concerns with the procedure behind this proposed rule and the substance of the proposed rule. I strongly recommend the Board follow the full set of public participation procedures set out in the Virginia Administrative Process Act (VAPA) Va. Code § 2.2-4000 et seq., including the opportunity to comment on a regulatory impact analysis. I further recommend the Board reject or substantially modify the proposal published by the staff of the Department of Labor and Industry (DOLI) for the variety of reasons discussed below.

COMMENTS

I. The Board Committed to Follow the Virginia Administrative Process Act

Department of Labor and Industry (DOLI) staff has proposed this rule without proper legal authority to do so. Regardless, DOLI staff has followed and is further proposing an illegal process. The proposal further violates the commitment of the Board as specifically stated in the Emergency Temporary Standard (ETS). Section 16VAC25-220-10 in the ETS specifically states:

This standard shall not be extended or amended without public participation in accordance with the Virginia Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) and 16VAC25-60-170. The Board has not revoked this requirement through a rulemaking or in any manner. Nonetheless, the proceedings for the proposed rule have violated numerous provisions of Virginia Administrative Process Act (VAPA) regarding the public participation process.

II. DOLI Staff Lacks Authority to Propose the Rule VAPA defines “agency” to be any authority, instrumentality, officer, board or other unit of the state government empowered by basic laws to make regulations or decide cases. It is apparent from, Va. Code §40.1-22 that the Virginia Safety and Health Board (Board) is empowered by the basic laws to make regulations in this case and not DOLI staff. See also definition of “agency” under 16VAC25-11-20. The Board must propose regulations not DOLI staff. The Board may not delegate the authority to propose regulations that satisfy VAPA or form the basis for a final regulation. The Board has exclusive regulatory authority regarding any such standards and the Board did not provide and did not vote on this “proposal” before seeking comment or submitting to the Virginia Registrar. Accordingly, this proposal does not satisfy the requirement that it constitutes the necessary proposal from the Board

III. The Proposed Rule Must Have the Economic Impact Statement and Regulatory Flexibility Analysis Available for a 60-day Public Comment Period Va. Code §2.2-4007.05 styled Submission of proposed regulations to the Registrar states:

The summary; the statement of basis and purpose, substance, and issues; the economic impact analysis; and the agency’s response shall be published in the Virginia Register of Regulations and be available on the Virginia Regulatory Town Hall, together with the notice of opportunity for oral and written submittals on the proposed regulation. It is clear the economic impact analysis must be available for public comment. The current plan of DOLI staff does not appear to provide this opportunity for the public. The Board must. It also not clear whether the economic impact analysis that is planned will include the effect on small businesses as set

out in Va. Code §2.2-4007.04(A)(2). 1 Va. Code §40.1-51.1 provides a structure where the State Health Commissioner provides advice and the Department of Labor and Industry staff provides drafting as proposals for the Board. This structure does not make DOLI the agency with delegated authority for the rules. The DOLI staff prepared proposed rule has significant impacts on small businesses. Thus, under Va. Code §2.2-4007.1(B), the agency proposing a regulation shall prepare a regulatory flexibility analysis in which the agency shall consider utilizing alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small businesses. The agency shall consider, at a minimum, each of the following methods of reducing the effects of the proposed regulations on small businesses:

1. The establishment of less stringent compliance or reporting requirements;
2. The establishment of less stringent schedules or deadlines for compliance or reporting requirements;
3. The consolidation or simplification of compliance or reporting requirements;
4. The establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and
5. The exemption of small businesses from all or any part of the requirements contained in the proposed regulation. The Board has considered none of these.

The current process is further in violation of 16VAC-11-50 which requires that the agency shall accept public comments in writing for a minimum of 60 calendar days following the publication of a proposed regulation. The comment period of July 27, 2020 to September 25, 2020 did not qualify both because there was no regulatory impact statement and because the Board did not vote on the ETS as a proposed permanent regulation. Commenters need 60 days to comment on the regulatory impact analysis and the regulatory flexibility analysis. The regulatory flexibility analysis, and the basic standard to determine whether a provision is necessary to protect against a grave danger, must be component by component.

IV. DOLI Staff Seeks to Substitute a Non-statutory Adoption Section that Conflicts with VAPA on Process and Effective Dates Proposed 16VAC25-220-20(A) fails on numerous fronts and it is novel to include an adoption process as a part of a rule since rulemaking is governed by a standard process. First, under proposed 16VAC25-220-20(A)(3) and (4) DOLI staff proposes to have the standard take effect upon filing with the Registrar of Regulations and publication in a newspaper of general circulation published in the City of Richmond, Virginia. Under Va. Code §2.2-4013(D) and §2.2-4015(A) the effective date can be no earlier than 30-days after publication of the final regulation in the Register. Moreover, the DOLI staff adoption proposal pays homage to the Governor but not to the potential review of the legislative branch under Va. Code §2.2-4014 which would be thwarted by the DOLI staff proposal on adoption. To the extent, DOLI staff is pursuing a hybrid approach there is a fundamental question as to which businesses are aware of the ETS let alone the permanent standard. It would not provide for fundamental procedural due process unless businesses are aware of this novel approach. What efforts will be made to inform businesses before the effective date. Even if the Board provides some hybrid approach it must satisfy proper public notice that would satisfy due process.

V. DOLI Staff Refusal to Consider and Relay Responses Because Commenters Are Challenging the ETS In Court Is Inappropriate DOLI staff has failed to include response to my comments from the earlier comment period and the earlier comments of the Virginia Manufacturers Association and the Board has failed also. I took a great deal of effort to provide those comments and assume VMA did as well. It does not matter that VMA is a plaintiff in a

lawsuit regarding the ETS or than I am an attorney in that case. VMA's right and my right to have its comments fully considered by the Board is not affected by that litigation. Nor does the fact that some of the same comments are relevant to the legal proceeding make those comments out of bounds for consideration by the Board. Quite the opposite. The litigation and the public process concerning the proposed rule are public proceedings. And the Board should consider all arguments, including legal arguments, as part of its consideration. This is particularly important given that DOLI staff is attempting so many novel mechanisms for a rulemaking that belongs to the Board. The DOLI staff approach to discarding portions of my comments and VMA comments appear to be an illegal and inappropriate filter. In as much as DOLI staff has taken the role of preparing a response to comments document, that document should include responses to the full reach of my comments and the VMA comments. Importantly, the Board should be made aware of these comments. At this juncture, we are unclear whether the Board will consider our comments in their entirety. There was no discussion of my prior significant comments in the meeting of the Board which had at least some discussion of prior public comments.

VI. The Board Should Ensure That No One Can Apply Sanctions Under the Illegal Incorporation of the Orders of the Governor and Health Commissioner Under the ETS DOLI staff has proposed to remove the illegal incorporation of Executive Orders and Orders of Public Health Emergency into the proposed permanent COVID rules. Those Orders themselves are illegal – failing to comply with procedures required by law, in excess of a permissible grant of rulemaking authority, and impermissibly infringing on fundamental rights. The incorporation was doubly illegal as it was an unlawful delegation of the Boards authority to create rules that DOLI can enforce through the DOLI enforcement authorities. Since DOLI may enforce the ETS for up to sixth months later based on the statute of limitations, the Board should provide a specific provision prohibiting any DOLI enforcement of those portions of the ETS.

VII. The Board, the Governor and the Health Commissioner Must Eliminate the Confusing Conflicts and Overlaps Between the Safer at Home Document and the Proposed Rule Executive Order 72 and Order of Public Health Emergency 9, (collectively "EO72" or the "Orders") tries to accomplish the same illegal objectives as the cross-references to the Orders in the ETS. This approach illustrates the same lack of concern for the confusion caused by this matrix of rules to the regulated community. Specifically, under new enforcement sections or EO72, the Governor and the Health Commissioner claim that DOLI can enforce the Orders when DOLI is supposed to enforce the regulations of the Board. In addition, EO72 has a new rule of construction which states:

Construction with the Emergency Temporary Standard "Infectious Disease Prevention: SARSCoV-2 Virus That Causes COVID-19" Where the Emergency Temporary Standard "Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19" adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern.

The terms guidelines applicable to businesses refer to the document incorporated by reference in the Orders is styled Safer at Home: Phase Three Guidelines for All Business Sectors ("Safer at Home" document). The Safer at Home document has mandatory sections and sections that ultimately appear mandatory in additional circumstances due to certain statements in EO72 and by cross-reference from the mandatory sections. The combined sections of EO72, the Safer at Home document, and the ETS form a complex matrix of overlapping and confusing rules. First, the ETS and a permanent rule should have more legal standing than the Orders. The purported basis for the Health Commissioner under the Orders is Va. Code §§ 32.1-13 and 32.1-20. Va. Code §32.1-13 states:

The Board may make separate orders and regulations to meet any emergency, not provided for by general regulations, for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious and infectious diseases and other dangers to the public life and health. (Emphasis added). The ETS and a permanent COVID rule would be general regulations. If the ETS or permanent rule and an Order of Public Health Emergency cover the same subject matter the ETS, or permanent COVID rule, then there should be no Orders on the same subject under Va. Code § 32.1-13. Separately, E072 and Order of Public Health Emergency 9 claims the source of authority for DOLI enforcement over the Orders is §40.1-51.1—the general duty clause. Specific regulations of the Board supersede the general duty clause. If an employer is following regulations on a topic, the general duty clause cannot add more and anything in conflict. Moreover, §40.1-51.1(C) sets out the universe of enforcement as Title 40 or standards, rules, and regulations promulgated thereunder. This is not a source of enforcement authority for Orders of Public Health Emergency or Executive Orders.

DOLI has a role administering and enforcing occupational safety and occupational health activities as required by the Federal Occupational Safety and Health Act of 1970 and rules under Virginia Code Title 40. The provisions of Title 32 and Title 44 have separate enforcement structures and do not include DOLI. Regardless, this structure of overlap and confusion poses substantial questions as to the point and status of the permanent rule. The Safer at Home document covers numerous areas that overlap with the permanent rule including with respect to employee monitoring, requirements that employees with symptoms of COVID must not stay at the work site, with respect to return to work protocols. While the Safer at Home document and the permanent rule overlap on this subject matter, they use different language. According to E072, the Safer at Home document would apply, and the permanent rule would not, although that is based on whether one is in conflict. This overlap creates substantial confusion in an area that is separately substantially confusing in both documents. The Board should not force conflicting rules which are needlessly confusing, basically redundant and, therefore, not necessary or appropriate. Accordingly, it is the obligation of the Governor, the Commissioner of Health and the Board not to create conflicting, confusing rules. Under the Safer at Home document, many businesses and business types must, as mandatory requirements, strictly adhere to the physical distancing guidelines, enhanced cleaning and disinfection practices, and enhanced workplace safety practices of the Safer at Home document. In addition to businesses, the following sentence in the Safer at Home document is ambiguous with respect to other businesses, but one interpretation is that the sentence creates mandatory and enforceable requirements:

Any business not listed in Section II, subsections A or C below must adhere to the Guidelines for All Business Sectors expressly incorporated by reference here in as best practices. Accordingly, there is a substantial scope of employers both subject to the Safer at Home document and the ETS and, potentially, the proposed rule.

While there are conflicts on multiple issues, the following focuses on the enhanced workplace safety practices in the Safer at Home Document. The Safer at Home document requires employers to instruct employees to stay home who are “sick”. One could either assume this means sick with COVID or it could mean sick with a cold or allergy or other condition. The COVID-19 screening protocols for employee self-checks suggest a structure with a check list if the symptom “cannot be attributed to another health condition”. This is a different standard than the “alternate diagnosis” language of the ETS and proposed rule at 16VAC25-220-40(B)(4). The language “sick” is different than “suspected COVID.” Those provisions of the Orders may be more rationale as potential rules, at some level, than the language of the proposed rule. The Orders may allow some flexibility to employees to consider whether a symptom is more likely a cold or flu or allergy. The bottom line is the risk of being infected with COVID involves numerous factors and symptoms like a cough or sneeze or runny nose or headache are not very dispositive. There are more conflicts. 16VAC25-220-40(B)(6) states:

“To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies”. The Safer at Home Document is more specific: Develop or adopt flexible sick leave policies to ensure that sick employees do not report to work. Policies should allow employees to stay home if they are sick with COVID-19, if they have a positive diagnostic test for the virus that causes COVID-19, if they need to self-quarantine due to exposure, and if they need to care for a sick family member. The provisions are similar but not the same. The proposed rule at 16VAC25-220-40(B)(2) states:

Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs and/or symptoms of an oncoming illness.

The Safer at Home document has an affirmative obligation to:

[i]mplement practices such as those described in the VDH Interim Guidance for COVID-18 Daily Screening of Employees for examples of screening questionnaire.

One standard in the proposed rule is informational. The standard in the Safer at Home document appears to be more than that. Possibly, compliance with either the Orders or the ETS/proposed rule should be considered full compliance in order to provide flexibility. The Orders seek to apply one or the other or both through some complex “conflict” standard between two separate documents. Moreover, neither DOLI nor the Board appear to interpret the Safer at Home document. The Virginia Department of Health (VDH) appears to assume this task, although, everything about the matrix of rules that Governor, the Health Commissioner, DOLI staff, and the Board have spun out is filled with ambiguities. What we do know is

VDH is not the Board. The matrix is even more complex as each portion of the matrix of rules cross references numerous guidance documents either implying or requiring that those guidance documents are rules. Those documents were not written to be rules. VIII. The Board Should Not Support DOLI Enforcement or Any Enforcement on Portions of the Executive Orders, Orders of Public Health Emergency, or the Safer at Home Document that Force or Enlist Employers to Impermissibly Infringe on Fundamental Rights of Assembly and Association

The Board’s prior support for incorporation of the Orders in the ETS was a problem. The authority of DOLI under §40.1-49.4 is to enforce Title 40, not the Orders. EO72 suggests there is a bridge through the general duty clause. The Board has the authority for regulations in the area. Between DOLI, the Board, the Health Commissioner and the Governor, businesses should not be enlisted to infringing on fundamental rights. The provisions are similar but not the same.

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Continued fundamental rights. VA. Const., Art. I, § 12 states: "the General Assembly shall not pass any law abridging the freedom of speech or of the press, nor the right of the people peaceably to assemble" By definition, a numerical limitation by the state on the size of assemblies is an infringement on the right to peaceably assemble. A statewide limitation on the size of assemblies in Virginia is unprecedented. Moreover, the infringement on the right of assembly has uneven application under the rules of the orders. For months, there was a 10-person, and then a 50-person, restriction on assembly, including for weddings, celebrations, sporting events, family reunions, and Easter church services. Now the restriction has a higher limit (but includes a restriction on occupancy in certain settings that are lower limits). However, these same restrictions did not and do not now apply to a large meeting of lawyers at a law firm. Countless individuals performing functions together through their employment is not a “gathering” under the Order. Crowds are allowed at a Walmart, Lowes, or other large “essential” stores without those restrictions.

The numerical limits of 10 persons currently under EO72 and the Safer at Home Document apply in some situations related to employers in certain circumstances. The limits on assembly apply in certain circumstances, but not in others, without apparent reasons being given to attempt to justify the distinctions. EO72, Order of Public Health Emergency 9, and the Safer at Home document have many inconsistent exceptions on distancing. Where EO72 has a “family” exception for distancing, the “mandatory requirements” provisions employ the term “members of the same household” and the term “at all times” in various sections. Curiously, the definition of “Family members” in EO72 would not even include a married couple who are not currently “residing in the same household.” For Farmers markets, “non-essential” brick and mortar retail establishments, indoor and outdoor swimming pools, and horse and other livestock shows, the Guidelines use the narrower terms “household,” whereas EO72 uses the term “family.” For purposes of the right of assembly in innumerable situations, and especially given that such rules apply to all Virginians, distinctions like this have major implications, particularly when violating them carries a criminal penalty. This regulatory inconsistency also deprives every Virginian of due

process because it makes it impossible for anyone to know with whom they may gather and when without risking committing a criminal offense. Notably, the Safer at Home document for performing arts venues, concert venues, movie theaters, drive in entertainment, sports venues, botanical gardens, zoos, fairs, carnivals, amusement parks, museums, aquariums, historic horse racing facilities, bowling alleys, skating rinks, arcades, amusement parks, trampoline parks, fairs, carnivals, arts and craft facilities, escape rooms, trampoline parks, public and private social clubs, and all other entertainment centers and places of public amusement all use the term “members of the same household” as an exception. However, that term is not used in EO72 itself. For Horse Racing Racetracks, the Mandatory Guidelines say all must observe distancing, but exceptions-- whether household or family-- are not included.

A government scheme that prohibits every instance of physical proximity among individuals within six feet of one another, based on nothing more than the government’s arbitrary and unilateral classification of their relationship statuses, is an infringement of fundamental rights under the Virginia Constitution. The right of association is both an integral part of the right of assembly and a separate fundamental right. Ordinary conversations at a distance much closer than 6 or 10 feet is also important to the right of free speech. It is the kind of speech that can, and in many instances, must occur among two people or a few people to maintain their right to privacy without others intruding or overhearing. At issue is nothing less than the right of a free people to determine, apart from government rules or coercion, with whom they can sit or whom they can stand next to, perhaps to have a private conversation or maybe simply to hold hands – or frankly any other manner of close personal activity. Virginians have a fundamental right in who they choose to dance with, who to hold close, who to have a normal conversation with, and, generally, who to be next to as long as the other person wants the same.

All Virginians “have certain inherent rights, of which, when they enter into a state of society, they cannot, by any compact, deprive or divest their posterity; namely, the enjoyment of life and liberty, with the means of acquiring and possessing property, and pursuing and obtaining happiness and safety.” Va. Const., Art. I, § 1. The Constitution of Virginia notes the desire to have a government that is most effectually secured against the dangers of maladministration. Va. Const., Art. I, § 3. Virginians have a fundamental freedom of speech and assembly. Va. Const., Art. I, § 12. We know that “No free government, nor the blessings of liberty, can be preserved to any people, but ...by frequent recurrence to fundamental principles.” Va. Const., Art. I, § 15. A government definition of who can be close to other people and who cannot, imposed broadly, indefinitely, arbitrarily, and unilaterally upon all Virginians is a profound and impermissible assault on their fundamental rights. EO72 provides several definitions of who may associate without distancing, which apply in certain settings but not in others. Several elements of EO72 require maintaining a 6-foot or 10-foot distance in certain settings for certain groups but not others based on a definition in the order of either family or household. The Virginia Supreme Court has stated that provisions of the Constitution of Virginia that are substantively similar to those in the United States Constitution will be afforded the same meaning. See, e.g., *Shivae*, 270 Va. at 119, 613 S.E.2d at 574 (“due process protections afforded under the Constitution of Virginia are co-extensive with those of the federal constitution.”); *Habel v. Industrial Development Authority*, 241 Va. 96, 100, 400 S.E.2d 516, 518 (1991) (federal construction of the Establishment Clause in the First Amendment “helpful and persuasive” in construing the analogous state constitutional provision). While the First Amendment does not, by its terms, protect a “right of association,” the United States Supreme Court has recognized such a right in certain circumstances. *Dallas v. Stanglin*, 490 U.S. 19, 23-24 (1989). In *Roberts v. United States Jaycees*, 468 U.S. 609 (1984), the Court defined the right at issue to include choices to enter into and maintain certain intimate human relationships and the separate but related right to “expressive association.” By penalizing employers for not

following impermissible infringements on Constitutional rights by the Governor, the Health Commissioner, and the Board itself in the ETS, forces employers to participate in an illegal scheme. There should be no government definition of who must distance versus not distance based on relationships which neither the government nor businesses can reasonably assess. In various settings the Board would have employers ask customers about their family or household relationships to enforce the distancing requirements. This is not a workable scheme. There is no evidence after many months that this scheme has yielded any benefit other than to threaten all with criminal sanctions. The Board would penalize a wedding venue because a boyfriend and girlfriend not residing in the same house sat together at a religious service or walked at a farmer's market together. These requirements have never been feasible. The requirements if enforced by a local police department would place those police officers at threat for damages under a section 1983 civil rights suit. There is nothing reasonable or workable about these provisions. The Board should not allow that any such requirements are requirements for employers as the Board, the Governor and the Commissioner of Health review these provisions in the context of this process.

IX. The Proposed Rules Many Footnote References to Websites Is Yet Another Example That the Proposal Is Not an Understandable or Enforceable Regulation Why does the proposed rule have 20 footnotes that link to websites? What is the legal import of the footnotes and websites? When the owners of the websites change the language on the website is that intended change the legal import of the proposed rule? In the footnote referring to the frequently asked questions regarding the ETS, is that intended to have legal effect? Who is providing the content of the frequently asked questions, if it is intended to have legal impact? What is the purpose of the websites? Can there be subsequent changes to the frequently asked question document intended to have legal effect. Are they necessary to understand the text of the rule? How will the Virginia Registrar incorporate the websites in the Virginia Administrative Code? X. If the Permanent Standard Is Adopted, It Should Sunset When the PHE is Over or Earlier Where Provisions Are Not Necessary to Prevent a Grave Danger The onerous requirements of the permanent standards are not likely useful and do not address a grave danger when the Governor either removes the Declaration of a State of Emergency or when COVID-19 transmission rates among employers or categories of employers are found to be low. Accordingly, there should be a sunset clause. The proposed rule would delay the end of the rule and requirements and, effectively require another rulemaking process to end the rule. There is no justification for such an approach. Indeed, if anything the rule should expire in 6 months or earlier unless the Board republishes the rule.

XI. The Board and DOLI Staff Should Provide an Analysis of What Has Happened Related to Operation of the ETS and Employers in Virginia Over the Past Months The unfortunate ETS has been effective since July 27, 2020. It is incumbent on the Board and DOLI to provide information on its operation. This should include a survey of what employers know about the standards, what reporting as occurred, how many employees have been sent home, and some assessment of how the operation of the rules have impacted the transmission of COVID based on actual evidence supporting such assessment. In conversations with multiple employers, there seems to be almost no understanding that the rules exist much less compliance. This is a point that strongly weighs against the hasty promulgation of a rule that threatens businesses but for which the Board and DOLI have done little to explain. There is no evidence to support a claim that businesses are aware of the ETS much less in compliance.

XII. The Illegal Mandates of Governor Northam In EO 63 Regarding an Emergency Temporary Standard or Rule Undermine the Validity of the Proposed Permanent COVID rule On May 26, 2020, Governor Ralph Northam issued a revised Executive Order 63 that provides in part: "E. Department of Labor and Industry Except for paragraph B above, this Order does not apply to employees, employers, subcontractors, or other independent contractors in the workplace. The Commissioner of the Virginia Department of Labor and Industry shall

promulgate emergency regulations and standards to control, prevent, and mitigate the spread of COVID-19 in the workplace. The regulations and standards adopted in accordance with §§ 40.1-2(6a) or 2.2-4011 of the Code of Virginia shall apply to every employer, employee, and place of employment within the jurisdiction of the Virginia Occupational Safety and Health program as described in 16 Va. Admin. Code § 25-60-20 and Va. Admin. Code § 25-60-30. These regulations and standards must address personal protective equipment, respiratory protective equipment, and sanitation, access to employee exposure and medical records and hazard communication. Further, these regulations and standards may not conflict with requirements and guidelines applicable to businesses set out and incorporated into Amended Executive Order 61 and Amended Order of Public Health Emergency Three.”(Emphasis added). The Governor’s directives in EO63 as mandates to the Department of Labor and Industry are illegal, in excess of authority and inconsistent with law. The directive fails all tests related to Separation of Powers and violates the independence of the Board itself. The Board is a separate statutory creation of the General Assembly with separate duties and powers from those of the Governor.

The Governor’s mandate that “The Commissioner of the Virginia Department of Labor and Industry shall promulgate emergency regulations and standards to control, prevent, and mitigate the spread of COVID-19 in the workplace” was issued in excess of the Governor’s authority and is, therefore, void. Workplace standards and whether they are emergency standards are set forth in the basic laws and policies of this Commonwealth or implemented by the Board following regular and reasonable procedures. Workplace standards in this Commonwealth have never been based on unilateral directives from the Governor and no such authority is available to the Governor. The Governor’s mandate that “The regulations and standards adopted in accordance with §§40.1-22(6a) or 2.2-4011 of the Code of Virginia shall apply to every employer, employee, and place of employment within the jurisdiction of the Virginia Occupational Safety and Health program” is both in excess of the Governor’s authority and unlawfully constrains the lawful discretion of the Virginia Safety and Health Codes Board. The scope of any regulations under the basic laws must be decided by the Board through a process based on statutory policies and standards, rather than by directive from the Governor.

The directive in EO63 that “[t]hese regulations and standards must address personal XIII. The ETS And Now the Proposed Rule Fail to Meet the Requirements of Law Which Cannot Support the Scope and Unworkable Provisions of the Rule.

The Safety and Health Codes Board (the Board) is authorized by Va. Code §40.1-22(5) to: “adopt, alter, amend, or repeal rules and regulations to further, protect and promote the safety and health of employees in places of employment over which it has jurisdiction and to effect compliance with the federal OSH Act of 1970...as may be necessary to carry out its functions established under this title.” (emphasis added). Va. Code §40.1-22(5) provides that rules must be to the extent "feasible" and be supported by the "best available evidence" To restate this point, any standard must be necessary and supported by best available evidence. It is not evidence that COVID-19 is dangerous. It is evidence that the standard is necessary. The Board shall evaluate the "feasibility of the standards" and experience gained under this and other health and safety laws. The Governor's mandates poisoned the process and the Government's mandates are not substantial evidence or proof of necessity or anything else relevant to the decision of the Board. This is so, even the Governor appoints most members of the Board. The Board has legal obligations and acquiescing to illegal mandates is not consistent with those legal obligations. The text of the final ETS does not itself contain findings that the all the major components of the final ETS are necessary to meet a “grave danger.” The issue is not whether any ETS is necessary to meet the “grave danger” standard but whether all of the substantial elements of this ETS as applied across the scope of every employer in Virginia is necessary under the procedures of Va. Code §40.1-22(6a).

There are a wide range of problems but, as an example, the data has not shown a direct and immediate grave danger for those workers whose tasks fall into the “Low” and “Medium” categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. These activities are the same risks that virtually everyone is facing while Virginia moved to Phase III. If these were a grave danger it must be different and bigger than the ordinary danger from people’s general activities.

XIV. The Board Has Not Shown That the Sweep, Components or Approach of the Standards Are Necessary Considering that the Federal Occupational Health and Safety Administration Has Guidelines and Certain Rules and Recommended Against the Basic Action the Board Has Taken XIII. The ETS And Now the Proposed Rule Fail to Meet the Requirements of Law Which Cannot Support the Scope and Unworkable Provisions of the Rule The Safety and Health Codes Board (the Board) is authorized by Va. Code §40.1-22(5) to: “adopt, alter, amend, or repeal rules and regulations to further, protect and promote the safety and health of employees in places of employment over which it has jurisdiction and to effect compliance with the federal OSH Act of 1970...as may be necessary to carry out its functions established under this title.” (emphasis added). Va. Code §40.1-22(5) provides that rules must be to the extent “feasible” and be supported by the “best available evidence”. To restate this point, any standard must be necessary and supported by best available evidence. It is not evidence that COVID-19 is dangerous. It is evidence that the standard is necessary. The Board shall evaluate the “feasibility of the standards” and experience gained under this and other health and safety laws. The Governor's mandates poisoned the process and the Government's mandates are not substantial evidence or proof of necessity or anything else relevant to the decision of the Board. This is so, even the Governor appoints most members of the Board.

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Commonwealth to his whims. Nor can the independent agencies abdicate the responsibility that the legislature has given them to regulate in a manner that meets certain legislative policies and procedures out of a desire not to adopt regulations which conflict with the Governor's aims.

It appears that neither DOLI Staff nor the Board ever questioned the authority of the Governor's EO63 mandates. DOLI's website states "In accordance with Executive Order 63, the Department presented to the Safety and Health Codes Board an emergency temporary standard/emergency regulation to address COVID-19, applicable to all employers and employees covered by Virginia Occupational Safety and Health (VOSH) program jurisdiction." In document styled Draft Safety and Health Codes Board Public Hearing and Meeting Minutes, June 24, 2020, the second sentence describes the Governor's directive in EO63. The draft agenda for the July 24, 2020 describes the directives in EO63 under Summary of Rulemaking Process. The lawful exercise of authority or discretion by executive agencies with a separate legal existence or to subvert all otherwise-lawful regulation in the Commonwealth to his whims. Nor can the independent agencies abdicate the responsibility that the legislature has given them to regulate in a manner that meets certain legislative policies and procedures out of a desire not to adopt regulations which conflict with the Governor's aims.

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substantial evidence or proof of necessity or anything else relevant to the decision of the Board. This is so, even the Governor appoints most members of the Board.

The Board has legal obligations and acquiescing to illegal mandates is not consistent with those legal obligations. The text of the final ETS does not itself contain findings that the all the major components of the final ETS are necessary to meet a "grave danger." The issue is not whether any ETS is necessary to meet the "grave danger" standard but whether all of the substantial elements of this ETS as applied across the scope of every employer in Virginia is necessary under the procedures of Va. Code §40.1-22(6a). There are a wide range of problems but, as an example, the data has not shown a direct and immediate grave danger for those workers whose tasks fall into the "Low" and "Medium" categories as defined in 16VAC25-220-30, These categories should be removed from the Permanent Standard for those industries regulated by OSHA. These activities are the same risks that virtually everyone is facing while Virginia moved to Phase III. If these were a grave danger it must be different and bigger than the ordinary danger from people's general activities. XIV. The Board Has Not Shown That the Sweep, Components or Approach of the Standards Are Necessary Considering that the Federal Occupational Health and Safety Administration Has Guidelines and Certain Rules and Recommended Against the Basic Action the Board Has Taken The Federal occupational Safety and Health Administration ("OSHA") took the position that it will not be promulgating an emergency standard pursuant to its authority under the OSH Act of 1970, instead opting to rely upon many voluntary guidelines for various business sectors. There is no evidence the Board meaningfully considered OSHA's regulatory framework, even though the Virginia Code provides that OSHA standards are presumptively lawful when adopted by the Board under its powers.

The Safety and Health Codes Board has failed to meet the standard of finding that the full scope of the ETS are "necessary" to address a "grave danger". There are many reasons the ETS fails on this front. First, it is important to consider the scope of the rule. The rule covers virtually every private and public employer in Virginia. Second, the rule is unworkable. Under the ETS, a single cough means an employee cannot work for 10 days. The ETS requires unrealistic reporting and planning burdens for every employer regardless of whether that employment situation is substantially above the background risk facing Virginians in multiple settings. That is not a burden that is proportional or reasonable for the risk. By their own statements and structure of the rule, the Board has stated 4 levels of risk from low to very high. Yet the rule poses substantial requirements on all levels. Additionally, the Board cannot justify how it can simultaneously designate parties to be a "low" risk while still regulating those same parties on the basis that they face "grave danger." The Board has provided no comparative assessment or statement to support its finding of "grave danger." More importantly the Board has not shown that the burdens in the ETS and now the proposed rule are necessary to address a grave danger. The US Department of Labor and US Court of Appeals for the District of Columbia Circuit have already provided direction on this issue. On April 28, 2020, AFL-CIO President, Richard Trumka, petitioned US Secretary of Labor Eugene Scalia to adopt a Department of Occupational Safety and Health Administration (OSHA) emergency temporary standard for COVID-19. On April 30, 2020, US Secretary of Labor Eugene Scalia rejected the AFL-CIO petition from April 28, 2020, and stated: "Coronavirus is a hazard in the workplace. But it is not unique to the workplace or (except for certain industries, like health care) caused by work tasks themselves. This by no means lessens the need for employers to address the virus. But it means that the virus cannot be viewed in the same way as other workplace hazards."

The letter also states "your letter disparages OSHA's guidelines as 'only voluntary', suggesting that there are no compliance obligations on employers. That is false... Indeed, the contents of the rule detailed in your letter add nothing to what is already known and recognized (and in many instances required by the general duty clause itself). Compared to that proposed rule, OSHA's industry specific guidance is far more informative for workers

and companies about the steps to be taken in their particular workplaces" That is one of the reasons OSHA has considered tailored guidance to be more valuable than the rule you describe." On June 11, 2020, the US Court of Appeals for the District of Columbia Circuit denied the AFL-CIO's May 18 petition. The Board has not shown evidence that the myriad requirements it imposed are "necessary" with substantial evidence to address a "grave danger" and "feasible." First, for the requirements to be "necessary" and "feasible" they would need to be operationally workable and "necessary" in the sense that the timing concerns warranted the extraordinary step of not following the ordinary requirements of VAPA. VAPA would require economic impact analyses, regulatory flexibility analyses and a more meaningful comment period than provided by the Board. The general duty requirements of Va. Code § 40.1-51.1 (a) of the Code of Virginia apply to all employers covered by the Virginia State Plan for Occupational Safety and Health. Under this provision "...it shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.." Accordingly, the baseline for understanding what is "necessary" to address a "grave danger" should be viewed against the baseline that employers already have legal obligations relating to COVID-19. There is no evidence that the Board has taken steps to make all Virginia employers aware of the rule and set-up appropriate steps for such a massive program.

XV. The Proposed "Suspected" COVID Provisions Remain Unworkable, Vague and Not Supported by Evidence. The operation of the latest proposed rule "suspected" COVID provisions are unworkable. The term "suspected to be infected with SARS-CoV-2 virus" means "a person that has signs or symptoms of COVID-19 but has not tested positive for SARS-CoV-2 and no alternative diagnosis has been made." See §16VAC25-220-30. The proposed rule defines "signs of COVID-19" are "abnormalities that can be objectively observed, and may include fever, trouble breathing or shortness of breath, cough, vomiting, new confusion, bluish lips or e face, etc." The proposed rule defines "symptoms of COVID-19 " as abnormalities that are subjective to the person and not observable to others, and may include chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, congestion, runny nose, diarrhea, etc." "Symptomatic" means a "person is experiencing signs and/or symptoms attributed to COVID. The proposed rule states "[a] person may become symptomatic 2 to 14 days after exposure to the SARS-Cov-2." This combined structure has three fundamental problems. The first problem is those same symptoms may be unrelated to COVID. The proposed rule does nothing to address this problem and neither the Board nor DOLI staff analysis has done anything to address the problem that is both obvious and was directly pointed to by me and others in prior comments. The proposed rule states that employers shall not permit employees or other persons suspected to be infected with SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work. The universe of employees with suspected COVID-19 that pose the stated risk includes, among a broader universe, anyone who has a cough or headache or sore throat or congestion or runny nose, or fatigue, as just some examples. Neither the Board nor DOLI staff has made any effort to work on the problems posed by cold, flus, allergies, and all manner of other issues that are not COVID. Indeed, I would posit the universe of "suspected COVID" but is really not COVID vastly exceeds the universe that is COVID.2 DOLI staff and the Board in the ETS force an unworkable and damaging.

According to CDC: Both COVID-19 and flu can have varying degrees of signs and symptoms, ranging from no symptoms (asymptomatic) to severe symptoms. Common symptoms that COVID-19 and flu share include:

Fever or feeling feverish/chills

Cough

☒ Shortness of breath or difficulty breathing

☒ Fatigue (tiredness)

☒ Sore throat

☒ Runny or stuffy nose

☒ Muscle pain or body aches

☒ Headache

☒ Some people may have vomiting and diarrhea, though this is more common in children than adults. According to CDC cold symptoms can include sneezing, stuffy nose, runny nose, sore throat, coughing. Less frequently there is fever. According to CDC overlapping symptoms from allergies include cough, shortness of breath and difficulty breathing, fatigue, headache, sore through, congestion or runny nose.

<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/infographic-overlapsymptoms.html>.
scheme on employees who cannot afford absences for common colds, flus and allergies. It may be that Some settings might deserve such caution that even a cough, headache, sore throat, congestion, or runny nose should warrant removal from the worksite. That might be the right approach at a nursing home for employees in contact with nursing home patients. That same level of caution across the board will substantially and negatively impact businesses and are not necessary or useful. The second problem is that the proposed rule, and the ETS before it, is filled with words of vague and indefinite meaning. Such an approach does not satisfy the requirements for standards of law. Who decides the alternative diagnosis?" Is that the employee, the employer, a doctor, a relative? If it is a medical professional what kind of delay and economic burden does this pose? What is the standard for an alternative diagnosis? Does the alternative diagnosis have to rule out COVID? Or can someone have COVID and an alternative diagnosis. Someone can have COVID with no symptoms at all. What must the employer or DOLI learn about the "alternative diagnosis"? Who defines abnormalities? If symptoms are "subjective" can an employer rely on the subjective views of the employee? Can other information besides the symptoms come to play. What if a person believes something is a cold because his or her spouse had a cold? What if the person previously had COVID? It is unrealistic to expect employers and contractors, including small and medium sized employers to evaluate alternative diagnosis or expect timely assessments by medical personnel in the time frames for the kinds of low-level symptoms described. There is no evidence that this is feasible or that this approach is necessary or even useful. If anything, the proposed rule and ETS creates a situation in which employees will be skittish to cooperate at all.

Pursuant to the ETS, employers are required to prohibit employees or other persons known or suspected to be infected with the SARS-CoV-2 virus to report to or remain at the work site or engage in work at a customer or client location until cleared for return to work. See proposed §16VAC25-220-40 (A)(5) and proposed §16VAC25-220-40 (C) Similar language covers subcontractors. See proposed §16VAC25-220-40 A(7) .No employee or subcontractor can return to the worksite until at least 72 hours since the signs of any symptom have passed and ten days have elapsed, whichever period is longer. (Note §16VAC25-220-40(B) seems to be missing?). The return-to-work test-based strategy can be problematic because of the lack of testing availability but should not have been removed from the proposal. The regulation also requires compliance with symptom-based strategy if a known asymptomatic employee refuses to be tested. The Rule is asking both employers and employees to affect their business and livelihood, based symptoms that cannot be evaluated as being beyond ordinary and common circumstances. This is neither workable, feasible, nor supported by an evidence of operation.

The return to work provisions assume there is a passing illness, but coughs and shortness of breath may be present for reasons unrelated to COVID. Ten days is a long time if the person does not have COVID. The addition of 16VAC25-220-40(C)(2)(iii), is an example of relevant guidance for people but it is unclear what the obligations are for an employer. Similarly, what are employers supposed to do with 16VAC25-220-70(C)(3)(a)(ii) (suspected), (iii) different jobs, (iv) higher risk activities, (b) individual risk factors?

XVI. The Board has not Evaluated the Likely Substantial Negative Impact of the Proposed Rule “Suspected” COVID and Return to Work Restrictions Where the Symptoms Are Not Really COVID It is possible to model the impact of the problem of an aggressive “suspected” COVID section with a difficult return to work policy. CDC has information on other medical issues that share COVID symptoms. A 2018 CDC study looked at the percentage of the U.S. population who were sickened by flu using two different methods and compared the findings. Both methods had similar findings, which suggested that on average, about 8% of the U.S. population gets sick from flu each season, with a range of between 3% and 11%, depending on the season. The 3% to 11% range is an estimate of the proportion of people who have symptomatic flu illness.

<https://www.cdc.gov/flu/about/keyfacts.htm>

Common colds are the main reason that children miss school and adults miss work. Each year in the United States, there are millions of cases of the common cold. Adults have an average of 2-3 colds per year, and children have even more. Sore throat and runny nose are usually the first signs of a cold, followed by coughing and sneezing. <https://www.cdc.gov/features/rhinoviruses/index.html>

According to CDC 7.7% of adults have been diagnosed with allergies annually.

<https://www.cdc.gov/nchs/fastats/allergies.htm>

In 2015, 20.0% of women and 9.7% of men aged ≥ 18 years had a severe headache or migraine in the past 3 months. Overall and for each age group, women aged ≥ 18 years were more likely than men to have had a severe headache or migraine in the past 3 months. For both sexes, a report of a severe headache or migraine in the past 3 months decreased with advancing age, from 11.0% among men aged 18–44 years to 3.4% among men aged ≥ 75 years and from 24.7% among women aged 18–44 years to 6.3% among women aged ≥ 75 years.

Source: National Health Interview Survey, 2015. <https://www.cdc.gov/nchs/nhis/index.htm>.

These statistics would suggest 4x these numbers for the yearly presence of headaches. Each year, on average in the United States, norovirus causes:

☐ 900 deaths, mostly among adults aged 65 and older

☐ 109,000 hospitalizations

☐ 465,000 emergency department visits, mostly in young children

☐ 2,270,000 outpatient clinic visits annually, mostly in young children

☐ 19 to 21 million cases of vomiting and diarrhea illnesses

<https://www.cdc.gov/norovirus/trends-outbreaks/burden-US.html>

There are many more conditions that have symptoms that overlap with suspected COVID conditions. However, it is possible to model out the lost days from this proposal with a series of assumptions. Certainly, one could provide a range. The modelling could include the cost of getting a professional “alternative diagnosis.” The 10-days without symptoms can be modelled as pure days lost.

XVII. The Problems with the Suspected COVID Provisions Flow to Other Provisions. The exposure risk level structure in proposed 16VAC25-220-10 (D)(1) uses the word “suspected” and “suspected to be infected.” Since everyone has colds, flus etc, this is a useless and confusing structure. The same problem applies in the definition of airborne infection isolation room. The definition of very high exposure risk, high exposure risk, medium exposure risk, and lower exposure risk all require evaluation using the term “suspected” COVID, which, as discussed above is an unreasonably ambiguous and difficult to define term. Similarly, the term “may be infected” excludes a person who may be suspected with COVID, and this cannot be ascertained by employers. The areas in the place of employment requirement cleaning requirement under Sanitation and disinfecting also relies on the construct of “suspected” COVID. There are many other examples of this problem. XVIII. The Proposed Regulations Require Employers to Classify each Employee for Risk Level of Exposure and this Review Process Conflicts with Current OSHA Guidance. The proposed regulations conflicts with OSHA Guidance on Preparing Workplace for COVID-19, OSHA 3990-03 2020, since it confuses job tasks with employee job classifications. Guidance requires assessing employees by hazards and tasks. Risk assessments should be done by tasks not job titles. This would be a massive burden for employers. Further, OSHA Guidance is predicated on the use of a risk management process to determine appropriate control measures. The Regulations deviate to mandate specific control measures in workplace situations, regardless of potential exposures or other mitigating circumstances arising from the required risk assessment process.

XIX. Prohibiting Consideration of Serologic Tests Is Anti-Science and Illegal

Pursuant §16VAC25-220-40(A)(3), employers are prohibited from even considering serologic test results in deciding when an employee can return to work. A prohibition on using relevant medical information for decisions is an unprecedented political restriction of medical assessments. Not only has the Board seen fit to prohibit serologic testing from being conclusive or determinative of any issue, but the Board has outright prohibited employers from considering scientific evidence in their decision making. Such an across-the-board prohibition is per se unreasonable and unnecessary. The proposed rule frequently refers to the standards applicable to the industry which is language that may be appropriate for guidance but is too vague to be meaningful. This is compounded by numerous vague and unworkable definitions. For example, the physical distancing requirement in the ETS is unworkable and ambiguous. Distancing is not available for restaurant wait staff, personal services, physical instructors. The application of this rule is overly broad, unclear and not justified.

XX. The Americans with Disabilities Act Poses More Restrictions than Suggested in the Proposed D26d Rule and The Burden of Compliance Makes Several Provisions of the Proposal Not Reasonable for Small Businesses Under the Americans with Disability Act (ADA), an inquiry asking an employee to disclose a compromised immune system or a chronic health condition is disability-related because the response is likely to disclose the existence of a disability. The ADA does not permit such an inquiry in the absence of objective evidence that pandemic symptoms will cause a direct threat. As another example, an ADA covered employer may not ask employees who do not have influenza symptoms to disclose whether they have a medical condition that the CDC says could make them especially vulnerable to influenza complications. This is on top of the burdens of managing information under the privacy provisions of the Health Information Portability and Accountability Act (HIPAA). These points have relevance in various sections including for alternative diagnosis but also under (C)(3)(b)(Plan) EEOC also notes:

As a practical matter, however, doctors and other health care professionals may be too busy during and immediately after a pandemic outbreak to provide fitness-for-duty documentation. Therefore, new approaches

may be necessary, such as reliance on local clinics to provide a form, a stamp, or an e-mail to certify that an individual does not have the pandemic virus. This point goes to the burden of the Suspected COVID provisions on the health care system.

XXI. The Board Lacks Authority Over Sick Leave Policies and Recitation to Such Policies in the Proposed rule is Illegal Proposed §16VAC25-220-40(B)(6) states that "employers shall ensure that sick leave policies are flexible and consistent with public health guidance..." Although the ETS contains language that is vague and threatens potential penalties, the Safety and Health Codes Board does not have authority over sick leave policies. Therefore, the proposal with regard to such policies is illegal and in excess of authority.

The Board should eliminate all human resource policies from the proposed rule. The statement regarding sick leave nonetheless illustrates the problem with the ETS. An employee who coughs or sneezes loses work for significant time. That may deny that employee important employment opportunities, the ability to contribute to specific projects, and cause great disruption.

XXII. The Testing and Reporting Scheme Is Unreasonable and Requires Agreement with Third Parties Who May or May Not Cooperate. The proposed rule has a test reporting scheme that penalizes employers who cannot gain agreements with third parties and operate within unrealistic time frames and at risk for mishandling the privacy of medical information. See §16VAC25-220-40(B)(8). The system for reporting positive tests includes employees, subcontractors, contract employees, temporary employees, building owners, tenants, residents in a building, and 24-hour time frames is overly broad, not shown to be necessary, and not feasible for the full scope of employers. There is no information provided as to what either VDH or DOLI does with the information. There needs to be some time frame to consider the thresholds. Is it whenever two has occurred over a year? Or a week? There needs to be clarity on this point. There has been no explanation over why this reporting scheme is necessary. This is a redundant activity, healthcare professionals already notify VDH, and the requirement should be struck from the proposed rule. If the data is not being analyzed, requiring employers to file these case reports within 24 hours is burdensome and detracts from ensuring employee safety. The private information required for this reporting can necessitate coordination between three groups within a company: Health Services, Human Resources, and Environmental Health & Safety. Few facilities staff these functions 24/7, whereas most production functions run 24/7. This makes reporting for compliance with these regulations over weekends and holiday periods impossible. It is not clear that VDH or DOLI are using this information in any way that necessitates a 24-hour reporting requirement. For small businesses this is very difficult. A regulatory flexibility analysis should review whether the provision is necessary or practical.

XXIII. The Provisions Asking Building or Facility Owners to Require All Employer Tenants to Satisfy Requirements is Beyond the Boards Authority

The provisions referencing building owners and tenants seem to imply third party obligations and third-party cooperation with employers. At best this is unclear but the source of authority for the Board beyond employers themselves is unclear. The lack of authority makes employer obligations unfair because of the necessary reliance on third parties. Indeed, throughout the proposed rule there are many sort of communal cooperation or mandatory cooperation concepts that include building owners, contractors and subcontractors, but these are not well thought through from a regulatory perspective.

These provisions are unfair and unenforceable. The system to receive reports is one of these issues.

While it might seem useful, it is unclear who to begin enforcement on.

XXIV. All Employers should not Have to Complete a COVID-19 Infections Disease Preparedness and Response Plan This mandate is overly burdensome, and “low and medium” risk facilities should not be regulated at this level. The burdens of this provision and others must be reviewed under the regulatory flexibility analysis.

XXV. The Proposed Rule Does Not Have A Rational Approach to Economic Feasibility That Meets the Statutory Standards

The proposed rule definition of economic feasibility at §16VAC25-220-30 is not appropriate.

The rule defines “economic feasibility” to mean the employer is financially able. The standard does no task whether the employer could stay in business or avoid releasing employees in order to find the funds to pay for the costs of the rule. The failure to provide an economic impact assessment or regulatory flexibility analysis for comment compounds this problem.

XXVI. The Physical Separation Requirements Are Not Rational

The ETS states under the definition of physical distancing pursuant to §16VAC25-220-30 that “physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall constitutes physical distancing from an employee or other person stationed on the other side of the wall.” Yet, as pointed out in comments to the Board, physical separation does not have to be achieved by permanent or floor to ceiling walls. Temporary plexiglass and other hard surface barriers are regularly used to retrofit workstations, counters and cubicles as physical separation “shields” or barriers for employees.

XXVII. The HVAC Requirements for Medium Risk Businesses Are Not Reasonable

The Regulations state under the definition of physical distancing pursuant to § 16VAC25-220-30 that "physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall constitutes physical distancing from an employee or other person stationed on the other side of the wall." Temporary plexiglass and other hard surface barriers are regularly used to retrofit workstations, counters, seating, and cubicles as physical separation "shields" or barriers for employees, particularly when coupled with PPE or face coverings. To complicate matters further, § 16VAC25-220-50 (applicable to hazards or job tasks classified as very high or high exposure risk) specifically states that “physical barriers” are “e.g., clear plastic sneeze guards, etc.). These conflicting references should be removed from the Regulations along with any reference to “permanent or floor to ceiling walls.” There is insufficient evidence that this requirement is workable or is necessary to address a grave danger.

XXVIII. The Physical Distancing Requirements Are Either Unworkable or Ambiguous

There are many sentences in the proposed rule regarding distancing. Proposed 16VAC25-220-10(D)(1) states:

It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons. The above can be a good sentence but unclear how operative. Proposed 16VAC25-220-30 under definitions state

"Physical distancing” also called "social distancing” means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent,

solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

This definition does not itself provide needed flexibility

Proposed 16VAC25-22-40 (D) states:

Unless otherwise provided in this standard, employers shall establish and implement policies and procedures that ensure that employees observe physical distancing while on the job and during paid breaks on the employer's property, including policies and procedures that:.....

This is stated as a mandate, and exceptions are ambiguous although there is some claim to exceptions.

Proposed 16VAC25-22-40(G) states:

Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements from employees or other persons, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry. This provision may suggest some flexibility. More, and clearer, statements of flexibility would be useful removed from the Regulations along with any reference to "permanent or floor to ceiling walls." There is insufficient evidence that this requirement is workable or is necessary to address a grave danger.

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Proposed 16VAC25-220-30 under definitions state "Physical distancing" also called "social distancing" means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

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This provision may suggest some flexibility. More, and clearer, statements of flexibility would be useful."

Outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

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This is stated as a mandate, and exceptions are ambiguous although there is some claim to exceptions.

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Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements from employees or other persons, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry. This provision may suggest some flexibility. More, and clearer, statements of flexibility would be useful. 16VAC25-22-40(G) may or may not say at least the following does not require distancing, for example for serving staff, certain physical instructions, personal care and grooming, performance areas where space is not available, medical professionals, ceremonies, hibachi-style table grills and chefs, laborers and skilled trade that need to work together to accomplish certain tasks, sports teams, police teams, fire teams, certain construction teams, certain manufacturing activities, child care, home aides, and more. Beyond that differences in whether the workers are outside or inside could make a difference. Some businesses are family businesses and the rules should not require distancing between such parties. What happens with respect to people who are vaccinated? If they no longer have a significant risk, why impose the requirement? Regardless, the overlap of the Orders and Safer at Home documents create more problems of lack of flexibility and ambiguity.

XXIX. The Decontamination Requirements when an Infected Person has been within the Facility within the Past 7 days are not Based upon Science

According to the CDC and US Department of Homeland Security, the SARS-CoV-2 Virus is predominantly transmitted through inhalation of airborne droplets and surface transmission has been verified to be eliminated within 70 hours not 7 days. The 7-day requirement is not necessary to protect against a grave danger.

XXX. The Face Coverings Provision Should Not Be Restricted to Washable Fabric The 16VAC25-220-30 "PPE" definition should include "face coverings," but not limit their materials to washable fabrics only. Washable fabric masks are not appropriate for many FDA regulated factory areas. These facilities use disposable sterile masks,

and they should be accommodated in any “face covering” or “PPE” definition. This requirement may be anti-protective and is not necessary to protect against a grave danger.

XXXI. The Rule Concerning Handwashing Facilities and Sanitizer should not be Required in All Workplaces. CDC and OSHA guidance requires only either a handwashing facility or sanitizer but not both. The requirement is not necessary to protect against a grave danger.

XXXII. The Heat-Related Illness Provision Does Not Belong in This Rule 16VAC25-220-80 includes a training mandate for “Heat-related illness prevention...” that has no connection to COVID-19 infection protection. In addition, it cannot be a coincidence that the agency issued a Notice of Intended Regulatory Action (NOIRA) on Heat Illness Prevention on 4/2/20 and that document has been with the Secretary of Commerce and Trade for 200+ days but a heat-related illness prevention training mandate was inserted into the Regulations. This should be removed from the proposed rule.

XXXIII. The Non-Discrimination Provisions Need Revision Proposed section 16VAC25-220-90(C) states No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer’s agent, other employees, a government agency, or to the public such as through print, online, social, or any other media. To be clearer, it would be better if this was written as:

No person shall discharge or in any way discriminate against an employee who on the grounds that employee raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer’s agent, other employees, or a government agency, or to the public such as through print, online, social, or any other media. The first part is just a drafting issue. The substance regarding print, online, social or any other media may cause confusion regarding the rights of employers to contest unfair charges. Everyone has a right to defend themselves and if the charges are unfair or need clarification that right includes employers. If the rule provides one-sided language it makes it unclear whether the employer maintains its communication rights. Moreover, there are reasons that having public debates are not good for employers and employees. No evidence has been provided that this change to existing whistleblower law is addressing a grave danger or is just the opportunity to advance communication agendas. If an employer brings a cause of action for false or misleading statements, is that affected by this provision?

Proposed section 16VAC25-220-90(D) states:

Nothing in this standard shall limit an employee from refusing to do work or enter a location that the employee feels is unsafe. However, employees should familiarize themselves with 16VAC25-60-110, which contains the requirements concerning discharge of discipline of an employee who has refused to complete an assign task because of a reasonable fear of injury or death.

Of course, no employer can force someone to enter any location, but the question is can there be consequences if an employee does not perform the job. The standard that an “employee feels” something is unsafe is not an objective standard and if this is to be a rule, there must be an objective, credible standard. It his hard to see how the language of proposed 16VAC25-220-90(D) is doing anything other than making regulatory language murkier. It is probably wise to just rely on 16VAC25-60-

110 and not to cloud the issue with new language that adds nothing.

XXXIV. Employers Must Always Be Provided Due Process and Prior Notice

The proposed rule has no identifiable “due process” for employers involving a “whistleblower,” and no requirement that complaints filed with DOLI require identification of the plaintiff. Anonymous complaints should not be allowed as disgruntled employees, punitive customers, and unethical competitors could use complaints for destructive purposes. The employer should be afforded due process to defend themselves against accusations of safety violations and this should be included in the proposed rule.

XXXV. Much of the Proposed Rule Is Ambiguous and Vague Creating Problems Under Due Process Under the Virginia Constitution and In General Worker’s rights and employer’s liabilities turn on the vagaries and complex interrelationships between the Orders, the Safer at Home document, the proposed rule and many other laws. One of the largest sources of vagueness is the Suspected COVID provisions which really have so many convolutions and distinctions that science cannot make, and employers cannot reasonably interpret. The proposed regulations frequently refer to the standards applicable to the “industry” which is language that may be appropriate for guidance but is too vague to be meaningful and should be removed from the ETS and consideration for Regulations. It is unclear about which version of CDC guidance an employer may reference for purposes of compliance with the Regulations found in 16VAC25-220-10(G) since guidance is changing so rapidly. It is also unclear who determines that the “CDC recommendation provides equivalent or greater protection than provided by this standard.”

There are 20 footnotes that refer to websites. There are cross-references to multiple guidance documents. No effort has been made to translate these guidance documents and CDC constructs into operable and fair regulatory language. Employer responsibilities through-out the proposed rule depend on employee information which may or may not be forthcoming and the interaction is in the face of privacy and disability law. The rules themselves would make employees skittish to provide information as it may result in long absences from work. The entire scheme applies in the face of frequently conflicting OSHA guidance.

There are many more questions than answers in the text of the rules. Is the general contractor or owner exposed to potential citation if the subcontractor violates any of the provisions of the ETS or Regulations without providing this information to the employer? This liability should not be shifted to an employer and the relationship is unclear. Similarly, the provisions apply to building owners and tenants and their relationships to employers is unclear and likely outside of the authority of the Board. The entire structure relating the rules to the Executive Orders, Orders of Public Health Emergencies and the Safer at Home document. This is especially so since the Orders have been changing all the time. Officials at VDH have been interpreting rules differently and the regional departments have been further interpreting rules differently. The Orders themselves often ask businesses to infringe on the fundamental rights of customers to stand, sit or have an ordinary conversation within six-feet of people of their own choosing. The distancing requirements in the proposed rule offer no clarifications and, potentially, make the issue worse. There is language in the proposed rule protecting employees who refuse to work because they “feel” unsafe. The criteria for protected work refusals are already in the Administrative Regulatory Manual and this provision is just adding more confusion.

These rules are simply not being followed now. Few employers are even aware of them. In the face of that, there has been no impact analysis and no outreach with respect to an impact analysis. Compound this problem with a proposal to have an immediate effective date and only by publishing notice in the city of Richmond, outside of the normal Virginia Registrar process where all regular rules, including emergency rules, appear.

All-in-all, as drafted, enforcing these provisions should be found void for vagueness and lack of due process. The Constitutional standard and the standard of fairness look at the resulting situation that includes the various overlaps between the Executive Orders, Orders of Public Health Emergency, Safer at Home document and the

proposed rule if it became law. The analysis would include confusion with the ADA and HIPAA and OSHA standards. Under the Constitution, law or regulation that purports to penalize will not support laws that are so ambiguous or lacking standards that they invite arbitrary and discriminatory enforcement actions. According to the Supreme Court in *Federal Communications Commission et al v. Fox Television Stations, Inc.* (SC June 21, 2012): A fundamental principle in our legal system is that laws which regulate persons or entities must give fair notice of conduct that is forbidden or required. See *Connally v. General Constr. Co.*, 269 U. S. 385, 391 (1926) (“[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law”); *Papachristou v. Jacksonville*, 405 U. S. 156, 162 (1972) (“Living under a rule of law entails various suppositions, one of which is that ‘[all persons] are entitled to be informed as to what the State commands or forbids’” (quoting *Lanzetta v. New Jersey*, 306 U. S. 451, 453 (1939) (alteration in original))). This requirement of clarity in regulation is essential to the protections provided by the Due Process Clause of the Fifth Amendment. See *United States v. Williams*, 553 U. S. 285, 304 (2008).

It requires the invalidation of laws that are impermissibly vague. A conviction or punishment fails to comply with due process if the statute or regulation under which it is obtained “fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement.” *Ibid.* As this Court has explained, a regulation is not vague because it may at times be difficult to prove an incriminating fact but rather because it is unclear as to what fact must be proved. See *id.*, at 306. Even when speech is not at issue, the void for vagueness doctrine addresses at least two connected but discrete due process concerns: first, that regulated parties should know what is required of them so they may act accordingly; second, precision and guidance are necessary so that those enforcing the law do not act in an arbitrary or discriminatory way. See *Grayned v. City of Rockford*, 408 U. S. 104, 108–109 (1972). When speech is involved, rigorous adherence to those requirements is necessary. In various sections, the proposed rule does not meet this Constitutional standard and the Board should abandon such an approach will not support laws that are so ambiguous or lacking standards that they invite arbitrary and discriminatory enforcement actions. According to the Supreme Court in *Federal Communications Commission et al v. Fox Television Stations, Inc.* (SC June 21, 2012):

A fundamental principle in our legal system is that laws which regulate persons or entities must give fair notice of conduct that is forbidden or required. See *Connally v. General Constr. Co.*, 269 U. S. 385, 391 (1926) (“[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law”); *Papachristou v. Jacksonville*, 405 U. S. 156, 162 (1972) (“Living under a rule of law entails various suppositions, one of which is that ‘[all persons] are entitled to be informed as to what the State commands or forbids’” (quoting *Lanzetta v. New Jersey*, 306 U. S. 451, 453 (1939) (alteration in original))). This requirement of clarity in regulation is essential to the protections provided by the Due Process Clause of the Fifth Amendment. See *United States v. Williams*, 553 U. S. 285, 304 (2008). It requires the invalidation of laws that are impermissibly vague. A conviction or punishment fails to comply with due process if the statute or regulation under which it is obtained “fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement.” *Ibid.* As this Court has explained, a regulation is not vague because it may at times be difficult to prove an incriminating fact but rather because it is unclear as to what fact must be proved. See *id.*, at 306.

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That are impermissibly vague. A conviction or punishment fails to comply with due process if the statute or regulation under which it is obtained "fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement." *Ibid.* As this Court has explained, a regulation is not vague because it may at times be difficult to prove an incriminating fact but rather because it is unclear as to what fact must be proved. See *id.*, at 306. Even when speech is not at issue, the void for vagueness doctrine addresses at least two connected but discrete due process concerns: first, that regulated parties should know what is required of them so they may act accordingly; second, precision and guidance are necessary so that those enforcing the law do not act in an arbitrary or discriminatory way. See *Grayned v. City of Rockford*, 408 U. S. 104, 108–109 (1972). When speech is involved, rigorous adherence to those requirements is necessary. In various sections, the proposed rule does not meet this Constitutional standard and the Board should abandon such an approach.

RECOMMENDATIONS:

For the reasons discussed above the Board should not promulgate a permanent standard and not promulgate the current proposal from DOLI staff. The Board should provide or obtain a regulatory impact statement and regulatory flexibility analysis concerning the rules including an opportunity for public comment. The Board should obtain an evaluation of the implementation of the ETS as it seems that few are aware of it, but the working information can provide information on what might work and what might not."

NOTE: THE COMMENTER IS A PARTY TO A LAWSUIT CHALLENGING THE LEGALITY OF 16VAC25-220 Temporary Standard (ETS) Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 As Adopted by the Safety and Health Codes Board on July 15, 2020. LEGAL ISSUES RAISED BY THE COMMENTER THAT RELATE TO THE ONGOING LITIGATION WILL NOT BE ADDRESSED FOR THAT REASON.

NOTE: TO THE EXTENT THAT THE COMMENTER DISCUSSES THE LEGALITY OF ORDERS OF PUBLIC HEALTH EMERGENCY BY THE HEALTH COMMISSIONER OR EMERGENCY DECLARATIONS AND EXECUTIVE ORDERS OF THE GOVERNOR, THE DEPARTMENT CONSIDERS SUCH COMMENTS TO NOT BE GERMANE TO THIS STANDARD AND PROVIDES NO RESPONSE.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

SEE DEPARTMENT RESPONSE TO COMMENT 20002

A Regulatory Flexibility Analysis is contained in the Department's Briefing Package for the Board dated January 4, 2021.

With regard to effective dates for any adopted final standard, Va. Code 40.1-22(6a) controls and not the APA.

For those commenters who argued that that certain gubernatorial mandates (e.g., "face mask" mandate) are unconstitutional, according to the Office of the Attorney General on at least twelve occasions the Governor's COVID-19 restrictions have been upheld by circuit courts throughout the Commonwealth. Two of these specifically challenged the face covering requirements. *Schilling et al. v. Northam*, CL20-799 (Albemarle Co. Cir. Ct. July 20, 2020); *Strother, et al. v. Northam*, CL20-260 (Fauquier Co. Cir. Ct. June 29, 2020).

With regard to any potential conflicts between Executive Orders and the standard, any conflicts identified between Executive Orders and the ETS would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov. Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

On the issue of footnotes being included in documents containing draft text for the standard being considered by the Board, they were provided for ease of reference and not as regulatory text.

The Department provides background and statistics on its enforcement of the ETS in its response to COMMENT 87834 and the January 4, 2021 Board Briefing Package.

The Department's views on the support and legality for the Board's findings of grave danger are included in the Briefing Package(s) to the Board during the adoption of the ETS.

The Commenter's reference to federal OSHA action or inaction regarding the adoption of an ETS at the federal level have no legal bearing on the Board's decision to adopt an ETS. The Department and Board legal authority to adopt an ETS derive from state law.

16VAC25-220-40.B.4 of the COVID-19 Emergency Temporary Standard (ETS), provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza)...." Such employees are then classified as "Suspected to be infected with SARS-CoV-2 virus" and may not report to the workplace until they have been cleared for return to work in accordance with ETS requirements. In situations where there is the possibility for an alternative diagnosis (such as allergies, the common cold, the flu, an ear infection, etc.) the employer has a number of options, including but not limited to, a positive test for influenza or the employee obtaining an alternative diagnosis from a medical authority.

In addition, the Virginia Department of Health provides the following guidance:

If the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

The Department respectfully disagrees with the Commenter's assertion that the standard is vague.

The Commenter is incorrect in stating that employers are required by the standard to classify each employee for risk of level exposure. 16VAC25-220-40.B1 provides "1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall

classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes."

The provisions in the standard regarding serologic testing are consistent with CDC provisions.

The Department does not plan to recommend changes to sick leave provisions in the Final Standard.

The Standard does not require employers to provide sick leave to employees. It does reference the Families First Coronavirus Response Act (FFCRA) at 16VAC25-220-40.B.6:

6. To the extent feasible and permitted by law, including but not limited to the Families First Coronavirus Response Act, employers shall ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

Further information about the FFCRA and sick leave policies can be found at:

<https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

The Consolidated Appropriations Act (CAA 2021) was signed into law on December 27, 2020. "The CAA 2021 allows FFCRA-covered employers to voluntarily extend two types of emergency paid leaves through March 31, 2021 that were originally mandated between April 1, 2020 and December 31, 2020 by the Families First Coronavirus Response Act (FFCRA). These FFCRA leaves are Emergency Paid Sick Leave (EPSL) and Emergency Family and Medical Leave (EFMLA).

The FFCRA provided up to 10 days of EPSL, with varying levels of pay, for any of six COVID-19 qualifying reasons between April 1, 2020 and December 31, 2020. Carryover of unused EPSL into 2021 was not allowed under the FFCRA—at least not as originally written.

The CAA 2021, however, amends the carryover provision of EPSL. Employers may now voluntarily choose to permit the carryover of unused 2020 EPSL into the first quarter of 2021. If they do, EPSL tax credits associated with this paid leave can be taken through March 31, 2021. The tax credits are an incentive for FFCRA-covered employers to choose to carryover unused EPSL.

It is important to note that the CAA 2021 does not provide employees with additional EPSL. Employees who emptied their EPSL tank of 10 days in 2020 have nothing to carry over into the first quarter of 2021 should their employers decide to allow EPSL carryover. The CAA 2021 merely extends the tax credit available to private employers under the FFCRA, and does not create new EPSL leave.

The Department does not plan to recommend that the notification requirements to tenants be removed from the Standard. The Department notes that the Standard does not apply to non-business tenants in an apartment building. The intent of the notification requirement is to provide employees information of a "possible" exposure so that employees can make decisions for themselves on the appropriate course of action to take.

16VAC25-220-70.A does not apply to lower risk hazards and job tasks. It states: A. Employers with hazards or job tasks classified as:

1. Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan;

2. Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.

With regard to feasibility (technical/economic), The Standard's definitions of technical and economic feasibility are based on a longstanding definition contained the VOSH Field Operations Manual (FOM) and federal OSHA's FOM. The Department does not intend to recommend any change to the definition.

Infeasibility defense.

Feasibility is defined (based on longstanding definitions of OSHA and VOSH in their respective Field Operations Manuals) and referenced numerous times in the Standard to provide a level of flexibility to employers to achieve compliance with the requirements of the Standard and to mitigate the spread of SARS-CoV-2 to employees while at work.

Here is a summary of the defense:

Infeasibility Defense (previously known as the "impossibility" defense)

A citation may be vacated if the employer proves that:

1. The means of compliance prescribed by the applicable standard would have been infeasible under the circumstances in that either:

- a. Its implementation would have been technologically or economically infeasible or
- b. Necessary work operations would have been technologically or economically infeasible after its implementation; and

2. Either:

- a. An alternative method of protection was used or
- b. There was no feasible alternative means of protection.

NOTE: Evidence as to the unreasonable economic impact of compliance with a standard may be relevant to the infeasibility defense.

Source: Occupational Safety and Health Law, Randy S. Rabinowitz, 2nd Edition (2002)

The language referenced by the Commenter (physical separation of employees at low-risk businesses by a permanent, solid floor to ceiling wall) is one method described in the Standard for mitigating the spread of SARS-CoV2; however, employers are not required to do so.

With regard to FDA regulated facilities, place of business uses surgical/medical procedure mask consistent with Food and Drug Administration (FDA) guidance, it will be in compliance with the standard. Surgical/medical procedure masks are defined in the standard are regulated by the FDA, and are a form of personal protective equipment permitted under the standard.

16VAC25-220-30:

"Surgical/medical procedure mask" means a mask to be worn over the wearer's nose and mouth that is fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other

hazardous fluids, and prevents the wearer from exposing others in the same fashion. A surgical/medical procedure mask protects others from the wearer's respiratory emissions. A surgical/medical procedure mask has a looser fitting face seal than a tight-fitting respirator. A surgical/medical procedure mask does not provide the wearer with a reliable level of protection from inhaling smaller airborne particles. A surgical/medical procedure mask is considered a form of personal protective equipment, but is not considered respiratory protection equipment under VOSH laws, rules, regulations, and standards. Testing and approval is cleared by the U.S. Food and Drug Administration (FDA).

The Department is recommending a language change to the provision that references heat-related illness prevention: "Heat-related illness prevention including the signs and symptoms of heat-related illness associated with the use of COVID-19 PPE and face coverings"

The Department does not intend to recommend any change to 16VAC25-220-90.C as it is the position of the Department that it reflects the current state of case law on the subject.

Pursuant to Va. Code §40.1-51.2:1, employees are protected from discrimination when they engage in activities protected by Title 40.1 of the Code of Virginia ("because the employee has filed a safety or health complaint or has testified or otherwise acted to exercise rights under the safety and health provisions of this title for themselves or others.").

Whether an employee engaged in a "protected activity" under Title 40.1 is very fact specific, but can include occupational safety and health information shared by an employee about their employer on a social media or other public platform in certain situations.

16VAC25-220-90.C provides that:

No person shall discharge or in any way discriminate against an employee who raises a reasonable concern about infection control related to the SARS-CoV-2 virus and COVID-19 disease to the employer, the employer's agent, other employees, a government agency, or to the public such as through print, online, social, or any other media.

If an employee raises an unsubstantiated COVID-19 related claim or makes a false COVID-19 related claim against their employer through print, online, social, or any other media, such an act by an employee would not be considered "reasonable" under the ETS and disciplinary action taken against the employee in accordance with the employer's human resource policies would not be considered "discrimination" under the ETS/ER or Va. Code §40.1-51.2:1.

VOSH Whistleblower regulations can be found at 16VAC25-60-110. The VOSH Whistleblower Investigation Manual can be found at: <https://townhall.virginia.gov/L/ViewGDoc.cfm?gdid=6012>

OSHA and VOSH standards and regulations fall into the following categories: Construction Industry, Agricultural Industry, Maritime Industry and General Industry (all employers not covered by Construction, Agricultural or Maritime Industry Standards are covered by the General Industry Standards).

VOSH multi-employer worksite regulations and the multi-employer worksite defense can be found at 16VAC25-60-260.F and G."

16VAC25-220, DRAFT Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19 Please accept the following comments regarding:

16VAC25-220, DRAFT Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19

Issue 1:

16VAC25-220-40 F.

When multiple employees are occupying a vehicle for work purposes, employers shall:

1. Ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry. Until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings while occupying a work vehicle with other employees or persons

Comment 1:

Although providing respirators to all employees 2 or more in a vehicle is conceptually appropriate considering the pandemic and although the standard accommodates supply issues that could limit respirator compliance, the requirement to wear respirators will create a number of burdens to employers. These issues include coordination to medically clear employees to comply with the OSHA respirator requirements requiring employee medical questionnaires reviews by a qualified medical professional and consequently a physical if the employee has too many risk factors. In addition, employees will require initial fit testing, training and associated documentation. Regretfully, there will be a percentage of employees that will be determined as medically unfit to wear a respirator that could jeopardize their employment. In addition when supplies become available, fit testing may not be a possibility due to a shortage of sizes. The compliance with this aspect of the standard abruptly may also overwhelm medical facilities attempting to evaluate a large volume of employees. Additional issues include costs of physicals, PPE and training that are secondary issues but could be challenging particularly for smaller employers.

Recommendation:

Consider other options than respirators that may not be as effective but may provide a reasonable level of protection, particularly for vehicle sharing by small groups or pairs for only short durations. Another consideration, provide employers a significant time to comply with the respirator directive to allow employers reasonable time to phase in the requirements and consider alternative work assignments and transportation.

Issue 2:

16VAC25-220-40 G.

Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements from employees or other persons, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry. In such situations, and until adequate supplies of respiratory protection and/or personal protective equipment become readily available for non-medical and non-first responder employers and employees, employers shall provide and employees shall wear face coverings.

Comment 2:

Although providing respirators to all employees who may work within six feet of each other is conceptually appropriate considering the pandemic, consideration should include permitting face masks rather than respirators for outdoor work that although may require working within six feet, may be of short duration and risk mitigated by outside fresh air. The other issues, as expressed in Comments 1, relate to the logistics of coordination to medically clear employees to comply with the OSHA respirator requirements requiring employee medical questionnaires reviews by a qualified medical professional and consequently a physical if the employee has too many risk factors. In addition, employees will require initial fit testing, training and associated documentation. Regretfully, there will be a percentage of employees that will be determined as medically unfit to wear a respirator that could jeopardize their employment. In addition when supplies become available, fit testing may not be a possibility due to a shortage of sizes. The compliance with this aspect of the standard abruptly may also overwhelm medical facilities attempting to evaluate a large volume of employees. Additional issues include costs of physicals, PPE and training that are secondary issues but could be challenging particularly for smaller employers.

Recommendation:

Consider other options than respirators that may not be as effective but may provide a reasonable level of protection particularly for outdoor work. Another consideration, provide employers a significant time to comply with the respirator directive to allow employers reasonable time to phase in the requirements and consider alternative work assignments and transportation.

Issue 3:

16VAC25-220-30. Definitions

"Physical distancing" also called "social distancing" means keeping space between yourself and other persons while conducting work-related activities inside and outside of the physical establishment by staying at least six feet from other persons. Physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall (e.g., an office setting) constitutes one form of physical distancing from an employee or other person stationed on the other side of the wall, provided that six feet of physical distance is maintained from others around the edges or sides of the wall as well.

Comments 3:

Although creating solid floor to ceiling walls may appear conceptually appropriate to limit the spread of COVID-19, it would be impractical to build walls in facilities due to the impact on the designed operation of HVAC units that serve the structure to maximize appropriate airflow and air exchanges. Building walls can interfere with air distribution and air flow to design return locations. In addition to constructed walls impairing air circulation, there are fire suppression systems that could be impacted such as sprinkler systems and building walls may encumber emergency escape access that is critical for life safety and active shooter considerations.

Recommendation:

Instead of walls, suggest requiring functional barriers that provide reasonable protection such as large plastic barriers at work stations with openings for contactless transactions (similar those in prevalent use for cashiers or retail barriers but in office or administrative settings) that can effectively limit exposure from person to person

and can be readily added at low expense. These temporary shields would have the advantage of being temporary and at a reasonable cost so when the pandemic hopefully ends, work stations can return to normal.

Issue 4:

16VAC25-220-40. Mandatory requirements for all employers

C. Return to work.

1. The employers shall develop and implement policies and procedures for employees known or suspected to be infected with the SARS-CoV-2 virus to return to work:

a. Symptomatic employees known or suspected to be infected with the SARS-CoV2 are excluded from returning to work until all three of the following have been met:

(1) The employee is fever-free (less than 100.0° F) for at least 24 hours), have passed since recovery, defined as resolution of fever without the use of fever-reducing medications, and

(2) Respiratory symptoms, such as cough, and shortness of breath have improved, and

(3) At least 10 days have passed since symptoms first appeared. However, a limited number of employees with severe illness may produce replication competent virus beyond 10 days that may warrant extending duration of isolation for up to 20 days after symptom onset. Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.

Comment 4:

16VAC25-220-40 C.3. states that “Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.

Due to HIPAA restrictions, information concerning an employee’s health would only be known if an employee discloses their medical condition voluntarily.

Recommendation:

Remove the immunocompromised section of the proposed standard or reword it so that the burden is on the employee to disclose the condition voluntarily which may require confirmation from their personal physician.

Issue 5: 16VAC25-220-50. Requirements for hazards or job tasks classified as very high or high exposure risk

16VAC25-220-40 B.1.vi. states “Have staff work in “clean” ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open)”.

Comment 5:

Although limited to employees determined at a very high or high risk exposure, the wording of this provision inhibits workplace-specific risk assessment of “clean” and “higher-risk” areas.

Recommendation:

Consider a modifier such as “if feasible and determined to provide lesser risk” because in some settings limiting public interactions to a lobby station best accommodates physical distancing, prevents greater foot traffic

throughout a work site, and risk can be mitigated by plastic barriers or other engineering of administrative controls as discussed in Comment 3.

With regard to the issue of respirators in vehicles, 16VAC25-220-40.B, provides that:

B. Exposure assessment and determination, notification requirements, and employee access to exposure and medical records.

1. Employers shall assess their workplace for hazards and job tasks that can potentially expose employees to the SARS-CoV-2 virus or COVID-19 disease. Employers shall classify each job task according to the hazards employees are potentially exposed to and ensure compliance with the applicable sections of this standard for very high, high, medium, or lower risk levels of exposure. Tasks that are similar in nature and expose employees to the same hazard may be grouped for classification purposes.

The Standard also provides in 16VAC25-220-10.D.1 provides in part:

D. Application of this standard to a place of employment will be based on the exposure risk level presented by SARS-CoV-2 virus-related and COVID-19 disease-related hazards present or job tasks undertaken by employees at the place of employment as defined in this standard (i.e., very high, high, medium, and lower risk levels).

1. It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard.

While employers are required to conduct the risk assessment, that determination is subject to review by the VOSH program as to whether the assessment was conducted in a reasonable fashion in accordance with the requirements of the standard.

The Department does not intend to recommend removal of the language referenced by the Commenter in 16VAC25-220-40 C.3. (states that “Employees who are severely immunocompromised may require testing to determine when they can return to work - consider consultation with infection control experts.”). The language is consistent with current CDC and VDH recommendations. In addition, HIPAA applies to “covered entities” and “business associates” (see attached description), and in most cases does not apply to employers.

<https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html>. HIPAA only applies to health departments when they meet the definition of a covered entity (“For example, a state Medicaid program is a covered entity (i.e., a health plan) as defined in the Privacy Rule. Some health departments operate health care clinics and thus are health care providers.”). <https://www.hhs.gov/hipaa/for-professionals/faq/358/are-state-county-or-local-health-departments-required-to-comply-with-hipaa/index.html>. Finally, HIPAA does not apply to federal OSHA or states that operate their own occupational safety and health plans, such as VOSH. <https://www.osha.gov/Publications/OSHA-factsheet-HIPPA-whistle.pdf>

The language referenced by the Commenter (physical separation of employees at low-risk businesses by a permanent, solid floor to ceiling wall) is one method described in the Standard for mitigating the spread of SARS-CoV2; however, employers are not required to do so.

The standard provides for flexibility in light of shortages of PPE generally and respirators specifically, including the ability to use surgical/medical procedure face mask and face coverings depending on the employers hazard assessment.

With regard to 16VAC25-220-40 B.1.vi. (states "Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open)"), the Department does not intend to recommend changes to the language. Feasibility is consideration in all occupational safety and health standards and regulations, and the reference to "clean ventilation zones" addresses the lesser hazard concern of the Commenter.

10021 Richard Hatch 1.9.21 rhatch@cwa-union.org

On behalf of all of our hard-working members, we are writing to encourage the adoption of a strong Permanent Standard for Infectious Disease Prevention for COVID-19. Our members desperately need the protection these standards provide.

Communications Workers of America (CWA) represent thousands of workers throughout the Commonwealth in the areas of Corrections, Telecom, Manufacturing, Healthcare, Airlines and Journalism. These workers have been in the forefront of "essential" services and thus we know very well how important these standards have been.

The Temporary standard has been essential in protecting workers in Virginia. It can however be improved. We would suggest the following improvements:

Virginia's Correctional, Jail, and Detention facilities have been some of the hardest hit. As an example, the Department of Corrections (DOC) has had 1000's of positive cases for both housed offenders and DOC staff. There have also, unfortunately, been 48 offender and 2 staff deaths. This environment is unique in that it does not easily allow isolation, six-foot separation and other guidelines set up to prevent COVID. It is for these reasons that this type of work should be removed from the "Medium" risk category and placed in the "High" risk.

Employers should also set up a hierarchy of controls when employees are forced to share vehicles.

In regard to training on the use to extend the use of PPE, CWA has concerns in reusing PPE at any time. We believe this should not be allowed. If this is to be allowed the training should at least include criteria on how PPE would be extended, how to properly store PPE and criteria on determination if said PPE would be safe to use in an extended period.

We would encourage passage of these standards without any delay. We have heard some members of the business community continue to delay with calls for a longer "commenting" period, delay in training implementation and now a so-called "cost/benefit" analysis to be done. These delays forget the very real reasons that a standard is needed in the first place; the safety of our workers and citizens. We should instead think of how many Virginians will die if delays are put in place. How many workers will get sick? What will be the impact to their livelihood if rules aren't there? We cannot put a cost on a life and we cannot delay any standard for a virus that has impacted so many Virginian's lives.

This pandemic has been a learning experience for us all. But what it has shown us is that bold decisive action to isolate those infected and protect those who are not is the best way to return us to normal and allow our economy to get going again. CWA urges the quick adoption of a permanent standard.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

An amendment has been submitted by a Board member to include "6. Correctional facilities, jails detention centers, and juvenile detention centers." in the definition of "Exposure risk level, high"

PUBLIC HEARING COMMENTS

20001 Brett Vassey 1/5/2021

[WRITTEN COMMENTS SUBMITTED BY SPEAKER, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4> January 5, 2021

Virginia Manufacturers Association

VDOLI Safety & Health Codes Board: COVID-19 Permanent Regulations Testimony

Brett A. Vassey, President & CEO, VMA

OPENING:

My name is Brett Vassey. I am the CEO of the Virginia Manufacturers Association. Thank you for considering my testimony today. Transparency and public participation are the foundations of regulation.

The VMA has been the trade association for manufacturers in the Commonwealth since 1922.

Virginia's manufacturing sector includes approximately 6,750 manufacturing facilities that employ over 230,000 individuals and contributes \$43 billion to the gross state product. Over 80% are small businesses.

The VMA and its member companies are committed to protecting employees, contractors, suppliers, and communities from COVID-19 infection.

The manufacturing sector is one of the most experienced business sectors with VOSH regulations and compliance. The VMA has a long history of advocacy for science-based, practical health and safety regulations, and support for voluntary compliance programs. We have provided COVID-19 ETS compliance training to hundreds of individuals, instituted a COVID-19 MFG Model Action Plan, developed a rapid response decontamination service, assisted with increasing testing sites, maintained a cloud-based COVID-19 Resource Center, commercialized a cloud-based PPE Sourcing Center, distributed over 4,000 cloth masks from the U.S. Department of Health & Human Services to chemical and allied product essential workers, assisted the Virginia Department of Emergency Management (VDEM) increase domestic supplies, donations and production of PPE (including over 100,000 bottles of hand sanitizer, 1,250 Tyvek® 400 hooded coveralls, and a UV-C sanitation cabinet for public health workers), contributed to the Governor's COVID-19 Business Task Force, and implemented the MFG Makes Virginia Safer Pledge.

The VMA is also a member of the Virginia Business Coalition, the largest business association Coalition in Virginia today (33 business associations ranging from retail to agriculture) that has submitted comments throughout the last year regarding the COVID-19 ETS and draft permanent regulations.

It is through this filter that the VMA will provide you with its detailed comments on the proposed permanent COVID-19 regulations. I say "regulations," plural, because there are now two drafts which is one of our detailed complaints. Since we do not have time to review all our complaints today, I will draw your attention to a few highlights that speak to our overarching concerns about transparency, process, statutory authority, and feasibility.

DETAILED COMPLAINTS:

1. It is unreasonable to apply “one size fits all” COVID-19 regulations to all employers and employees. The Board’s determination of “grave danger” in relation to the COVID-19 ETS has not materialized for ALL workplaces. In fact, we argue that the lack of verifiable data on infections, hospitalizations, and deaths by workplaces (categorized by low to very high risk) is effectively non-existent. In fact, VDH data indicates that COVID-19 confirmed deaths are primarily with citizens over 70 years old and with individuals in long term care facilities.

VDOLI also cannot demonstrate employer compliance with the COVID-19 ETS. We contend that most Virginia employers are not in compliance with the COVID-19 ETS and infections have been reduced entirely by employer compliance with CDC guidance, OSHA guidance, and Governor’s Executive Orders – not the COVID-19 ETS.

Therefore, the Board cannot simply assume and apply its prior “grave danger” determination and COVID-19 ETS efficacy as the basis for permanent regulations. Further, since 46 other states have neither a COVID-19 ETS or permanent regulation, the Board has not proven the necessity for such a permanent regulation.

VMA Recommendations:

- a. The “grave danger” determination for ALL workplaces must be reconsidered especially when it is still unclear how many infections by type of workplace have been documented and the number of resulting hospitalizations and deaths have been confirmed by type of workplace (low to very high risk).
- b. The Board should direct VDOLI to complete an assessment of verified COVID-19 infections, hospitalizations, and deaths by workplace type (low to very high risk).
- c. The Board should direct VDOLI to assess employer compliance with the COVID-19 ETS vs. CDC guidance, OSHA guidance, and Executive Orders to validate or invalidate regulatory efficacy.
- d. The Virginia Safety and Health Codes Board (“Board”) should withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.”
- e. The Board should convene a working group of stakeholders to revise and recommend a second COVID-19 Emergency Temporary Standard (ETS) that expires within 6 months of adoption or when the State of Emergency expires.

2. If the Board will not withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220” and/or convene a working group of stakeholders to revise and recommend a second COVID-19 ETS, the Board must reconsider its current process. There have been ongoing concerns raised by the VMA and Virginia Business Coalition about the Board’s compliance with the Virginia Administrative Process Act and the Board’s own bylaws including public notice, barring public testimony, failing meeting notice and agenda publication requirements, and failure to assess the impact of these Regulations on manufacturers and all businesses in accordance with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA). The Board has also violated the Virginia Administrative Process Act by providing a second draft permanent regulation on January 4, 2021. The VMA would argue that these process issues limit Board information needed to make good decisions, limit public participation, increase the probability of litigation, and result in substantial regulatory non-compliance.

VMA Recommendations:

- a. The Board must make the January 4, 2021 proposed rule available for a new 30-day public comment period.

b. The Board must have the Economic Impact Statement and Regulatory Flexibility Analysis available for a 60-day public comment period.

c. VMA comments previously submitted where VDOLI refused to respond because we are challenging the COVID-19 ETS in Circuit Court is inappropriate and bars us from receiving the necessary information to make informed comments on the permanent regulation (either version). This tactic limits our ability to help the Board make better decisions. The Board should direct VDOLI to respond to all our previous comments.

3. The Board, the Governor and the Health Commissioner must eliminate the conflicts and overlaps between the “Safer at Home” guidance, Executive Order 72, and the proposed rule. Executive Order 72 now contains a new Section IV that states the following:

IV. ADDITIONAL PROVISIONS A. Construction with the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19” Where the Emergency Temporary Standard “Infectious Disease Prevention: SARS-CoV2 Virus That Causes COVID-19” adopted by the Safety and Health Codes Board of the Virginia Department of Labor and Industry pursuant to 16 Va. Admin. Code §§ 25-60-20 and 25-60-30 conflicts with requirements and guidelines applicable to businesses in this Order, this Order shall govern

However, the second version of the draft permanent rule (1/4/21 version), 16VAC25-220-10. E states that:

To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard...

VMA Recommendation:

- The regulation should govern, and this should be explicitly stated in the permanent regulation. Otherwise, the regulation must be inadequate to protect worker safety.

In our last testimony, we expressed concerns about:

a. HVAC system requirements.

b. Cleaning and disinfecting common spaces at the end of each shift for businesses with complicated shift schedules.

c. The Board’s lack over organizational sick leave policies, flexible worksites, flexible work hours, flexible meeting and travel, teleworking, the delivery of services or the delivery of products.

d. Physical barriers – permanent and temporary.

e. Requiring “respiratory protection” and “personal protective equipment standards applicable to the employer’s industry” in vehicles with more than 1 person.

f. Enforcement without prior notice to an employer and “due process” for employers involving a whistleblowers, including VDOLI requiring identification of the plaintiff.

g. Heat-related illness prevention.

- h. Training and infectious disease preparedness and response plan compliance feasibility.
- i. Sunsetting regulations based upon an event not a date, such as the end of the State of Emergency.

We will enumerate our comprehensive concerns on these issues and others in a detailed public comment filing by January 8, 2021.

CLOSING:

The VMA asserts that adopting 16VAC25-220 as permanent Regulations is overly burdensome and unnecessary.

VOSH has failed to demonstrate an inability to enforce CDC, OSHA, or other agency COVID-19 safety guidance through the general duty requirements of § 40.1-51.1 (a) of the Code of Virginia. This code section specifically states that under this provision:

...it shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees...

As such, the VMA requests that the Virginia Safety and Health Codes Board withdraw its "Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220." Should the Board demonstrate a necessity to pursue regulation, it should convene a working group to develop a second COVID-19 ETS that expires with a State of Emergency.

Finally, should the Board ignore the necessity to demonstrate a need for regulations and proceed, the Board should not consider any amendments to the regulations that would incorporate other infectious diseases.

ADDENDUM:

Health & Safety Board Bylaws Excerpts:

IX. DESIGNATED REPRESENTATIVES. The Commissioner of Health or the Executive Director of the Department of Environmental Quality may authorize a representative to sit in his or her place on the Board. Such authorization shall be made in writing to the Chair of the Board. The designation shall state the name of the authorized representative, and the letter of appointment shall be made a part of the permanent minutes of the Board. The authorized representative for the Commissioner of Health or Executive Director of the Department of Environmental Quality will have full membership status. Any other members may authorize a representative to sit in his or her place in the same manner as is provided for the Commissioner of Health and Executive Director of the Department of Environmental Quality except that such authorized representative is not entitled to vote on matters before the Board or be counted as part of a quorum.

MEETINGS. Except for closed meetings conducted in accordance with the Virginia Freedom of Information Act, all meetings and hearings of the Board shall constitute business of the citizens of the Commonwealth and shall be open to the public. At all such open meetings of the Board, there shall be a designated time when members of the public may address the Board on any subject or issue under the jurisdiction of the Board.

The Board shall notify its members of all meetings or public hearings of the Board not less than 30 calendar days prior to the scheduled date of such meeting or hearing and have a notice to the public regarding the meeting posted on the Department's website.

AGENDA. Unless circumstances otherwise dictate, a proposed agenda shall be sent to each member of the Board at least two weeks prior to the time for meeting. LEGALITY OF 16VAC25-220 Emergency Temporary Standard (ETS) Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 As Adopted by the Safety and Health Codes Board on July 15, 2020.

NOTE: THE COMMENTER IS A PARTY TO A LAWSUIT CHALLENGING THE LEGALITY OF 16VAC25-220 Emergency Temporary Standard (ETS) Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 As Adopted by the Safety and Health Codes Board on July 15, 2020. LEGAL ISSUES RAISED BY THE COMMENTER THAT RELATE TO THE ONGOING LITIGATION WILL NOT BE ADDRESSED FOR THAT REASON.

NOTE: TO THE EXTENT THAT THE COMMENTER DISCUSSES THE LEGALITY OF ORDERS OF PUBLIC HEALTH EMERGENCY BY THE HEALTH COMMISSIONER OR EMERGENCY DECLARATIONS AND EXECUTIVE ORDERS OF THE GOVERNOR, THE DEPARTMENT CONSIDERS SUCH COMMENTS TO NOT BE GERMANE TO THIS STANDARD AND PROVIDES NO RESPONSE.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees that the Standard is a “one size fits all” regulatory approach.

At its core the Standard is a risk management system to prevent or limit the spread in the workplace of the SARS-CoV-2 virus which causes COVID-19.

It is designed to provide basic protections for all employees and employers within the jurisdiction of the Virginia Occupational Safety and Health program.

It provides certain mandatory requirements for all employers and specific additional requirements for Very High, High, and Medium risk job tasks centered around mitigation of hazards.

The Standard is also designed to incentivize employers to make changes in the workplace that will enable employees in certain situations to be classified to a reduced level of risk (e.g., from high to medium or from medium to lower), thereby also reducing the employer’s compliance and cost burdens.

It is the Department's position that COVID-19 has had a significant and widespread impact on Virginia employees and employers in the workplace. Since February, 2020, the Virginia Workers’ Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020 in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH has been notified of 2,823 work locations where 3 or more positive COVID-19 employee cases occurred within a 14 day period in a wide variety of industries and workplace settings.

Through January 1, 2021, VOSH, with its approximately 47 compliance safety and health officers, has received and either informally investigated or inspected 1,537 employee complaints and referrals from other government agencies in a wide variety of industries and workplace settings - over 900 of those complaints and referral occurred after the effective July 27, 2020 effective date of the ETS. In each of those over 900 cases, VOSH has undertaken to determine whether employers were complying with the ETS or not and either close the case with no action, or initiate an inspection which includes the consideration of potential violations and penalties. In addition, VOSH has received notifications of 30 COVID-19 related employee deaths and 61 employee

hospitalizations. To date, VOSH has opened 103 inspections, a number of which resulted from employers not taking advantage of either working cooperatively with the Virginia Department of Health, or not taking advantage of VOSH's informal investigation process, which does not result in citations and penalties, provided the employer provides a satisfactory response. Of the first 94 inspections conducted by VOSH, 43 remained under investigation as of January 4, 2021, 25 were closed with no violations issued, and 26 resulted in the issuance of violations (29 serious and 29 other-than-serious violations) and a total of \$226,780.00 in penalties.

It is the position of the Department based on consultation with the Office of the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA."

The proposed permanent standard has been subject to the following notice and comment procedures within the time constraints contained in Va. Code §40.1-22(6a). The Board held a 60 day written comment period for the Proposed Permanent Standard, with the comment period running from August 27, 2020 to September 25, 2020. The Board held a Public Hearing on September 30, 2020. The Revised Proposed Permanent Standard was published with an additional 30 day comment period from December 10, 2020 to January 9, 2021. A second public hearing was held on January 5, 2021. An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04 will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm. Members of the public will be provided the opportunity to address the Board at its January 12, 2021 meeting to consider the Draft Final Standard.

The Department respectfully disagrees with the Commenter's assertion that the Department did not respond to Comments previously submitted by the Commenter during the 60 day written comment period. The Department's combined responses to those comment consisted of more than 4,400 words.

Any conflicts identified between Executive Orders and the ETS would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

The Standard does not cover other infectious diseases like influenza, tuberculosis, etc.

20002 Nandan Kenkeremath 1/5/2021

WRITTEN COMMENTS SUBMITTED BY SPEAKER, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4>

Thank you, Madam Chairman and the Board, for the opportunity to speak on the record at this public hearing. I am a concerned citizen and lawyer with extensive background in regulatory law and policy. I have worked on dozens of statutory programs for many years as Senior Counsel to the Energy and Commerce Committee in the U.S. House of Representatives and worked in the Office of General Counsel for the U.S. Environmental Protection Agency. I have substantial concerns with the proposed rule and strongly recommend the Board follow the full procedures of the Virginia Administrative Process Act (VAPA) (Va. Code 2.2-4000 et seq), as the Board committed to do. I further ask the Board not to adopt the proposal published by DOLI staff. The proposal is, from my assessment and experience, filled with provisions that are not workable and do not have benefits that outweigh the costs relative to the base line of OSHA laws and previous Virginia law. I have previously submitted a detailed and comprehensive set of comments under the name Leading Edge Policy & Strategy during the last comment period. These comments are posted on the Department of Labor and Industry (DOLI) website. I am going to submit revised comments during this comment period. I am eager to answer questions at any time and have discussion with the Safety and Health Codes Board (the "Board") or the DOLI. My short statement is a nonexclusive list of concerns.

In the Emergency Temporary Standard ("ETS"), committed fully to follow public participation under the VAPA under 16VAC25-220-10(B). Under VAPA, there must be a regulatory impact analysis and regulatory flexibility analysis for the public to comment on, not after the public comment period. DOLI staff has a fiduciary obligation to implement the commitment of the Board and not deny the process the Board promised. In addition, DOLI staff does not have authority to issue a proposed rule. The Board is the agency with such authority, not DOLI staff.

The economic impact analysis, including the analysis of impacts on small business, is critical to a regulatory flexibility analysis. The claim by DOLI staff that they have performed the regulatory flexibility analysis without understanding small business impacts makes those statements not well founded. I further note that the recent language in the background documents do not suffice for a regulatory flexibility analysis. All the background document does is claim certain elements of flexibility. There needs to be an analysis and discussions on the effects on small businesses including potential exemptions.

It would be reasonable to consider additional elements of flexibility and possibly reject them, but the analysis does not present any alternatives to the proposed regulations. I do not know whether DOLI or the Board have contacted the Joint Commission on Administrative Rules regarding the analysis.

I am further concerned that DOLI staff has not responded to and not properly relayed my previous comments. I spent a long time on them. They have headers for each significant issue. I was expecting see a header and a response to the issue in the response to comment document. As an example, I noted that the Board does not have authority concerning sick leave policies. There could have been a response pointing to what the purported source of authority was. However, there was no response.

Instead, DOLI staff provided a statement to the effect that the commenter (me) is a party to a lawsuit challenging the ETS. DOLI staff further stated that legal issues raised by the commenter (me) that relate to the ongoing litigation will not be addressed for that reason.

The document further stated that DOLI would not respond to my comments concerning the overlap and incorporation by reference of the Executive Orders and Orders of Public Health because the Department does not consider such comments to be germane. DOLI staff said the same things for comments of the Virginia Manufacturers Association. This approach of filtering out the comments of those involved in litigation is not

appropriate. I provided extensive comments for the Board to consider, including the legal ones. It is not the job of DOLI staff to create a comment category that staff consider off limits or to filter what responses the Board considers. There is no such separate category.

Obviously, a lawsuit may cover all manner of issues that are also in comments. There is no comment period penalty for parties that pursue their rights in court. There is no comment period penalty for attorneys that participate. So, I hope DOLI staff does not do the same to my new comments and that the Board reads my comments in entirety.

I am further concerned that DOLI staff wants to provide a response to comment document within only one or two days after the close of the current comment period and only immediately prior to beginning Board discussion of a final rule. It is hard to see how the Board can properly consider my comments through such an approach.

Moreover, my concerns go straight to how impacts should be modelled and that the regulatory impact analysis will not be well informed from confusing regulatory language and from a failure to interact with public comments. As an example, the approach in the proposal where a cough, sneeze, runny nose, or headache means people have symptoms of COVID and cannot stay at a work site would devastate the employment situation because they are common symptoms that are occurring for other reasons. It is certainly plausible to model what happens under that interpretation. It would mean collecting information on the yearly prevalence of colds, flus and allergies. However, I have no confidence that impact will be modelled at all.

It is also odd that the provisions of the ETS that referenced the Executive Orders have been removed from the text of the proposed rule with no explanation by DOLI staff in the background document. Instead, a new legal structure has appeared in the Executive Orders themselves that purported to override the ETS and presumably, in the future, any final rule. My prior comments extensively pointed out the problems with these overlapping provisions. The same construct of overlap and conflict is now set out in Executive Order 72 and Order of Public Health Emergency 9. To be clear, the terms guidelines applicable to businesses referred to in the Orders is a document incorporated by reference styled Safer at Home: Phase Three Guidelines for All Business Sectors ("Safer at Home" document). The Board, the Commissioner of Health, and the Governor have an obligation to eliminate these confusing conflicts. Instead, Executive Order 72 and Order of Public Health Emergency 9 added new language saying that the Orders and the mandatory sections of the associated Safer at Home document apply if there is a conflict with the proposed rule. The Board has not discussed the needless overlap and confusion and there has been no side-by-side analysis in any background document. Just as a few examples, there are significant differences between the Safer at Home document and the proposed rule related to when employees must be sent home, who makes an alternative diagnosis, and different language concerning sick leave policies. The regulated community should not be held hostage to these conflicts.

Compliance with either the Orders, the Safer at Home Document or the proposed rule if they overlap should satisfy the requirements. Otherwise, the Board is adding to an already vague and confusing regime for little reason. It is incumbent on the Board to look at all overlapping and potentially overlapping provisions side by side and explain clearly what different.

On some things, the Safer at Home documents are better with respect to my concerns. For example, the Safer at Home document requires employers to instruct employees to stay home who are "sick" as opposed to suspected to have COVID. The COVID-19 screening protocols referred to in the Safer at Home documents for employee self-checks suggest a structure with a check list if the symptom "cannot be attributed to another

health condition". This is a different standard than the "alternate diagnosis" language of the ETS and proposed rule at 16VAC25-220-40(B)(4). While neither document is workable, the Safer at Home document at least allow some flexibility to employees to consider whether a symptom is more likely a cold or flu or allergy.

The "Suspected" COVID provisions in the proposed rule, among other provisions, remain unworkable, vague and not supported by evidence. None of the proposals has made sense of how to deal with symptoms like a cough, sneeze, runny nose or headache which are also symptoms of flus, colds, or allergy. If people with any of those symptoms may not be at a worksite the damage to businesses and employees will be substantial. This scheme means employees lose work and employers lose an employee for a length of time. That time could repeat each time there is a symptom. Such caution may or may not be relevant to certain high-risk settings. However, this approach is not feasible for all employment settings, including in settings that are outside or where distancing is available in the employment setting. Employees may use up their sick leave, they may miss important training, projects or job opportunities. Many temporary or contract employees may have no sick leave and no alternative funds-- all because an employee has a cold or a cough or a headache. The system means that employees will not want to be honest about their symptoms with their employers for fear of the losses they may entail.

Broadly speaking, language that might make sense for guidance does not often translate well for enforceable standards. Sometimes it is not possible to do in a satisfactory manner. Information is good, but legal penalties flowing from ambiguous language is not acceptable and lends itself to arbitrary enforcement and confusion. As another example, consider the requirement to consider employee's individual risk factors including all manner of personal medical information under the preparedness and response plan. One can understand the medical point but expecting employer assessments like this is not enforceable and there is insufficient guidance on what employers should do with this information, if any is available. Expecting small businesses to accomplish this is a dramatic burden.

I request that the Board start over and consider component by component whether the requirements are reasonable and necessary and provide a regulatory impact analysis and regulatory flexibility analysis for public comment. In addition, the Board should insist on information on how the ETS has operated so far. There should be no final rule without evaluation of the program under the ETS and public comment on that information.

Thank you again for the opportunity and I look forward to working with the Board, DOLI staff, and other stakeholders.

NOTE: THE COMMENTER IS A PARTY TO A LAWSUIT CHALLENGING THE LEGALITY OF 16VAC25-220 Temporary Standard (ETS) Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 As Adopted by the Safety and Health Codes Board on July 15, 2020. LEGAL ISSUES RAISED BY THE COMMENTER THAT RELATE TO THE ONGOING LITIGATION WILL NOT BE ADDRESSED FOR THAT REASON.

NOTE: TO THE EXTENT THAT THE COMMENTER DISCUSSES THE LEGALITY OF ORDERS OF PUBLIC HEALTH EMERGENCY BY THE HEALTH COMMISSIONER OR EMERGENCY DECLARATIONS AND EXECUTIVE ORDERS OF THE GOVERNOR, THE DEPARTMENT CONSIDERS SUCH COMMENTS TO NOT BE GERMANE TO THIS STANDARD AND PROVIDES NO RESPONSE.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

It is the position of the Department based on consultation with the Office of the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on

page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA."

The Commenter is incorrect in stating that the Board committed to follow the full procedures of the Virginia Administrative Process Act (VAPA) (Va. Code 2.2-4000 et seq). The Board did make clear its intent during the adoption process for the ETS that during any process to adopt a permanent replacement standard it would attempt to substantially comply with the core requirements in the APA within the time constraints of the requirements of Va. Code §40.1-22(6a) by holding a 60 day written comment period and a public hearing along with obtaining an Economic Impact Analysis and holding a meeting to consider a final standard. All four of those conditions have or will be met by January 11, 2021. With regard to the issue of a regulatory impact analysis and regulatory flexibility analysis being provided to comment on, the January 4, 2021 Draft Briefing Package for the Board contains information that addresses both topics. Such information in various forms was also included in the June 23, 2020 Briefing Package to the Board for the ETS. The 30 day written comment period runs from December 10, 2020 to January 9, 2021.

The Commenter is incorrect in stating that the DOLI staff issued a proposed rule. DOLI staff published for Board consideration recommended changes to the proposed standard which was originally noticed at the same time and in conjunction with publication of the ETS on July 27, 2020.

The Department respectfully disagrees with the Commenter's assertion that "DOLI staff has not responded to and not properly relayed my previous comments." The Commenter's original comments from the 60 day comment period and September 30, 2020 public hearing were provided in full to the Board for its consideration. In total, the Department provided over written responses to the Commenter totaling over 2,000 words.

With regard to legal arguments made by the Commenter, as noted above, his comments were provided in full to the Board for their review and consideration.

With regard to the Commenter's reference to language in the standard referencing signs and symptoms of COVID-19 (based on CDC documents), the Department notes that the standard in 16VAC25-220-40.B.4 provides that "Employers shall develop and implement policies and procedures for employees to report when employees are experiencing symptoms consistent with COVID-19, and no alternative diagnosis has been made (e.g., tested positive for influenza)...." Such employees are then classified as "Suspected to be infected with SARS-CoV-2 virus" and may not report to the workplace until they have been cleared for return to work in accordance with ETS requirements. In situations where there is the possibility for an alternative diagnosis (such as allergies, the common cold, the flu, an ear infection, etc.) the employer has a number of options, including but not limited to, a positive test for influenza or the employee obtaining an alternative diagnosis from a medical authority.

In addition, the Virginia Department of Health provides the following guidance:

If the employee DID NOT have close contact with a COVID-19 case or an area with substantial COVID-19 transmission, but does have signs or symptoms and tested negative for SARS-CoV-2, the negative test can be considered as supporting an "alternative diagnosis", and the person would not be considered suspected to be infected with SARS-CoV-2 virus. The employee must remain out of work until signs and symptoms have resolved and the employee has been fever-free for at least 24 hours without the use of fever-reducing medicine (unless symptoms are due to a known non-infectious cause, such as allergies).

NOTE: It is important to remember that a negative test for SARS-CoV-2 only means that the person wasn't infected at the time the test was taken. If the person is ill one week, tests negative for SARS-CoV-2, and recovers from their illness, only to become ill again soon after, there is always the potential that the repeat illness may be related to COVID. Each illness should be handled as a distinct situation, meaning, the employee should not always be considered to be COVID-19 negative because they tested negative previously.

With regard to any potential conflicts between Executive Orders and the standard, any conflicts identified between Executive Orders and the ETS would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov. Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

20003 Laura Karr 1/5/2021

WRITTEN COMMENTS SUBMITTED BY SPEAKER, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4> "First, the ATU stands with our labor movement allies, as represented by the AFL-CIO, in strongly supporting a permanent standard to protect Virginia workers from SARS-CoV-2. The emergency temporary standard approved by this Board has made a substantial impact in our members' workplaces and gone a long way toward keeping them safe on the job.

But ATU members continue to get Covid-19, and they continue to die from it. And while vaccines have begun to arrive, public health experts tell us that it will be months before all essential workers, like ATU members, are vaccinated, and even longer before we reach population-level immunity – if we ever get there. Meanwhile, the ETS expires in just 3 weeks, and infections are increasing.

This isn't the time to let up on our efforts; it's the time to commit to protecting Virginia workers from SARS-CoV-2 for as long as they need that protection, and the way to do that is through a permanent standard that is at least as protective as the ETS.

In fact, ATU members are pleased to see that the proposed permanent standard is better than the ETS in some ways, which brings me to my second point: that the new ventilation requirements in Section 25-220-60 must remain in place as the permanent standard is promulgated. In the ETS and in the initial proposal for the permanent standard, the ventilation requirements for medium-risk workplaces, which includes transit, focused on requiring employers to abide by ANSI and ASHRAE standards. But, as I explained when I had the chance to speak with you in September, the ANSI and ASHRAE guidelines were developed for buildings, not for vehicles, and for the most part, they do not apply to vehicle ventilation systems.

What ATU members need are ventilation rules that focus on outcomes – on system maintenance, outside air, overall airflow, and effective filtration. This is exactly what the revised proposal for the permanent standard provides, and it's essential that these provisions remain in the standard as it gets codified. It's essential that the permanent standard focuses on the specific ventilation improvements that keep workers safe, instead of on third-party guidelines that don't apply to all of the worksites covered by the standard.

That said, while the ATU is certainly pleased to see these worker-protective changes in the revised proposal for the permanent standard, that doesn't mean that there isn't still room for improvement – which brings me to my third point: that this Board can and should do more to protect workers, including transit workers, from airborne SARS-CoV-2. The revised proposal is absolutely correct in noting, in Section 25-220-60, that surface transportation workers have unique needs and require unique protections from airborne virus. As the revised proposal states specifically, one of the main ways to protect transit workers is to increase the flow of outside air into vehicles.

The proposal suggests that employers do this by mandating that the windows stay open. This sounds like a simple solution, but in fact, it increases the likelihood that drivers will become infected. This is because the air within a transit vehicle flows from back to front, toward the driver, due to the vehicle's shape. When windows are open, this flow – which carries any airborne virus that might be in the vehicle directly toward the driver – is even stronger.

While it might seem counterintuitive, employers actually need to keep transit vehicle windows closed and bring fresh air in through the vents in the driver's seat area, while keeping the vehicle's back hatch open. This reverses the internal airflow so that fresh air goes toward the driver, the air travels through the vehicle, and then exits at the back. The ATU's written comments cover this matter in more detail, but for now, suffice it to say that the reference to open windows needs to be removed – and it would be even better if employers were directed to use vehicle vents in the way that I've described.

Another way to protect transit workers from airborne SARS-CoV-2 is to expand the applicability of Section 25-220-40(F)(2) to cover these workers. This provision requires employers to eliminate air recirculation in vehicles that transport multiple workers for job-related purposes. It's absolutely correct that recirculated air is dangerous air, and eliminating it is an important component of SARS-CoV-2 protection.

However, the revised proposal does not require employers to eliminate air recirculation in vehicles, like transit vehicles, that transport a mix of workers and members of the general public. There's no good reason for this; the threat of multiple people breathing recirculated air in a confined space is the same regardless of whether some of those people are members of the public. This is especially true given that the revised proposal requires workers riding together to wear face coverings, but it does not mandate that employers require members of the public who visit a worksite – and a transit vehicle is a worksite – to do the same. Eliminating air recirculation is just as important for transit workers transporting members of the public as it is for workers riding together – and the permanent standard should reflect this fact.

The bottom line is that ATU members need and look forward to the promulgation of a permanent and effective SARS-CoV-2 standard. The ATU thanks the members of this Board for your hard work in that regard, and for your time this morning. Thank you.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

SEE DEPARTMENT RESPONSE TO COMMENT 89008

20004 Kyle Shreve 1/5/2021

[SUMMARY OF ORAL COMMENTS PREPARED BY DEPARTMENT STAFF, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4>

1. Request "sunset provision" to appeal ETS when Governor lifts "state of emergency";
 2. Econ. Impact Statement - Board and public need comment period to review and comment on final EIS when available.
 3. Conflict between EO and ETS: which to follow? Who has authority to enforce conflicts?
 4. No authority to expand permanent standard to "any and all future infectious diseases".
-

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Any conflicts identified between Executive Orders and the ETS would be evaluated on a case by case basis depending on the fact of the situation. Employers can contact DOLI with such questions of interpretation by sending an email to webmaster@doli.virginia.gov.

Depending on the determination of whether the EO or ETS applied, enforcement authority would either be vested with VDH, VOSH, or other agencies having jurisdiction (e.g., Virginia Alcoholic Beverage Control Authority; Virginia Department of Agriculture and Consumer Services).

20005 Hobey Bauhan 1/5/2021

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Poultry plants in Virginia were successful implementing COVID-19 prevention measures WELL prior to adoption of the ETS, and will continue to make worker safety a top priority. According to data posted by the Virginia Department of Health (VDH), about 90 percent of cases among poultry workers occurred in April and May, with a dramatic decline after that, even as total Virginia cases increased. The data show the industry's implementation of OSHA, CDC, and VDH guidance was successful.

To reiterate our previous written comments and testimony in September on a permanent standard:

- A static regulation is inappropriate in light of the changing scientific understanding of COVID-19.
- OSHA and CDC guidance are updated frequently and are a more appropriate mechanism to guide protective measures.
- VOSH already has the ability under the OSHA general duty clause to cite a company that fails to take actions to protect its workers from COVID-19, as recommended by OSHA or CDC.

The proposed permanent standard published for a 30 day public comment period did not contain the language that had been included in the ETS at §16VAC25-220-10. G.1 concerning compliance with CDC guidelines. I was going to ask, what is the purpose of removing this reference? But then suddenly, the day before the public hearing, a new draft emerges containing a version of 10 G.1. If anything, Virginia should rely MORE heavily upon and correlate more closely to CDC guidance.

But what else was changed from the version that was publicly noticed? It is hard to know because we only saw it this morning. Also, where is the economic impact analysis to determine cost to small businesses?

How are impacted stakeholders able to review and comment on this analysis, which has not been released, before the comment period ends this week or before the Board votes next week?

In our view, DOLI should not adopt a permanent standard. Disease pandemics are temporary; regulations addressing them should be as well. If anything, you should consider another temporary standard.

However, whatever you do requires additional time for appropriate deliberation, transparency, and stakeholder input, and it should contain an explicit mechanism to allow it to expire immediately upon the end of the state of emergency.

We plan to submit additional written comments.

"SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word “permanent” in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

20006 Vanessa Patterson 1/5/2021

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RAMCA and PCAV’s employees are essential and have worked since the start of the pandemic to keep Virginia’s infrastructure open and in good repair. Most heavy construction work is done outside, and physical distancing is a natural part of our work environment. The health and safety of every employee is the top priority of RAMCA and PCAV member companies.

The proposed permanent standard is “designed to supplement and enhance VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards”. This proposed permanent standard, with no specified end date, is based on a temporary standard for a temporary health crisis for which there are now 2 vaccines distributed to Virginia with over 90% efficacy and several more candidates nearing the end of their trials. If the standard is adopted, it should sunset upon the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public

Emergency. There is no logical or scientific justification for the continuance of a standard that was specifically crafted in response to an Executive Order during the COVID-19 State of Emergency. Why would the Safety and Health Codes Board continue the burdensome, costly mandates enacted as temporary measures during an emergency, once that emergency has passed.

The standard states the Safety and Health Codes Board is required, within 14 days of the expiration of the State of Emergency, to make a “determination” as to whether there is a continued need for the standard. The three choices noted are:

1. There is no need to continue the standard
2. There is a need to continue the standard with no changes
3. There is a continued need for a revised standard

What metrics, scientific data, or criteria will the board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?

I have reviewed comments posted on the townhall forum. There are comments suggesting that adoption of the permanent standard for COVID-19 will protect and keep workers safe in future pandemics and from common contagious illnesses like seasonal cold and flu. Adopting a permanent standard for COVID-19 should not be used to mandate employers permanently become responsible for the public health in Virginia.

Science and data should guide our decisions and actions during this pandemic. Analyzing the data on Virginia’s COVID-19 dashboard, the most impacted age groups are not the working age population but instead those who are 70 years or older and particularly those in assisted living/nursing homes. As of yesterday, those over age 70 represent 9.8% of the total cases since March yet account for 75.3% of all deaths. The the COVID-19 data for the working age population does not support a direct and immediate danger. This raises the question why a permanent standard, particularly for job tasks classified as low and medium exposure risk, is necessary, particularly for industries regulated by OSHA?

There is the question as to the effectiveness of these standards. In the last nine-week period, the number of positive COVID-19 cases (183,285) exceeds the total number of COVID-19 cases for the 8 months from March until October 31st (181,998). This increase in cases comes 4 ½ months after the temporary standards went into effect. What data does the board have to support the effectiveness as cases continue to increase? California adopted Virginia’s standard almost word for word and their lockdown mandates are among the strictest in the country, yet their cases have only increased despite their measures being in place since September. The cases among those under 60 in Virginia have increased since the end of October. Contact tracing has indicated that 74% of cases are occurring as a result of gatherings that take place outside of the workplace. Gatherings in private homes are difficult, if not impossible, to restrict by Executive Order or other measures. Employers cannot and should not be permanently (or even temporarily) responsible for employee behavior and activities that occur outside of the workplace.

The temporary, and now the proposed permanent standard, is burdensome, quickly obsolete, difficult to enforce, costly in time and money, lacks flexibility to adapt to current science and the effectiveness is not apparent in the data. The economic impact on businesses and entire industries will inevitably impact workers and the Commonwealth as the cost of doing business continues to increase. No decision to approve a

permanent standard should be made until the economic impact report is complete and sufficient time is allowed for public review and comment.

On behalf of RAMCA and the PCAV, I oppose adopting a permanent standard for COVID-19, particularly with no sunset clause tied to the State of Emergency.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word “permanent” in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

C. Within fourteen (14) days of the expiration of the Governor’s COVID-19 State of Emergency and Commissioner of Health’s COVID-19 Declaration of Public Emergency, the Virginia Safety and Health Codes Board shall notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for the standard.

The Commenter asks "What metrics, scientific data, or criteria will the board use to continue a standard for COVID-19 after the Governor, a physician, has allowed the State of Emergency to expire and the Commissioner of Health has determined COVID-19 no longer presents a public health emergency for Virginians?" The Board will follow the requirements of Va. Code §40.1-22(5), which provides:

(5) The Board, with the advice of the Commissioner, is hereby authorized to adopt, alter, amend, or repeal rules and regulations to further, protect and promote the safety and health of employees in places of employment over which it has jurisdiction and to effect compliance with the Federal Occupational Safety and Health Act of 1970 (P.L. 91-596), and as may be necessary to carry out its functions established under this title. The Commissioner shall enforce such rules and regulations. All such rules and regulations shall be designed to protect and promote the safety and health of such employees. In making such rules and regulations to protect the occupational safety and health of employees, the Board shall adopt the standard which most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity. However, such standards shall be at least as stringent as the standards promulgated by the Federal Occupational Safety and Health Act of 1970 (P.L. 91-596). In addition to the attainment of the highest degree of health and safety protection for the employee, other considerations shall be the latest available scientific data in the field, the feasibility of the standards, and experience gained under this and other health and safety laws. Whenever practicable, the standard promulgated shall be expressed in terms of objective criteria and of the performance desired...."

The Standard does not cover other infectious diseases like influenza, tuberculosis, etc.

The Department respectfully disagrees with the Commenter's statement that "The COVID-19 data for the working age population does not support a direct and immediate danger." There is overwhelming evidence to the contrary. The January 4, 2021 Briefing Package for the Safety and Health Codes Board contains information

in section V.C on the aging of the workforce and the high percentages of the American populace that are in COVID-19 high risk health categories:

“Older adults make up a large percentage of many of the jobs in these industries. For example, nearly half of bus drivers are older than 55, while almost 1 in 5 ticket takers and ushers are 65 or older. And although the BLS didn’t specifically call them out, farmers have also been impacted by the toll of the virus, with both prices of commodities and consumption declining. The median age of farmers and ranchers in the U.S. is 56.1 years old.” <https://www.seniorliving.org/research/senior-employment-outlook-covid/> the CDC conducted a study of “Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016” of the general population. Although the working population of the country is only a subset of the totals for the table, the data nonetheless demonstrates the significant risk that SARS-CoV-2 and COVID-19 related hazards pose to the U.S. and Virginia workers. Using the age adjusted statistical totals:

- 14.7% of the population suffer from diabetes,
- 12.2% from high cholesterol
- 30.2% suffer from hypertension
- 39.7% suffer from obesity

<https://www.cdc.gov/nchs/data/hus/2018/021.pdf>

The Briefing package also contains Virginia specific information on COVID-19 related workers' compensation claims, employee hospitalizations and employee deaths in section IV.E:

Since February, 2020, the Virginia Workers’ Compensation Commission received 9,773 COVID-19 related claims as of November 30, 2020.

Thirty employee deaths and 61 employee hospitalizations have been reported to VOSH as of January 1, 2021.

NOTE: The VOSH Program has investigated an average of 37 annual work- related employee deaths over the last five calendar years. The 30 COVID-19 death notifications so far in 2020 would represent 81% of the deaths investigated by VOSH in an average year.

The Commenter states that "Employers cannot and should not be permanently (or even temporarily) responsible for employee behavior and activities that occur outside of the workplace." It is exactly because there currently is a real possibility that infections obtained outside of work – whether by an employee, or a customer, or a patient, or a subcontractor – that employers need to maintain workplace COVID-19 protections for those employees who do act responsibly away from work. There is substantial scientific evidence and infection, hospitalization and death statistics that support the conclusion that SARS-CoV-2 presents a danger to employees in the workplace.

It is the Department’s position that the danger posed to employees and employers by the SARS-CoV-2 virus and COVID-19 disease are necessary and appropriate to regulate after the expiration of the current COVID-19 Emergency Temporary Standard (ETS) on January 26, 2021. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission and the continuing possibility of the introduction of SARS-CoV-2 into Virginia’s workplaces for many months to come. It is well recognized that one or more vaccines will not be widely available to the public and employees until well after January 26, 2021.

The Department also believes that the Standard will ultimately help businesses to grow and bring customers back when those customers see that employers are providing employees with appropriate protections required by the Standard from SARS-CoV-2. If customers don't feel safe because employees don't feel safe, it will be hard for a business to prosper in a situation where there is ongoing community spread.

The Department respectfully disagrees with the Commenter's statement that the standard was quickly obsolete, difficult to enforce, and lacked flexibility to adapt to current science.

The Department has not found the ETS hard to enforce. Through January 1, 2021, VOSH has received 1,537 employee complaints and referrals from other government agencies. It has received notifications of 30 COVID-19 related employee deaths and 61 employee hospitalizations. To date, VOSH has opened 103 inspections, a number of which resulted from employers not taking advantage of either working cooperatively with the Virginia Department of Health, or not taking advantage of VOSH's informal investigation process, which does not result in citations and penalties, provided the employer provides a satisfactory response. Of the first 94 inspections conducted by VOSH, 43 remained under investigation as of January 4, 2021, 25 were closed with no violations issued, and 26 resulted in the issuance of violations (29 serious and 29 other-than-serious violations) and a total of \$226,780.00 in penalties.

While one or two provisions based on CDC guidance changed after the adoption date of the ETS, the ETS allowed employers who complied with the revised CDC guidance to do so without being in violation of the ETS.

The Department notes that the Standard provides flexibility to business through 16VAC25-220-10.E which provides that "To the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard, the employer's actions shall be considered in compliance with this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigate SARS-COV-2 and COVID19 related hazards or job tasks addressed by a provision of this standard shall be considered evidence of good faith in any enforcement proceeding related to this standard. The Commissioner of Labor and Industry shall consult with the State Health Commissioner for advice and technical aid before making a determination related to compliance with CDC guidelines."

It is the Department's position that the ETS has been an important enforcement tool to reduce or eliminate the spread of the virus in the workplace and assures that similarly situated employees and employers exposed to the same or even more serious hazards or job task should all be provided the same basic level of safety and health protections.

The Commenter's reference to California's ETS is misleading in that while Virginia's ETS took effect on July 27, 2020, California's ETS did not take effect until November 30, 2020, barely one month ago and with very little time to impact the spread of virus in the workplace that has an incubation period.

20007 Doris Crouse-Mays 1/5/2021

[SUMMARY OF ORAL COMMENTS PREPARED BY DEPARTMENT STAFF, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4> Support Permanent Standard

1. Positivity rate is increasing; new variance of virus potential.
 2. Permanent standard protects works and consumers and provides increase in consumer confidence. Therefore business will increase with consumer safety standards.
-

SEE DEPARTMENT RESPONSE TO COMMENT 87825

20008 Nicole Riley 1/5/2021

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1. Sales levels - huge decrease since ETS effective date. Permanent standard will increase costs and most businesses have made required changes following CDC/EO protocols;
 2. Need "sunset provision" as businesses need certainty to plan for future.
 3. EIS needs to be available to public with comment period/review;
 4. Permanent standard should not include "all infectious diseases" and should apply only to current situation. "
-

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

The use of the word "permanent" in reference to the Standard reflects the fact that, if adopted, the Standard does not currently have a date on which it would expire. However, the Board has the authority to amend or repeal the Standard as the workplace hazards associated with the SARS-CoV-2 virus and COVID-19 disease evolve and eventually lessen. DOLI is recommending to the Board the following revision to 16VAC25-220-20.C in the final standard:

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20009 Jodi Roth 1/5/2021

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1. "Sunset provision" is necessary - Board agreed to a sunset provision in July Board meetings.
 2. EIS - procedures for Board and public review and comment once it is final is necessary and appropriate.
-

SEE DEPARTMENT RESPONSE TO COMMENT 87834

Va. Code §40.1-22(6a) under which the Emergency Temporary Standard (ETS) was adopted does not permit the ETS to be extended beyond 6 months.

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20010 Terry Durkin 1/5/2021

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Supports all "opposition" comments previously stated by commenters

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20011 Mike Wilson 1/5/2021

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1. Workers deserve protection of permanent standard;
 2. Commitment to protecting workers in Virginia needs to continue;
 3. Mask mandate - still not being enforced properly in many situations.
-

SEE DEPARTMENT RESPONSE TO COMMENT 87825

20012 David Broder 1/5/2021

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SEIU 512: union representing health care and public service workers (nurses, social workers, educators, public works workers, etc.)

Support a permanent standard. Vaccine will take a long time for immunity and Virginia can be a leader in the nation with a strong permanent standard.

1. DOLI ETS has been a "life saver" for (health care and public service) workers;

2. SPECIFIC CONCERNS of revised permanent standard:

- delayed effective date for requirements (training, etc.) already in place with ETS will cause lapse in coverage;
- allowing "face coverings" when respirators are required/needed is a problem
- training workers to extend ("re-use") PPE is problematic
- it is not safe to reuse PPE. Standard should include training to properly use PPE.
- Return to work - "asymptomatic" needs to be clarified given CDC guidelines have been updated?

"SEE DEPARTMENT RESPONSE TO COMMENT 87825

The Department is recommending an expanded time for employee training from 30 days to 60 days in response to employer concerns expressed during multiple public comment opportunities about the ability to develop and provide effective training to management personnel and employees in 30 days. The Department does not believe the request is unreasonable in light of the unprecedented nature of the pandemic and the need for employers to modify orientation and training materials for new hires and retraining materials for current employees. The Department does not intend to change its recommendation in response to the comment.

The Department note with regard to the face covering/respirator issue that 16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or

provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms." The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

With regard to the reuse of respirators issue, the VOSH Program follows OSHA's April 3, 2020 Memorandum entitled "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" which "outlines enforcement discretion to permit the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer's recommended shelf life (sometimes referred to as "expired")."

The VOSH Program also follows OSHA's April 24, 2020 Memorandum entitled "Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic."

With regard to the Commenter's request to clarify asymptomatic [return to work] issues, the standard provides in 16VAC25-220-40.C.1.b provides:

b. Employees known to be infected with SARS-CoV-2 who never develop signs or symptoms [IN OTHERWORDS, THEY ARE ASYMPTOMATIC] are excluded from returning to work until 10 days after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.

20013 Ron Jenkins 1/5/2021

WRITTEN COMMENTS SUBMITTED BY SPEAKER, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4>

VLA is a 501 C 6 trade association representing smaller family – owned forest harvesting businesses and forest products mills. Our members consist of businesses engaged in logging, mill processing, and supporting businesses from many walks of life.

VLA requests the Virginia Safety & Health Codes Board reject the proposal to adopt a permanent standard related to COVID-19. Instead of reiterating reasons already stated, I refer our reasons already outlined by Virginia Manufacturers' Association, National Federation of Independent Businesses, Virginia Agribusiness Council, Virginia Poultry Association, and other members of the Coalition for a Strong Virginia Economy (CFASVE).

VLA supports a healthy environment and workplace for employees, clients, and customers. In other words, we all want to do the right thing to safeguard the health and welfare of our family, staff, customers, and the public.

Speaking from the perspective of having first - hand knowledge of the lives of our smaller and family – owned businesses, I have witnessed the challenges these businesses face as local, state, and federal government apply more regulations. Business owners with a limited administrative staff must wear multiple hats to pay bills, order supplies, maintain payroll, pay taxes, and keep the company compliant with many regulations from many local, state, and federal agencies.

Business owners are very smart and make good decisions based on timely, accurate information. In addition to those comments made earlier by our peers in the CFASVE, we strongly encourage major efforts be placed on the improvement of communications to rapidly deliver accurate, timely information to these owners across in the Commonwealth in the rural and urban areas. Some members often reach out to our association to seek clarification for a mandate. We often look through many sources before finding the right answer.

Many businesses in the forest products sector have been hurt by regulations placed at large to prevent the spread of COVID-19. They have lost production and not been able to make up for the losses.

VLA understands and agrees that some rules must be in place to protect our citizens and others around the globe. We also understand that we all must be responsible and do our part. Each business sector is a little different and owners must have the flexibility to apply recommended practices to fit their environment.

At a time like this when COVID-19 affects the entire globe, we recommend an approach that protects employees, customers, public, as well as business owners. The last thing business owners need in these situations is a government agency ready to punish, penalize, and threaten to put them out of business.

Business leaders and government leaders can find better solutions. Please reject a permanent standard and create a working group to find solutions to benefit all.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20014 Charlotte Brody 1/5/2021

[SUMMARY OF ORAL COMMENTS PREPARED BY DEPARTMENT STAFF, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4>

Support permanent standard; Data shows even if 4% COVID transmission is work related - if initial transmission is private gatherings - will return to work and spread. Section B.2., page 22 - Employers to communicate to employees to self monitor - is this meant to ensure reporting if suspect possible exposure? or just self monitor? PLEASE CLARIFY.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

16VAC25-220-40.B.2 provides: "2. Employers shall inform employees of the methods of and encourage employees to self-monitor for signs and symptoms of COVID-19 if employees suspect possible exposure or are experiencing signs or symptoms of an illness.

16VAC25-220-40.B.2 is solely directed at self-monitoring of employees. It does not require employers to report "suspect possible exposure." Employee notification requirements are contained in 16VAC25-220-40.B.8 and only apply to "positive SARS-CoV-2 tests."

20015 Rebecca Reindel 1/5/2021

[SUMMARY OF ORAL COMMENTS PREPARED BY DEPARTMENT STAFF, A VERBATIM RECORDING OF THE ORAL COMMENTS CAN BE FOUND AT: <https://www.doli.virginia.gov/wp-content/uploads/2021/01/SHCB-Public-Hearing-20210105-1416-1.mp4>

Supports swift final permanent standard; COVID cases are surging currently. SPECIFIC CONCERNS:

1. Delayed effective date for training, etc. will leave gap in coverage. Especially since ETS currently has those requirements.
 2. "outbreak" provision changes - we support current outbreak reporting as it is critical to report outbreaks to CDC/VDH.
 3. ventilation - update specific measures will help ensure employers address ventilation and airborne issues."
-

"SEE DEPARTMENT RESPONSE TO COMMENT 87825

The Department is recommending an expanded time for employee training from 30 days to 60 days in response to employer concerns expressed during multiple public comment opportunities about the ability to develop and provide effective training to management personnel and employees in 30 days. The Department does not believe the request is unreasonable in light of the unprecedented nature of the pandemic and the need for employers to modify orientation and training materials for new hires and retraining materials for current employees. The Department does not intend to change its recommendation in response to the comment.

With regard to the outbreak reporting requirements, at the request of VDH, the Department proposed changing the COVID-19 case reporting requirement threshold from one case to two cases so that it aligned with current statutory/regulatory/procedural VDH reporting requirements. The lower reporting threshold was negatively impacting VDH's ability to effectively and efficiently use its limited employee resources and caused some confusion in the regulated community. The Department does not intend to change its recommendation in response to the comment.

20016 MK Fletcher 1/5/2021

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Support permanent standard; I would like to address 3 specific issues:

1. Respirator Protection: determining when respirators are needed. Proposed permanent standard rolls back on those protections by allowing "face coverings" when respirators are needed in certain circumstances. Current ETS was more appropriate and maintained respirator requirement when determined to be necessary.
 2. Require training on extend use (re-use) of respiratory PPE. It is not acceptable to "re-use" respirators/ PPE. The Agency can address the issues of proper use in enforcement.
 3. Only allow workers to return when determined safe. Need to address removal of workers of positive or exposed workers.
-

SEE DEPARTMENT RESPONSE TO COMMENT 87834

The Department respectfully disagrees with the Commenter's statement that "Proposed permanent standard rolls back on those protections by allowing "face coverings" when respirators are needed in certain circumstances. Current ETS was more appropriate and maintained respirator requirement when determined to be necessary."

16VAC25-220-10.C clearly states that:

"This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards such as, but not limited to, those dealing with personal protective equipment, respiratory protective equipment, sanitation, access to employee exposure and medical records, occupational exposure to hazardous chemicals in laboratories, hazard communication, § 40.1-51.1 A of the Code of Virginia, etc. Should this standard conflict with an existing VOSH rule, regulation, or standard, the more stringent requirement from an occupational safety and health hazard prevention standpoint shall apply."

The standard does recognize the practical effects of the persistent shortage of certain types of PPE, including respirators in 16VAC25-220-10.C

"Notwithstanding anything to the contrary in this standard, no enforcement action shall be brought against an employer or institution for failure to provide PPE required by this standard, if (i) such PPE is not readily available on commercially reasonable terms, and (ii) the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms. The Department of Labor and Industry shall consult with the Virginia Department of Health as to the ready availability of PPE on commercially reasonable terms and, in the event there are limited supplies of PPE, whether such supplies are being allocated to high risk or very high risk workplaces."

The Department interprets the phrase "no enforcement action" to mean that either no citation shall issue, or if a citation has already been issued it shall be vacated, "if such PPE is not readily available on commercially reasonable terms, and the employer or institution makes a good faith effort to acquire or provide such PPE as is readily available on commercially reasonable terms." The Department will still retain the right to carry out its statutory authority to conduct informal investigations or onsite inspections and verify employer compliance with this provision.

With regard to reuse of respirators, the VOSH Program follows OSHA's April 3, 2020 Memorandum entitled "Enforcement Guidance for Respiratory Protection and the N95 Shortage Due to the Coronavirus Disease 2019 (COVID-19) Pandemic" which "outlines enforcement discretion to permit the extended use and reuse of respirators, as well as the use of respirators that are beyond their manufacturer's recommended shelf life (sometimes referred to as "expired")." <https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus>

The VOSH Program also follows OSHA's April 24, 2020 Memorandum entitled "Enforcement Guidance on Decontamination of Filtering Facepiece Respirators in Healthcare During the Coronavirus Disease 2019 (COVID-19) Pandemic." <https://www.osha.gov/memos/2020-04-24/enforcement-guidance-decontamination-filtering-facepiece-respirators-healthcare>

With regard to return to work requirement the standard has been changed to match current CDC and VDH requirements.

20017 Donald Baylor 1/5/2021

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Support adoption of a permanent standard Represents front line employees working in juvenile and justice systems. These employees cannot work from home. Department of Corrections DATA:

OFFENDERS: 4702 - positive COVID cases; 837 - positive on-site cases today; 47 - COVID deaths among offenders;

EMPLOYEES: 374 positive COVID cases among employees, 2 - deaths among employees.

SEE DEPARTMENT RESPONSE TO COMMENT 87825

20018 Clayton Medford 1/5/2021

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Support and agree with all previous "opposition" comments.

We are not asking for an appeal today - only asking for ETS to remain temporary and expire with the pandemic.

"Sunset" provision is necessary. Small businesses are using resources for ETS compliance that could be used to build businesses back safely.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20019 Dale Bennett 1/5/2021

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Trucking workers are essential workers providing services to transport for essential businesses.

- Oppose permanent standard for temporary issues. "Sunset" provision necessary.
- EIS is not available to address and evaluate for comments.
- Not all infectious diseases are the same and should not expand standards to other diseases.

- Support the revision that was added to permanent standard to treat truck drivers as having minimal impact exposure workers.

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20020 Susan Seward 1/5/2021

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Oppose permanent standard and regulations that add cost of doing business for small businesses.

Permanent standard for a temporary virus -= static answer to fluid situation.

Better Approach:

- continue with a temporary ETS that will allow for changes in science
 - "Sunset" provision that ends with "state of emergency"
 - Do not expand permanent standard to other infectious diseases
-

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20021 Brandon Robinson 1/5/2021

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Oppose permanent standard and agree with previous "opposition" comments.

- Asking for "Sunset" provision - Resources need to be put towards the greatest concerns for businesses after virus is gone. Not to continue resources into an outdated permanent standard.

- Businesses understand that healthy workers are more effective and efficient workers.

- Request that you do not make any permanent standard applicable to future infectious diseases and "issues"

SEE DEPARTMENT RESPONSE TO COMMENT 87834

20022 Kim Bobo 1/5/2021

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Largest faith based coalition in Virginia strongly supports permanent standard.

Employer and employee members of this group agree that the ETS is a good balance

SEE DEPARTMENT RESPONSE TO COMMENT 87825

20023 Rachel McFarland 1/5/2021

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Strongly supports a permanent standard to protect workers.

- It takes a lot of courage for workers to protect themselves by filing complaints, etc.
 - They are being forced to choose between dangerous working conditions and putting food on the table for their families.
 - Workers feel much safer with ETS and permanent standards to protect them in the workplace.
-

SEE DEPARTMENT RESPONSE TO COMMENT 87825

20024 Emily Hasty 1/5/2021

WRITTEN COMMENTS SUBMITTED BY SPEAKER, THE SPEAKER DID NOT SPEAK AT THE PUBLIC HEARING AND SUBMITTED ONLY WRITTEN COMMENTS

Good morning my name is Emily Reynolds and I am the Executive Director of Governmental Affairs for the Hampton Roads Chamber. The Hampton Roads Chamber is the premier pro-business organization serving over 1,200 members representing more than 400,000 members of Virginia's workforce. The Chamber supports public policies that strengthen free enterprise and regional collaboration efforts that promote economic development and conditions for businesses to succeed.

The Hampton Roads Chamber is strongly opposed to the Department of Labor and Industry's COVID-19 emergency regulations becoming permanent. Businesses, especially our small businesses, are already struggling to survive these hard economic times and regulations only increase the burden on them. In a time where some reports estimate that 20-25% of businesses will shut down permanently, these regulations threaten to drive those numbers even higher.

We believe the board should NOT adopt a permanent standard for the following reasons:

- 1) The science of COVID-19 is continuously being updated. Therefore, the CDC and OSHA guidelines are frequently updated to reflect the science. If the Emergency Temporary Standards were to become permanent, it would continue to require businesses to comply with outdated regulations.
- 2) The Board made it very clear in its July deliberations that since the pandemic is temporary in nature any regulations put in place related to COVID-19 would sunset with the Governor's State of Emergency Order. If the Board intends to move forward with a permanent standard when the Emergency Temporary Standard expires, we expect the Board to stick by its decision to end these regulations at the end of the pandemic. The expectation is the pandemic will end and when that happens so should any regulations.
- 3) It is our understanding there is still no economic impact statement prepared to evaluate the cost on small businesses as required with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA). Since there is no economic impact statement at this time, businesses have no opportunity

to address any findings from that analysis for today's hearing or in time for written comments which are due this Friday, January 9th.

4) Infectious diseases are not all the same. Therefore, the Board should not expand these regulations to other infectious diseases. We have no idea what protocols will be necessary for future infectious diseases, so it doesn't make sense to create a permanent standard for all infectious diseases.

While facing devastating economic conditions Virginia's businesses continue to keep the safety and health of their employees as their top priority. We respectfully request that you reject the proposed permanent emergency regulations. Thank you for your time and consideration.

SEE DEPARTMENT RESPONSE TO COMMENT 87834



PREPARED FOR
Virginia Department of Labor and Industry



January 11, 2021

ECONOMIC IMPACT

PROPOSED STANDARD FOR INFECTIOUS DISEASE PREVENTION OF THE SARS- COV-2 VIRUS THAT CAUSES COVID-19

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1. Background

During the COVID-19 pandemic, the Commonwealth of Virginia was the first state to issue a mandatory COVID-19 Emergency Temporary Standard (ETS) establishing workplace safety and health requirements. The ETS, 16VAC25-220, was first published by the Virginia Safety and Health Codes Board (“Board”) and the Virginia Department of Labor and Industry (DOLI) with an effective date of July 27, 2020 and applied to all Virginia employers under the jurisdiction of the Virginia Occupational Safety and Health (VOSH) program. The ETS lapses on January 26, 2021.

The Board and DOLI are in the process of considering replacing the ETS with a permanent standard (16VAC25-220) which, if adopted, would be effective on or after January 27, 2021. This standard is designed to supplement and enhance existing Virginia Occupational Safety and Health (VOSH) laws, rules, regulations, and standards applicable directly or indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards.

Chmura Economics & Analytics (Chmura) was commissioned to conduct the economic impact analysis for the standard 16VAC25-220. Chmura understands there are several components to the economic impact analysis of the proposed regulation. The analysis will include the following elements:

- Number of businesses and other entities impacted, including the number of small businesses impacted
- Localities disproportionately impacted
- Projected number of persons and employment positions to be affected
- Projected costs to affected businesses, localities, or entities of implementing or complying with the standard, including training costs, costs for personal protective equipment, costs for installing physical barriers, etc.

Information from DOLI indicates that some items listed in this standard overlap with existing federal or state regulations, or governor’s executive orders issued during the COVID-19 pandemic. This economic impact analysis only assesses incremental cost to Virginia businesses.

As noted in this document, a number of the requirements with associated costs related to the Commonwealth’s response to the COVID-19 pandemic are contained in various Governor’s executive orders, including, most recently, Executive Order 72. To the extent that a requirement is included in both executive orders and the standard, DOLI does not consider the standard to impose any new cost burden on a covered locality or employer.

In addition, many of the costs associated with dealing with workplace hazards associated with COVID-19 are the result of requirements contained in current federal OSHA or VOSH unique standards and regulations already applicable to local governments, and therefore DOLI does not consider them to be new costs associated with adoption of the standard.

The following are federal OSHA identical and state unique standards and regulations applicable in the construction industry, agriculture industry, public sector maritime industry,¹ and general industry (“general industry” covers all employers not otherwise classified as construction, agriculture, or maritime) that can be used in certain situations to address COVID-19 hazards in the workplace:

General Industry

- 1910.132, Personal Protective Equipment in General Industry (including Workplace Assessment)
- 1910.133, Eye and Face Protection in General Industry
- 1910.134, Respiratory Protection in General Industry
- 1910.138, Hand Protection
- 1910.141, Sanitation in General Industry (including Handwashing Facilities)
- 1910.1030, Bloodborne Pathogens in General Industry
- 1910.1450, Occupational Exposure to Hazardous Chemicals in Laboratories in General Industry

Construction Industry

- 1926.95, Criteria for Personal Protective Equipment in Construction
- 1926.102, Eye and Face Protection in Construction
- 1926.103, Respiratory Protection in Construction
- 16VAC25-160, Sanitation in Construction (including Handwashing Facilities)

Agriculture

- 16VAC25-190, Field Sanitation (including Handwashing Facilities) in Agriculture

Public Sector Maritime

- 1915.152, Shipyard Employment (Personal Protective Equipment)
- 1915.153, Shipyard Employment (Eye and Face Protection)
- 1915.154, Shipyard Employment (Respiratory Protection)
- 1915.157, Shipyard Employment (Hand and Body Protection)
- 1917.127, Marine Terminal Operations (Sanitation)
- 1917.92 and 1917.1(a)(2)(x), Marine Terminal Operations (Respiratory Protection, 1910.134)
- 1917.91, Marine Terminal Operations (Eye and Face Protection)
- 1917.95, Marine Terminal Operations (PPE, Other Protective Measures)
- 1918.95, Longshoring (Sanitation)
- 1918.102, Longshoring (Respiratory Protection)
- 1918.101, Longshoring (Eye and Face Protection)

¹ VOSH standards and regulations only apply to public sector maritime employers and employees. OSHA retains jurisdiction over private sector maritime employers and employees in Virginia.

Multiple Industries

- 16VAC25-220, Emergency Temporary Standard in General Industry, Construction, Agriculture and Public Sector Maritime
- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture and Public Sector Maritime
- 1910.142, Temporary Labor Camps (including Handwashing Facilities) in Agriculture and General Industry
- 1910.1020, Access to Employee Exposure and Medical Records in General Industry, Construction, and Public Sector Maritime (excludes Agriculture)
- 1910.1200, Hazard Communication in General Industry, Construction, Agriculture and Public Sector Maritime
- 16VAC25-60-120 (General Industry), 16VAC25-60-130 (Construction Industry), 16VAC25-60-140 (Agriculture), and 16VAC25-60-150 (Public Sector Maritime),
 - The above standards provide that manufacturer's specifications and limitations are applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment, which can be used to apply to operation and maintenance of air handling systems in accordance with manufacturer's instructions.

In addition, Va. Code §40.1-51.1.A, provides that:

“ A. It shall be the duty of every employer to furnish to each employee safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.”

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such things as national consensus standards, manufacturer’s requirements, requirements of the Centers for Disease Control (CDC), or an employer’s safety and health rules.

To the extent that the general duty clause could be used by DOLI to address COVID-19 workplace hazards to the same extent as and in the same manner as the standard were the standard not in effect, DOLI does not consider any of the costs associated with such use of the clause to be new costs associated with adoption of the standard.

2. Business Categorization

In the standard 16VAC25-220, different requirements apply to different businesses based on the “exposure risk level,” which is defined as an assessment of the possibility that an employee could be exposed to hazards or job tasks associated with the SARS-CoV-2 virus and the COVID-19 disease. In this standard, hazard and job tasks are divided into four risk exposure levels: very high, high, medium, and lower. However, since workplace standards for businesses with jobs having very high or high risks are the same (16VA25-220-50 applies to both risk levels), these two risk levels are grouped together in this study.

Very high exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure to known or suspected sources of the SARS-CoV-2 virus (e.g., laboratory samples) or persons known or suspected to be infected with the SARS-CoV-2 virus, including, but not limited to, during specific medical, postmortem, or laboratory procedures.

High exposure risk hazards or job tasks are those in places of employment with high potential for employee exposure inside six feet with known or suspected sources of SARS-CoV-2, or with persons known or suspected to be infected with the SARS-CoV-2 virus that are not otherwise classified as very high exposure risk. Those businesses with such hazards and job tasks may include, but are not limited to, many healthcare delivery and support services, first responder services, medical transport services, and mortuary services.

Medium exposure risk hazards or job tasks are those not otherwise classified as very high or high exposure risk in places of employment that require more than minimal occupational contact inside six feet with other employees, other persons, or the general public who may be infected with SARS-CoV-2, but who are not known or suspected to be infected with the SARS-CoV-2 virus. Those businesses with such hazards and job tasks may include, but are not limited to, food processing, agriculture, manufacturing, education, retail, entertainment, food services, passenger transportation, and lodging.

Lower exposure risk hazards or job tasks are those not otherwise classified as very high, high, or medium exposure risk that do not require contact inside six feet with persons known to be, or suspected of being, or who may be infected with SARS-CoV-2. Employees in this category have minimal occupational contact with other employees, other persons, or the general public, such as in an office building setting; or are able to achieve minimal occupational contact with others through the implementation of engineering, administrative and work practice controls.²

As the standard notes, “It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons.”

While the technical categorization of exposure risk is based on job tasks or job functions, Chmura uses the same category of risk levels to define business as well. In this study, any businesses with high-risk job tasks are classified as high-risk businesses, even if some job tasks in those businesses are of medium or lower risk. Other businesses are defined accordingly. In addition, to estimate the number of business and jobs impacted by 16VAC25-220, Chmura worked with

² Above definitions are from the document: 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-Cov-2 Virus that Causes COVID-19, DOLI, December 10, 2020.

DOLI to classify different industries into the above four risk levels based on the North America Industry Classification System (NAICS) code.

Chmura uses the latest employment and establishment data to estimate number of businesses that may be affected by the regulation. The latest establishment data were for the year 2019, while the latest employment data were for the four quarters ending with the second quarter of 2020.³ This economic impact analysis also estimates the number of small businesses—defined as those with fewer than 500 employees or six million dollars of annual revenues. The business firm size data were from U.S. Census Business Survey for 2018.⁴

Table 2.1 presents the estimated number of Virginia business establishments and employment. In 2019, there were an estimated 285,486 establishments in Virginia, with 13,522 being categorized as very high or high risk, 122,753 establishments classified as being medium risk, and the rest classified as being lower risk. The latest employment data show that there were 4.1 million workers in Virginia as of the second quarter of 2020, with 361,408 working in very-high- or high-risk businesses, 2.0 million in medium-risk business, and 1.8 million in lower-risk businesses. Almost all Virginia establishments (99.6%) have fewer than 500 employees, and 74.4% of jobs in Virginia are in small businesses.

Table 2.1: Estimated Virginia Business Establishments and Employment

Exposure Risk Level	All Businesses		Small Businesses		Percent of Small Business	
	Establishment (2019)	Employment (Q2-2020)	Establishment (2019)	Employment (Q2-2020)	Establishment (2019)	Employment (Q2-2020)
Very High or High	13,522	361,408	13,474	266,627	99.6%	73.8%
Medium	122,753	2,019,672	122,243	1,579,407	99.6%	78.2%
Lower	149,211	1,750,265	148,698	1,228,249	99.7%	70.2%
Total	285,486	4,131,345	284,415	3,074,283	99.6%	74.4%

Source: U.S. Census and JobsEQ by Chmura

In estimating the economic impact of 16VAC25-220, Chmura focuses on the incremental cost due to this standard. For example, if certain stipulations of this standard overlap with existing federal or state regulations or governor’s executive orders, this standard will not cause additional cost for affected businesses. With regard to the issue of face coverings, for instance, Governor Northam issued Executive Order 72 on December 10, 2020, which requires all employees of all businesses in certain industries—including retail and food services, and entertainment—to wear a face covering while working at their place of employment.⁵ While the above requirement is in place, there would be no incremental cost associated with wearing a face covering applicable to DOLI’s standard. Chmura worked with DOLI to identify the standards that exceed existing federal and state regulations, thus resulting in incremental costs for Virginia businesses.

The standard 16VAC25-220 has nine sections, numbered 16VAC25-220-10 to 16VAC25-220-90. The section of 16VAC25-220-10 outlines the purpose, scope, and applicability; 16VAC25-220-20 stipulates the effective date of the standard; and 16VAC25-220-30 defines terminologies used in the standard. Furthermore, 16VAC25-220-90 states that discrimination

³ The affected businesses presented in this report are measured by the number business establishments, not the number of firms. For example, a bank can have many branches in Virginia, and each branch is a separate establishment. The employment number will be simply referred as the second quarter of 2020.

⁴ In this analysis, Chmura only used the number of employees to classify establishments into small business, as revenue information is not available.

⁵ Source: [https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-(COVID-19).pdf)

against an employee for exercising rights under this standard is prohibited. Those four sections do not result in incremental costs for businesses in Virginia and are excluded from this analysis. As a result, the rest of the report will evaluate the economic impact of the five sections, 16VAC25-220-40 to 16VAC25-220-80.

3. Impact of 16VAC25-220-40

3.1. Economic Impact

16VAC25-220-40 outlines the mandatory requirements for all employers in Virginia. There are 13 sections lettered A to M. Under each section, there are additional sub-sections. Some of these sections do not result in additional costs for businesses. For example, Section A states “employers shall ensure compliance with the requirements in this section to protect employees in all exposure risk levels from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease”. This requirement itself does not incur additional cost for businesses.⁶

Some requirements overlap with existing regulations and executive orders. Section B is related to exposure assessment, notification requirements, and employee access to exposure and medical records. The current regulations by the federal Occupation Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards.⁷ Thus, Section B will not incur additional costs for Virginia businesses except for businesses in construction, agriculture, and maritime industries. For businesses in those three industries, it is estimated that risk assessment, discussion with sub-contractors, notifying employees, and having a system to report positive COVID-19 cases may take approximately four to five hours of staff time to perform.

Section C is related to the return-to-work policies all businesses need to have regarding infected employees, or those suspected to be infected by the SARS-CoV-2 virus. The key component of Section C is that those infected or suspected to be infected are not allowed to return to work. While those stipulations may cause businesses to lose potential revenues, those requirements are already in effect under Virginia Department of Health requirements for isolation of infected employees and quarantine of people who were in close contact with an infected person.⁸ The only cost for a business is to develop policies and procedures related to employees. It is estimated that approximately seven to ten hours may be needed to develop such policies. The Virginia Department of Health provides guidelines for this, which could reduce the time needed to develop this plan.⁹

Section D concerns the establishment and implementation of policies and procedures that “ensure employees observe physical distancing while on the job and during paid breaks on the employer’s property”. There is no incremental cost for Virginia businesses, as similar stipulations have been in effect since the Executive Order 72 was issued by Virginia Governor Northam on December 10, 2020;¹⁰ while some restrictions were also in place under previous executive orders, including Amended Executive Order 63 issued on November 13, 2020.¹¹

Section E is related to the access to common areas and breakrooms in the workplace, requiring businesses to limit occupancy of such areas, provide hand-washing facilities or supplies, post signage, and to clean and sanitize such areas. There is no incremental cost for businesses from this requirement, as stipulations related to signage, cleaning, and

⁶ All direct quotes in this document are from: 16VAC25-220, Revised Proposed Permanent Standard for Infectious Disease Prevention of the SARS-Cov-2 Virus that Causes COVID-19, DOLI, December 10, 2020, unless noted otherwise. The Appendix includes the itemized list of cost estimates.

⁷ Source: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132>

⁸ Source: https://www.vdh.virginia.gov/coronavirus/frequently-asked-questions/virginia-questions/#_heading=h.3rdcrjn

⁹ Source: <https://www.vdh.virginia.gov/coronavirus/vdh-interim-guidance-for-implementing-safety-practices-for-critical-infrastructure-workers-non-healthcare-during-widespread-community-transmission-in-virginia/>

¹⁰ Source: <https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/Forward-Virginia-Phase-Three-Guidelines-December-2020.pdf>

¹¹ Source: <https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-63-AMENDED-and-Order-Of-Public-Health-Emergency-Five---Requirement-To-Wear-Face-Covering-While-Inside-Buildings.pdf>

disinfecting common areas have been in effect due to the Executive Order 72 issued by Virginia Governor Northam. The requirement of a hand-washing facilities is covered in existing OSHA and DOLI standards and regulations.

Section F is associated with multiple employees occupying a vehicle for work purposes. Businesses are required to develop a procedure when maintaining social distance is not feasible while traveling for work, and need to provide face coverings for employees. It is estimated that approximately one to two staff hours may be needed to develop such policies. The face-covering requirement results in no incremental cost for businesses, as similar stipulations have been in effect due to Executive Order 72; while some restrictions were also in place under previous executive orders, including Amended Executive Order 63.

Section G, H, and I are regulations related to wearing face covering in workplaces when social distancing is not feasible. Those requirements generate no incremental cost for businesses, as similar stipulations have been in effect due to the Executive Order 72, and the previous Executive Order 63.

Section J is related to the use of face shields when the use of face coverings would be “contrary to the employee's health or safety because of a medical condition.” The current OSHA regulation 1910.132 has required employers in general industry (excluding construction, agriculture, and maritime industries) to provide personal protective equipment (PPE) for their employees.¹² Thus, Section J stipulations will not incur additional costs for businesses except for businesses in construction, agriculture, and maritime industries. For businesses in those three industries, face shields can be acquired for a price ranging from \$1.00 to \$7.00 per piece.¹³ The cost of face shields is lower if purchased directly from overseas producers, but additional shipping costs will apply, which could be approximately half of the unit price.¹⁴

Section K concerns the process to apply for a waiver related to face coverings, and does not generate incremental cost for Virginia businesses.

Section L involves sanitation and disinfection standards at the workplace. Section M requires employers to provide PPE for employees in situations when “engineering, work practice, and administrative controls are not feasible or do not provide sufficient protection.” These requirements generate no incremental cost for businesses, as similar stipulations have been in effect due to the Executive Order 72; while some restrictions were also in place under previous executive orders, including Amended Executive Order 61 issued on May 8, 2020.¹⁵

In summary, 16VAC25-220-40 generates limited incremental costs for businesses in Virginia, as most of the regulations specific to SARS-CoV-2 virus overlap with existing regulations businesses are required to follow. The only additional costs are staff hours to develop policies and procedures related to return-to-work and travel policies. For businesses in construction, agriculture, and maritime industries not covered by existing rules, there are additional costs to conduct a risk assessment and provide face shields.

¹² Source: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132>

¹³ Source: <https://www.qualitylogoproducts.com/bulk-face-shields.htm>

¹⁴ Source: https://www.made-in-china.com/products-search/hot-china-products/Wholesale_Face_Shield.html

¹⁵ Source: [https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-61-and-Order-of-Public-Health-Emergency-Three---Phase-One-Easing-Of-Certain-Temporary-Restrictions-Due-To-Novel-Coronavirus-(COVID-19).pdf)

3.2. Businesses and Entities Affected

16VAC25-220-40 will affect all businesses in Virginia, estimated at 285,456 establishments in 2019, with employment of 4.1 million as of the second quarter of 2020. For establishments in construction, agriculture, and maritime industries, it is estimated that there were 23,654 Virginia businesses in these industries in 2019, with total employment being 279,636 as of the second quarter of 2020.

3.3. Localities Particularly Affected

Since 16VAC25-220-40 applies to all businesses, no locality will be particularly affected by this proposed regulatory action.

For some stipulations that will incur additional costs for construction, agriculture, and maritime industries, some localities in Virginia will be disproportionately affected. As

Table 3.1 shows, many of those are rural counties with a large number of workers in the agriculture industry.

Table 3.1 Top Ten Localities with Highest Percentage of Employment in Construction, Agriculture and Maritime Industries

Locality	Percent of Employment
Manassas Park City, Virginia	36.9%
Highland County, Virginia	30.8%
Charles City County, Virginia	30.1%
Amelia County, Virginia	26.9%
Cumberland County, Virginia	26.4%
Northampton County, Virginia	23.3%
Powhatan County, Virginia	22.3%
King and Queen County, Virginia	22.1%
Floyd County, Virginia	21.8%
Rappahannock County, Virginia	21.5%
Virginia State Average	6.8%

Source: JobsEQ by Chmura

3.4. Projected Impact on Employment

The proposed regulations will have minimal impact on the overall employment of the state, since the estimated incremental monetary costs are limited and only apply to businesses in construction, agriculture, and maritime industries. Other costs are staff hours, and can be accommodated by existing staff without the need to hire additional workers.

3.5. Small Businesses Impact

It is estimated that the number of small businesses impacted was 284,415, based on 2019 figures, with an associated employment of 3.1 million as of the second quarter of 2020. For businesses in construction, agriculture, and maritime industries, it is estimated that 23,632 small businesses were impacted based on 2019 figures, with a total employment of 259,719 as of the second quarter of 2020.

4. Impact of 16VAC25-220-50

4.1. Economic Impact

16VAC25-220-50 outlines the mandatory requirements for employers in Virginia categorized as having very high or high exposure risks. There are four sections lettered A to D under this standard, with additional subsections under each section. Some of those sections or subsections do not result in additional costs for businesses. For example, Section A defines the businesses this standard should apply to and does not incur additional cost for businesses.

As the standard notes, “It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons.”

4.1.1. Section B

Section B is related to the engineering controls for very-high-risk or high-risk businesses. Specifically, subsection B.1 and B.2 state that air-handling systems under the control of these businesses need to meet manufacturing instructions and additional operating instructions specific for SARS-CoV-2 virus. Pre-existing Virginia Occupational Safety and Health Administration (VOSH) regulations already require that employers to comply with “the manufacturer’s specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment”.¹⁶ It is estimated that the subsections B1 and B2 will not generate incremental costs for Virginia businesses with very high or high exposure risks.

Subsection B.3 states that “hospitalized patients known or suspected to be infected with the SARS-CoV-2 virus, where feasible and available, shall be placed in airborne infection isolation room (AIIRs)”. Subsection B.4 states that employers “shall use AIIRs when available for performing aerosol-generating procedures on patients with known or suspected to be infected with the SARS-CoV-2 virus”. The Virginia Department of Health has existing regulations regarding hospitals and AIIRs, and the utilization of AIIRs is dependent on the availability. It is thus estimated that subsections B3 and B4 will not generate incremental costs for Virginia businesses with very high or high exposure risks.

Subsection B.5 regulates postmortem activities, “employers shall use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of persons known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.” For businesses involved in postmortem activities without such a facility, the cost of construction for a new unit can be substantial in the range of tens of thousand dollars.¹⁷ Rental is an option during the pandemic. It is estimated that rental rate of a cold storage facility with fan-filter unit, based on CDC recommendations, may range from \$2,000 to \$3,000 a month.¹⁸

Subsection B.6 is related to the handling of specimens from patients or persons known or suspected to be infected with the SARS-CoV-2 virus, and it needs to follow precautions associated with Biosafety Level 3 (BSL-3). All laboratories licensed

¹⁶ Source: 16VAC25-60-120 [General Industry], <https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section120/>

¹⁷ Source: <https://massfatalityresponse.com/decendent-refrigeration/morgue-trailer-systems/>

¹⁸ Source: <https://www.kwipped.com/rentals/restaurant/walkin-cold-storage-trailers-and-containers/1022>

by Virginia Department of Health are required to meet BSL-2 or BSL-3 standards. It is estimated that Subsection B6 will not generate incremental costs for businesses.

Subsection B.7 states that “to the extent feasible, employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.” The cost of a physical barrier ranges from \$50 to \$300, depending on the size of such barriers.¹⁹ The cost of physical barriers is lower if purchased directly from overseas producers, but substantial additional shipping costs will apply.²⁰ In addition, this requirement is optional for businesses and may not result in incremental costs if other mitigation strategies are implemented.

4.1.2. Section C

Section C is related to administrative and work practice control of employers categorized as having very high and high risk exposures.

Subsection C.1 requires pre-screening or surveying of employees before the commencement of each work shift. Affected businesses will develop a certain screening method and devote staff hours to perform the screening. Guidelines from the Virginia Department of Health for screening include temperature checks and asking several screening questions.²¹ It is estimated that the cost of a digital non-contact thermometer ranges from \$20 to \$80.²² The cost is lower if purchased directly from overseas producers, but additional shipping costs will apply.²³ However, please note that although it is a generally accepted practice, the standard does not specifically require that employers check the temperatures of employees. Businesses need to have dedicated staff to perform screening. It is estimated that screening of each employee may take a two to five minutes.

Subsections C.2 and C.3 require employers to follow existing guidelines and limit or restrict access to work areas, and they do not result in incremental costs for businesses.

Subsection C.4 requires employers to post signs “requesting patients and family members to immediately report signs and/or symptoms of respiratory illness on arrival at the healthcare facility and use disposable face coverings.” The cost of plastic signs ranges from \$6.10 to \$9.40, for workplace uses, depending on the size of signs.²⁴

Subsection C.5 requires employers to “offer enhanced medical monitoring of employees during COVID-19 outbreaks.” This section does not provide details regarding what constitutes the enhanced medical monitoring. It is assumed that the enhanced medical monitoring may involve checking temperatures and other vital signs of employees such as blood oxygen levels and asking various screening questions. The overall costs involve the purchasing of medical devices as well as assigning employees to perform monitoring. It is estimated that the cost of a digital non-contact thermometers ranges from \$20 to \$80, while cost of blood oxygen monitors range from \$20 to \$50 per unit.²⁵ It is assumed that since monitoring is an

¹⁹ Source: <https://www.zumaoffice.com/search.aspx?keyword=physical+barriers>; <https://www.dgsretail.com/P1711/Portable-Freestanding-Sneeze-Guard-Desk-Countertops-Acrylic-W/Base-24x24H>

²⁰ Source:

https://www.alibaba.com/showroom/plastic+shield+for+countertop.html?fsb=y&IndexArea=product_en&CatId=&SearchText=plastic+shield+for+countertop&isGalleryList=G

²¹ Source: <https://www.vdh.virginia.gov/coronavirus/vdh-interim-guidance-for-implementing-safety-practices-for-critical-infrastructure-workers-non-healthcare-during-widespread-community-transmission-in-virginia/>

²² <https://www.zumaoffice.com/search.aspx?keyword=thermometer>

²³ https://www.alibaba.com/showroom/thermometer.html?fsb=y&IndexArea=product_en&CatId=100009295&SearchText=thermometer&isGalleryList=G

²⁴ Source: <https://www.zumaoffice.com/search.aspx?keyword=social+distancing+sign>

²⁵ <https://www.4mdmedical.com/ssearch?q=pulse+oximeter>

ongoing process, dedicated employees are needed for businesses with a larger number of workers, such as hospitals. A study done by Vanderbilt University Medical Center shows that one full-time monitoring worker is needed for 800 employees.²⁶

Subsection C.6 states that business shall offer psychological and behavioral support when feasible. Since this is not a required mandate, it is estimated that it does not generate incremental costs for businesses.

Subsection C.7 requires that in healthcare settings, employers shall provide alcohol-based hand sanitizers containing at least 60% ethanol or 70% isopropanol to employees, emergency responders, and other personnel. The cost of hand sanitizer is estimated to be around \$5.00 for bottles around 12 to 17 ounces, or \$35 per gallon.²⁷

Subsection C.8 requires that “employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus to contain respiratory secretions until the non-employees are able to leave the site.” The cost of face coverings, such as a standard disposable face covering, is about \$0.10 per piece, when purchased in bulk.²⁸

While some Subsections from C.1 to C.8 necessitate that businesses with very high or high risk exposure incur incremental costs to meet those requirements, Subsection C.9 states that employers shall implement flexible worksites, flexible work hours, and flexible meeting and travel options, when feasible. Those options can provide significant cost savings for businesses. For employers that can work from home or conduct meetings remotely, businesses do not need to comply with the regulations related to the workplace. Other provisions under Subsection C.9, including increasing social distances and delivering services remotely, do not generate additional costs for businesses as they are optional mitigation strategies.

4.1.3. Section D

Section D is related to the personal protection equipment (PPE) in the workplace. It requires employers to assess hazardous risks, complete a written certification, and implement respiratory protection programs. Those requirements are similar to those in 16VAC25-220-40, Section B. The current regulations by Occupational Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards.²⁹ Since none of the businesses with very high or high risk exposure are in the above three industries, Section D will not incur additional costs for all businesses.

In summary, 16VAC25-220-50 will incur additional costs for employers with very high or high exposure risk. Most of those costs are related to administrative control, such as conducting screening, installing physical barriers, posting signs, having hand sanitizers, and providing face coverings for non-employees. Only businesses with postmortem activities may need to invest in special facilities if they do not currently have one, which can have a substantial price tag. Large employers may need to have dedicated staff to perform enhanced medical screening. However, those employers can mitigate those costs by adopting more flexible work-site and work-hours arrangements.³⁰

²⁶ Source: <https://www.vumc.org/coronavirus/latest-news/medical-surveillance-key-covid-19-response-vumc>

²⁷ Source:

https://www.bulkofficesupply.com/search.aspx?keyword=hand+sanitizer&onatalp=4024471056375168968&fph=0_41bfd98c84e3ed86d3746ed1a8c10870

²⁸ Source: <https://www.turmerry.com/pages/wholesale-face-mask-usa-suppliers>

²⁹ Source: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132>

³⁰ The Appendix has an itemized list of the estimated economic impact.

4.2. Businesses and Entities Affected

16VAC25-220-50 will affect very high and high-risk businesses in Virginia, estimated at 13,522 establishments in 2019, with employment of 361,408 as of the second quarter of 2020.

4.3. Localities Particularly Affected

In Virginia, an estimated 8.7% of all jobs are in very high or high-risk businesses. However, in some localities, those percentages are significantly higher. Many of them are locations with a high concentration of healthcare or nursing home facilities, such as Northern City, Emporia City, and Charlottesville City.

Table 4.1 Localities with High Percentage of Very-High and High Risk Employment

Locality	Percent of Total Employment
Norton City, Virginia	26.2%
Emporia City, Virginia	24.6%
Charlottesville City, Virginia	24.5%
Petersburg City, Virginia	23.4%
Winchester City, Virginia	22.5%
Franklin City, Virginia	21.0%
Lancaster County, Virginia	20.6%
Salem City, Virginia	18.9%
Alleghany County, Virginia	17.6%
Fredericksburg City, Virginia	17.6%
Virginia State Average	8.7%

Source: JobsEQ by Chmura

4.4. Projected Impact on Employment

The proposed regulations will have a limited impact on the overall employment of the state. Since the estimated incremental costs are not substantial, it is unlikely that any of the affected businesses will need to reduce costs elsewhere or even employment payroll to meet those requirements. Some large employers may need to hire additional workers to perform enhanced medical monitoring for their employees, which may increase costs to businesses, but will create jobs for the state. In addition, 16VAC25-220-50 will have some positive effects on state businesses engaging in supplying products such as face masks, sanitizers, and other PPE. It will increase opportunities for businesses supplying or installing physical barriers as well.

4.5. Small Businesses Impact

It is estimated that the number of small businesses impacted is 13,474, based on 2019 data. with associated employment of 266,627 as of the second quarter of 2020.

5. Impact of 16VAC25-220-60

5.1. Economic Impact

16VAC25-220-60 outlines the mandatory requirements for employers in Virginia with medium exposure risks. There are four sections lettered A to D. Some of those requirements are similar to those applicable to very high or high-risk businesses. Section A defines the businesses 16VAC25-220-60 should apply to and does not incur additional costs for businesses.

As the standard notes, “It is recognized that various hazards or job tasks at the same place of employment can be designated as very high, high, medium, or lower exposure risk for purposes of application of the requirements of this standard. It is further recognized that various required job tasks prohibit an employee from being able to observe physical distancing from other persons.”

5.1.1. Section B

Section B.1 is related to the engineering controls for businesses with medium risks. Specifically, subsection B.1 states that air-handling systems under the control of those businesses need to meet manufacturing instructions and additional operating instructions specific to the SARS-CoV-2 virus. Preexisting Virginia Occupational Safety and Health Administration (VOSH) regulations already require that employers comply with “the manufacturer’s specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment.”³¹ It is estimated the subsection B1 will not generate incremental costs for businesses.

Subsection B.2 states that where feasible, “employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.” The cost of a physical barrier ranges from \$50 to \$300, depending on the size of such barriers.³² The cost of physical barriers is lower if purchased directly from overseas producers, but additional shipping costs will apply.³³ In addition, this requirement is optional for businesses and may not result in incremental costs if other mitigation strategies are implemented.

5.1.2. Section C

Section C concerns administrative and work practice control of employers with medium exposure risk. Subsection C.1.a requires pre-screening or surveying of employees before the commencement of each work shift. Affected businesses will develop certain screening methods and devote staff hours to perform the screening. Guidelines from Virginia Department of Health for screening includes temperature checks and asking several screening questions.³⁴ It is estimated that the cost of digital non-contact thermometer ranges from \$20 to \$80.³⁵ The cost is lower if purchased directly from overseas producers, but additional shipping costs will apply.³⁶ However, please note that although it is a generally accepted practice,

³¹ Source: 16VAC25-60-120 [General Industry], <https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section120/>

³² Source: <https://www.zumaooffice.com/search.aspx?keyword=physical+barriers>; <https://www.dgsretail.com/P1711/Portable-Freestanding-Sneeze-Guard-Desk-Countertops-Acrylic-W/Base-24x24H>

³³ Source: https://www.alibaba.com/showroom/plastic+shield+for+countertop.html?fsb=y&IndexArea=product_en&CatId=&SearchText=plastic+shield+for+countertop&isGalleryList=G

³⁴ Source: <https://www.vdh.virginia.gov/coronavirus/vdh-interim-guidance-for-implementing-safety-practices-for-critical-infrastructure-workers-non-healthcare-during-widespread-community-transmission-in-virginia/>

³⁵ <https://www.zumaooffice.com/search.aspx?keyword=thermometer>

³⁶ https://www.alibaba.com/showroom/thermometer.html?fsb=y&IndexArea=product_en&CatId=100009295&SearchText=thermometer&isGalleryList=G

the standard does not specifically require that employers check the temperatures of employees. Business needs to have dedicated staff to perform screenings. It is estimated that screening of each employee may take a two to five minutes.

Subsection C.1.b requires that “employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus to contain respiratory secretions until the non-employees are able to leave the site.” The cost of face coverings, such as standard disposable face coverings, is about \$0.10 piece, when purchased in bulk.³⁷

Subsection C.2.a to C.2.i states that employers shall implement flexible worksites, flexible work hours, and flexible meeting and travel options, when feasible. Those options can provide significant cost savings for businesses. For employers that can work from home, or conduct meetings remotely, businesses do not need to comply with workplace regulations. In addition, some provisions, including increasing social distances and delivering services remotely, do not generate additional costs for businesses as they are optional mitigation strategies.

Subsection C.2.j and C.2.k require that employers provide face coverings for employees who cannot maintain social distance, or in customer-facing or other personal-facing roles. There is no additional cost to businesses as similar stipulations have been in effect due to Executive Order 72 issued by Virginia Governor Northam; while some restrictions were also in place under previous executive orders, including Amended Executive Order 63.

5.1.3. Section D

Section D is related to the personal protection equipment (PPE) in the workplace. It requires employers to assess hazardous risks, complete a written certification, and implement respiratory protection programs. Those requirements are similar to those in 16VAC25-220-40, Section B. The current regulations by Occupational Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards.³⁸ For businesses in those three industries, it is estimated that risk assessment, discussion with sub-contractors, notifying employees, and having a system to report positive COVID-19 cases may take approximately four to five staff hours.

In summary, 16VAC25-220-60 will incur limited additional costs for employers with medium exposure risk. Most of those costs are related to administrative controls, such as conducting screenings, installing physical barriers, and supplying face coverings for non-employees. However, businesses can mitigate these costs by adopting more flexible work-site and work-hours arrangements.³⁹

5.2. Businesses and Entities Affected

These proposed regulations will affect medium-risk businesses in Virginia, estimated at 122,753 establishments in 2019, with an employment of 2.0 million as of the second quarter of 2020.

³⁷ Source: <https://www.turmerry.com/pages/wholesale-face-mask-usa-suppliers>

³⁸ Source: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132>

³⁹ The Appendix has an itemized list of the estimated economic impact.

5.3. Localities Particularly Affected

In Virginia, an estimated 48.9% of all jobs are in medium-risk businesses. But in some localities, higher percentages of employees work for medium risk businesses. As Table 5.1 shows, examples of those localities are Covington City, Greensville County, and Madison County.

5.4. Projected Impact on Employment

The proposed standard will have limited impact on the overall employment of the state. Since the estimated incremental costs are not substantial, it is unlikely that any of affected businesses will need to reduce staff size to meet those requirements. However, it will have some positive effect on state businesses engaging in supplying products such as face masks and physical barriers.

5.5. Small Businesses Impact

It is estimated that number of small businesses impacted was 122,243, based on 2019 establishment estimate, with associated employment of 1.6 million, as of the second quarter of 2020.

Table 5.1: Top Ten Localities with Highest Percentage of Medium Risk Employment

Locality	Percent in Total Employment
Covington City, Virginia	73.0%
Greensville County, Virginia	72.8%
Madison County, Virginia	72.8%
Pulaski County, Virginia	72.0%
New Kent County, Virginia	71.8%
Dinwiddie County, Virginia	71.1%
Montgomery County, Virginia	71.0%
Henry County, Virginia	70.8%
Campbell County, Virginia	70.3%
Northampton County, Virginia	70.3%
Virginia State Average	48.9%

Source: JobsEQ by Chmura

6. Impacts of 16VAC25-220-70

6.1. Economic Impact

16VAC25-220-70 is related to the development of a written Infectious Disease Preparedness and Response Plan. It only applies to very high and high-risk employers, as well as medium-risk employers with 11 or more employees. It is estimated that risk assessment and implementation of respiratory protection programs may take approximately 10 to 20 hours of staff time to develop. To mitigate such costs to businesses, Virginia Occupational Safety and Health Administration has provided a free online, editable WORD version of an infectious disease preparedness and response plan that can be used by employers to satisfy the requirements of 16VAC25-220-70. This template can reduce the costs for businesses significantly.⁴⁰

6.2. Businesses and Entities Affected

The proposed regulation will affect very high and high-risk businesses, and medium-risk businesses with 11 or more employees. It is estimated that the number of establishments in those categories was 54,960 in 2019, with an employment of 2.2 million as of the second quarter of 2020.

6.3. Localities Particularly Affected

In Virginia, an estimated 52.3% of all employees are in the affected business categories. Some localities have higher percentages of employees in affected businesses. As Table 6.1 shows, examples of those localities are Galax City, Emporia City, and Williamsburg City.

Table 6.1: Top Ten Localities with Highest Percentage of Employment in Affected Businesses

Locality	Percent in Total Employment
Galax City, Virginia	74.8%
Emporia City, Virginia	74.6%
Williamsburg City, Virginia	73.2%
Colonial Heights City, Virginia	72.4%
Pulaski County, Virginia	71.4%
Montgomery County, Virginia	71.2%
Floyd County, Virginia	70.9%
Hopewell City, Virginia	70.6%
Amherst County, Virginia	70.4%
Greensville County, Virginia	70.3%
Virginia State Average	52.3%

Source: JobsEQ by Chmura

6.4. Projected Impact on Employment

The proposed regulations will have no impact on the overall employment of the state. The estimated incremental costs are only staff hours, and can be accommodated by existing staff of the businesses without the need to hire additional workers.

6.5. Small Businesses Impacts

It is estimated that number of small businesses impacted was 54,402, based on 2019 establishment estimate, with associated employment of 1.6 million as of the second quarter of 2020.

⁴⁰ Source: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>

7. Impact of 16VAC25-220-80

7.1. Economic Impact

16VAC25-220-80 is related to providing employees with training on the hazards and characteristics of the SARS-CoV-2 and COVID-19 disease. The training requirement only applies to employers with employees exposed to very high, high, and medium exposure risk. For employers with lower exposure risk, they need to provide information sheets to employees exposed to such hazards.

Typically, developing a training material may take about 40 hours of staff time for training lasting one hour.⁴¹ Delivering the training and maintaining training certifications will also take some staff hours in human resources or management. To mitigate such costs to businesses, VOSH has provided the free online training materials that satisfy training materials requirements of 16VAC25-220-80. In addition, VOSH has provided a free online training certification form for employers to use.⁴² As a result, employers may not need to develop new training materials, and all the business costs are related to training delivery to each employee (about an hour) and staff time to maintain the certifications.

For businesses categorized as having lower exposure risk, preparing information sheets for employees may take a few hours. VOSH has provided a free online two-page document that satisfies the requirements.⁴³ As a result, the cost for lower-risk businesses is minimal.

7.2. Businesses and Entities Affected

Overall, 16VAC25-220-80 will affect all businesses in Virginia, estimated at 285,456 establishments in 2019, with an employment of 4.1 million as of the second quarter of 2020. The training requirements only apply to businesses with very high, high and medium risks. The total number of businesses establishments is estimated to be 136,275 in 2019, with 2.4 million employees as of the second quarter of 2020. The total number of businesses establishments with lower risk is estimated to be 149,211 in 2019, with 1.8 million employees as of the second quarter of 2020.

7.3. Localities Particularly Affected

Since 16VAC25-220-80 applies to all businesses, no locality will be particularly affected by this proposed regulatory action. However, for training requirements, some localities affected the most include Galax City, Williamsburg City, and Emporia City. For lower-risk businesses, localities with high percentages of employment are King George County, Goochland County, and Arlington County. Those are localities with a large number of jobs in financial services, professional services, or government.

⁴¹ Source: <https://trainlikeachampion.blog/why-does-it-matter-how-long-it-takes-to-design-a-presentation/>

⁴² Source: <https://www.doli.virginia.gov/wp-content/uploads/2020/08/ETS-Full-Training-Presentation.pdf> <https://www.doli.virginia.gov/wp-content/uploads/2020/07/Infographic.pdf> and <http://www.doli.virginia.gov/wp-content/uploads/2020/07/Training-Certification.xlsx>

⁴³ Source: <https://www.doli.virginia.gov/wp-content/uploads/2020/07/Lower-Risk-Training-1.pdf>

Table 7.1 Top Ten Localities with Highest Percentage of Affected Businesses

Locality	Percent of Employment in Very High, High, and Medium-Risk Businesses	Locality	Percent of Employment in Lower-Risk Businesses
Galax City	82.0%	King George County	72.6%
Williamsburg City	80.9%	Goochland County	70.2%
Emporia City	80.7%	Arlington County	64.9%
Colonial Heights City	79.6%	Surry County	62.1%
Pulaski County	79.3%	Alexandria City	59.9%
Montgomery County	79.0%	Fairfax County	58.1%
Floyd County	78.6%	Dickenson County	51.3%
Greensville County	78.3%	Stafford County	48.6%
Amherst County	77.9%	Buchanan County	48.2%
Madison County	77.8%	Henrico County	46.9%
Virginia State Average	57.6%	Virginia State Average	42.4%

Source: JobsEQ by Chmura

7.4. Projected Impact on Employment

The proposed regulations will have no impact on the overall employment of the state. Since the estimated incremental costs are minimal, those efforts can be accommodated by existing staff of the businesses without the need to hire additional workers.

7.5. Small Businesses Impacts

It is estimated that number of small businesses impacted was 284,415, based on 2019 establishment estimate, with associated employment of 3.1 million as of the second quarter of 2020. Training requirements apply to businesses with very high, high, and medium risks. The total number of small businesses establishments in those categories is estimated to be 137,717, based on 2019 establishment estimate, with 1.8 million employees as of the second quarter of 2020. The total number of small business establishments with lower risk is estimated to be 148,498 in 2019, with 1.2 million employees as of the second quarter of 2020.

Appendix: Summary Table of Impact

Table A1: Economic Impact Summary

Standard	Description	Include in the Study	Estimated Cost
16VAC2 5-220-40	All Businesses		
A	Ensure Compliance	N/A	
B	Exposure assessment (9 items)	Overlap with current regulations, with exception of construction, agriculture and maritime industries	4-5 hours for construction, agriculture and maritime businesses
C	Develop return to work policy	Staff Hours	7-10 hours
	Not allow infected individuals to work (10-20 days)	Overlap with current regulations	
	Medical examination	Overlap with current regulations	
D	Develop social distance policies	Overlap with current regulations	
E	Common space	Overlap with current regulations	
	Clean and disinfect	Overlap with current regulations	
	Handwashing facilities and suppliers	Overlap with current regulations	
F	Wear face covering	Overlap with current regulations	
	Develop procedure during travel	Staff Hours	1-2 hours
G	Provide face covering	Overlap with current regulations	
H	Provide face covering	Overlap with current regulations	
I	Provide face covering	Overlap with current regulations	
J	Provide face shields	Overlap with current regulations, with exception of construction, agriculture and maritime industries	\$1.0-\$8.0 per unit for construction, agriculture, and maritime businesses
K	Waiver to face covering requirement	N/A	
L	Clean and disinfection	Overlap with current regulations	
M	Provide PPE	Overlap with current regulations	
16VAC2 5-220-50	Very high and high-risk businesses		
A	Definition	N/A	
B	Air handling system (B.1 and B.2)	Overlap with current regulations	
	Hospitalized patients & AIIR (B.3 and B.4)	Overlap with current regulations	
	Postmortem activities (B.5)	isolation facilities similar to AIIR	\$2,000-\$3,000 rental per month
	Install physical barriers (B.7)	Cost of physical barriers	\$50-\$300 per unit, optional
C	Screening employees for symptoms before work shift (C.1)	Cost of screening methods	\$20-80 for thermometer, plus staff hours of 2-5 minutes per employee
	Post signs (C.4)	Cost of signs	\$6.1-\$9.4 per sign
	Enhanced medical monitoring (C.5)	Cost of monitoring	\$20-80 for thermometer, \$20-\$50 for blood oximeter, one full-time staff for 800 employees
	Psychological and behavior support (C.6)	Optional requirement	
	Alcohol-based hand sanitizer (C.7)	Cost of hand sanitizer	\$5 per bottle (12-17 ounce), \$35 per gallon
	Face cover (C.8)	Cost of face covering	\$0.8-\$0.9 per unit of disposable mask
	Flexible worksite, work hours (C.9)	Provide cost savings for business	Benefit can offset costs
D	PPE	Overlap with current regulations	

Table A1: Economic Impact Summary

Standard	Description	Include in the Study	Estimated Cost
16VAC2 5-220-60	Medium-risk businesses		
A	Definition	N/A	
B	Air handling system (B.1)	Overlap with current regulations	
	Install physical barriers (B.2)	Cost of physical barriers	\$50-\$300 per unit, optional
C	Screening employees for symptoms (C.1)	Cost of screening methods	
	Face cover to non-employees (C.1)	Cost of face covering	\$0.8-\$0.9 per unit of disposable mask
	Flexible worksite, work hours (C.2)	Provide cost savings for business	Benefits can offset costs
	Face cover to employees when social distance is not feasible	Overlap with current regulations	
D	Respiratory protection program	Overlap with current regulations	
	written certification	Staff Hours	
	implement respiratory protection program	Staff Hours	
	PPE	Overlap with current regulations, with exception of construction, agriculture and maritime industries	4-5 hours for construction, agriculture and maritime businesses
16VAC2 5-220-70	Develop Preparedness and response plan	Staff Hours	10-20 hours
16VAC2 5-220-80	Training	Staff Hours	About one hour to each employee,
	Information sheet	Staff Hours	Minimal

Source: Chmura



COMMONWEALTH of VIRGINIA
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January 11, 2021

DEPARTMENT OF LABOR AND INDUSTRY (DOLI)
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM

DOLI ADDENDUM

To January 11, 2021, Economic Impact Proposed Standard For Infectious Disease Prevention Of The Sars-Cov-2 Virus That Causes Covid-19,¹ Prepared by Chmura Economics and Analytics.

BACKGROUND

The Virginia Safety and Health Codes Board (“Board”) adopted 16 VAC 25-220, Emergency Temporary Standard (ETS), Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, with an effective date of July 27, 2020. The ETS was limited by statute to be in effect for no more than six months, and expires on January 26, 2021. Va. Code §40.1-22(6a) under which the ETS was adopted does not permit the ETS to be extended beyond 6 months.

A permanent replacement standard for the ETS is being considered by the Board, and in accordance with §40.1-22(6a):

“The Board by similar publication shall prior to the expiration of six months give notice of the time and date of, and conduct a hearing on, the adoption of a permanent standard.”

The Board published a proposed permanent standard to replace the ETS on July 27, 2020. During the adoption process for the ETS, the Board made clear that during any process to adopt a permanent replacement standard it would attempt to substantially comply with the core requirements in the APA within the six month time constraint of Va. Code §40.1-22(6a) by

¹ It is the position of the Department based on consultation with the Attorney General that by virtue of Va. Code §40.1-22(6a), the Administrative Process Act does not apply to adoption of either an ETS or permanent replacement standard adopted under the specific procedures outlined in that statute. As noted on page 180 of the June 23, 2020 Briefing Package to the Board regarding proposed adoption of an ETS/emergency regulation, the OAG noted: The clear intent of 40.1-22(6a) and 29 USC Section 655(c) in the OSH Act – is to create an alternative path to a temporary and permanent standard outside of the rigors and processes of the APA.”

holding a sixty day written comment period² and a public hearing³ along with obtaining an Economic Impact Analysis and holding a meeting to consider a final standard.⁴

Although not required by Va. Code §40.1-22(6a) DOLI contracted on behalf of the Board with Chmura Economics and Analytics (“Chmura”) to conduct an economic impact analysis of the standard that would attempt to address elements contained in Va. Code §2.2-4007.04.A.1,⁵ with the exception of three issues: costs associated with property value, fiscal impact on localities and potential funds to implement this standard. The purpose of this Addendum is to address those three issues.

For comparison purposes please see the EIA for VOSH’s Tree Trimming Operations Standard at:

https://townhall.virginia.gov/L/GetFile.cfm?File=92\2513\4713\EIA_DOLI_4713_v2.pdf,

and the EIA for VOSH’s Reverse Signal Procedures - General Industry - Vehicles/Equipment Not Covered by Existing Standards at:

https://townhall.virginia.gov/L/GetFile.cfm?File=92\2040\4053\EIA_DOLI_4053_v1.pdf

DEPARTMENT RESPONSE

1. The Department is not aware of the standard resulting in any additional costs related to impact of the standard on the use and value of private property, including additional costs related to the development of real estate for commercial or residential purposes. While Governor’s Executive Orders (EO) (see the most recent EO 72⁶) have contained restrictions on the use of and operating hours, including closings, of private businesses, the standard contains no such restrictions.
2. Since the standard would apply to all businesses, including state and local government employers, no locality will be particularly affected differently than any other local government entity by adoption of the standard. Any fiscal impact on a locality will be determined by the extent to which individual worksites contain hazards or job tasks which expose employees to risks classified as very high, high, medium or lower.

² The sixty day comment period was held from August 27, 2020 to September 25, 2020.

³ The initial public hearing was held September 30, 2020.

⁴ The Board held a thirty day comment period on a draft revised proposed standard from December 10, 2020 to January 9, 2021, and a second public hearing on January 5, 2021.

⁵ Va. Code §2.2-4007.04.A.1: The economic impact analysis shall include but need not be limited to the projected number of businesses or other entities to which the regulation would apply; the identity of any localities and types of businesses or other entities particularly affected by the regulation; the projected number of persons and employment positions to be affected; the impact of the regulation on the use and value of private property, including additional costs related to the development of real estate for commercial or residential purposes; and the projected costs to affected businesses, localities, or entities of implementing or complying with the regulations, including the estimated fiscal impact on such localities and sources of potential funds to implement and comply with such regulation.

⁶ [https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-72-and-Order-of-Public-Health-Emergency-Nine-Common-Sense-Surge-Restrictions-Certain-Temporary-Restrictions-Due-to-Novel-Coronavirus-(COVID-19).pdf)

Those projected costs by risk category and cost item (e.g., cost of face coverings, physical barriers, employee training, etc.) are delineated on a per employee or per item basis in the Economic Impact Analysis (EIA) prepared by Chmura, and in the view of the Department would be applicable in a local government setting.

Those localities that incur costs uniquely attributable to compliance with the standard will likely use revenue they generate from their own taxes and fees. As noted in the EIA, a number of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in various Governor's Executive Orders, including most recently Executive Order 72. To the extent that a requirement is included in both Executive Orders and the standard, the Department does not consider the standard to impose any new cost burden on a covered locality.

In addition, many of the costs associated with dealing with workplace hazards associated with COVID-19 are the result of requirements contained in current federal OSHA or VOSH unique standards and regulations already applicable to local governments, and therefore DOLI does not consider them to be new costs associated with adoption of the standard.

Following are federal OSHA identical and state unique standards and regulations applicable in the Construction Industry, Agriculture Industry, Maritime Industry (public sector employment only as OSHA retains jurisdiction over private sector employment in Virginia), and General Industry ("General Industry" covers all employers not otherwise classified as Construction, Agriculture, or Maritime) that can be used in certain situations to address COVID-19 hazards in the workplace:

General Industry

- 1910.132, Personal Protective Equipment in General Industry (including workplace assessment)
- 1910.133, Eye and Face Protection in General Industry
- 1910.134, Respiratory Protection in General Industry
- 1910.138, Hand Protection
- 1910.141, Sanitation in General Industry (including handwashing facilities)
- 1910.1030, Bloodborne pathogens in General Industry
- 1910.1450, Occupational exposure to hazardous chemicals in laboratories in General Industry

Construction Industry

- 1926.95, Criteria for personal protective equipment in Construction
- 1926.102, Eye and Face Protection in Construction
- 1926.103, Respiratory Protection in Construction
- 16VAC25-160, Sanitation in Construction (including handwashing facilities)

Agriculture

- 16VAC25-190, Field Sanitation (including handwashing facilities) in Agriculture

Public Sector Maritime

- 1915.152, Shipyard Employment (Personal Protective Equipment)
- 1915.153, Shipyard Employment (Eye and Face Protection)
- 1915.154, Shipyard Employment (Respiratory Protection)
- 1915.157, Shipyard Employment (Hand and Body Protection)
- 1917.127, Marine Terminal Operations (Sanitation)
- 1917.92 and 1917.1(a)(2)(x), Marine Terminal Operations (Respiratory Protection, 1910.134)
- 1917.91, Marine Terminal Operations (Eye and Face Protection)
- 1917.95, Marine Terminal Operations (PPE, Other Protective Measures)
- 1918.95, Longshoring (Sanitation)
- 1918.102, Longshoring (Respiratory Protection)
- 1918.101, Longshoring (Eye and Face Protection)

Multiple Industries

- 16VAC25-220, Emergency Temporary Standard in General Industry, Construction, Agriculture and Public Sector Maritime
- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture and Public Sector Maritime
- 1910.142, Temporary Labor Camps (including handwashing facilities) in Agriculture and General Industry
- 1910.1020, Access to employee exposure and medical records in General Industry, Construction, and Public Sector Maritime (excludes Agriculture)
- 1910.1200, Hazard Communication in General Industry, Construction, Agriculture and Public Sector Maritime
- 16VAC25-60-120 (General Industry), 16VAC25-60-130 (Construction Industry), 16VAC25-60-140 (Agriculture), and 16VAC25-60-150 (Public Sector Maritime), Manufacturer's specifications and limitations applicable to the operation, training, use, installation, inspection, testing, repair and maintenance of all machinery, vehicles, tools, materials and equipment (can be used to apply to operation and maintenance of air handling systems in accordance with manufacturer's instructions)

General Duty Clause

In addition, Va. Code §40.1-51.1.A, provides that:

A. It shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees and to comply with all applicable occupational safety and health rules and regulations promulgated under this title.

Otherwise known as the “general duty clause” (the Virginia equivalent to §5(a)(1)) of the OSH Act of 1970), Va. Code §40.1-51.1.A can be used to address “serious” recognized hazards to which employees of the cited employer are exposed through reference to such

things as national consensus standards, manufacturer's requirements, requirements of the Centers for Disease Control (CDC), or an employer's safety and health rules.

To the extent that the general duty clause could be used by the Department to address COVID-19 workplace hazards to the same extent as and in the same manner as the standard were the standard not in effect, the Department does not consider any of the costs associated with such use of the clause to be new costs associated with adoption of the standard.

Potential Cost Centers for Localities on a Per Hour or Per Item Basis by Standard Section

16VAC25-220-40.B

Some requirements overlap with existing regulations and executive orders. Section B is related to exposure assessment, notification requirements, and employee access to exposure and medical records. The current regulations by the federal Occupation Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards. Thus, Section B will not incur additional costs for Virginia businesses except for businesses in construction, agriculture, and maritime industries. For businesses in those three industries, it is estimated that risk assessment, discussion with sub-contractors, notifying employees, and having a system to report positive COVID-19 cases may take approximately four to five hours of staff time to perform.

16VAC25-220-40.C

Section C is related to the return-to-work policies all businesses need to have regarding infected employees, or those suspected to be infected by the SARS-CoV-2 virus. The key component of Section C is that those infected or suspected to be infected are not allowed to return to work. While those stipulations may cause businesses to lose potential revenues, those requirements are already in effect under Virginia Department of Health requirements for isolation of infected employees and quarantine of people who were in close contact with an infected person. The only cost for a business is to develop policies and procedures related to employees. It is estimated that approximately seven to ten hours may be needed to develop such policies. The Virginia Department of Health provides guidelines for this, which could reduce the time needed to develop this plan.

16VAC25-220-40.F

Section F is associated with multiple employees occupying a vehicle for work purposes. Businesses are required to develop a procedure when maintaining social distance is not feasible while traveling for work, and need to provide face coverings for employees. It is estimated that approximately one to two staff hours may be needed to develop such policies. The face covering requirement results in no incremental cost for businesses, as similar stipulations have been in effect due to Executive Order 72; while some restrictions were also in place under previous executive orders, including Amended Executive Order 63.

16VAC25-220-40.J

Section J is related to the use of face shields when the use of face coverings would be “contrary to the employee's health or safety because of a medical condition.” The current OSHA regulation 1910.132 has required employers in general industry (excluding construction, agriculture, and maritime industries) to provide personal protective equipment (PPE) for their employees. Thus, Section J stipulations will not incur additional costs for businesses except for businesses in construction, agriculture, and maritime industries. For businesses in those three industries, face shields can be acquired for a price ranging from \$1.00 to \$7.00 per piece. The cost of face shields is lower if purchased directly from overseas producers, but additional shipping costs will apply, which could be approximately half of the unit price.

16VAC25-220-50.B.5

Subsection B.5 regulates postmortem activities, “employers shall use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of persons known or suspected to be infected with the SARS-CoV-2 virus at the time of their death.” For businesses involved in postmortem activities without such a facility, the cost of construction for a new unit can be substantial in the range of tens of thousand dollars. Rental is an option during the pandemic. It is estimated that rental rate of a cold storage facility with fan-filter unit, based on CDC recommendations, may range from \$2,000 to \$3,000 a month.

16VAC25-220-50.B.7

Subsection B.7 states that “to the extent feasible, employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.” The cost of a physical barrier ranges from \$50 to \$300, depending on the size of such barriers. The cost of physical barriers is lower if purchased directly from overseas producers, but substantial additional shipping costs will apply. In addition, this requirement is optional for businesses and may not result in incremental costs if other mitigation strategies are implemented.

16VAC25-220-50.C.1

Subsection C.1 requires pre-screening or surveying of employees before the commencement of each work shift. Affected businesses will develop a certain screening method and devote staff hours to perform the screening. Guidelines from the Virginia Department of Health for screening include temperature checks and asking several screening questions. It is estimated that the cost of a digital non-contact thermometer ranges from \$20 to \$80. The cost is lower if purchased directly from overseas producers, but additional shipping costs will apply. However, please note that although it is a generally accepted practice, the standard does not specifically require that employers check the temperatures of employees. Businesses need to have dedicated staff to perform screening. It is estimated that screening of each employee may take two to five minutes.

16VAC25-220-50.C.4

Subsection C.4 requires employers to post signs “requesting patients and family members to immediately report signs and/or symptoms of respiratory illness on arrival at the healthcare facility and use disposable face coverings.” The cost of plastic signs ranges from \$6.10 to \$9.40, for workplace uses, depending on the size of signs.

16VAC25-220-50.C.5

Subsection C.5 requires employers to “offer enhanced medical monitoring of employees during COVID-19 outbreaks.” This section does not provide details regarding what constitutes the enhanced medical monitoring. It is assumed that the enhanced medical monitoring may involve checking temperatures and other vital signs of employees such as blood oxygen levels and asking various screening questions. The overall costs involve the purchasing of medical devices as well as assigning employees to perform monitoring. It is estimated that the cost of a digital non-contact thermometers ranges from \$20 to \$80, while cost of blood oxygen monitors range from \$20 to \$50 per unit. It is assumed that since monitoring is an ongoing process, dedicated employees are needed for businesses with a larger number of workers, such as hospitals. A study done by Vanderbilt University Medical Center shows that one full-time monitoring worker is needed for 800 employees.

16VAC25-220-50.C.8

Subsection C.8 requires that “employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus to contain respiratory secretions until the non-employees are able to leave the site.” The cost of face coverings, such as a standard disposable face covering, is about \$0.10 per piece, when purchased in bulk.

16VAC25-220-60.B.2

Subsection B.2 states that where feasible, “employers shall install physical barriers, (e.g., clear plastic sneeze guards, etc.), where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission.” The cost of a physical barrier ranges from \$50 to \$300, depending on the size of such barriers. The cost of physical barriers is lower if purchased directly from overseas producers, but additional shipping costs will apply. In addition, this requirement is optional for businesses and may not result in incremental costs if other mitigation strategies are implemented.

16VAC25-220-60.C

Section C concerns administrative and work practice control of employers with medium exposure risk. Subsection C.1.a requires pre-screening or surveying of employees before the commencement of each work shift. Affected businesses will develop certain screening methods and devote staff hours to perform the screening. Guidelines from Virginia Department of Health for screening includes temperature checks and asking several screening questions. It is estimated that the cost of digital non-contact

thermometer ranges from \$20 to \$80. The cost is lower if purchased directly from overseas producers, but additional shipping costs will apply. However, please note that although it is a generally accepted practice, the standard does not specifically require that employers check the temperatures of employees. Business needs to have dedicated staff to perform screenings. It is estimated that screening of each employee may take two to five minutes.

Subsection C.1.b requires that “employers shall provide face coverings to non-employees suspected to be infected with SARS-CoV-2 virus to contain respiratory secretions until the non-employees are able to leave the site.” The cost of face coverings, such as standard disposable face coverings, is about \$0.10 piece, when purchased in bulk.

16VAC25-220-60.D

Section D is related to the personal protection equipment (PPE) in the workplace. It requires employers to assess hazardous risks, complete a written certification, and implement respiratory protection programs. Those requirements are similar to those in 16VAC25-220-40, Section B. The current regulations by Occupational Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards. For businesses in those three industries, it is estimated that risk assessment, discussion with subcontractors, notifying employees, and having a system to report positive COVID-19 cases may take approximately four to five staff hours.

16VAC25-220-70

16VAC25-220-70 is related to the development of a written Infectious Disease Preparedness and Response Plan. It only applies to very high and high-risk employers, as well as medium-risk employers with 11 or more employees. It is estimated that risk assessment and implementation of respiratory protection programs may take approximately 10 to 20 hours of staff time to develop. To mitigate such costs to businesses, Virginia Occupational Safety and Health Administration has provided a free online, editable WORD version of an infectious disease preparedness and response plan that can be used by employers to satisfy the requirements of 16VAC25-220-70. This template can reduce the costs for businesses significantly.

16VAC25-220-80

16VAC25-220-80 is related to providing employees with training on the hazards and characteristics of the SARS-CoV-2 and COVID-19 disease. The training requirement only applies to employers with employees exposed to very high, high, and medium exposure risk. For employers with lower exposure risk, they need to provide information sheets to employees exposed to such hazards.

Typically, developing a training material may take about 40 hours of staff time for training lasting one hour. Delivering the training and maintaining training certifications will also take some staff hours in human resources or management. To mitigate such costs to businesses, VOSH has provided the free online training materials that satisfy

training materials requirements of 16VAC25-220-80. In addition, VOSH has provided a free online training certification form for employers to use. As a result, employers may not need to develop new training materials, and all the business costs are related to training delivery to each employee (about an hour) and staff time to maintain the certifications.

For businesses categorized as having lower exposure risk, preparing information sheets for employees may take a few hours. VOSH has provided a free online two-page document that satisfies the requirements. As a result, the cost for lower-risk businesses is minimal.

DOLI RESOURCES AVAILABLE TO LOCAL GOVERNMENT EMPLOYERS

The Department strongly encourages Virginia's local government employers to take advantage of free and confidential occupational safety and health onsite and virtual consultation and training services to address COVID-19 compliance issues. More information about the VOSH Consultation Services can be found at:

<https://www.doli.virginia.gov/vosh-programs/consultation/>

In addition, free Outreach, Training, and Educational materials to assure compliance with COVID-19 requirements can be found at: <https://www.doli.virginia.gov/covid-19-outreach-education-and-training/>