COMMONWEALTH of VIRGINIA

DEPARTMENT OF LABOR AND INDUSTRY

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COMMISSIONER

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DRAFT AGENDA

IN PERSON AND VIRTUAL
SAFETY AND HEALTH CODES BOARD EMERGENCY MEETING

In person location:
Patrick Henry Building
1111 E. Broad Street
East Reading Room
Richmond, VA 23219

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

August 26, 2021
10:00 AM

1. **Call to Order**

2. **Approval of Agenda**

3. **Opportunity for the Public to Address the Board on the issues pending before the Board today, as well as any other topics that may be of concern to the Board and within its scope of authority.**

   This will be the only opportunity for public comment at this meeting. Remarks will be limited to 5 minutes in consideration of others wishing to address the Board.

4. **New Business**

   a) Recommended Revisions to the Proposed Amendments of the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.
   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. **Items of Interest from the Department of Labor and Industry**

6. **Items of Interest from Members of the Board**

7. **Meeting Adjournment**

PUBLIC PARTICIPATION

This meeting will be held both ***in person*** **and** ***virtually***.

Members of the public may attend in person or listen to/witness 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. Electronic participation capacity is limited and is on a first come, first serve basis due to the capacity of CISCO WebEx technology.

Agency staff will be following the latest CDC guidance dated July 27, 2021 for the in person location. As such, if you plan to attend this hearing in person, please be aware that **face coverings** are required and **physical distancing** will be observed. The room will be subject to an occupancy limit of 25 people. Entrance will be on a first come, first serve basis.

If you are attending in person, please be aware that to enter the Patrick Henry Building, members of the public will have to go through security. **You must have a valid state or federal I.D. to enter the building.** Please be prepared to go through a security scanner and/or be wanded by the Capitol Police. Once you have passed through security, you will be required to sign in with Agency staff and you will be escorted to the East Reading Room. Upon departure, you will be required to sign out with Agency Staff.

For more information on what to expect at Security, including which entrance of the Patrick Henry building you must enter, please see: https://dgs.virginia.gov/facilities-management/dgs-facilities-information/expect-the-check/.

Parking is limited. For information on parking garages in the area, please visit: https://dgs.virginia.gov/parking--building-access/parking-services/visitor-parking-deck/.

If you wish to make an Oral Public Comment either, in person or virtually, during the "Opportunity for the Public to Address the Board" period of this meeting, you must follow the instructions below:

- Oral public comments will be received from those persons who have submitted an email to **Princy.Doss@doli.virginia.gov** no later than **12:00 PM (NOON)** on **August 25, 2021.** indicating that they wish to offer **either in person or electronic oral comments**. Comments may be offered by these individuals when their name is announced by Ms. Doss. Oral comments will be **restricted to 5 minutes** each.
- **For oral comments received electronically:**
    - 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 who offer both in person and virtual comments during the Safety and Health Codes Board Meeting on August 26, 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 **August 27, 2021.**

VIRTUAL ACCESS INFORMATION

Event address for attendee:
https://covaconf.webex.com/covaconf/onstage/g.php?MTID=e48fec552a7ef9266052d624eae9bfb60

Event number (access code): 161 720 9332

Event password: DOLI2021

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: 161 720 9332

Should any interruption of the electronic 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

PREPARED FOR
Virginia Department of Labor and Industry

August 20, 2021

ECONOMIC IMPACT

PROPOSED AMENDMENTS TO THE VOSH STANDARD FOR INFECTIOUS DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19

CHMURA

Contents

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 to mitigate the spread of the SARS-CoV-2 virus.[1]

The ETS, 16VAC25-220,[2] was adopted by the Virginia Safety and Health Codes Board (Board) and published by the Virginia Department of Labor and Industry (DOLI). The effective date of the ETS was July 27, 2020, and applied to all Virginia employers under the jurisdiction of the Virginia Occupational Safety and Health (VOSH) program. The ETS lapsed on January 26, 2021.

To replace the ETS, the Board adopted a permanent VOSH Standard,16VAC25-220,[3] which took effect on January 27, 2021. This standard is designed to supplement and enhance existing VOSH laws, rules, regulations, and standards applicable directly or indirectly to the SARS-CoV-2 virus or COVID-19 disease-related hazards.

On June 29, 2021, the Board adopted proposed amendments (amendments) to the standard, which are the subject of this Economic Impact Analysis (EIA). The amendments address the advent of widely available and effective vaccines in Virginia, updated CDC guidelines, and revised relevant requirements for employers.

Chmura Economics & Analytics (Chmura) was commissioned by DOLI to conduct the EIA for the amendments to 16VAC25-220. Chmura understands that regarding the amendments, there are several components to be addressed in the EIA. The analysis will include the following elements:

- Number of businesses and other entities impacted, including the number of small businesses
- Localities disproportionately impacted
- Projected employment affected
- Projected incremental costs for affected businesses, localities, or entities from implementing the standard

Information from DOLI indicates that some items listed in this standard overlap with existing federal or state regulations/requirements, or the governor's executive order issued during the COVID-19 pandemic

[1] Source: https://www.doli.virginia.gov/archive-page-for-all-ets-related-material/.
[2] Source: https://www.doli.virginia.gov/wp-content/uploads/2020/07/RIS-filed-RTD-Final-ETS-7.24.2020.pdf.
[3] Source: https://www.doli.virginia.gov/wp-content/uploads/2021/01/Final-Standard-for-Infectious-Disease-Prevention-of-the-Virus-That-Causes-COVID-19-16-VAC25-220-1.27.2021.pdf.

(currently Executive Order 79.[4] For instance, a small number of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in Governor's Executive Order 79 (K-12 employees must wear facemasks (face coverings in VOSH Standard) while on school grounds), and the Transportation Security Administration's (TSA) requirement that employees wear face masks on commercial flights, buses and trains through Jan. 18, 2022.[5]

To the extent that a requirement is included in both the VOSH Standard, and executive orders or existing federal or state regulations/requirements, DOLI does not consider the standard to impose any new cost burden on a covered locality or employer. This economic impact analysis only assesses incremental costs to Virginia businesses.

In addition, many of the costs associated with COVID-19 workplace hazards are the result of requirements contained in current federal Occupational Safety and Health Administration (OSHA) or VOSH unique standards and regulations already applicable to private and public sector employers, including local governments. Therefore, DOLI does not consider them to be new costs associated with adoption of the proposed amendments to the standard.

NOTE: The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether revisions should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance[6] for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

DOLI and VDH are in agreement that some revisions[7] should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.

The Dept. invited the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum.[8] The forum will be open for 7 days from August 16, 2021 to August 23, 2021.

This EIA does not address the revisions.

The following are federal OSHA identical and state unique standards and regulations applicable in the construction industry, agriculture industry, public sector maritime industry,[9] and general industry[10] that can be used in certain situations to address COVID-19 hazards in the workplace:

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[4] https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-79-and-Order-of-Public-Health-Emergency-Ten-Ending-of-Commonsense-Public-Health-Restrictions-Due-to-Novel-Coronavirus(COVID-19).pdf

[5] The Transportation Security Administration on Tuesday extended a federal requirement that travelers [and employees] wear masks on commercial flights, buses and trains through Jan. 18, 2022." Please see:
https://www.cnbc.com/2021/08/17/biden-administration-set-to-extend-mask-mandate-for-travel-through-mid-january.html.
https://www.tsa.gov/news/press/releases/2021/04/30/tsa-extends-face-mask-requirement-airports-and-throughout

[6] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

[7] https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf

8 https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=130

[9] 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.

[10] General industry covers all employers not otherwise classified as construction, agriculture, or maritime.

Occupational Exposure to COVID-19, Emergency Temporary Standard, 1910.502, et seq.

On June 21, 2021, OSHA issued an emergency temporary standard to protect healthcare and healthcare support service workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present.

On June 29, 2021, the Virginia Safety and Health Codes Board adopted the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq.[11] This standard is in effect in Virginia and is applicable to all settings where any employee provides healthcare services or healthcare support services. The effective date is August 2, 2021. The emergency temporary standard will expire within six months or when repealed by the Board, whichever occurs first.

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)

[11] Found at https://townhall.virginia.gov/L/ViewStage.cfm?stageid=9308.

- 1918.101, Longshoring (Eye and Face Protection)

Multiple Industries

- 16VAC25-220, VOSH COVID-19 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, Virginia Code §40.1-51.1.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 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 and Prevention (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. Employer Categorization

In the amendments to 16VAC25-220, certain mandatory requirements apply to all covered Virginia employers, and additional requirements apply to some employers based on an increased risk of potential exposure associated with the SARS-CoV-2 virus and the COVID-19 disease. In the amendments, workplaces are divided into three risk exposure levels: healthcare services[12] and healthcare support services, higher-risk workplaces, and other.

Healthcare services are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, and oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Healthcare services are delivered through various means including: hospitalization, long-term care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. For the purposes of this analysis, healthcare services include autopsies. Healthcare support services facilitate the provision of healthcare. Healthcare support services include patient intake/admissions, patient food services, equipment and facility maintenance, housekeeping, laundry services, medical waste handling, and medical equipment cleaning/reprocessing.

Higher-risk workplaces will have employees who are fully vaccinated employees and those who are not fully vaccinated. In this report, employees who are not fully vaccinated are considered to be "at-risk" employees.[13] Higher-risk workplaces include, but are not limited to: manufacturing, meat and poultry processing, high-volume retail and grocery, transit, seafood processing, correctional facilities, jails, detention centers, and juvenile detention centers. In those workplaces, employees who are not fully vaccinated work close to one another, or have close contact with the general public who may not be fully vaccinated, and thus are considered at-risk.

In this analysis, Chmura classifies Virginia employers into the above categories based on the North America Industry Classification System (NAICS) codes. It is understood that businesses with the same NAICS code may be classified differently. For example, cleaning services for healthcare facilities should be classified as healthcare support services, but those cleaning offices or homes face a lower exposure risk. However, the available data do not allow Chmura to make that distinction. Chmura worked with DOLI to classify different employers into the above three categories.

Chmura uses the latest employment and establishment data to estimate the number of employers that may be affected by the amendments. The latest establishment data were for the year 2020, while the latest employment data were for the four quarters ending with the first quarter of 2021.[14] This economic impact analysis also estimates the number of small businesses—defined as those with fewer than 500 employees or less than $6 million of annual revenue. The business size data are from the U.S. Census Business Survey for 2019.[15]

Finally, some of the regulations contained in these amendments apply only to the workers who are not fully vaccinated. Chmura uses vaccination rate data from the Virginia Department of Health to estimate the number of unvaccinated employees. As of August 4, 2021, 65.3% of adults (age 18 and older) in Virginia were fully vaccinated.[16] It is likely that there may be differences among workers in different categories of workplaces. It was initially expected that healthcare workers

[12] In this report, healthcare services are also referred to as healthcare.
[13] For brevity, when this report mentions "at-risk" employees, this refers to employees who are not fully vaccinated.
[14] The affected businesses presented in this report are measured by the number of business establishments, not the number of firms. For example, a bank can have many branches in Virginia, and each branch is a separate establishment. Employment data will be referred to as employment as of the second quarter of 2020.
[15] In this analysis, Chmura only used the number of employees to classify establishments into small business, as revenue information is not available.
[16] Source: Virginia Department of Health, https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/.

may have higher vaccination rates than the general population, as they were the first to be eligible for vaccines. But a recent national study on the healthcare workforce reviewed by Chmura does not provide conclusive evidence. As of July 2021, it was reported that at the national level, vaccination rates among healthcare workers vary greatly: 96% of physicians, 55% of nursing home staff, less than 50% of nurses, and just 26% of home health aides were fully vaccinated.[17] As a whole, those data suggest the overall vaccination rate for healthcare workers is no better than the overall rate for adults in the country, as physicians only account for a small percentage of the healthcare workforce. As a result, Chmura applied the same vaccination rates to all employees in this study.

Table 2.1 presents the estimated number of Virginia business establishments and related employment. In 2020, there were an estimated 289,782 establishments in Virginia, with 45,567 in healthcare or healthcare support services. There were 70,700 establishments classified in the higher-risk category, and the rest were classified as other workplaces. The latest employment data show that there were 4 million workers in Virginia as of the first quarter of 2021, with 454,841 in healthcare or healthcare support services, 1.6 million in higher-risk workplaces, and 1.9 million in other workplaces. Almost all Virginia establishments (99.7%) have fewer than 500 employees, and 75.5% of jobs in Virginia are in small businesses. Finally, an estimated 1.4 million Virginia workers were not fully vaccinated as of early August 2021, and 1.0 million of them work in small businesses.

Table 2.1: Estimated Virginia Business Establishment and Employment

	All Businesses			Small Businesses			Percent of Small Business	
Workplace Exposure Risk Level	Establishment (2020)	Employment (Q1-2021)	At-Risk Employees (Q1-2021)	Establishment (2020)	Employment (Q1-2021)	At-Risk Employees (Q1-2021)	Establishment (2020)	Employment (Q1-2021)
Healthcare/ Healthcare Support	45,567	454,841	157,830	45,401	334,233	115,979	99.6%	73.5%
Higher-Risk	70,700	1,592,221	552,501	70,482	1,253,921	435,110	99.7%	78.8%
Other	173,515	1,919,022	665,901	172,967	1,405,320	487,646	99.7%	73.2%
Total	**289,782**	**3,966,084**	**1,376,231**	**288,850**	**2,993,473**	**1,038,735**	**99.7%**	**75.5%**

Source: U.S. Census and JobsEQ by Chmura

In estimating the economic impact of the 16VAC25-220 amendments, Chmura focuses on the incremental cost due to these amendments. As stated in Section 1, if certain stipulations contained in these amendments overlap with existing federal or state regulations/requirements, the stipulations will not create an additional cost for affected employers. Chmura worked with DOLI to identify the standards that exceed existing federal and state regulations, thus resulting in incremental costs for Virginia businesses.

The 16VAC25-220 amendments have 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 amendments. Furthermore, 16VAC25-220-90 states that discrimination against an employee for exercising rights under this standard is prohibited. These 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.

[17] Source: Annals of Internal Medicine, https://www.acpjournals.org/doi/10.7326/M21-3150.

3. Impact of 16VAC25-220-40

3.1. Economic Impact

Section 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.

Section A states the following. "Employers shall have a policy in place to ensure compliance with the requirements in this section to protect employees from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease. Such policy shall have a method to receive anonymous complaints of violations. 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."[18] It is estimated that approximately one to two staff hours may be needed to develop such policies.

Section B is related to exposure assessment, notification requirements, and employee access to exposure and medical records. The current regulations by the federal Occupational Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards.[19] Thus, Section B will not incur additional costs for Virginia businesses except for those 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 sick employees or those possibly infected by the SARS-CoV-2 virus. The key component of Section C is that those infected or thought to be infected are not allowed to return to work, and employers shall provide COVID-19 testing at no cost for employees. While those stipulations may cause businesses to lose potential revenue, the requirements are already in effect under existing CDC guidelines related to return-to-work.[20] 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.[21]

Section D concerns the establishment and implementation of policies and procedures that "ensure employees that are not fully vaccinated and otherwise at-risk employees observe physical distancing while on the job and during paid breaks on the employer's property." Employers should use verbal announcements, signage, or visual cues to promote physical distancing. It is estimated that approximately one to two staff hours may be needed to develop such policies. The cost of signs ranges from $1.80 to $9.40, for workplace use, depending on the size.[22]

Section E concerns the access to common areas and breakrooms in the workplace for at-risk employees, requiring businesses to limit occupancy of such areas, provide handwashing facilities or supplies, post signage, and to clean and sanitize such areas. The additional cost to businesses includes physical distancing signage, ranging from $1.80 to $9.40,

[18] All direct quotes in this document are from: Proposed Amendments to Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, DOLI, June 29, 2021, unless noted otherwise. The Appendix includes the itemized list of cost estimates.
[19] Source: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132.
[20] Source: https://www.vdh.virginia.gov/coronavirus/frequently-asked-questions/virginia-questions/#_heading=h.3rdcrjn.
[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] Source: https://www.zumaoffice.com/search.aspx?keyword=social+distancing+sign.

and hand sanitizer, estimated to be around $5.00 for a 12 to 17-ounce bottle, or $25 to $35 per gallon.[23] In addition, professional cleaning services for commercial buildings range from $50 to $100 per hour.[24] The requirement of handwashing facilities is covered in existing OSHA and DOLI standards and regulations.

Section F is associated with multiple employees occupying a vehicle for work purposes, if any of them are not fully vaccinated. Employers are required to mitigate the hazards associated with SARS-CoV-2 and COVID-19. Employers should eliminate the need for employees sharing work vehicles, provide access to fresh air ventilation, and provide respiratory protection, such as a filtering respirator. Face coverings should be provided for employees until adequate supplies of respiratory protection and/or personal protective equipment become readily available. It is estimated that the cost of respiratory protection, such as N95 respirators, are available at a cost of $1.50 per piece for disposables, and $14.00 per piece for reusables.[25] Face coverings, such as standard disposable masks, cost about $0.10 per piece when purchased in bulk.[26]

Section G is related to wearing face coverings in indoor workplaces for at-risk employees. In addition, when a face shield is required to comply with the regulation, an employer must ensure that face shields are cleaned daily. Also, employers can provide disposable face shields; prices range from $0.40 to $4.00 per piece.[27]

Sections H, J, and K are reserved, and Section I stipulates how a face covering should be worn. There is no incremental cost for employers associated with those sections.

Section L involves workplace sanitation and disinfection standards. While employers shall comply with VOSH standards, this regulation requires prompt cleaning and/or disinfection of workplaces accessed by employees suspected to have COVID-19, or employees who have tested positive for the virus. The cost of professional cleaning services for commercial buildings ranges from $50 to $100 per hour. This cleaning requirement does not apply to food agricultural production, manufacturing, or food prepared in food service areas where specific regulations apply. In addition to the requirement of cleaning and disinfecting possibly contaminated areas, all common spaces should be cleaned at least once during or at the end of each shift. Employers should also make available to employees various cleaning products. Examples of those products include hand sanitizer, which costs around $5.00 for a 12 to 17-ounce bottle, or $25 to $35 per gallon; liquid hand soap, ranging from $12 to $50 per gallon;[28] and all-purpose cleaning products, between $20 to $35 per gallon.[29]

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.” Chmura estimates the cost of PPE to outfit

[23] Source: https://www.bulkofficesupply.com/search.aspx?keyword=hand+sanitizer&onatalp=40244710563751689 68&fph=0_41bfd98c84e3ed86d3746ed1a8c10870
[24] Source: https://desertoasiscleaners.com/commercial-cleaning-cost/.
[25] Source: https://www.costco.com/niosh-n95-round-respirator%2c-100-masks.product.100707773.html and https://www.amazon.com/3M-Respirator-6300-Respiratory-Protection/dp/B007JZ1MK6/ref=sr_1_5?dchild=1&keywords=respirator&qid=1626783913&sr=8-5.
[26] Source: https://www.turmerry.com/pages/wholesale-face-mask-usa-suppliers.
[27] Source: https://www.amazon.com/Pack-Protective-Face-Shields-Health/dp/B08KT42ST2/ref=zg_bs_11312309011_32?_encoding=UTF8&refRID=81Z183PNKBPFTM6B1J72&th=1.
[28] Source: https://www.amazon.com/gallon-hand-soap/s?k=gallon+hand+soap.
[29] Source: https://www.amazon.com/Glissen-Chemical-Nu-Foamicide-Disinfectant-Food-Contact/dp/B086339RQS/ref=sr_1_3?dchild=1&keywords=commercial+disinfecting&qid=1628619803&sr=8-3.

one person is $4.00. This cost includes disposable gloves at $0.10 per pair,[30] disposable gowns at $0.65 per piece,[31] disposable goggles at $1.70 per piece,[32] and disposable N95 respirators at $1.50 per piece.

In summary, 16VAC25-220-40 generates moderate incremental costs for covered businesses in Virginia. One major cost addition is staff hours required to develop policies and procedures related to return-to-work and travel. Another is the cost of cleaning services, cleaning products, hand sanitizer, face coverings, and PPE. For businesses in construction, agriculture, and maritime industries not covered by existing rules, there are additional costs to conduct a risk assessment.

3.2. Businesses and Entities Affected

All covered businesses in Virginia will be affected by 16VAC25-220-40. There are an estimated 289,782 total establishments in 2020, with an employment of 4.0 million as of the first quarter of 2021. Some regulations will only affect at-risk employees. Healthcare services and healthcare support services will not be impacted during the period that the ETS is in effect (45,567 establishments are in healthcare or healthcare support services). It is estimated that 1.4 million Virginia workers are not fully vaccinated as of August 2021. For establishments in construction, agriculture, and maritime industries, it is estimated that there were 23,680 Virginia businesses in these industries in 2020. They employed 277,981 workers as of the first quarter of 2021, with an estimated 96,459 employees who had not been fully vaccinated.

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 stipulations that will incur additional costs for construction, agriculture, and maritime industries, some localities in Virginia will be disproportionally affected. As Table 3.1 shows, many are rural counties with a large number of workers in the agriculture industry.

Table 3.1: Top Ten Virginia Localities with the Highest Percentage of Employment in Construction, Agriculture, and Maritime Industries

Locality	Percent Employment
Manassas Park City	35.2%
Highland County	34.6%
Charles City County	32.7%
Amelia County	28.9%
Cumberland County	28.8%
Northampton County	23.9%
Rappahannock County	23.1%
Floyd County	22.8%
Powhatan County	22.6%
King and Queen County	21.8%
Virginia	**7.0%**

Source: JobsEQ by Chmura

3.4. Projected Impact on Employment

The proposed regulations will have a limited impact on overall employment in the state, since the estimated incremental costs are limited. One cost is additional hours that can be accommodated by existing staff without the need to hire additional workers. Other incremental costs are cleaning services, cleaning products, and face

[30] Source: https://www.amazon.com/Examination-100-Count-Disposable-Ultra-Strong-Healthcare/dp/B07KYV178H/ref=sxin_12_alexaas_0_B07KYV178H?cv_ct_cx=gloves&dchild=1.
[31] Source: https://www.amazon.com/Disposable-Isolation-Latex-Free-Non-Woven-Industries/dp/B08NFK2463/ref=sr_1_4?dchild=1&keywords=medical+gowns&qid=1626783382&sr=8-4.
[32] Source: https://www.amazon.com/dp/B087D6NLH1/ref=sspa_dk_detail_5?psc=1&pd_rd_i=B087D6NLH1&pd_rd_w=sDk1m&pf_rd_p=887084a2-5c34-4113-a4f8-b7947847c308.

coverings. The products are inexpensive and can be absorbed by businesses, having limited impact on employment.

3.5. Small Business Impact

It is estimated that the number of small businesses impacted by 16VAC25-220-40 is 288,850, based on 2020 data. Associated employment was 3.0 million as of the first quarter of 2021. It is estimated that 1.0 million Virginia workers in small businesses are not fully vaccinated. In construction, agriculture, and maritime industries, it is estimated that 23,662 small businesses are impacted based on 2020 data. Total associated employment is 263,885, and 91,568 of these workers were not fully vaccinated as of the first quarter of 2021.

4. Impact of 16VAC25-220-50

4.1. Economic Impact

16VAC25-220-50 outlines the mandatory requirements for Virginia employers categorized as healthcare services or healthcare support services. There are four sections lettered A to D within this standard, with additional subsections under each section.

On June 21, 2021, the federal OSHA issued an emergency temporary standard (ETS) to protect both healthcare and healthcare support service workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present.[33]

On June 29, 2021, the Virginia Safety and Health Codes Board (Board) adopted the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq. It is applicable to all settings where any employee provides healthcare services or healthcare support services. The effective date is August 2, 2021, and shall expire within six months or when repealed by the Board, whichever occurs first.

In its motion to adopt the ETS, the Virginia Safety and Health Codes Board also accepted the recommendation of the Virginia Department of Labor and Industry that:[34]

1. Application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.
2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services be later stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.
3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services be later stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall, within 30 days notice, conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be maintained, modified, or revoked.

[33] For federal OSHA materials, see COVID-19 Healthcare ETS Outreach.
[34] To access the final rule see Occupational Exposure to COVID—19; Emergency Temporary Standard, Interim Final Rule. For more information on the regulatory process followed regarding the adoption of the rule, please visit the Virginia Regulatory Town Hall.

In summary, 16VAC25-220-50 will not incur additional costs for employers in healthcare and healthcare support service, because the 16VAC25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, is suspended while the federal OSHA emergency temporary standard is in effect.

4.2. Businesses and Entities Affected

In Virginia, it is estimated that 45,567 establishments in 2020 were in healthcare and healthcare support services, with employment of 454,841 as of the first quarter of 2021.

4.3. Localities Particularly Affected

In Virginia, an estimated 11.5% of all jobs are in healthcare and healthcare support services. However, in some localities, those percentages are significantly higher. Many of these localities have a high concentration of healthcare or nursing home facilities, such as Petersburg City, Winchester City, and Charlottesville City.

Table 4.1: Top Ten Virginia Localities with the Highest Percentage of Employment in Healthcare and Healthcare Support

Locality	Percent Employment
Petersburg City	31.6%
Winchester City	28.9%
Charlottesville City	27.9%
Norton City	27.5%
Franklin City	25.5%
Emporia City	25.2%
Alleghany County	24.8%
Fredericksburg City	24.4%
Galax City	24.3%
Martinsville City	23.3%
Virginia State Average	**11.5%**

Source: JobsEQ by Chmura

4.4. Projected Impact on Employment

There will be no impact on the overall employment in the state. The proposed regulations are currently suspended as long as the federal ETS is in effect.

4.5. Small Business Impact

It is estimated that the number of small businesses in healthcare and healthcare support is 45,401, based on 2020 data. Associated employment is 334,233 as of the first quarter of 2021.

5. Impact of 16VAC25-220-60

5.1. Economic Impact

16VAC25-220-60 outlines the requirements for employers having higher-risk workplaces with mixed-vaccination-status employees. There are four sections lettered A to D. Section A defines the applicable businesses for 16VAC25-220-60 and lists various factors that may increase the risks of COVID-19. This section poses no incremental cost to employers.

5.1.1. Section B

Section B.1 is related to the engineering controls for businesses with higher-risk workplaces with mixed-vaccination-status employees. 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 (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."[35] It is estimated that subsection B.1 will not generate incremental costs for businesses.[36]

Subsection B.2 states that where feasible, "employers shall install physical barriers, (such as plexiglass shields), for employees who are not vaccinated and otherwise at-risk employees, where such barriers will aid in mitigating the spread of SARS-CoV-2 and COVID-19 virus transmission." Similarly, subsection B.3 also requires that for workplaces with process and assembly lines (and employees who may not be fully vaccinated), employers should ensure proper spacing or use physical barriers when necessary. The cost of a physical barrier ranges from $15 to $300, depending on the size.[37] In addition, if other mitigation strategies are implemented in higher-risk workplaces, this requirement is optional for businesses and may not result in incremental costs.

5.1.2. Section C

Section C concerns administrative and work practice control of employers with higher-risk workplaces and mixed-vaccination-status employees. 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 the Virginia Department of Health for screening includes temperature checks and screening questions.[38] It is estimated that the cost of a digital non-contact thermometer ranges from $14 to $80.[39] 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 screenings. It is estimated that screening each employee may take two to five minutes.

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[35] Source: 16VAC25-60-120 [General Industry], https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section120/.

[36] DOLI states that the air handling provisions in the VOSH Standard were specifically reviewed by the Virginia Department of Housing and Community Development (DHCD) and found to be consistent with Virginia Statewide Building Code requirements.

[37] 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.

[38] 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/.

[39] Source: https://www.zumaoffice.com/search.aspx?keyword=thermometer.

Subsection C.2 requires that "employers shall provide face coverings to suspected COVID-19 non-employees to contain respiratory secretions until the non-employees are able to leave the site." Face coverings, such as standard disposable masks, cost about $0.10 per piece when purchased in bulk.

Subsection C.3 requires employers to stagger break times, while Section C.4 requires employers to stagger employees' arrival and departure times, to avoid congregating during breaks or in parking areas. Section C.5 states that employers shall implement flexible work hours (staggered shifts). Those measures pose no incremental costs for businesses.

Subsection C.6 requires employers to provide visual cues (floor markers or signs) as a reminder to maintain physical distancing. The additional cost to businesses includes physical distancing signage, which range from $1.80 to $9.40, and floor markers, at $0.60 per piece.[40]

Subsection C.7 stipulates the requirement for retail workspaces where there are at-risk employees. Those measures include signage requesting face coverings, requiring physical distance, installing barriers when physical distancing is not feasible, moving electronic payment terminals away from at-risk employees, and shifting stocking activities to off-peak hours. Those requirements only apply to at-risk employees. Expenses for retail businesses are signs encouraging masks ($1.80 to $9.40 per sign), and floor markers ($0.60 per piece).[41] The cost of a physical barrier ranges from $15 to $300, depending on the size.[42] Other requirements such as moving cash registers or changing stocking hours can be accomplished by adjusting current staff hours. These will not create new costs for retail businesses.

Subsections C.8 and C.9 require businesses to deliver services remotely and deliver products through curbside pick-up. Those requirements will not pose new costs for businesses and can be accomplished using current staff and contractors. Some measures, such as delivering services remotely, may even provide cost savings for businesses.

5.1.3. Section D

Section D is related to personal protective equipment (PPE) in the higher-risk workplace. It requires employers to assess hazardous risks, complete a written certification, and select PPE for at-risk employees. The current regulations by the Occupational Safety and Health Administration (OSHA) have required employers in general industry (excluding construction, agriculture, and maritime industries) to assess workplace hazards.[43] For businesses in those three industries, it is estimated that risk assessment and certification may take approximately four to five staff hours. Chmura estimates the cost of PPE to outfit one person is around $4.00, including disposable gloves at $0.10 per pair, disposable gowns at $0.65 per piece, disposable goggles at $1.70 per piece, and disposable N95 respirators at $1.50 per piece.

In summary, 16VAC25-220-60 will incur limited incremental costs for employers at higher-risk workplaces with mixed-vaccination-status employees. Most of those costs are related to administrative controls, such as conducting screenings, installing physical barriers, and providing PPE for those not fully vaccinated. However, businesses can mitigate these costs by adopting more flexible worksites and shift arrangements.

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[40] Source: https://www.amazon.com/Social-Distancing-Floor-Decal-Stickers/dp/B089KCQHQL/ref=sr_1_8?dchild=1&keywords=social+distancing+signs&qid=1626877296&sr=8-8.
[41] Ibid.
[42] 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.
[43] Source: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132.

5.2. Businesses and Entities Affected

In Virginia, it is estimated that 70,700 establishments in 2020 were higher-risk workplaces with mixed-vaccination-status employees. They employed 1.6 million workers as of the first quarter of 2021, with an estimated 552,501 employees who were not fully vaccinated. This section has some specific requirements for retail businesses. In Virginia, it is estimated that 25,309 establishments in 2020 were in retail businesses. They employed 401,227 workers as of the first quarter of 2021, with an estimated 139,226 who were not fully vaccinated.

5.3. Localities Particularly Affected

In Virginia, an estimated 40.1% of all jobs are in higher-risk workplaces. In some localities, a high percentage of employees work for those businesses. As Table 5.1 shows, examples of those localities are Williamsburg City, Radford City, and Pulaski County. On average, 10.1% of Virginia employees are in retail, and localities such as Colonial Heights City, Franklin City, and Madison County have the highest percentage of local employment in retail businesses.

Table 5.1: Top Ten Virginia Localities with Employees in Higher-Risk Workplaces

Locality	Percent of Employees at Higher-Risk Workplaces	Locality	Percent of Employees in Retail
Williamsburg City	67.7%	Colonial Heights City	26.3%
Radford City	67.3%	Franklin City	21.5%
Pulaski County	65.4%	Madison County	21.1%
Greensville County	64.6%	Waynesboro City	20.4%
Henry County	64.2%	Essex County	20.4%
Montgomery County	63.6%	Greene County	20.0%
Harrisonburg City	63.0%	Rockbridge County	19.4%
Covington City	62.0%	Appomattox County	19.3%
Dinwiddie County	61.4%	Gloucester County	19.2%
Isle of Wight County	60.7%	Norton City	18.7%
Virginia State Average	**40.1%**	**Virginia State Average**	**10.1%**

Source: JobsEQ by Chmura

5.4. Projected Impact on Employment

The proposed standard will have a limited impact on overall employment in the state. Since the estimated incremental costs are not substantial, it is unlikely that any of the affected businesses will need to reduce staff size to meet those requirements. However, it will have a positive effect on businesses supplying products such as face masks and physical barriers.

5.5. Small Business Impact

The number of small businesses impacted by the requirement is 70,482, based on the 2020 establishment estimate. As of the first quarter of 2021, associated employment was 1.3 million. Among those employees, 435,710 were not fully vaccinated. It is estimated that 25,297 retail establishments in 2020 were small businesses. They employed 391,218 workers as of the first quarter of 2021, and an estimated 135,752 of those employees were not fully vaccinated.

6. Impact 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 employers in healthcare and healthcare support services, as well as employers with higher-risk workplaces and 11 or more employees who are not fully vaccinated. Subsections A and B stipulate the classification level of employers required to have this plan, which will not result in additional costs for businesses.

NOTE: Healthcare services and healthcare support services will not be impacted by 16VAC25-220-70 during the period that the ETS is in effect (45,567 establishments are in healthcare or healthcare support services).

Subsection C provides details related to the components of such a plan. Employers should designate a person responsible for the plan. Other components of the plan include identifying sources that expose employees at work, an employee's individual risk factor, contingency plans if a virus outbreak occurs, and identifying infection prevention measures. It is estimated that risk assessment and implementation of an infectious disease preparedness and response plan may take approximately 10 to 20 hours of staff time to develop. To mitigate such costs to businesses, the Virginia Occupational Safety and Health Program has provided a free online WORD template 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 significantly reduce the cost for businesses.[44]

6.2. Businesses and Entities Affected

The proposed regulations will affect healthcare and healthcare support services employers, and those with higher-risk workplaces having 11 or more unvaccinated employees. It is estimated that the number of establishments in this category was 57,368 in 2020, with an employment of 1.6 million as of the first quarter of 2021.

6.3. Localities Particularly Affected

In Virginia, an estimated 39.3% of all employees are in the affected business category. Some localities have a higher percentage of employees in affected businesses. As Table 6.1 shows, examples of those localities are Emporia City, Galax City, and Williamsburg City.

6.4. Projected Impact on Employment

The proposed regulations will have no impact on overall state employment. The only incremental cost is additional hours, which can be accommodated by existing staff. Businesses will have no need to hire additional workers.

Table 6.1: Top Ten Virginia Localities with the Highest Percentage of Affected Employment

Locality	Percent of Affected Employment
Emporia City	62.5%
Galax City	62.1%
Williamsburg City	59.5%
Winchester City	59.5%
Danville City	58.5%
Petersburg City	57.0%
Norton City	56.8%
Greensville County	56.5%
Colonial Heights City	56.3%
Smyth County	56.2%
Virginia State Average	**39.3%**

Source: JobsEQ by Chmura

[44] Source: https://www.doli.virginia.gov/covid-19-outreach-education-and-training/.

6.5. Small Business Impact

It is estimated that the number of impacted small businesses is 57,098, based on the 2020 establishment estimate. Associated employment was 1.2 million as of the first quarter of 2021.

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. Subsection A identifies employers which are required to provide training for their employees. The training requirement only applies to healthcare and healthcare support employers; and for higher-risk workplaces, training is required only for at-risk employees. For fully vaccinated employees, written information can be provided in lieu of training.

NOTE: Healthcare services and healthcare support services will not be impacted by 16VAC25-220-80 during the period that the ETS is in effect (45,567 establishments are in healthcare or healthcare support services).

Section B outlines information that should be covered in the training, and Section C requires that employers in healthcare and healthcare support services should maintain certification records for employees completing the training. Typically, development of material takes about 40 hours of staff time for a one-hour training course.[45] Delivering the training and maintaining training certifications will also require staff hours in human resources or management. To mitigate costs to businesses, VOSH has provided free online training materials that satisfy the requirements of 16VAC25-220-80. In addition, VOSH has provided a free online training certification form for employers to use.[46] As a result, employers may not need to develop new training materials, and all business costs are related to training each employee (about an hour) and staff time to maintain the certifications.

Other employers need to provide written or oral information to their employees (Sections E and F). The Virginia Department of Labor and Industry will develop an information sheet for employees to distribute. As a result, the cost to other affected businesses is minimal.

7.2. Businesses and Entities Affected

Overall, 16VAC25-220-80 will affect all businesses in Virginia, but the responsibility varies based on business categorization. The training requirement is for all employees in healthcare and healthcare support businesses, and for at-risk employees in higher-risk workplaces. Chmura estimates that there are 116,267 businesses in those two categories, with 1.0 million employees needing training. It is estimated that about 1.0 million fully vaccinated employees in higher-risk workplaces need to be provided with an information sheet. There were 173,515 other businesses in Virginia, with 1.9 million employees, who will need to be provided with an information sheet.

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, since it only applies to healthcare, healthcare support services, and higher-risk workplaces, some localities affected the most include Williamsburg City, Emporia City, and Galax City. For other businesses without a training requirement, localities with high percentages of employment are Goochland County, King George County, and Surry County (Table 7.1).

[45] Source: https://trainlikeachampion.blog/why-does-it-matter-how-long-it-takes-to-design-a-presentation/.
[46] Source: https://www.doli.virginia.gov/wp-content/uploads/2020/08/ETS-Full-Training-Presentation.pdf; https://www.doli.virginia.gov/wp-content/uploads/2020/08/ETS-Abbreviated-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.

NOTE: Local government healthcare services and healthcare support services will not be impacted by 16VAC25-220-80 during the period that the ETS is in effect.

Table 7.1: Top Ten Virginia Localities with the Highest Percentage of Affected Businesses

Locality	Percent of Employment in Healthcare / Support / Higher-Risk Workplaces	Locality	Percent of Employment in Other Businesses
Williamsburg City	80.2%	Goochland County	77.1%
Emporia City	78.9%	King George County	76.2%
Galax City	78.7%	Surry County	74.8%
Greensville County	76.2%	Manassas Park City	70.1%
Danville City	75.0%	Arlington County	67.8%
Pulaski County	74.9%	Charles City County	63.9%
Colonial Heights City	73.8%	Fairfax County	63.1%
Montgomery County	73.8%	Alexandria City	62.4%
Smyth County	73.6%	Highland County	61.7%
Henry County	73.5%	King and Queen County	56.2%
Virginia State Average	**51.6%**	**Virginia State Average**	**48.4%**

Source: JobsEQ by Chmura

7.4. Projected Impact on Employment

The proposed regulations will have no impact on overall state employment. Since the estimated incremental costs are minimal, those efforts can be accommodated by existing staff without the need to hire additional workers.

7.5. Small Business Impacts

Overall, 16VAC25-220-80 will affect all small businesses in Virginia, but training requirements are for all employees in healthcare, healthcare support businesses, and at-risk employees in higher-risk workplaces. Chmura estimates that there are 115,883 small businesses in those categories, with an estimated 769,344 employees needing training. It is estimated that about 818,810 million fully vaccinated employees of small businesses with higher-risk workplaces need to be provided with an information sheet. For other businesses, 172,967 are small businesses in Virginia, with 1.4 million employees, who will need to be provided with an information sheet.

Appendix: Summary Table of Impact

Table A1: Economic Impact Summary

Standard	Description	Included in the Study	Estimated Cost
16VAC25-220-40	**All Businesses**		
A	Have a policy to ensure compliance	Staff hours	1-2 hours
B	Exposure assessment (8 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	
	Provide COVID-19 test	Overlap with current regulations	
D	Develop social distancing policies	Staff hours, signage	1-2 hours
	Use signage	Cost of signs	$1.80-$9.40 per sign
E	Post signage in common spaces	Cost of signs	$1.80-$9.40 per sign
	Clean and disinfect common areas	Cost of cleaning services	$50-$100 per hour for commercial cleaning
	Handwashing facilities	Overlap with current regulations	
	Handwashing supplies	Cost of hand sanitizer and soap	$5 per bottle (12-17 ounces) or $25-$35 per gallon for hand sanitizer; $12-$50 per gallon for liquid hand soap
F	Provide N95 respiratory protection	Cost of N95 respirators	$1.50 per piece (disposable); $14.00 per piece (reusable)
	Provide face coverings when respirators are not available	Cost of face coverings	$0.10-$0.90 per unit (disposable); $0.50-$3.00 (reusable)
G	Provide face coverings	Cost of face coverings	$0.10-$0.90 per unit (disposable); $0.50-$3.00 (reusable)
	Face shields in certain circumstances	Cost of face shields	$0.40-$4.00 (disposable); $1.50-$8.00 (reusable)
H	Reserved	N/A	
I	Correct ways to wear face coverings	N/A	
J	Reserved	N/A	
K	Reserved	N/A	
L	Cleaning and disinfection	Cost of cleaning services	$50-$100 per hour for commercial cleaning
	Cleaning and disinfecting products available	Cost of cleaning and disinfecting products	$20-$35 per gallon for all-purpose cleaning products
	Access to soap and water, and hand sanitizer	Cost of soap and hand sanitizer	$5 per bottle (12-17 ounces) or $25-$35 per gallon for hand sanitizer; $12-$50 per gallon for liquid hand soap
	Provide mobile crews with hand sanitizer	Cost of hand sanitizer	$5 per bottle (12-17 ounces) or $25-$35 per gallon
	Ensure protective measures are in place	N/A	
M	Provide PPE	Cost of PPE	$0.10 per pair for disposable gloves; $0.65 per piece for disposable gowns; $1.70 per piece for disposable goggles; $1.50 per piece for disposable N95 respirators
16VAC25-220-50	**Healthcare Services and Healthcare Support Services**		
	Suspended, following federal OSHA ETS	N/A	

Table A1: Economic Impact Summary

Standard	Description	Included in the Study	Estimated Cost
16VAC25-220-60	**Higher-risk Workplaces**		
A	Definition	N/A	
B	Air handling system (B.1)	Overlap with current regulations	
	Install physical barriers (B.2)	Cost of physical barriers	$15-$300 per unit
	Ensure proper spacing, use physical barriers if necessary (B.3)	Cost of physical barriers	$15-$300 per unit
C	Screening employees for symptoms (C.1)	Cost of screening methods	$14-$80 per thermometer, staff hours of 2-5 minutes per employee
	Face coverings to non-employees (C.2)	Cost of face coverings	$0.10-$0.90 per unit (disposable); $0.50-$3.00 (reusable)
	Stagger break times (C.3)	N/A	
	Stagger arrival and departure times (C4)	N/A	
	Flexible work hours (C.5)	N/A	
	Visual cues for social distancing (C.6)	Cost of signs or floor markers	$1.80-$9.40 per sign; $0.50 per piece for floor markers
	Retail settings (C7a, C7b)	Cost of signs/physical barriers	$15-$300 per unit for physical barrier, $1.80-$9.40 per sign
	Moving cash register, non-peak stocking hours (C7c, C7d)	N/A	
	Deliver services remotely (C8)	Cost savings for business	
	Deliver products using curbside pickup	N/A	
D	Hazard assessment & certification (D1 & D2)	Staff hours	4-5 hours staff time
	Select PPE (D1)	Cost of PPE	$0.10 per pair for disposable gloves; $0.65 per piece for disposable gowns; $1.70 per piece for disposable goggles; $1.50 per piece for disposable N95 respirators
	Other requirements (D3.D4)	N/A	
16VAC25-220-70	Develop preparedness and response plan	Staff hours	10-20 hours
16VAC25-220-80	Training & certification (B, C, D)	Staff hours	About one hour for each employee
	Information sheet (E, F)	Staff hours	Minimal

Source: Chmura

COMMONWEALTH of VIRGINIA

DEPARTMENT OF LABOR AND INDUSTRY

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August 20, 2021

DEPARTMENT OF LABOR AND INDUSTRY (DOLI)
VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM

DOLI ADDENDUM

To the August 20, 2021, Economic Impact Analysis of the Proposed Amendments to the VOSH 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 expired on January 26, 2021.

A final VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, was adopted by the Board and took effect on January 27, 2021.

On June 29, 2021, the Board adopted proposed amendments to the VOSH Standard. During the adoption process for the proposed amendments, the Board made clear that it would attempt to substantially comply with the core requirements in the APA by holding a thirty day written comment period[2] and a public hearing[3] along with obtaining an Economic Impact Analysis

[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."

[2] The thirty day comment period was held from July 1, 2021 to July 31, 2021.

[3] The public hearing was held August 5, 2021.

https://www.doli.virginia.gov/wp-content/uploads/2021/08/VDOLI_COVID_Amendment_20210820.pdf and holding a meeting to consider final adoption of the proposed amendments.[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 proposed amendments to the VOSH 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.

NOTE: The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether revisions should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some revisions should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E., https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).

The Dept. invited the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

The EIA prepared by Chmura does not address the above-referenced revisions.

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

[4] The Board is meeting August 26, 2021 to consider final adoption of the proposed amendments and certain revisions recommended by the Department.

[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.

related to the development of real estate for commercial or residential purposes. While Governor's Executive Orders (EO) (see the most recent EO 79[6]) 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 applies 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 whether of the employer's operations are considered "high risk" and the the extent to which employees are fully vaccinated or not.

   Those projected costs (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 (See Summary Table of Impact in EIA). https://www.doli.virginia.gov/wp-content/uploads/2021/08/VDOLI_COVID_Amendment_20210820.pdf

   Those localities that incur costs uniquely attributable to compliance with the standard will likely use revenue they generate from their own taxes and fees. A small number of the requirements with associated costs related to the Commonwealth's response to the COVID-19 pandemic are contained in Governor's Executive Order 79 (K-12 employees must wear face masks (face coverings in VOSH Standard) while on school grounds), and the Transportation Security Administration's (TSA) requirement that employees wear face masks on commercial flights, buses and trains through Jan. 18, 2022. [7]

   To the extent that a requirement is included in both an Executive Order and the standard, or a TSA requirement 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 such costs 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

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[6] https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/EO-79-and-Order-of-Public-Health-Emergency-Ten-Ending-of-Commonsense-Public-Health-Restrictions-Due-to-Novel-Coronavirus(COVID-19).pdf

[7] The Transportation Security Administration on Tuesday extended a federal requirement that travelers [and employees] wear masks on commercial flights, buses and trains through Jan. 18, 2022." https://www.cnbc.com/2021/08/17/biden-administration-set-to-extend-mask-mandate-for-travel-through-mid-january.html
https://www.tsa.gov/news/press/releases/2021/04/30/tsa-extends-face-mask-requirement-airports-and-throughout

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.

COMMONWEALTH of VIRGINIA

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UPDATE: August 25, 2021

[to August 19, 2021 Document - See added Comments Sent Direct to DOLI starting on page 137 and Public Hearing Comments starting on page 159]

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY

VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM

PROPOSED AMENDMENTS TO THE 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 268 written comments through the Virginia Regulatory Townhall for the 30 day written comment period from July 1, 2021 to July 31, 2021.

There were 19 written comments sent directly to DOLI 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 7 oral comments received during the public hearing on August 5, 2021.

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 on a number of issues:

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 99342).

COMMENTS POSTED ON THE VIRGINIA REGULATORY TOWNHALL

99342 Jonathan Bottoms
United Steelworkers Union local 12103 7/2/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99342

Vaccination discrimination. On behalf of my Union body, and many others who have suffered at the hand of these standards, I do not support the changes in this standard that open the door for discrimination against individuals who choose not to receive this vaccination. We, as a state & a country, need to move forward together - without infringing on anyone's freedom to choose what is best for their own body. As someone who has contracted COVID-19 myself, I would like to know why there is no language about immunity gained from natural antibodies? Additionally, why should a non-vaccinated person be required to wear a mask while working next to someone who is vaccinated? This, in my opinion, casts doubt on the effectiveness of the vaccines all together. As is true of anything in life, we must all retain our right to form opinions & make our own decisions accordingly. These amendments will create more division & promote animosity amongst co-workers, employees, and employers. The analogy I think about here is a very simple one, comparing mask usage to wearing a seatbelt - I choose to wear my seatbelt to protect myself & my family, but I cannot & will not try to force my beliefs behind that choice on anyone else. These are decisions that people must make for themselves. The leaders of our great state have the opportunity here to restore a sense of normalcy to a population that severely needs it. I, for one, hope that we can ALL move past this pandemic, together, without divisive regulations. I was raised to shake hands & make direct eye contact with those who I respect, and that is exactly what I intend to do from here on out - regardless of my lack of the check-in-the-box that is a vaccination card.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

On July 9, 2021, the CDC has estimated that "Preliminary data from several states over the last few months suggest that 99.5% of deaths from COVID-19 in the United States were in unvaccinated people."

"CDC Director Rochelle Walensky said that cases, hospitalizations and deaths from the coronavirus are increasing nationwide, adding that over 97% of new hospitalizations are in patients who are unvaccinated."
The Department has relied heavily on guidance from the CDC and federal OSHA in developing the VOSH Standard because they are the two primary national authorities on infectious disease transmission in the workplace.
The CDC has provided detailed guidance on the need for and efficacy of COVID-19 vaccines and what mitigation strategies should be used by persons and businesses to slow the spread of the virus. They have also issued guidance on what precautions should be observed by those who have been fully vaccinated.

"On July 27, 2021, CDC released updated guidance on the need for urgently increasing COVID-19 vaccination coverage and a recommendation for everyone in areas of substantial or high transmission to wear a mask in public indoor places, even if they are fully vaccinated. CDC issued this new guidance due to several concerning developments and newly emerging data signals. First is a reversal in the

downward trajectory of cases. In the days leading up to our guidance update, CDC saw a rapid and alarming rise in the COVID case and hospitalization rates around the country.
• In late June, our 7-day moving average of reported cases was around 12,000. On July 27, the 7-day moving average of cases reached over 60,000. This case rate looked more like the rate of cases we had seen before the vaccine was widely available.

[As of August 11, 2021,"the current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619)."]

Second, new data began to emerge that the Delta variant was more infectious and was leading to increased transmissibility when compared to other variants, even in vaccinated individuals. This includes recently published data from CDC and our public health partners, unpublished surveillance data that will be publicly available in the coming weeks, information included in CDC's updated Science Brief on COVID-19 Vaccines and Vaccination, and ongoing outbreak investigations linked to the Delta variant. Delta is currently the predominant strain of the virus in the United States."

As of August 16, 2021:
55.2% of the Virginia population is fully vaccinated. 66.3% of the adult Virginia population is fully vaccinated. 62.3% of the Virginia populations is vaccinated with at least one dose of the vaccine.
The current 7-day positivity rate PCR only in Virginia is 8.2%.
The 7-day average of number of new cases reported in Virginia is 2,058.

It continues to remain the CDC's position that persons who have previously have COVID-19 should get vaccinated "because experts do not yet know how long you are protected from getting sick again after recovering from COVID-19." In addition, "Studies have shown that vaccination provides a strong boost in protection in people who have recovered from COVID-19."

A recent study published in the CDC's Morbidity and Mortality Weekly Report on August 13, 2021 found that:
Although laboratory evidence suggests that antibody responses following COVID-19 vaccination provide better neutralization of some circulating variants than does natural infection, few real-world epidemiologic studies exist to support the benefit of vaccination for previously infected persons. This report details the findings of a case-control evaluation of the association between vaccination and SARS-CoV-2 reinfection in Kentucky during May–June 2021….
Among Kentucky residents infected with SARS-CoV-2 in 2020, vaccination status of those reinfected during May–June 2021 was compared with that of residents who were not reinfected. In this case-control study, being unvaccinated was associated with 2.34 times the odds of reinfection compared with being fully vaccinated.
https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm

How Long Does Vaccine Immunity Last?
USAToday.com, August 19, 2021, "Vaccine effectiveness declines over time, studies say"
Protection provided by COVID-19 vaccines declines over time, but protection against the most severe effects of the disease — including hospitalization and death — remains strong, according to three studies published Wednesday by the Centers for Disease Control and Prevention.
Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "New COVID-19 Cases and Hospitalizations Among Adults, by Vaccination Status — New York, May 3–July 25, 2021"

In this study, current COVID-19 vaccines were highly effective against hospitalization ([vaccine effectiveness] VE >90%) for fully vaccinated New York residents, even during a period during which prevalence of the Delta variant increased from <2% to >80% in the U.S. region that includes New York, societal public health restrictions eased,§§ and adult full-vaccine coverage in New York neared 65%. However, during the assessed period, rates of new cases increased among both unvaccinated and fully vaccinated adults, with lower relative rates among fully vaccinated persons. Moreover, VE against new infection declined from 91.7% to 79.8%. To reduce new COVID-19 cases and hospitalizations, these findings support the implementation of a layered approach centered on vaccination, as well as other prevention strategies.
https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e1.htm?s_cid=mm7034e1_w

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, " Effectiveness of Pfizer-BioNTech and Moderna Vaccines in Preventing SARS-CoV-2 Infection Among Nursing Home Residents Before and During Widespread Circulation of the SARS-CoV-2 B.1.617.2 (Delta) Variant — National Healthcare Safety Network, March 1–August 1, 2021"
Analysis of nursing home COVID-19 data from NHSN indicated a significant decline in effectiveness of full mRNA COVID-19 vaccination against laboratory-confirmed SARS-CoV-2 infection, from 74.7% during the pre-Delta period (March 1–May 9, 2021) to 53.1% during the period when the Delta variant predominated in the United States. This study could not differentiate the independent impact of the Delta variant from other factors, such as potential waning of vaccine-induced immunity. Further research on the possible impact of both factors on VE among nursing home residents is warranted. Because nursing home residents might remain at some risk for SARS-CoV-2 infection despite vaccination, multipronged COVID-19 prevention strategies, including infection control,§§ testing, and vaccination of nursing home staff members, residents, and visitors are critical.
https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e3.htm?s_cid=mm7034e3_w

Medrxiv.org, August 8, 2021, "Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence"
Although clinical trials and real-world studies have affirmed the effectiveness and safety of the FDA-authorized COVID-19 vaccines, reports of breakthrough infections and persistent emergence of new variants highlight the need to vigilantly monitor the effectiveness of these vaccines. Here we compare the effectiveness of two full-length Spike protein-encoding mRNA vaccines from Moderna (mRNA-1273) and Pfizer/BioNTech (BNT162b2) in the Mayo Clinic Health System over time from January to July 2021, during which either the Alpha or Delta variant was highly prevalent. We defined cohorts of vaccinated and unvaccinated individuals from Minnesota (n = 25,589 each) matched on age, sex, race, history of prior SARS-CoV-2 PCR testing, and date of full vaccination.
Both vaccines were highly effective during this study period against SARS-CoV-2 infection (mRNA-1273: 86%, 95%CI: 81-90.6%; BNT162b2: 76%, 95%CI: 69-81%) and COVID-19 associated hospitalization (mRNA-1273: 91.6%, 95% CI: 81-97%; BNT162b2: 85%, 95% CI: 73-93%).
However, in July, the effectiveness against infection was considerably lower for mRNA-1273 (76%, 95% CI: 58-87%) with an even more pronounced reduction in effectiveness for BNT162b2 (42%, 95% CI: 13-62%).
https://www.medrxiv.org/content/10.1101/2021.08.06.21261707v1

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).

The Dept. invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

USA Today, August 19, 2021, "Vaccine effectiveness declines over time, studies say"
Protection provided by COVID-19 vaccines declines over time, but protection against the most severe effects of the disease — including hospitalization and death — remains strong, according to three studies published Wednesday by the Centers for Disease Control and Prevention. (Emphasis added).
https://www.usatoday.com/story/news/health/2021/08/19/covid-vaccine-mask-mandates-biden-administration/8189622002/

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "Sustained Effectiveness of Pfizer-BioNTech and Moderna Vaccines Against COVID-19 Associated Hospitalizations Among Adults — United States, March–July 2021"

In a multistate network that enrolled adults hospitalized during March–July 2021, effectiveness of 2 doses of mRNA vaccine against COVID-19–associated hospitalization was sustained over a follow-up period of 24 weeks (approximately 6 months). These findings of sustained VE were consistent among subgroups at highest risk for severe outcomes from COVID-19, including older adults, adults with three or more chronic medical conditions, and those with immunocompromising conditions. Overall VE in adults with immunocompromising conditions was lower than that in those without immunocompromising conditions but was sustained over time in both populations.

These data provide evidence for sustained high protection from severe COVID-19 requiring hospitalization for up to 24 weeks among fully vaccinated adults, which is consistent with data demonstrating mRNA COVID-19 vaccines have the capacity to induce durable immunity, particularly in limiting the severity of disease (9,10). Alpha variants were the predominant viruses sequenced, although Delta variants became dominant starting in mid-June, consistent with national surveillance data (8). Because of limited sequenced virus, Delta-specific VE was not assessed. VE was similar during June–July when circulation of Delta increased in the United States compared with VE during March–May when Alpha variants predominated, although further surveillance is needed.
https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e2.htm?s_cid=mm7034e2_w

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99346 Johnny Jacobs 7/2/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99346
Permanent Covid amendments
This permanent covid was way to late and made pernanent as the vaccine was rolling out to the public. My issue is it being behind with the cdc guidance. I'm fully vaccinated yet at my job everybody vaccinated or not has to wear a mask., This bit of freedom of choice should be eliminated as it comes to the vaccine. Employers should mandate their employees to be vaccinated or leave. If you gettin covid was only affecting the individual yes that's their choice whether to get vaccinated but that's not the

case. Unvaccinated people are spreading that crap to others. U have no right to be able to do that. At the least it would be nice for the vaccinated people to have a choice to wear the mask or not. If ur unvaccinated wear the mask should be mandatory. That would maybe get more to get vaccinated if that was enforced. But I truly believe it's an employers right to mandate this vaccine to their employees. They are the real problem and the reason the delta variant is out.,
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99360 Josh Phelps 7/8/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99360

Opposition to the EPS and any amendments. If the mission of any mitigation strategies for Covid-19 is still to limit the overwhelming of hospitals, that has been completely accomplished based on the VDH data in the graph above. The darkest blue is current hospitalizations for CV-19 and the dotted yellow is surge capacity (not overwhelmed capacity). As can be seen, we have never been anywhere near capacity nor in danger of overwhelming the hospital beds. Shown is Northwest region, but all graphs show the same overall trends. If the mission of any mitigation strategy is something other than preventing hospitals from becoming overwhelmed, then that should be explained by the DOLI board at the outset.

The % positivity rates are also as low as they've ever been, even before any executive orders were implemented last year, why doesn't that metric mean anything to DOLI?

Also, we are still referencing PCR tests as the accepted measurement for infection. However, just detecting virus using this test doesn't equate to an infection, hospitalization, or death. It just means the virus was detected. The CDC spells this out here:

This means just because someone submits to a PCR test and that test, run at higher than recommended cycles, finds traces of virus, that person is deemed to be a positive case. That person may never be in need of medical care, may never have a symptom, and may never transmit enough virus to cause illness to anyone else, yet they are recorded as a positive case. That seems like an improper way to measure the presence of a lethal virus in a population. I'd expect that in VA, with a governor who was trained as a medical doctor, we would require a higher level of verification to declare someone as a positive case.

Deaths are also now at incredibly low numbers. Ultimately that is what is trying to be reduced or prevented from a viral spread, that has happened. In the same Northwest region, the 7-day average is 3 deaths/day. That is less than deaths from any number of other daily activities and certainly not worthy of statewide intervention policies.

Also, according to VDH data, 11,436 individuals have deaths attributed to CV-19 out of 681,599 reported cases. That's a death rate of .0168% or 99.9832% survivability when a positive case is identified (notwithstanding the above issues with positive case identification). This assumes accuracy of reporting is 100% as well. Knowing this, we are taking all these mitigation efforts? Does anyone at DOLI do a risk/benefit analysis with respect to this public data? If called as a witness in a legislative session, could a DOLI official explain the return on investment to a business for implementing any strategy at all for anything that has less than a 1% chance of happening??

With respect to placing demands on the employers of VA to mitigate this virus, the data doesn't point to this being the proper protocol. See this chart from VDH data where the vast majority of cases/deaths/hospitalizations are from people near or beyond retirement age (in fact most deaths are from people beyond the average expected life span). So it really makes no sense to put controls or restrictions on businesses whose employees are in low risk age and demographic groups and contribute nothing to any risk of overwhelmed hospitals or severe disease outbreaks or deaths.

Also quite curious is VDH website won't allow me to build a chart just based on death counts alone. It combines cases and hospitalizations. So drilling down on the data becomes quite a chore which seems like something that should be fixed.

The current round of EUA vaccines on the market are just that, experimental. There have been zero long-term tests done to know if there are any impacts 2, 5, 10 years from now on recipients. For this reason alone, employers should not be compelling their teams to do anything with respect to this procedure unless they somehow assume the risk of any adverse events. In VA, according to VAERS, 44,910 adverse events have been reported. 4,373,518 people in VA are fully vaccinated. It has been widely estimated that VAERS reporting only captures anywhere from 1-10% of incidents. Even if not, there's a 1% chance that a recipient of this experimental intervention will have an adverse reaction and less than a 1% chance of mortality from contracting the virus. Based on those odds alone, individuals are far better off accepting the low risk of natural disease especially when long-term impacts of the experimental drug on their life is completely unknown. As an employer, there's no way to ethically compel or entice employees to accept this risk.

There's also no evidence to show someone who has received the experimental intervention helps anyone but themselves. A person who receives this treatment, then has exposure to the virus, is now an asymptomatic carrier, and not masking (per these guidelines), making them far more dangerous in the workplace than before (if we assume masks have any impact at all). If the experimental shot is truly effective, then it shouldn't matter who wears masks and who doesn't because the recipients of the shot are supposedly immune.

To illustrate why these programs really will not work, look at the case of the first cruise to take place in North America since all of this has happened. All crew and passengers were required to be fully vaccinated and have a negative test within 72hrs of departure. Yet, 2 passengers tested positive for CV-19 while on the cruise. This could equate to any business you can imagine, anywhere. Basically, they fully complied and there were still people with the virus. So what good did any of this do? Why were they even testing if the vaccine requirements were supposedly enough? Celebrity Millennium - Two passengers on first fully vaccinated cruise in North America test POSITIVE for Covid (the-sun.com)

Are workers given fully informed consent when they are taking this shot? Do they know the risks as outlined by the FDA?

Does DOLI plan to publish these risks as part of the standard when discussing vaccinated employees versus non-vaccinated employees?

How can people who have had a natural interaction with the virus and survived be discounted as being any different from someone who has received the experimental shot? Humans have developed lifelong or nearly lifelong immunity or resistance to viruses since we have existed. Are we now ignoring millions of years of development as a species because some new virus showed up in 2020? Can DOLI refute this? This article spells it out quite well: Good news: Mild COVID-19 induces lasting antibody protection – Washington University School of Medicine in St. Louis (wustl.edu)

Should people who have recovered from COVID take a vaccine? (trialsitenews.com)

Many more articles and studies like that can be found quite easily.

As of the date of implementation of the ETS (now EPS) in VA, there were approximately 3,200 reported deaths. VA now stands at approximately 11,400 deaths meaning that since implementation of these mitigation strategies and other statewide mandates, deaths have tripled. Also during this time the experimental vaccines were introduced and widely implemented. Can DOLI or anyone at VDH explain this trend sufficiently to make us think that continuing these policies is in any way a net positive for the workers and employers and citizens of VA?

There are treatments available. They have worked and are working worldwide and in the US where brave doctors have risked their careers to save lives while being suppressed by local and state authorities and definitely censored when trying to share best practices with others in their profession on the front lines. Anyone interested can find these credible testimonies on a variety of platforms and should be appalled and the silencing of these experts. Dr Pierre Kory, Dr Brett Weinstein, Dr Richard

Bartlett, Dr Vladimir Zelenko to name a few that should be looked at. Knowing this, the EUA should have never been allowed to move forward, that alone should give pause to officials here in VA not wanting future lawsuits for our state to have to defend using taxpayer dollars. While this is not the role of DOLI, it is something that should be understood and investigated because there will be legal battles coming and this discussion will emerge as part of those cases.
In summary, while safety of the workforce appears to be the underlying motivator by DOLI, data suggests safety has not and will not be improved by any measures implemented and enforced thus far. Data also suggests that the most vulnerable population to this particular virus is largely not in the workforce. Asking employers to now get into the business of openly discriminating against people who choose or choose not to have an experimental drug injected into their body is really a frightening prospect after a year in which we've been asked to enforce state rules on our own with no training or guidance, become nurses and doctors in assessing an employee's health, taking temperatures or daily medical surveys and also trying to remain open in the face of an economic downturn caused largely by government intervention.
DOLI has not had proper public testimony from expert witnesses on any of the topics spelled out in the standard. Myriad states in the USA have done little to no intervention and had similar or better outcomes with no negative impact on their economies or business freedoms, and those states have recovered faster and are seeing an influx of residents and businesses. Yet DOLI and VA ignore all of this and just keep making policy.
There are things that are not known. We really do not know if face coverings do any good or not. We really do not know if social distancing does any good or not. We really do not know if constant sanitizing does any good or not. We really do not know if asymptomatic spread is real or not. We really do not know if assuming everyone has a virus is a good idea or not. We really do not know if natural immunity is as effective as that obtained by the various experimental drugs available. We really do not know if there are long term effects of these drugs. We really do not know if there have been outbreaks prevented by the measures set out in this standard since last fall. We really do not know far too many things to implement any policy ethically, or morally here in the commonwealth. Given the above, I am opposed to the continuation of this standard or any regulation not supported by validated data and public, expert testimony and on the record votes by elected officials.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99363 Chris Cook 7/9/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99363
Opposition to Continuation of the Emergency Continuation of the Emergency standard, with or without, the proposed changes, will create a burden on most employers and employees, as well ruin the credibility of the Virginia Department of Labor and Industry.
1) On May 28th, Governor Northam, said the following at a press conference: "Today, we mark a tremendous milestone in our fight against COVID-19. As of 12:01 this morning, for the first time since March 2020, there are no limits on capacity or distancing in Virginia's restaurants, business, offices, or other venues." (Virginian-Pilot/Pilotonline, May 28th 2021 10:27 AM; similarly reported by all major media.)
At that moment, in the mind of the citizens of Virginia, the Governor ostensibly, invalidated the Emergency Permanent Standard by proclamation in virtually all settings.

2) Since then, employees, both vaccinated and unvaccinated, have been going to public events, going out to dinner, shopping, attending church, etc without becoming ill from COVID. As no requirement for proof of vaccination is required for the mask rules, it is impossible to say whether they are following that CDC guidance at all times.
With the exception of healthcare professions, where actively ill patients may be injured, or hospitalized, any reasonable person could presume that continuing the proposed restrictions, specifically on a subset of employees, who have chosen to not be vaccinated, nor required to provide proof one way or the other in their daily lives, will view attempted enforcement of these regulations on them in the workplace as a form of intimidation and harassment.

SEE RESPONSE TO COMMENT 99342
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99371 Anonymous* 7/13/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99371
COVID19 Permanent Standard Proposed Updates.
Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency.
If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.
Our businesses are committed to the safety and welfare of our customers, employees, and community. Please help ensure a speedy economic recovery by eliminating burdensome regulations on our businesses.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

Many comments appear to be under a misunderstanding about the ability of the VOSH Standard to respond to changes in CDC guidance. While it is true that the text of the VOSH Standard remains as it was when first adopted effective January 27, 2021, please note that 16VAC25-220-10.E provides:
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 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. 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 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.
Contrary to many commenters stating that the VOSH Standard is inflexible and unable to account for the changing dynamic of the virus and the revised CDC recommendations that have issued, 16VAC25-220-10.E specifically does allow the Department's VOSH Standard to account for revised CDC recommendations which are issued in response to the changing dynamic of the virus.

As an example, in §40, FAQ 55 regarding CDC guidance changes for fully vaccinated persons, the Department consulted with the Virginia Department of Health (VDH) and concluded the following within a matter of days of the issuance of the updated CDC guidance on fully vaccinated people:
As the CDC comes out with revised guidelines for fully vaccinated employees in a public workplace setting, the Department reviews the changes with the Virginia Department of Health (VDH) and addresses any changes in compliance requirements in an FAQ.

The Department and VDH agree that based on the CDC's science-based determination that, with the exceptions previously noted, these FAQs, including §40, FAQs 46 to 57, fully vaccinated non-healthcare employees can safely resume indoor and outdoor workplace duties without wearing a face covering or physically distancing in public indoor settings if the place of employment is in an area of moderate or low COVID-19 transmission. Such activities would be in compliance with and provide employees equivalent protection to 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11. Face coverings must continue to be worn in public indoor settings if the place of employment is in an area of substantial or high COVID-19 transmission.

Unlike the states of California and Oregon, for instance, who issued Emergency Temporary Standards (that did not contain language similar to 16VAC25-220-10.E) and later had to convene their regulatory rulemakers to reissue updated regulatory text to reflect CDC changes, Virginia did not have to do so because it could address them within days of CDC changes through interpretative responses to questions asked by the regulated community and employee representatives.
In closing, 16VAC25-220-10.E, has turned out to be a very effective method for the Virginia to deal with "the changing dynamic of the virus and the revised CDC recommendations that have issued"
The Department has issued FAQs addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).
The FAQs can be found at: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC's updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask ("face covering" in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:
https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.
The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:

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.
Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021, which resulted in the CDC update:

Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

99372 Kathleen Washburn, NVUS, LLC* 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99372
COVID-19 permanent workplace standard Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency.
If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.
Our businesses are committed to the safety and welfare of our customers, employees, and community. Please help ensure a speedy economic recovery by eliminating burdensome regulations on our businesses.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99373 Vicki Arven 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99373
Permanent Workplace Standard Removal Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency.
If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.
Our businesses are committed to the safety and welfare of our customers, employees, and community. Please help ensure a speedy economic recovery by eliminating burdensome regulations on our businesses.

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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99374 Jay Gilliland 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99374
Proposed changes to the COVID-19 permanent workplace standards
Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency.
If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99375 Matthew Rosenbaum, MBA 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99375
Workplace Standard Good Afternoon,
I would like to echo comments of previous members of the public in saying that the emergency standard needs to be eliminated and federal guidelines should be followed. Federal guidelines are staying up to date with new and current scientific guidance, while the standard is several months behind.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99377 Anonymous 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99377
Support for Amendment Having a temporary and then permanent standard in our state has helped, in my opinion, develop more awareness about Covid-19 and means for protection, in addition to keeping the exposure and infection rate low among our employees.

As someone who is responsible for implementing the requirements of these standards, develop the Plan and conduct training, there were times when it was overwhelming to do it in addition to my regular job duties. However, looking back, I can see the benefits of having a compliance framework to assist employers and their employees navigate the pandemic and post-pandemic era. This framework, combined with the commitment of our leaders, had helped us stay safe and working, despite the polarized beliefs and views held by some employees at times.

Having to comply with these standards in VA had created for employers a different, more effective response to the pandemic in comparison with other states (based on conversations I had with professionals in other states (MD, GA, NY).

Moving forward, the Amendment would help, in my opinion, employers close the gap between their employees who are vaccinated and those who are not.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99484

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. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission of the virus, particularly the Delta variant, and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. While highly effective vaccines against the disease are widely available at no cost, there is still a considerable percentage of the population nationally and in Virginia that is not fully vaccinated.

It is the Department's position that the VOSH Standard remains 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 VOSH Standard ultimately helps 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.

The Department notes that the VOSH 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.

Some commenters raised concerns about the standard 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. 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. Va. Code § 40.1-22.

DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC's updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask ("face covering" in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:

https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.
The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:

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.
Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021, which resulted in the CDC update:

Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

99378 Anonymous 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99378
Covid restrictions I think all the covid restrictions should be removed and we should have the same work conditions we had prior to covid.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99379 Sofia Melnyk 7/13/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99379
Covid restrictions I live in Roanoke, VA. Covid restrictions put a lot of pressure on local businesses. I would like to have Covid restrictions removed so businesses can operate like they used to during pre pandemic time.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99381 Amy Wolford, DePaul Community Resources DePaul Community Resources 7/14/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99381
Comment regarding the proposed changes to the Final Permanent Standard for COVID-19
RE: Proposed Amendments to the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220, as Adopted by the Virginia Safety and Health Codes Board dated June 29, 2021
Dear Ms. Trice:

Thank you for the opportunity to provide a public comment. As safety is a top priority for our nonprofit human services organization, we would like to raise the following to items to your attention.

While the proposed Final Permanent Standard addresses workplace issues within an office setting, we are requesting specific guidance regarding employees who will have in-person contact with people who are unable to receive the vaccine or who are at a higher risk of severe COVID-19 even with a vaccine in a community setting, such as a home. Our work at DePaul requires our employees to be in foster homes with children who are unable to be vaccinated at this time due to their age, as well as in the homes of individuals with developmental disabilities. There is a need to provide appropriate precautions to protect our staff, the clients we serve (foster children and individuals with disabilities), and the people that care for them (foster parents and sponsored residential providers) in these community-based settings.

Additionally, we are requesting clarity regarding an employer's ability to mandate precautions that are stricter than the Final Permanent Standard. The Final Permanent Standard appears to indicate that employers are prevented from maintaining stricter precautions. While FAQ #49 in §40 from the current Final Permanent Standard indicates that ability, it is unclear if this revision of the Final Permanent Standard takes that allowance away from employers.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

See updated DOLI FAQs §40, FAQs 46-57 dealing with requirements for fully vaccinated employees and those who are not fully vaccinated.
https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

Employers can require safety and health protections for employees that exceed VOSH standards:
See §40, FAQ 50: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

50. IF AN EMPLOYER DETERMINES THAT FULLY VACCINATED EMPLOYEES MUST STILL WEAR FACE COVERINGS AND/OR PHYSICAL DISTANCE WHILE AT WORK, MUST EMPLOYEES COMPLY?
Yes. Va. Code §40.1-51.2(a), rights and duties of employees provides as follows:

(a) It shall be the duty of each employee to comply with all occupational safety and health rules and regulations issued pursuant to this chapter and any orders issued thereunder which are applicable to his own action and conduct.

Employers have the duty to "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," Va. Code §40.1-51.1.A; and the right to establish workplace safety and health rules and to enforce them, 16VAC25-60-260.B.

NOTE 1: For the purposes of this guidance, people are considered fully vaccinated for COVID-19 ≥2 weeks after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or ≥2

weeks after they have received a single-dose vaccine (Johnson & Johnson [J&J]/Janssen)±; there is currently no post-vaccination time limit on fully vaccinated status. This guidance can also be applied to COVID-19 vaccines that have been authorized for emergency use by the World Health Organization (e.g. AstraZeneca/Oxford). Unvaccinated people refers to individuals of all ages, including children, that have not completed a vaccination series or received a single-dose vaccine.

However, at this time, there are limited data on vaccine protection in people who are immunocompromised. People with immunocompromising conditions, including those taking immunosuppressive medications (for instance drugs, such as mycophenolate and rituximab, to suppress rejection of transplanted organs or to treat rheumatologic conditions), should discuss the need for personal protective measures with their healthcare provider after vaccination.
Reference: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).

The Dept. invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

99382 Visit Virginia's Blue Ridge
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99382
COVID 19 Guidelines It would be best for the Commonwealth of Virginia to align all workforce COVID19 standards with the CDC guidelines. This will reduce any confusion.

SEE RESPONSE TO COMMENT 99371

99383 TBS Construction, LLC*
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99383
Changes to the COVID-19 Permanent Workplace Standard
Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency.

If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.
Our businesses are committed to the safety and welfare of our customers, employees, and community. Please help ensure a speedy economic recovery by eliminating burdensome regulations on our businesses.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99384 Brooke Mills
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99384
Virginia COVID Standard
Dear Members of the Safety and Health Codes Board:

I am writing to ask that you rescind the COVID-19 permanent workplace standard. The guidance is outdated and does not reflect recent developments, specifically regarding vaccinations. The Occupational Safety and Health Administration (OSHA) and Centers for Disease Control (CDC) have provided sufficient guidance for employers that is frequently updated to reflect changes in science, best practices and standards.

As a Human Resources professional, I consider helping to provide a safe workplace for our employees one of my most important responsibilities. For many years, I have relied on guidance from OSHA to assist with various elements of a workplace safety. I trust that their recommendations on mitigating and preventing the spread of COVID-19 in our workplaces will be of the same caliber and high standard we are accustomed to. In addition, the CDC will continue to be our Company's "go-to" source of information for all pandemic related planning and response activities.

Rather than continuing with unnecessary and burdensome regulations, I urge you to rely on the expertise of the CDC and OSHA to guide Virginia's COVID-19 response.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99385 Anonymous
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99385
Your workplace "protections" are screwing retail workers
Drop mandatory daily health screening/surveys. Since implementation, these have forced otherwise honest employees to lie repeatedly about mundane, routine, non-COVID health conditions, or else take excessively long periods of unpaid time off of work due to the requirements in this policy. Nobody I know answers these surveys honestly unless they want 10 days off from work unpaid. This is an unnecessary reporting burden for the employee and employer, and is costing many front-line retail workers large amounts of lost wages.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

§40, FAQ 56 provides:
56. With the CDC updated guidance on fully vaccinated employees issued on May 13, 2021, are employers still required to conduct daily health assessments/screenings?

Yes, but only for employees that are exposed to COVID-19 related hazards and job tasks that are classified as very high, high or medium exposure risk. See 16VAC25-220-50.C.1 (very high and high exposure risk) and 16VAC25-220-60.C.1 (medium exposure risk).
The VOSH Standard does not require daily health assessments or daily screenings of employees only exposed to COVID-19 related hazards and job tasks classified as lower exposure risk. Instead, 16VAC25-220-40.B.4 provides:

4. Employers shall develop and implement policies and procedures for employees to report when they are experiencing signs 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."

See CDC guidance for fully vaccinated people that are experiencing COVID-19 signs or symptoms; and for fully vaccinated people that have tested positive for COVID-19 in the prior 10 days at:
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html#:~:text=Guiding%20Principles%20for%20Fully%20Vaccinated%20People,-Indoor%20and%20outdoor&text=Fully%20vaccinated%20people%20should%20still,are%20experiencing%20COVID%2D19%20symptoms.

https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

99386 John Avis
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99386
Rescind COVID-19 Standard
Dear Members of the Safety and Health Codes Board:
I am writing to ask that you rescind the COVID-19 permanent workplace standard. The guidance is outdated and does not reflect recent developments, specifically regarding vaccinations. The Occupational Safety and Health Administration (OSHA) and Centers for Disease Control (CDC) have provided sufficient guidance for employers that is frequently updated to reflect changes in science, best practices and standards.
As a Human Resources professional, I consider helping to provide a safe workplace for our employees one of my most important responsibilities. For many years, I have relied on guidance from OSHA to assist with various elements of a workplace safety. I trust that their recommendations on mitigating and preventing the spread of COVID-19 in our workplaces will be of the same caliber and high standard we are accustomed to. In addition, the CDC will continue to be our Company's "go-to" source of information for all pandemic related planning and response activities.
Rather than continuing with unnecessary and burdensome regulations, I urge you to rely on the expertise of the CDC and OSHA to guide Virginia's COVID-19 response.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99388 Danita Roble 7/15/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99388

Do Not make temporary regulations regarding COVID-19 permanent

If the mission of any mitigation strategies for Covid-19 is still to limit the overwhelming of hospitals, that has been completely accomplished based on the VDH data in the graph above. The darkest blue is current hospitalizations for CV-19 and the dotted yellow is surge capacity (not overwhelmed capacity). As can be seen, we have never been anywhere near capacity nor in danger of overwhelming the hospital beds. Shown is Northwest region, but all graphs show the same overall trends. If the mission of any mitigation strategy is something other than preventing hospitals from becoming overwhelmed, then that should be explained by the DOLI board at the outset.

The % positivity rates are also as low as they've ever been, even before any executive orders were implemented last year, why doesn't that metric mean anything to DOLI?

Also, we are still referencing PCR tests as the accepted measurement for infection. However, just detecting virus using this test doesn't equate to an infection, hospitalization, or death. It just means the virus was detected. The CDC spells this out here:

This means just because someone submits to a PCR test and that test, run at higher than recommended cycles, finds traces of virus, that person is deemed to be a positive case. That person may never be in need of medical care, may never have a symptom, and may never transmit enough virus to cause illness to anyone else, yet they are recorded as a positive case. That seems like an improper way to measure the presence of a lethal virus in a population. I'd expect that in VA, with a governor who was trained as a medical doctor, we would require a higher level of verification to declare someone as a positive case.

Deaths are also now at incredibly low numbers. Ultimately that is what is trying to be reduced or prevented from a viral spread, that has happened. In the same Northwest region, the 7-day average is 3 deaths/day. That is less than deaths from any number of other daily activities and certainly not worthy of statewide intervention policies.

Also, according to VDH data, 11,436 individuals have deaths attributed to CV-19 out of 681,599 reported cases. That's a death rate of .0168% or 99.9832% survivability when a positive case is identified (notwithstanding the above issues with positive case identification). This assumes accuracy of reporting is 100% as well. Knowing this, we are taking all these mitigation efforts? Does anyone at DOLI do a risk/benefit analysis with respect to this public data? If called as a witness in a legislative session, could a DOLI official explain the return on investment to a business for implementing any strategy at all for anything that has less than a 1% chance of happening??

With respect to placing demands on the employers of VA to mitigate this virus, the data doesn't point to this being the proper protocol. See this chart from VDH data where the vast majority of cases/deaths/hospitalizations are from people near or beyond retirement age (in fact most deaths are from people beyond the average expected life span). So it really makes no sense to put controls or restrictions on businesses whose employees are in low risk age and demographic groups and contribute nothing to any risk of overwhelmed hospitals or severe disease outbreaks or deaths.

Also quite curious is VDH website won't allow me to build a chart just based on death counts alone. It combines cases and hospitalizations. So drilling down on the data becomes quite a chore which seems like something that should be fixed.

The current round of EUA vaccines on the market are just that, experimental. There have been zero long-term tests done to know if there are any impacts 2, 5, 10 years from now on recipients. For this

reason alone, employers should not be compelling their teams to do anything with respect to this procedure unless they somehow assume the risk of any adverse events. In VA, according to VAERS, 44,910 adverse events have been reported. 4,373,518 people in VA are fully vaccinated. It has been widely estimated that VAERS reporting only captures anywhere from 1-10% of incidents. Even if not, there's a 1% chance that a recipient of this experimental intervention will have an adverse reaction and less than a 1% chance of mortality from contracting the virus. Based on those odds alone, individuals are far better off accepting the low risk of natural disease especially when long-term impacts of the experimental drug on their life is completely unknown. As an employer, there's no way to ethically compel or entice employees to accept this risk.

There's also no evidence to show someone who has received the experimental intervention helps anyone but themselves. A person who receives this treatment, then has exposure to the virus, is now an asymptomatic carrier, and not masking (per these guidelines), making them far more dangerous in the workplace than before (if we assume masks have any impact at all). If the experimental shot is truly effective, then it shouldn't matter who wears masks and who doesn't because the recipients of the shot are supposedly immune.

To illustrate why these programs really will not work, look at the case of the first cruise to take place in North America since all of this has happened. All crew and passengers were required to be fully vaccinated and have a negative test within 72hrs of departure. Yet, 2 passengers tested positive for CV-19 while on the cruise. This could equate to any business you can imagine, anywhere. Basically, they fully complied and there were still people with the virus. So what good did any of this do? Why were they even testing if the vaccine requirements were supposedly enough? Celebrity Millennium - Two passengers on first fully vaccinated cruise in North America test POSITIVE for Covid (the-sun.com)

Are workers given fully informed consent when they are taking this shot? Do they know the risks as outlined by the FDA?

Does DOLI plan to publish these risks as part of the standard when discussing vaccinated employees versus non-vaccinated employees?

How can people who have had a natural interaction with the virus and survived be discounted as being any different from someone who has received the experimental shot? Humans have developed lifelong or nearly lifelong immunity or resistance to viruses since we have existed. Are we now ignoring millions of years of development as a species because some new virus showed up in 2020? Can DOLI refute this? This article spells it out quite well: Good news: Mild COVID-19 induces lasting antibody protection – Washington University School of Medicine in St. Louis (wustl.edu)

Should people who have recovered from COVID take a vaccine? (trialsitenews.com)

Many more articles and studies like that can be found quite easily.

As of the date of implementation of the ETS (now EPS) in VA, there were approximately 3,200 reported deaths. VA now stands at approximately 11,400 deaths meaning that since implementation of these mitigation strategies and other statewide mandates, deaths have tripled. Also during this time the experimental vaccines were introduced and widely implemented. Can DOLI or anyone at VDH explain this trend sufficiently to make us think that continuing these policies is in any way a net positive for the workers and employers and citizens of VA?

There are treatments available. They have worked and are working worldwide and in the US where brave doctors have risked their careers to save lives while being suppressed by local and state authorities and definitely censored when trying to share best practices with others in their profession on the front lines. Anyone interested can find these credible testimonies on a variety of platforms and should be appalled and the silencing of these experts. Dr Pierre Kory, Dr Brett Weinstein, Dr Richard Bartlett, Dr Vladimir Zelenko to name a few that should be looked at. Knowing this, the EUA should have never been allowed to move forward, that alone should give pause to officials here in VA not wanting future lawsuits for our state to have to defend using taxpayer dollars. While this is not the role of DOLI, it is something that should be understood and investigated because there will be legal battles coming and this discussion will emerge as part of those cases.

In summary, while safety of the workforce appears to be the underlying motivator by DOLI, data suggests safety has not and will not be improved by any measures implemented and enforced thus far. Data also suggests that the most vulnerable population to this particular virus is largely not in the workforce. Asking employers to now get into the business of openly discriminating against people who choose or choose not to have an experimental drug injected into their body is really a frightening prospect after a year in which we've been asked to enforce state rules on our own with no training or guidance, become nurses and doctors in assessing an employee's health, taking temperatures or daily medical surveys and also trying to remain open in the face of an economic downturn caused largely by government intervention.

DOLI has not had proper public testimony from expert witnesses on any of the topics spelled out in the standard. Myriad states in the USA have done little to no intervention and had similar or better outcomes with no negative impact on their economies or business freedoms, and those states have recovered faster and are seeing an influx of residents and businesses. Yet DOLI and VA ignore all of this and just keep making policy. LINK: VDH

There are things that are not known. We really do not know if face coverings do any good or not. We really do not know if social distancing does any good or not. We really do not know if constant sanitizing does any good or not. We really do not know if asymptomatic spread is real or not. We really do not know if assuming everyone has a virus is a good idea or not. We really do not know if natural immunity is as effective as that obtained by the various experimental drugs available. We really do not know if there are long term effects of these drugs. We really do not know if there have been outbreaks prevented by the measures set out in this standard since last fall. We really do not know far too many things to implement any policy ethically, or morally here in the commonwealth. Given the above, I am opposed to the continuation of this standard or any regulation not supported by validated data and public, expert testimony and on the record votes by elected officials.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99389 Scott Miller 7/16/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99389

COVID-19 Regulations

Dear Members of the Safety and Health Codes Board:

I write to you today in regard to the proposed changes to the COVID-19 permanent workplace standard. The termination of Governor Northam's state of emergency has created confusion in the business community due to the many conflicting sources of ongoing health regulations. While many may look at the expiration of our state of emergency as welcome news that the pandemic is coming to an end, business owners still operate under regulations that are now outdated due to vaccinations and evolving federal guidelines. With capacity limits and mask mandates eliminated but a strict COVID-19 standard still in place, many Virginia business owners don't know which regulatory framework they should follow. To eliminate such confusion (and burden) on businesses and their employees as they seek to recover, it makes the most sense to rescind the standard as has been done with Virginia's state of emergency. If—and only if—it is the will of the Safety and Health Codes Board to keep a standard in place, it should mirror Center for Disease Control (CDC) guidelines so business owners need not worry about conflicting information from our state and federal governments. The CDC has long asked us to follow the science and a less burdensome approach to COVID-19 mitigation will allow for a speedier recovery while still keeping employees safe.

Our businesses are committed to the safety and welfare of our customers, employees, and community. Please help ensure a speedy economic recovery by eliminating burdensome regulations on our businesses.
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99390 Neil Biller 7/16/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99390
DOLI COVID Regulations"Dear Members of the Safety and Health Codes Board:
I write to you today in regard to the proposed changes to the COVD permanent workplace standards.
We do not feel that permanent regulations are necessary however if any regulations must be promulgated that they be exactly as those enacted by the United States Center for Disease Control (CDC). There are many conflicting regulations and policies concerning COVD therefore we recommend that simplicity and clarity become the standard.
Again, we want to be clear that we do not support any permanent regulations but if they are they must be simple, clear and identical to CDC guidelines.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99396 Diane Peters 7/20/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99396
Oppose Permanent Workplace Safety Standards
The proposed permanent standards being proposed in relation to COVID-19 unfairly affect businesses and their employees. DOLI should issue guidelines similar to the CDC, not permanent standards. Businesses should be allowed to set their own standards as far as k mask wearing and social distancing, but medical requirements proposed in these standards go against HIPPA.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99397 Southern Management 7/20/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99397
Opposing the Permanent Workplace Safety Standards

Opposing the Permanent Workplace Safety Standards.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99401 Patrick Burton 7/20/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99401
Permanent Workplace Safety Standards Workplace safety is something we all take seriously in the property management business. We have learned over the past 18 months how to conduct business and protect our team, customers, vendors and residents alike. We have thermometers and O2 Pulse Monitors and used them every day to determine that our team was healthy and not putting others at risk of infection. Permanent standards for workplace safety is not what we need in our industry. Guidelines offered in conjunction with updates from the CDC is a much better option now that we have learned so much about how to operate safely during a pandemic like COVID-19. Please establish guidelines not standards for workplace safety going forward.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99402 Anonymous 7/21/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99402
Permanent Standard Please reconsider making these standards permanent. As a business owner, I put the health and safety of my employees and patrons at the top of the list. But, as others have said, there is not across the board guidance on this. What about the newest research of natural, possible lifetime immunity? No one is making any new guidelines on such, which should be considered as a viable alternative to a vaccine. After all, the original goal was to get herd immunity for the population. Instead we get, put on a mask or you can be turned in by a peer…any government who encourages neighbors to turn on each other should look into the past and what those outcomes were and rethink it…

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99419 Charles Twigg, O.D. 7/22/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99419
PPE Requirements/Covid Education I think that PPE should be mandated in all healthcare settings. We (Healthcare Providers) need to be setting an example for the general public. We need to be a source of reliable information to deliver on a personal basis to all who seek our professional services.
We need to discourage the spread of Covid and its emerging variants both by example and by education of the “non-vaccers”.

We need to be able to provide an up to the minute reliable source (written documentation) of information to encourage the “spread” of accurate information about the risks of Covid-19 and the risks and benefits of immunization.
Our close personal relationship gives us a unique platform to deliver reliable information. We need to use our unique position of trust to “move the needle” of trust in our science towards “fact” in a non-political setting. "

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

See DOLI §40, FAQ 46 on respiratory protection requirements in the workplace.
https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

On June 21, 2021 Federal OSHA issued an emergency temporary standard (ETS) to protect healthcare and healthcare support service workers from occupational exposure to COVID-19 in settings where people with COVID-19 are reasonably expected to be present.

On June 29, 2021, the Safety and Health Codes Board (Board) adopted the federal COVID19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, with an effective date of August 2, 2021 and which shall expire within six months or when repealed by the Board, whichever occurs first.

The effective date of the ETS as adopted by the Board is August 2, 2021. Virginia employers must comply with all the requirements of the COVID-19 ETS except paragraphs §1910.502 (i), (k) and (n) by August 17, 2021. Employers must comply with paragraphs § 1910.502(i), (k), and (n) by September 1, 2021.
In its motion to adopt the Emergency Temporary Standard, the Safety and Health Codes Board also accepted the recommendation of the Department that:

1. Application of Virginia’s 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.
2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services be later stayed or invalidated by a state or federal court, the provisions of Virginia’s 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.
3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services be later stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia’s 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia’s 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be maintained, modified, or revoked.

To access the final rule see Occupational Exposure to COVID–19; Emergency Temporary Standard, Interim Final Rule. https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf

For Federal OSHA Outreach Materials, see COVID-19 Healthcare ETS Outreach. https://www.osha.gov/coronavirus/ets

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99465 Anonymous 7/23/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99465
unnecessary ETSq END THE ETS! for almost two years you have preached "follow the science", well it's time you took your own advice! These are not helpful, unnecessary and a violent overreach by the government! End the ETS!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99466 Joe Kouten
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99466ETS
Regs ETS is placing a burden on doing business and now that the Governor has lifted the emergency, this should also be lifted. Don;t drive small business' out of business!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99467 Bill Ragland 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99467
Really Really. More over reach from the government. Are you trying to make it harder to do business in Va. Stop over regulating

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99468 Jeff Foley 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99468
ETS is not good for small business! We are trying to recover financially from the pandemic and the ETS is a bad idea! We are vaccinated and the ETS is no longer necessary.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99469 Chuck Shifflett 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99469
Strongly oppose ETS Reg as Permanent As a company we have been and will continue to make sure the safety and well being of our employees and our customers is of the highest concern. People are more aware that their actions and or in-actions as it pertains to social distance, cleanliness, etc affects others and they have mostly now set their own standards higher. The burden the ETS puts on small businesses is higher than anyone ever probably thought it would be. It makes it harder to staff, service consumers, handle deliveries both in and out of the company, as well at the same time minimizing the profits of the company due to the costs involved all the way around. The ETS needs to be ended.

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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99470 Alice Coleman 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99470oppose
ETS This restriction places an undo burden on small business. Please do not support this. We have already suffered enough. We already comply with CDC guidelines. Please do not place additional restrictions on us. We have been financially impacted enough.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99471 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99471
Oppose ETS!!! "Our Governor has lifted the state of emergency; the ETS should be lifted as well.
We should only be required to follow CDC guidelines.
At this stage of the pandemic, ETS place an unnecessary burden on my small business as I try to recover financially from the COVID-19 pandemic. I am already complying with CDC guidelines, and additional restrictions and burdens on me will further hinder my financial recovery process.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99472 KK 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99472
Strongly oppose ETS and those who support it. "Permanent ETS standards will NOT be tolerated. Will fight back with those supporting this government overreach.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99473 old dominion tire services inc. Old Dominion Tire Services, Inc 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99473
ets mandate "i have a tire company located in Chesterfield County all of my team have had the vacation for COVID 19 . We don't need to be regulated by the government . i stand in opposition of this regulation.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99474 George Reynolds 7/23/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99474 Can small businesses please get a break? The title says it all. We're dying over here. Please don't make things even more difficult.

Do not make the ETS permanent. We're following CDC guidelines which should be sufficient.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99475 Bob 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99475
oppose We already have done everything asked of us, lets follow cdc guidelines, do not make this permanent, it holds businesses down.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99476 Dean C Rodgers 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99476
Time to Treat People Like Adults "There is adequate information exposure on the risks of covid.
There are successful treatments available to covid patients.
There is a FREE vaccine available to anyone who wants it.
It is time to allow adults to make decisions for themselvels and their children.
The government no longer has a role to play in this individual health care decision.
Businesses do not need government help in managing their employees in this matter.
End DOLI's involvement in it. Please.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99477 Ryan Hailey 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99477
stop the madness its time to stop worrying about a cloth face covering that is soaking up all the diseases and bringing them home or into your vehicles making you more sick then coving your face all day and making it hard to breathe

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99478 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99478
No to further mandates!!!! "Our Governor has lifted the state of emergency as it expired. The ETS should also be lifted. We should be required to only follow the CDC guidelines. The ETS is no longer necessary as very few people are hospitalized. At this stage of the pandemic, ETS place an unnecessary and a burden on my small business as I try to recover financially from the COVID-19 pandemic. I am already complying with CDC guidelines, and additional restrictions and burdens on me will further hinder my financial recovery process.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99479 Suzette Babcock Childcare Center 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99479
Childcare Center Owner"1) I would like to see ALL agencies get on the SAME PAGE! CDC says vaccinated individuals don't need to wear a mask, but DOLI says we do. Too many agencies giving us contradicting guidance. (CDC, VDH, DSS, DOE, DOLI, and any local regulating entity)
2) No masks for vaccinated individuals.
3) Allow business to make some individual common sense decisions. A 200+ student childcare center in the city is far different than a 40 student rural childcare center

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99480 Judy Miller 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99480
Stop The Mask Wearing NOW! This is Pure stupidity! Do YOU know the best action for Covid? FRESH AIR. and instead you quarantined people. Masks are not needed anymore. If people want them. Ok. But don't force them. THE END.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99481 Childcare Worker 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99481
No masks "Requiring everyone to wear a mask did not stop us from being closed for quarantine for 2 weeks losing pay. Requiring a mask for vaccinated people makes it seems as if vaccination doesn't work. Stop killing businesses.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99482 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99482
Strongly oppose Businesses in Virginia have suffered enough by the way our Governor and other officials have handled this pandemic, not to mention the recent statistics showing our state ranks 41st in returning jobs affected by the pandemic so far this year.
Enough is enough !!!

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99483 Javier 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99483
There is no more "EMERGENCY"!! "The jab was for emergency use and still NOT FDA APPROVE why is the Government pushing so hard!! I will defend THE CONSTITUTION from foreign and domestic.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99484 Nancy J Thomas 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99484
STRJGLY OPPOSED "There has never been a problem. The media falsely led and fed lies and inflated the numbers which made people scared. Continuing down this path you are sealing your fate and God will have all those involved to answer for this. Thank you for letting me comment.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671

The Department respectfully disagrees with the commenter's statement that "there has never been a problem."

The CDC reports the following as of August 11, 2021:

Reported Cases
The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619). A total of 36,268,057 COVID-19 cases have been reported as of August 11.

Deaths
The current 7-day moving average of new deaths (492) has increased 21.0% compared with the previous 7-day moving average (407). The current 7-day moving average is 59.3% lower compared to the peak observed on August 2, 2020 (1,210). The current 7-day moving average is 86.5% lower than the peak observed on January 13, 2021 (3,640) and is 170.4% higher than the lowest value observed on July 10, 2021 (182). As of August 11, a total of 617,096 COVID-19 deaths have been reported in the United States.

Hospitalizations
New Hospital Admissions
The current 7-day average for August 4–August 10 was 10,072. This is a 29.6% increase from the prior 7-day average (7,771) from July 28–August 3. The 7-day moving average for new admissions has consistently increased since June 25, 2021. New admissions of patients with confirmed COVID-19 are currently at their highest levels since the start of the pandemic in Florida, Louisiana, and Oregon.

Vaccinations
The U.S. COVID-19 Vaccination Program began December 14, 2020. As of August 12, 353.9 million vaccine doses have been administered. Overall, about 196.5 million people, or 59.2% of the total U.S. population, have received at least one dose of vaccine. About 167.4 million people, or 50.4% of the total U.S. population, have been fully vaccinated.* As of August 12, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 699,068, a 0.03% decrease from the previous week.

CDC's COVID Data Tracker Vaccination Demographic Trends tab shows vaccination trends by age group. As of August 12, 90.6% of people ages 65 or older have received at least one dose of vaccine and 80.6% are fully vaccinated. Over two-thirds (71.5%) of people ages 18 or older have received at least one dose of vaccine and 61.3% are fully vaccinated. For people ages 12 or older, 69.2% have received at least one dose of vaccine and 59% are fully vaccinated.

99485 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99485
Objection "This is crazy! Please do your research. Please present both sides of this issue to the public, and let the people decide for themselves if they prefer to mask & social distance. Crippling small businesses and mandating mask wearing is offensive and debilitating economically and physically.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99486 Mag. W. 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99486
Strongly against!!! No way! What has happened to individual rights?I

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99487 Dalila Adams 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99487
Stongly oppose "Another way to control others and take away freedim. No trust in CDC, FDA, Biden or government now.

ivermectin and hcq with zinc and antibiotics works. People died unnecessarily from censorship and de ual of these simple methods. Disgusting. also Trump won and you know it
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99488 David 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99488
You know damn well those masks do nothing. It says right on the box you buy - it does nothing.
It is time for you folks to be removed from office. Your agenda is not the agenda of the American people you are supposed to be representing. You know full well those masks do NOTHING. It says right on the box - does not protect from viruses or covid specifically on some. So why? Do you think we do not know what you are doing? The American people are waking up and becoming aware of your agenda. You best knock it off or your time in office will be short - the people of Virginia have had enough.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99489 Tammie Neff 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99489Mandates "Do not do this! It is all lies and we won't be locked down and smothered under masks any longer! There is no Covid nor a Delta virus!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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99490 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99490
Strongly Oppose "This is getting ridiculous. The majority of people getting COVID are those who have been vaccinated! Masks don't work and neither do vaccinations. This virus is 99.4% curable. Why are we STILL allowing it to run our lives and our businesses? It's beyond time to move on.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99491 Deborah Moomaw 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99491
I object! I object to this proposal!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99492 PWC Citizen 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99492
strongly oppose"There are still those who have never contracted the virus, always tested negative for COVID, wore their mask, and followed all guidelines. Those who have never tested positive shouldn't be forced to become vaccinated

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99493 Tanya 7/23/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99493
No More It is becoming more and more clear the “leadership” is far overreaching. Lockdowns, masking, vaccinations are proving they do not work and are far more harmful than helpful. Would you like for all small businesses to close? Families to financially collapse? Children to die of suicide? It is starting to feel that is the intention behind it all because it certainly isn’t backed by any common sense or real science. You are propagating fear and encouraging everyone to base their decisions out of fear. Most of us want to be left alone and do what we feel is best for our families. Stay out or get out. That’s how the vote will be moving forward from this mom of 3.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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99494 JIM 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99494
STRONGLY OPPOSED! NO MORE!! "This is Government overreach. It absolutely DOES NOT follow the science. I can assure you, We the people will not stand for anymore!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377

SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99496 Cynthia 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99496
Virginia businesses and the economy have suffered enough
For the sake of businesses in Virginia, their owners and their families, as well as the economy of this state, please end all mandates regarding COVID-1984 restrictions. It is in your power to stop the downward spiral we are experiencing into fascism and totalitarianism that Virginians have suffered through since April 2021. Having Virginia back to normal means people can once again use and enter businesses and buy things without unnecessary fascist rules that have prevented businesses from making money, in turn being able to support their families. Please return Virginia to its heritage of freedom and liberty--you have it in your power to do this if you really cared about the well-being of Virginia citizens. Everyday its flag flies all over the state with lady liberty conquering tyrants. Allow people to make their own decisions free from government tyranny.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99497 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99497
I don't consent to outright fraud and usurpation of human rights to HIPAA protected health standards
I don't consent to outright fraud and usurpation of human rights to HIPAA protected health standards. Fauci patented the vaccine full of spike proteins and "Dr" Burks has no license to practice medicine on live human beings. I suggest you listen to Dr. Andrew Kaufman, Robert O. Young, Tenpenny, and many other licensed doctors specializing in this field.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99498 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99498
Strongly object! Strongly Object!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99499 Debbie 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99499
16VAC25-220 / not the will of we the people Not the will of we the people- enough!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99500 Sheila T 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99500
Strongly Oppose This is definitely government overreach - not of the people and by the people. You're going way too far. This virus was patented years ago and is man made. Masks don't work. Your biological experiments have serious outcomes that are not being reported. We the people are not guinea pigs. I object to forced injections, especially to children. I object to mandatory masking.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99501 Rodney Miller 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99501I oppose! My body, my choice! Right!! The standard does not require employees to be vaccinated.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99502 Tim Kiser 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99502
I oppose 110% What you people are proposing is unconstitutional and asinine at best. You have no legal standing and no scientific proof to back it up. Goodluck.....

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99503 Gentlemans Ridge Farmstead and Catering Service 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99503

Permanent restrictions Absolutely oppose!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99504 Gentlemans Ridge Farmstead and Catering Service 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99504

Permanent restrictions Absolutely oppose!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99505 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99505
Health restrictions I strongly oppose all restrictions on anyone related to health.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99506 Jackie 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99506
No There is no emergency. COVID has a 99.9% recovery rate. We will not comply and we will take this to court.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99507 Gretel Mangigian RN 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99507
I do not consent I oppose!!!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99508 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99508

Nuremburg Be advised - Virginia state officials who endorse the vaccine and any related mandates will be subject to the Nuremberg code. Enough already. The public is on to your manipulation. We will vote you out and you will go to jail. We are watching you. "I was just following orders" is no excuse.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99509 Chris Cook 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99509
Absolutely no more laws! Let us be free! We are not children. We can take care of ourselves.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99510 Patricia Haman 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99510
I DO NOT CONSENT I do not consent

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99511 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99511
Unconstitutional COVID Rules I DO NOT CONSENT

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99512 Anonymous 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99512
I DO NOT CONSENT I DO NOT CONSENT

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99513 Anonymous, Albemarle County Schools 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99513
We the People are Waking Up-Stop the Madness Now
I absolutely oppose the continuation of these "health" restrictions in the workplace or any place. It makes no rational sense. The same people that are going to work are then leading their normal lives outside of work, as they should be. Why is the charade going on to "protect" people who are going to their place of employment? If you are sick, stay home. The End.

The media manipulated the numbers to create fear. They censored and suppressed real, working therapeutics such as Ivermectin and HCQ which could have prevented many deaths. Please do the research and find out the truth. Wake up, this is not about politicians and bureaucrats "caring" about our health. The PCR tests are not valid. Asymptomatic people are not spreaders.

First of all, it is not a vaccine. It is an experimental gene therapy. This is in the literature from the companies that make them. Can you imagine what it will be like for a person who chooses not to be injected with toxins and other non-kosher ingredients to be treated differently than those who took the experimental injection by wearing a mask on their face, thereby announcing to EVERYONE at work and the public their own private health information? Do you know of a time in history when a group had to self identify by wearing a symbol to separate them from the rest of society? (Hint: Germany.) This is disparate treatment plain and simple. If the vaccine works then those who are vaccinated are safe. Those who choose not to be vaccinated, or who can't be vaccinated because it might KILL THEM or make them permanently disabled should not be forced to wear a bacteria collecting cloth on their face to identify themselves. There is no scientific study to back up the benefits of wearing a mask to prevent COVID.

Stop masking children. It is child abuse, and unscientific. Stop masking adults. How many Virginians have committed suicide in this last year and more of debilitating tyranny and repression? How many people have lost their jobs, businesses, employees, their whole livelihood? This cannot continue. Humans need to see each others' facial expressions, to hug, to shake hands, to help and love one

another. Stop these mandates. We the People are not going to take it anymore, God is watching, and those in elected offices who facilitate this knowingly or without doing the due diligence to discern the truth will be removed through legal process, as well as those who are using this for personal gain or exploitation.

Those who want to wear masks and take the experimental gene therapy are free to do so. Those who want to stay home may do so as well. Virginians have a right to freedom, liberty and the pursuit of happiness. Without these rights, this state will fall into an economic, societal, and moral abyss. If you care about the working people of Virginia, remove these restrictions now.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99514 Amy 7/23/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99514

Ditto - “We the people are waking up”
The commenter just before me expressed my sentiments exactly. Let Virginian employees and employers be free to make their own health decisions!! We do not need special COVID laws in the workplace. This will only restrict and discourage businesses at a time when we need them to grow.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99515 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99515

This madness has to stop!!! The majority of Virginian's do not agree to have these restrictions continued to be placed on businesses in our state, or any state for that matter!!! This covid flu is 99% survival, there is no reason for these continued measures. Our community, our businesses, our state NEEDS to be able to open and function freely again!!! We need our Virginia back!!!!
Thank you for your time. And it's time to listen to the people who have hired you!!
Thank you,
A fellow Virginian

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99516 Doris 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99516

Pharma-Phile segregation WE DO NOT CONSENT to permanent fear mongering

The CDC is a captured agency with intent to sell vaccines only not heal people! They sell the drugs that people need after being injured. This is unconstitutional and irresponsible to allow this medical segregation to continue! What happened to HIPPA privacy laws? What happened to MY BODY MY CHOICE? What about natural immunity?? Has the world already not been destroyed enough? Leave our children ALONE! The CDC has lied and masks do not work! All this to coerce people to take an EUA shot! Racial segregation and medical segregation is unethical, immoral, unlawful and just plain evil!!! The CDC is not elected and Northam your term is about over thank God. There are cures for this Ivermectin, HCQ, and Budesonide we the people aren't falling for the fear mongering propaganda. No to this "New Normal" no way this should be permanent. This must stop we do not consent!! Bill Gates is no more of a Doctor than Anthony Fauci is honest. Please do the right thing and honor our first Amendment rights given to us by GOD! Our constitution is suppose to protect us from the government tyranny! This is absurd that these unelected officials who have a huge CONFLICT OF INTEREST should be listened to!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99517 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99517
OPEN UP Open the state completely without restrictions! This nonsense must stop! 99.7% survival rate! Enact common problem treatment protocols such as hydroxychloroquine, Zpac, vitamin C, Zinc, etc., etc! Stop the madness! Send the extra Federally funded $300 per week that was qualified to receive to the families STILL waiting since last spring!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99518 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99518Masking children is abuse "there is no evidence suggesting mask work for stopping a virus. In fact there is much evidence suggesting the molecules are too small to be stopped by any cloth masks. This is nonsense. Children are the least vulnerable almost none of whom have died of covid.. any children who have died had serious health issues that were the reason they died. Please stop the abuse of children. This is down right disgusting! Anyone suggesting such a thing should be ashamed of themselves...

SEE RESPONSE TO COMMENT 99520
The standard does not apply to children unless they are employed.

99519 lynn 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99519
We the People DO NOT CONSENT 99% survival rate does not a pandemic make. This was orchestrated to steal the election to prevent President Trump (the rightful winner) from restoring power

to the people of this beautiful Nation. Politicians forgot THEY WORK FOR US we ARE NOT subjects to be ruled. WE DO NOT CONSENT.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671

The Trump Administration initiated Operation Warp Speed to combat the spread of the SARS-CoV-2 virus and the initiative has resulted in significant reductions in U.S. and world deaths, hospitalizations, and long term illnesses. Per the Government Accounting Office "Operation Warp Speed (OWS)—a partnership between the Departments of Health and Human Services (HHS) and Defense (DOD)—aimed to help accelerate the development of a COVID-19 vaccine. GAO found that OWS and vaccine companies adopted several strategies to accelerate vaccine development and mitigate risk. For example, OWS selected vaccine candidates that use different mechanisms to stimulate an immune response (i.e., platform technologies; see figure). Vaccine companies also took steps, such as starting large-scale manufacturing during clinical trials and combining clinical trial phases or running them concurrently. Clinical trials gather data on safety and efficacy, with more participants in each successive phase (e.g., phase 3 has more participants than phase 2).
....
As of January 30, 2021, five of the six OWS vaccine candidates have entered phase 3 clinical trials, two of which—Moderna's and Pfizer/BioNTech's vaccines—have received an emergency use authorization (EUA) from the Food and Drug Administration (FDA). For vaccines that received EUA, additional data on vaccine effectiveness will be generated from further follow-up of participants in clinical trials already underway before the EUA was issued.

Technology readiness. GAO's analysis of the OWS vaccine candidates' technology readiness levels (TRL)—an indicator of technology maturity— showed that COVID-19 vaccine development under OWS generally followed traditional practices, with some adaptations. FDA issued specific guidance that identified ways that vaccine development may be accelerated during the pandemic. Vaccine companies told GAO that the primary difference from a non-pandemic environment was the compressed timelines. To meet OWS timelines, some vaccine companies relied on data from other vaccines using the same platforms, where available, or conducted certain animal studies at the same time as clinical trials. However, as is done in a non-pandemic environment, all vaccine companies gathered initial safety and antibody response data with a small number of participants before proceeding into large-scale human studies (e.g., phase 3 clinical trials). The two EUAs issued in December 2020 were based on analyses of clinical trial participants and showed about 95 percent efficacy for each vaccine. These analyses included assessments of efficacy after individuals were given two doses of vaccine and after they were monitored for about 2 months for adverse events.
https://www.gao.gov/products/gao-21-319

99520 Va Nurse Powhatan 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99520
Please stop, Our kids deserve better This madness has to stop. As a nurse, I see first hand the cases and occurrences of covid cases. Right now there is so many fabrications of covid numbers. Stop making people fearful for your agenda. Of course "this" variant "attacks" kids more, they are the only ones not eligible for a vaccine. Of course it would be the target range so moms will be scared and vaccinate when available, big pharma gets paid, as well as the pediatricians all over. Stop. Our kids don't need masks.

They have immune systems. God is more powerful than medicine and science. It should be parent choice.
By optional masking, both sides win. Those who want to wear a mask can...those who want freedom can have it. Stop mandating bull crap!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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With regard to the efficacy of face masks/face coverings, the CDC states:
"SARS-CoV-2 infection is transmitted predominately by inhalation of respiratory droplets generated when people cough, sneeze, sing, talk, or breathe. CDC recommends community use of masks, specifically non-valved multi-layer cloth masks, to prevent transmission of SARS-CoV-2. Masks are primarily intended to reduce the emission of virus-laden droplets ("source control"), which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than 50% of transmissions.1,2 Masks also help reduce inhalation of these droplets by the wearer ("filtration for wearer protection"). The community benefit of masking for SARS-CoV-2 control is due to the combination of these effects; individual prevention benefit increases with increasing numbers of people using masks consistently and correctly.

Source Control to Block Exhaled Virus
Multi-layer cloth masks block release of exhaled respiratory particles into the environment,3-6 along with the microorganisms these particles carry.7,8 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 ;3,5 which increase in number with the volume of speech10-12 and specific types of phonation.13 Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles3,14 and limit the forward spread of those that are not captured.5,6,15,16 Upwards of 80% blockage has been achieved in human experiments that have measured blocking of all respiratory droplets,4 with cloth masks in some studies performing on par with surgical masks as barriers for source control.

Filtration for Wearer Protection
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. The relative filtration effectiveness of various masks has varied widely across studies, in large part due to variation in experimental design and particle sizes analyzed. Multiple layers of cloth with higher thread counts have demonstrated superior performance compared to single layers of cloth with lower thread counts, in some cases filtering nearly 50% of fine particles less than 1 micron .14,17-29 Some materials (e.g., polypropylene) may enhance filtering effectiveness by generating triboelectric charge (a form of static electricity) that enhances capture of charged particles18,30 while others (e.g., silk) may help repel moist droplets31 and reduce fabric wetting and thus maintain breathability and comfort. In addition to the number of layers and choice of materials, other techniques can improve wearer protection by improving fit and thereby filtration capacity. Examples include but are not limited to mask fitters, knotting-and-tucking the ear loops of medical procedures masks, using a cloth mask placed over a medical procedure mask, and nylon hosiery sleeves."

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 VOSH Standard and the Emergency Temporary Standard (ETS), 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.

99521 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99521
WE DO NOT CONSENT ANY FURTHER ILLEGAL STATE POWERS AGAINST LAWS OF THE LAND We DO NOT GIVE OUR CONSENT to you to make permanent or temporary any further powers mandate or force FDA emergency Tests, Vaccines, Mask, or Lockdown on any school, business, recreational place, event, public, private, or non-profit entity any longer. Such acts or powers are illegal and against precedence of Nuremberg, Hippa, Magna Carter, Bill of Rights, and Constitution Laws which protect all citizens and aliens from any of your such actions. You do not have the right circumvent these protection laws for the people any longer. You have tried with no aveil and achieve same result and keep doing same action against our divine given freedoms of choice privacy and safety. We telling you to stop now. The light is shined on you. We the people are awake. Whether knowingly or not, each you are complicite. If you continue, you will be held accountable removed from office and prosecuted to maximum extent of the law for taking away our rights and infringe on laws of land. We are putting you on notice to stop these power grabs. You are not kings, tyrants. We elected you to enforce current laws of land and such amendments of obscene new power need be voted on by people. The few DO NOT outway our rights of many according to Nuremberg Laws with experimental medicine and acts take away our laws privacy and choice with uninformed consent and safety. Stop now and do right thing to these laws of land, people of VA can forgive.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99522 Debi Lovell 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99522
I do not consent You should not be making anything permanent concerning covid----its a virus--it has a 99% recovery rate. Do not implement any of the draconian rules you had in effect since last year. We the people do not consent....

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99523 Bobby Dunn 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99523
Total BS I think this is total BS we should be able to make our own decision on what we can and can't be told what to do, We are losing our FREEDOM day by day from these idiots and it's time we the people do something about it !!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99524 A Patriot Who Will Not Play Your Games 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99524
Follow real science, not $cience "What is being imposed has nothing to do with our health. This is pure political theater. As I am sure you are well aware, COVID has a 99.98% survival rate. That is real science. We the People are well aware that those such as Faucci are bad actors and promote junk $cience. There is an agenda at play, which is to establish the Great Reset, the global Marxist One World Order, where vaccine passports are the ticket for living in the confounds of this vision. We know this to be true since those of certain ruling families have talked openly about this for decades now. This is not some crazy conspiracy theory.

Here's the bottom line, We the People, the patriots, will not consent or take part in this Marxist takeover. We see straight through what you are doing. We will not wear your masks or get your vaccines. We will not subject our children to your forms of child abuse. We know they are virtually at no risk of catching COVID to begin with. We do not participate in your diabolical and destructive games, follow your toxic media whose lost the narrative, or listen to your junk $cience. We ask that you defend the dignity of a human being, from conception to natural death, because if the least vulnerable humans amongst us do not have their human rights honored, then none of us have human rights. When you start defending all human rights, born and unborn, then we know you are serious about saving "just one life." Until then, it's very clear what agenda you have at play, and it's not about saving lives or human rights. Choose wisely, we are watching you very closely.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.
The standard does not apply to children unless they are employed.

99525 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99525
Wrong "Trying to dictate mask use and vaccination is totally wrong. This has become nothing more than a political propaganda tool. You are now trying to infringe on personal liberty and fear mongering. This is

being used as a way to divide us so that we will be easier to control. Do not mandate masks or vaccines. Allow us the freedoms given us through the constitution and our rights afforded us by being an America Citizen. Step back from this attempt to strip our rights open up and remove all restrictions brought on by this last years events with COVID. It is again time to live in freedom.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99526 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99526
Stop It is time to conform to real science, not one politically motivated.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99527 Jessica Bauer 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99527
Strongly oppose
The damage done to society from covid is drastic, and much of it was largely preventable. The constant focus on fear-based tactics have destroyed businesses, academic achievement for students, and friendships. There is no need to make any of these policies and procedures permanent. I strongly oppose making policies that force people to continue to live in fear.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99528 Mr Not Consenting 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99528
Abssolutely not "I do not consent to any of this. Stay out of peoples lives or expect them to rise up! and take the stupid mask off of the kids.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The standard does not require employees to be vaccinated.
The standard does not apply to children unless they are employed.

99529 Heather M 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99529
I do not consent! This is a Nuremburg code violation
just stop with this. All of this is experimental. Nuremburg Code! Faith over Fear. Put God in your life and you wont be afraid!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99530 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99530
Vaccine Discrimination "I oppose the permanent restrictions. This appears to be political theatre or "the blind leading the blind". What happened to "My Body, My Choice..."

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99531 Citizen of VA and USA 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99531
STOP the Unjustified Restrictions!!
DO NOT permanently implement these temporary Standards!!!
There is absolutely no science or data to justify their implementation, which would impose undue and harsh restrictions and penalties upon the public and their ability to freely make a living and live their lives as they choose.
You were elected or appointed, directly or indirectly, by the people of Virginia, and thus your primary objective should be to do all in your power to enable them to live their lives freely and prosperously.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99532 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99532

”Ralph” means vomit for a reason!! You are ALL sick, . We the People do NOT consent and the power belongs to US.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99533 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99533OPPOSED
Read and re-read our Constitution and the Bill of Rights.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer’s Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer’s Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99534 The Land of the Free, Home of the Brave 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99534

The Constitution i is the Law of the Land. We are free people. You are all attempting to violate our rights which is a violation of the Nuremberg Code.
Do you know the penalty for Crimes Against Humanity?
WE DO.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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99535 richard bollinger 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99535
Just say nooooo"Look government is fine and needed in some cases, but seriously need to stop the intrusion into are lives and businesses. Take all this covid support and put it into our law enforcemeour law enforcement. Then maybe we can get drugs and gangs under control. If you want to help people in VA maybe consider a proper castle law for the protection of life and property

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671

99536 ANONYMOUS 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99536
ABSURD RESTRICTIONS FOR VIRGINIA CITIZENS!! "Why does our State Government want to punish us further? There is NO SCIENTIFIC PROOF that masks and social distancing reduce the possibility of infection for viral diseases. Furthermore, COVID was produced in a laboratory for use a a bioweapon. Instead of punishing citizens, we should throw the purveyors of this virus out of our government and our country.
Landlords, small businesses and even large businesses have suffered greatly due to the restrictions you want to make permanent. Regular citizens went unemployed for as long as a year and in the end, we learned that statistics were falsified with respect to the number of cases AND the number of deaths. All these losses were UNNECESSARY, just as your ridiculous restrictions are UNNECESSARY.
My question is: Why are you eager to make the citizens to SUFFER MORE? This is a legitimate question. Every day we learn more about why COVID 19 exists and who is behind its creation and spread.
If instituted permanently, these restrictions will result in numerous court cases related to the violation of rights under our Constitution. Our State will spend $$billions of dollars defending itself in for which costs will be passed along by way of taxation to the citizens.
As is occurring in California, PEOPLE WILL LEAVE THIS STATE IN DROVES and you can turn Virginia into a prison colony.
This proposed regulation is an absurdity and an affront to the tax paying citizens of Virginia

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99537 American Deplorable 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99537
HOLD THE LINE PATRIOTS! We will not bend. We will not break. We will not yield. We will not give up. We will not give in. We will never, never, ever surrender.
For God and country, We the People are strong in faith, in both our creator and each other, that together WE WILL WIN. No man can take what God has given, and we say that we decide where to go,,how to live and to defend our constitutional rights Be on notice that you are in violation of your constitutional oath, and not even George Soros can keep you in power
NCSWIC .

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99538 Tammy T. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99538
I strongly oppose this! "I strongly oppose making ANY COVID-19 prevention measures permanent for employers or any citizen in any circumstance. This is an exercise in further government control and should be left to each individual as to how to best protect themselves from COVID or any other illness in the world. Stop with the control measures and let people live in our free society! This would put an unnecessary burden on employers as well. I again vote no to making any current prevention procedures permanent in any circumstance as it relates to COVID-19.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99539 Virginia Citizen 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99539
No, just NO "It doesn't take a rocket scientist (or overpaid lying government health officials) to see that what has taken place regarding the "pandemic" response has been not only ridiculous, but detrimental to not only our state but the country as a whole.
Stop ruining our economy. Stop hurting our children. Stop trampling the God given rights of the citizenry, which flies in the face of The United States Constitution.
I have played along with your games until now. I have done your "15 days to flatten the curve" which has turned into the absolute worst year+ I can remember.
Whatever your decision on this matter is, I am done, I will refuse, I will not comply.

SEE RESPONSE TO COMMENT 99342
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SEE RESPONSE TO COMMENT 99671

99540 Amy 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99540
NO This needs to stop! And if more people were aware they could comment on this they would be. Primaries are coming soon and I hope Virginians get the people making poor decisions out and get good representatives in. Freedom!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377

SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99541 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99541
Cvd19 I strongly oppose!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99542 Suzanne G. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99542
Stop government control! "I oppose the continued restrictions. The mask mandates are NOT healthy. To continue this “theatre” in the community when it has been documented that homemade and store bought cloth masks do not work. People need fresh air! The proposed vaccine mandates have no place in a free country. All these people that think it is ok to pressure someone to take a vaccine with no long term studies is beyond comprehension. If you believe in the vaccine, get it and you are covered! It shouldn’t matter wether anyone else is vaccinated. Or don’t you people pushing this believe in the protection of the vaccine that you are pushing?

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99543 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99543
FOR SHAME "I absolutely OPPOSE making these standards permanent. This is lunacy, we are harming our children with this useless mask mandate, harming ourselves psychologically as adults and as far as the vaccine, what happened to my body, my choice?!
This is NOT a conspiracy statement: the deaths that GROW from this thing that hasn't had hardly enough YEARS of testing in humans is dangerous. I cannot believe that businesses, states, schools are mandating this thing.
And at this point, people need to be given back their responsibility for their own immune system and a chance to build their immunity on their own! I am furious about what is happening.
And discrimination against the unvaccinated is growing, it's horrendous.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99544 M smith 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99544
OPPOSED This is government overreach. Do not impose. This is not nazi Germany

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not apply to children unless they are employed.

99545 Kristy M. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99545
Communism 101 We are awake. Stop trying to take our God given freedoms. So, if an anonymous employee reports their workplace do you fine them or shut them down? Hmm, I've read about this in communist history where the government would fine places of employment an outrageous amount of money which the company was unable to pay, thus were shut down. Then, you crushed multiple players at the same time. You were able to shut down local business, cause workers to be unemployed and the general public could only shop where the government wanted. Fully dependent on the government. I see where you are going with this.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99546 Eric Kennedy 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99546
Science/Facts-on-the-Ground Do Not Support Continued Lockdowns
There is enough data now from various countries and states to strongly indicate that lockdowns are not effective. Worse, the continued lockdowns and forced wearing of masks is having MAJOR negative psychological effects on the population, especially children. In other words, the lockdowns/mask are doing far more harm than good. Whether you agree or not, the prevalent opinion in the country now is that the lockdowns are being used for political purposes.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The VOSH Standard does not contain any lockdown provisions.

99547 Lisa 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99547
Outrageous I feel like I've landed in a bad episode of the Twilight Zone. You people have stolen a year from my kids' lives. My son will never get his senior year of high school back. My daughter will never get her freshman year back. Small businesses all over the state and country will never return. Suicide rates are on the rise. I have personally watched young children become anxious and withdrawn. All of this over a virus with a 99.8% rate of recovery. 99.8%! That's not a number that came out of thin air…that comes directly from the CDC. Eliminate the useless mask mandate and allow people to make personal and PRIVATE health decisions with their doctors (my body, my choice, right?).

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The VOSH Standard does not contain any lockdown provisions.

99548 C.C. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99548
Ungoverned Individual Responsibility is Paramount to a Free Society
Throughout life, individuals are faced with choices. Many of these choice are between something of the highest good and that of a lower good. Historically, the masses, have chosen the higher good. This decrement, is what allows all of us to mingle in trust, without deeply knowing one another. It is what allows us to stand in line, with our backs towards another without fear that we will be slain. This trust in one another and the responsibility we hold within ourselves to be of the highest good, is what allows us to be free. As a nation, we have seen what these measures to do the human psyche, small business, and our developing youth. We see that less freedom and more law, results in increased drug use, suicide, depression, anxiety, and loss of income. People must have the ability to make their own choice, to live their lives in a way that fulfills their soul, and these regulations diminish the spark of life within us all. The survival rate of this virus is laughable to the mitigation measures. Even more so, the infection rate, with 7.5% of Virginians contracting the virus and .14% of these infections resulting in death. The death rate of this virus for Virginians is less than that of those who have died of cancer and heart disease. The argument has been made several times and falls on the deaf ears of politicians over and over again, but deaths of this virus could have been prevent before its existence. If the government was truly concerned with the health of the American population carcinogenic additives would not be allowed in our food, transfat would be eliminated from our diets, refined sugars, tobacco, alcohol, and human growth hormone would not be allowed to enter our bodies. Instead it is common place for all American to ingest one of the above daily, for many this happens more than once. It is known that obesity, smoking, and heart conditions contribute to the mortality of this virus, yet nothing has been done to address these circumstances that could be remedied or mitigated. Instead the focus is on oppressing the majority who are in proper health. Which in turn will create stress, which leads to use to alcohol, drugs, poor diet, increased cortisol (affecting the heart), and the new commonality, suicide. These measures will continue to strip freedoms and lessen individual responsibility. It must be up to the people to maintain their health, their sovereignty, and their responsibility to lookout for not only themselves but others for this Nation to remain free and heal.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377

SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99549 Brian 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99549
None of the Science supports Lockdowns or Mask Mandates
No more lockdowns or mask mandates. Studies have shown and continue to show that lockdowns do not help, and that masks are useless or nearly so against viruses. Future lockdowns and mandates would only cause more damage to the people.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The VOSH Standard does not contain any lockdown provisions.

99550 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99550
Opposed Strongly oppose this!!!! "SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99551 Sara P. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99551
No more mandates "The governing body in Virginia has done plenty to push locally owned small businesses to close their doors permanently. Forcing more restrictions permanently will only do further harm to the small number of locally owned small businesses that are left. Hasn't the population/economic well-being of Virginia suffered enough with the drastic lockdowns we experienced? I am absolutely opposed to further dividing society and causing grief for our citizens in this state. It seems odd that the state's governing body is trying to make permanent a temporary mandate for a temporary problem. Haven't the numbers in the Virginia statistics declined? Then there is no need to further force the citizens of this state to continue under such drastic measures.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The VOSH Standard does not contain any lockdown provisions

99552 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99552
No to more controls placed on bussinesses I am totally opposed to placing additional restrictions on our businesses. They have struggled enough to stay afloat during this difficult time. Instead, make laws that help our businesses!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99553 Amanda Edwards 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99553
OPPOSE!!!! The survival rate for this virus and vaccination rates of people do not support this type of government overreach. The government has no place in making any mandate regarding infectious disease permanent and is a violation of the Nuremberg code. I strongly oppose.

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99554 John Wilson 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99554
Absolutely oppose any further lockdowns or mask mandates. I absolutely oppose any further lockdowns or mask mandates. This charade has continued for far too long and needs to end. Herd immunity from a flu like virus (covid 19) is all that is necessary for this current flu strain to end. For the first time in history a mandated lockdown and mask wearing was instituted and it was an abject failure. See Sweden as comared to other European countries for the correct response to Covid 19. Never locked down, never mandated mask wearing. And don't get me started about the destruction to the economy and our childrens education over the last 18 months.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The VOSH Standard does not contain any lockdown provisions.

99555 Gainesville resident 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99555
STRONGLY OPPOSE We oppose this and any other of your tyrannical actions. We will recall and hold you personally responsible.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99556 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99556
I DO NOT CONSENT TO COMMUNISM "REAL science (you know, the science that is heavily censored on mainstream media and only available on mostly uncensored news sources) shows us that masks are useless against viruses. They create physical and mental stress, especially to children and to those having to wear one in order to keep their jobs or receive certain necessary health care services. This stress in turn decreases the immune system, creating increased vulnerability to illness. Of course, our governor, who is a pediatric neurologist, knows this to be true and factual. He is clearly more concerned for his own finances than for his constituents.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99557 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99557
Discrimination "Ready to FIGHT for our freedoms and God given alienable rights

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99558 R.M. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99558
Do we really want to get to this?
Do you really want to take it to this level? I am copying what another awesome citizen has done to combat this outrageous action.
I made it clear that through my lawyer I would begin to demand the status of all other employee's health conditions in regards to other forms of communicable diseases. We would be demanding information on employee's with aids, hepatitis, flu, STD's, measles, mumps, and so on. My lawyer already had the papers drawn up so I could serve him the first day he tried it and a part of the suit would be to force the company to make immediate policies to section off employees who had any illness they could spread including the common cold. If they were going to take responsibility in stopping the spread of covid-19 in the building they were now liable for the spread of anything else. Within 24 hours we were all informed that they would no longer demand to see our papers.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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See DOLI §10, FAQ 21: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

21. CAN MY EMPLOYER LEGALLY ASK IF I RECEIVED THE COVID-19 VACCINE AND AM FULLY VACCINATED?
The Department is not aware of any Virginia law, standard or regulation that prohibits employers from asking employees if they have received the COVID-19 vaccine and are fully vaccinated, and if so, requiring employees to show proof of full vaccination.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

EEOC
The Equal Employment Opportunity Commission (EEOC) indicates that employers may require employees to show proof of full vaccination, but notes certain issues associated with such a mandate: https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

K.3. Is asking or requiring an employee to show proof of receipt of a COVID-19 vaccination a disability-related inquiry? (December 16, 2020)

No. There are many reasons that may explain why an employee has not been vaccinated, which may or may not be disability-related. Simply requesting proof of receipt of a COVID-19 vaccination is not likely to elicit information about a disability and, therefore, is not a disability-related inquiry. However, subsequent employer questions, such as asking why an individual did not receive a vaccination, may elicit information about a disability and would be subject to the pertinent ADA standard that they be "job-related and consistent with business necessity." If an employer requires employees to provide proof that they have received a COVID-19 vaccination from a pharmacy or their own health care provider, the employer may want to warn the employee not to provide any medical information as part of the proof in order to avoid implicating the ADA.

99559 Robert Birch 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99559
No to making COVID-19 rules permanent
The State of Virginia can play an important role in accommodating special rule changes for natural disasters, pandemic, and other special circumstances. Extending such accommodations does not benefit the public good and creates undue burdens on businesses and the government. The considered changes are unnecessary, create regulatory and administrative complexity, and otherwise interfere with the Life,

Liberty, and Pursuit of Happiness as written in the Constitution. Please restrain your powers so as not to conflict with our collective individual liberties.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99560 Jenny 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99560
Ridiculous! This is ridiculous! End the madness now. People should not be forced to wear masks at work in order to keep their jobs! Breathing In Their own CO2 is proven to make people sick and break down their immunity! It's been a year and half now and it's time to let our own immune system do the work for us. You are NOT allowed to make decisions for us. We are grown ass adults. Allow us to govern OURSELVES!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99561 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99561
Mask and innoculations "Masks mandates are good. Everyone needs the covid shot or this will go on forever.

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

99562 Kim 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99562
Adding enactment based on incidence rate may be prudent Let me applaud you for attempting to make workplaces safer from respiratory illness while lessening some of the onus previously placed on employers during the height of the pandemic. Thank you for differentiating what is required based on vaccinated vs. unvaccinated/at risk employees and for wording this regulation in a manner that recognizes that "one-size does not fit all".

However, I do see room for improvement. Some of the mandates seem necessary now, but may not be so after COVID-19 waned (as we hope it does). For instance, we currently would want an employee with a fever, malaise, and respiratory symptoms to have a negative COVID PCR before returning to work, but what about the future when the COVID incidence is negligible? Before February 2019 if a patient presented with those symptoms during the summer months, we would not perform a rapid flu test due to the low incidence of infection during the summer. Will employers have to screen their employees in a mixed risk setting in perpetuity? By adding a line in the regulation that would define the minimum

incidence rate threshold at which the regulation would be enacted/enforced, VOSH would reduce confusion in the future.

SEE RESPONSE TO COMMENT 99377

Some commenters raised concerns about the standard 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. 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. Va. Code § 40.1-22.

99563 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99563
Absolutely NO "No to unconstitutional restrictions. No to human rights violations. No to HIPPA and ADA violations. No to COVID restrictions

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

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99564 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99564
NO! No to this.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99565 Sal F 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99565
No! Enough already No! Enough already

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99566 Susan Rose 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99566
NO No more masks. If people don't want to get vaccinated that's up to them and the responsibility of wearing a mask is up to them also. Vaccinated people are safe to be around. I oppose all further mask mandates and closures.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99567 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99567
NO! Data does not back this. Enough

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99568 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99568
NO Follow the actual data not the made up numbers. Enough already!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99569 Sherry B. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99569
NO!! NO!! & NO!! TO YOUR NWO PROPOSAL! We The People will NOT have it! You're destroying our society. NO!! TO YOUR NWO PROPOSAL! We The People will NOT have it! You're destroying our society and economy based on a SCAM!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99570 A wise soul 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99570
The New World Order of Things "Draconian Rule is designed to crush the human spirit.
Covid is just a front to control humanity. WE have naturally achieved herd immunity to the latest man made and chembombed viruses. There is no emergency and we need no state of that.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99571 Mel O 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99571
Absolutely Not!!! This has got to stop once and for all! The vaccines are killing people

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99572 Wendy L. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99572
Still don't believe in the NWO? New World Order. This is NOTHING but part of the agenda! We the people will NOT allow you to keep taking our freedoms away! You want everyone to toss the rights just to not get the flu?! I had it, my mom had(we are both diabetics and it became covid pneumonia but....WE SURVIVED) and my 82 year old grandmother had it and she did better with it than us! STOP with the lies. These lock downs are NOT concerns over people's health! IT'S ALL ABOUT CONTROL AND WE SAY NO!!!!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

Reports of death after COVID-19 vaccination are rare. More than 351 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through August 9, 2021. During this time, VAERS received 6,631 reports of death (0.0019%) among people who received a COVID-19 vaccine. FDA requires healthcare providers to report any death after COVID-19 vaccination to VAERS, even if it’s unclear whether the vaccine was the cause. Reports of adverse events to VAERS foll+H168owing vaccination, including deaths, do not necessarily mean that a vaccine caused a health problem. A review of available clinical information, including death certificates, autopsy, and medical records, has not established a causal link to COVID-19 vaccines. However, recent reports indicate a plausible causal

relationship between the J&J/Janssen COVID-19 Vaccine and TTS, a rare and serious adverse event—blood clots with low platelets—which has caused deaths. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html

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99573 A Concerned Citizen 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99573
Under NO Circumstances!!! You are overstepping your bounds, Governor Northam, and we the people do NOT consent! “Safety” at the cost of freedom and civil liberties is not safety at all — it’s an illusion and people are waking up.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99574 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99574
No, no, no to more government regulation. There is adequate information exposure on the risks of covid. There are successful treatments available to covid patients.
There is a FREE vaccine available to anyone who wants it.
It is time to allow adults to make decisions for themselvels and their children.
The government no longer has a role to play in this individual health care decision.
Businesses do not need government help in managing their employees in this matter.
End DOLI's involvement in it. Please." "The standard does not require employees to be vaccinated. The standard does not apply to children unless they are employed.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99575 Betsy Bartlett 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99575
covid restrictions I completely oppose any covid restrictions in Virginia including Mask wearing for anyone and vaccines for anyone none of this is needed for a made up pandemic that has harmed or killed less people than the flu. This government control has to stop.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99576 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99576
Covid measures Absolutely I DO NOT Consent! You're attemp to introduce the NWO is killing our beautiful country! NI to masks and vaccines! Stop killing our kids!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99577 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99577

Opposed Mandates and restrictions are not based on scientific evidence, it is complete government overreach and violation of constitutional rights. It is appalling to force young children to wear masks and be vaccinated. Those who are vaccinated are supposedly protected, as are those who have natural immunity. The government continues to deprive us of our rights. Of course we don't want anyone to fall ill and die, but Covid is not fatal for everyone. Hospitals are not overrun, hospitalizations and death are at a lower level than last year. It is impossible to eradicate a virus and the measures taken in 2020 caused major damage beyond this health crisis. America is turning into a Communist country.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99578 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99578
You've abused our constitutional rights This is just a giant pile of BS. Covid 19 is a SARS 2 Corona virus weaponized to cause blood clots. It's now easily treatable with therapeutics. If you have a very basic knowledge of virus' then you'd know that with every mutation it gets weaker. Unless the govt has come up with another one to use. It's time to get back to normal and open businesses up. Masks on kids and adults for that matter when tested show a high level of CO2 in less than three minutes. Making it harmful as well as causing bacterial infections. That's come from the top virologists in the world. I'll be happy to post to zoom site when they meet in a couple weeks. The covid spike you see if actually coming from those that are vaccinated. Testing done on vaccine samples showed graphine, morgellons and add in the blender of fetal tissue and you have a disaster waiting to happen. But it's for emergency use, which stops once we no longer under emergency conditions. You can listen to the people or not. If you chose to go forward with making it permanent, or people will have enough and rise up and take their lives back. Govt for the people? Or govt being pressured by big pharma and all those campaign dollars. The American people have some hard choices coming in the next few months. Good chance you'll all be without jobs if you don't listen.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99579 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99579
Personal Responsibility not Government Over reach "NO to more government regulation Enough already. There is adequate information exposure on the risks of covid.
There are successful treatments available to covid patients. There is a FREE vaccine available to anyone who wants it. It is time to allow adults to make decisions for themselvels and their children.
The government no longer has a role to play in this individual health care decision. Businesses do not need government help in managing their employees in this matter." "The standard does not require employees to be vaccinated.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not apply to children unless they are employed.

99580 Don't trust gov. 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99580
Thank you for your efforts however I do not consent to this. As a citizen of VA, I do not consent to this.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99581 Anonymous 7/24/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99581
Absolutely NOT We will not stand for this. Get ready for taxpaying citizens and businesses to leave this state if these draconian mandates continue. The corruption behind the false case reporting, fear-mongerjng, pushing a dangerous experimental vaccine that's not even FDA-approved, and parroting the faulty science of mask-wearing is doing nothing but dividing your citizens, ruining the economy, and causing serious psychological damage particularly to our children. Let people and employers make their own private choices for their comfort level and leave the rest of us alone. Please consider the overwhelming majority of comments opposing this and be a true representative of the people's wishes!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99582 David Williams 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99582
Strongly opposed. NO. "Enough is enough. People who wish to be vaccinated have had ample oppty to be vaccinated. Others have not because they will not... They willfully reject it and do not wish to put it in their body - my body, my choice. I mean, it's not like we're murdering the unborn by not getting it.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99583 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99583
Stop this foolishness This must end immediately!!!! Strongly opposed

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99584 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99584
Adamantly opposed !!!!!! I am adamantly opposed to this nonsensical proposal !!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99585 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99585
Strongly opposed No to more Government overreach

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99586 Mary Capwell 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99586
Permanent covid restrictions Strongly oppose!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99587 Anonymous 7/24/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99587
Science ?? Bacterial Pneumonia From Wearing a Medical Mask. Science ?? Bacterial Pneumonia From Wearing a Mask. Need to share/ save/ print this this 2008 article. Wearing those dam CCP manufactured masks 24/7 are going/have killed more people then the influenza virus strain(coronavirus)??
From the U.S. Department of Health & Human Services. Tuesday, August 19, 2008
Bacterial Pneumonia (Masks) Caused Most Deaths in 1918 Influenza Pandemic
Implications for Future Pandemic Planning. The cause and timing of the next influenza pandemic cannot be predicted with certainty, the authors acknowledge, nor can the virulence of the pandemic influenza virus strain. However, it is possible that — as in 1918 — a similar pattern of viral damage followed by bacterial invasion could unfold, say the authors. Preparations for diagnosing, treating and preventing ??bacterial pneumonia ??should be among highest priorities in influenza pandemic planning, they write. "We are encouraged by the fact that pandemic planners are already considering and implementing some of these actions," says Dr. Fauci.??????
NIH website, https://www.nih.gov/news-events/news-releases/bacterial-pneumonia-caused-most-deaths-1918-influenza-pandemic

CDC website https://wwwnc.cdc.gov/eid/article/14/8/07-1313_article

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The commenter appears confused in conflating the wearing of masks with "bacterial pneumonia" accounting for many deaths during the influenza pandemic of 1918-1919:

"The majority of deaths during the influenza pandemic of 1918-1919 were not caused by the influenza virus acting alone, report researchers from the National Institute of Allergy and Infectious Diseases (NIAID), part of the National Institutes of Health. Instead, most victims succumbed to bacterial pneumonia following influenza virus infection. The pneumonia was caused when bacteria that normally inhabit the nose and throat invaded the lungs along a pathway created when the virus destroyed the cells that line the bronchial tubes and lungs.
....
NIAID co-author and pathologist Jeffery Taubenberger, M.D., Ph.D., examined lung tissue samples from 58 soldiers who died of influenza at various U. S. military bases in 1918 and 1919. The samples, preserved in paraffin blocks, were re-cut and stained to allow microscopic evaluation. Examination

revealed a spectrum of tissue damage "ranging from changes characteristic of the primary viral pneumonia and evidence of tissue repair to evidence of severe, acute, secondary bacterial pneumonia," says Dr. Taubenberger. In most cases, he adds, the predominant disease at the time of death appeared to have been bacterial pneumonia. There also was evidence that the virus destroyed the cells lining the bronchial tubes, including cells with protective hair-like projections, or cilia. This loss made other kinds of cells throughout the entire respiratory tract — including cells deep in the lungs — vulnerable to attack by bacteria that migrated down the newly created pathway from the nose and throat."

https://www.nih.gov/news-events/news-releases/bacterial-pneumonia-caused-most-deaths-1918-influenza-pandemic

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99588 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99588
Enough! "Enough government restrictions on citizens and businesses. Enough discriminating and segregating vaccinated and unvaccinated people. We have had enough time to learn how this virus works and we now know that lockdowns/mask mandates don't work!! Europe has thought us that lockdowns have zero effect against COVID-19. It is time individuals got to decide for themselves and their families.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99589 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99589
Unconstitutional and illegal. We do not consent.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The constitutionality of the VOSH Standard does not contain any lockdown provisions.
was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99590 Josh 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99590
More over-reach anyone? No, NO, NO!!! No. I do not consent.
This is government overreach at its finest. (Sarcastically): sure, let's discriminate between vacc and unvacc. HIPAA rules anyone? "My body, my choice?" Imposition of mandates - closes in on CCP territory. That's right - I said it. China Communist Party. In great contrast, trusting the people to make their own decisions, in their own best interest... priceless. WE THE PEOPLE. Not, "we your subjects." Step off the high horse, the over-lording. Stop attempting to dominate the sh*t out of everyone. INSTEAD, look to

the founders' (Virginia-bred) notions of freedom, liberty, individual rights, for life, for the pursuit of happiness. This covid, greek-letter-whatever variant is still a "variant" of the CHINA VIRUS. Yes: say those words. CHINA VIRUS. China will be made (or shamed) to pay retributions, reparations. For the immense loss of life - and capital - their little "experiment" has caused. Keep Virginia Free. Make Virginia Freer. Stop the overreach. Abandon the overloading. Kill these regulations and their amendments. Free the people. See the glory, the fresh air of freedom that happens - when free people are kept... FREE.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99591 Donna M Williams More 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99591
I Support the Stadard "As an HR professional I support the new standard. Codifying what must be done helps me protect my co-workers. Masking, temperature screening, and sanitizing led to a decrease in passing around respiratory infections last winter. I don't think it should apply only to COVID, I think it should be widened to cover all communicable diseases.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99592 Tonya 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99592
No Mandatory Anything when it comes to our health! As an American citizen living in Virginia, I demand that my Rights according to the Constitution be recognized. You cannot force me to wear a mask, which has no scientific basis, and you cannot force my children to wear one. (which has been proven unsafe) You cannot keep Americans from traveling freely and you most certainly cannot force an experimental drug on us. You cannot keep us from gathering and you cannot close down businesses while leaving the Big Name franchises open! I demand to be heard and expect you to listen! I will not comply with unconstitutional orders.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.
The standard does not apply to children unless they are employed.

99593 Staunch Patriot of our Republic 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99593

FERVENTLY OPPOSED This goes against our Constitutional Republic which is the glue for our sovereign States. We, as a nation, have been controlled and manipulated long enough and this must stop! We want a living, thriving nation that includes the undergirding, supporting of our businesses, not strangulation of Virginia and it's citizens. This notice of action falls in line with crimes against humanity, which under the executive order placed in 2017 is a punishable offense. Fear mongering and mind control is a NWO mantra and implementation. I fervently oppose this proposal.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99594 Concerned Virginia Resident 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99594

Stop this Insanity! "Stop this insanity now! I am embarrassed for the first time to be a life long, born and raised, Virginia resident of 58 years after reading this Notice. You all know good and well masks, six foot distance does absolutely no good as studies have proven. Go do some research (America's Front Line Doctor's would be a good start). Also, there is no need for any kind of Vaccine passport in Virginia. I am afraid if you keep violating people's rights it's not going to end well (do you want that on your hands? Asking for a friend). Think about our great historical leaders from Virginia that helped form this nation and how disrespected they must feel from their graves as Virginia tries to trample on FREEDOM! Freedom to breath, congregate, worship and all the other things your trying to restrict. It is no wonder many in my area are exploring leaving the state (Never thought I'd ever say something like this!)

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require a vaccine passport.

99595 Formerly Free Citizen 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99595

YOU VIL OBEY: We are not children, we are not slaves Isn't ironic that the party that shrieks about racism and slavery wants to use force to make us show health passports. This is not the same as showing an officer ID for driving a car. Does it mean that, if you do not have a document, that you cannot travel to another state? Does it also mean that you cannot travel to another country? Does it also mean that if you do not have a document or refuse to carry a document that you will be put on a list somewhere, as a citizen who has not OBEYED? And we know what happens to a citizen who does not obey, in the leftist mind. What else will we be forced to do. Hmmm.... I've seen old photographs from other countries of subjects having to show documents, passports to the local police. It didn't end well. It never ends well. "

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require a vaccine passport.

99596 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99596
No Abusing Power If you do it, you become people's enemy!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99597 Di 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99597

Totally opposed, Stop controlling us Totally opposed, stop controlling us.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99598 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99598
CHECK THE SCIENCE-HIPPA Violation The CDC has recently disclosed that only 6% of deaths previously attributed to COVID were actually COVID. 94% were actually attributed to other causes. This means that out of of 160,000 in the US reported to have died from COVID, only 9000 were actually COVID. If you are getting scientific information from the main stream media and those who are standing to gain financially from this, you have been fooled. Look deeper.

Many of those who died of COVID could have recovered by early treatment with Ivermectin or HCQ. Why did the media censor valid scientific research from many years of the safety and effectiveness of these therapies? These are CRIMES AGAINST HUMANITY. The number of people that died in 2020 was the same as the number of people who died in 2019, 2018, 2017. There was no reported FLU in 2020. THERE IS NO PANDEMIC.

10,000 people have so far have been reported to VAERS in the US as having died from the experimental shot since Dec 2020. It is estimated that only 1-10% of actual experimental shot deaths are recorded or reported. Is the state of Virginia and all those who are making these unscientific, unconstitutional and controlling rules going to be responsible for their wrong actions when the truth comes out? Yes they are. And like at Nuremburg, saying that "I was just following orders" is not going to save you.

When you go to work or school, should you be asked, "do you have a cold, do you have AIDS, do you have a disability, are you ADHD, do you have measles, do you have cancer, do you have chronic inflammatory disease, do you have ringworm.....". It has NEVER been the responsibility of an employer to monitor the health or diseases in the community or the private health choices of customers or

employees. This will not stand and those who are complicit in creating these rules in future WILL BE HELD ACCOUNTABLE in both professional and PERSONAL capacities.

SEE RESPONSE TO COMMENT 99342
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The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

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99599 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99599
NO You know better that this is all about control. Stop doing this to yourself and to others . What you do will come back to you. Promise. so, NO!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99600 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99600
NO You know better that this is all about control. Stop doing this to yourself and to others . What you do will come back to you. Promise. so, NO!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99601 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99601
Absolutely not!! Strongly opposed!! Absolutely not!!! Strongly opposed!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377

SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99602 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99602

No! My body, my choice. This is absolute foolishness to attempt to require everyone to get mostly untested chemicals injected into their bodies. This shot was only just released for EU because prior animal reactions were horrific. It was rushed out to the masses before complete safety trials were done. Do NOT require everyone to get this shot, especially children.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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99603 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99603
No way It is a choice and should stay that way.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
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99604 Debra Goodman 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99604"Virginia Tegulatory Toen Hall covid regulations. I strongly disagree with this.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99605 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99605
"Time TO EVACUATE VIRGINIA. TIME TO EVACUATE VIRGINIA….WERE IS OUR SOVEREIGNTY…

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99606 Ed Zachary 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99606
top Holding Virginia Hostage It's time to quit trying to rule by mass hysteria and let the people of the Commonwealth have their lives back. It is not up to you to tell us how to take care of our health, or when we can work. You are elected officials who are supposed to be working to represent the voters, but you, by all appearances are far more worried about controlling us than anything else.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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99607 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99607
Strongly oppose this madness I strongly disagree with the attempts to make the COVID regulations permanent. This is affecting personal businesses negatively and is harming our children. Do not force this socialism upon us. At this point I have little hope for our children's generation and the generations after.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99608 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99608
NOOO I DO NOT SUPPORT THIS IN ANY WAY SHAPE OR FORM. I OPPOSE THIS

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99609 Kristen Huffman 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99609
Please stop holding Virginia hostage. " Please stop holding Virginia hostage with regulations that are unnecessary. Each employer should be able to decide for themselves how the Business should be run. Let's get everyone back to work.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99610 Betsy 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99610
Don't sign! That/ this is unnecessary and outrageous. Please do not sign this.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99611 Anonymous 7/25/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99611
Remove the Covid Restrictions, I live in Reston Virginia. I would like the Covid restrictions removed as they are not necessary at this time and adversely affect businesses in the area!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99612 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99612
Just stop! Just stop!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99613 Sarah 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99613
Say no! NO! We vaccinated people are not the culprits here! It's the unvaccinated people who are catching it spreading it and obviously causing the mutations. Vaccine people did their part. We have even risked our lives by taking a new vaccine that could potentially cause future Heath problems. We are the ones who caused the cases to drop and almost ended the pandemic until the UNVACCINATED caused a new covid mutation; because I hope we all realize that a virus doesn't just mutate as it floats through air. It mutates inside the body of people who are sick. The covid vaccine is highly effective. Therefor it is no longer my problem. We did our part. It's the unvaccinated people's problem. I will not

be punished for their stupidity. I will not be forded to wear a mask again. I'm done. It's time to stand up and say no!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99614 monica 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99614
do not agree--No! I think everyone is different and everyone has a different kind of health situation. To say that a vaccine, and in particular a genetic therapy, is right for everyone, especially children is not good science or prudent healthcare. We need more open debate on this topic (genetic therapies both in vaccines and other areas such as cancer). Also: why not increase the funding and research for safe treatments for covid, such as ivermectin? Why not more funding and interest in increasing all of our health by way of cleaner air, water, protections for nature, organic and healthy food, renewable energy, funded health insurance for all etc etc. There are other ways to deal with this pandemic aside from knee jerk fear responses of both the left (enforced vaccination with ensuing billions being made by pharma and the rest of it) and the right (conspiracy theories and crying "communism" or "socialism" which are both glaringly born of ignorance). Not everyone who disagrees with these proposals are far right (such as racists and those who storm the US capital et al...) although the media makes it seems so. Thank you.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99615 Karen 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99615
No no no. I am 100% against this!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99616 mbl 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99616
Revoke the Final Permanent Standard does not contain any lockdown provisions.
and any amendments The Virginia Final permanent standard places undue burden on employers throughout the state. The standard needs to be revoked as there is no longer a need for these workplace standards. Virginia as a whole is over the 70% mark in vaccinated people, which means more vaccinated employees in our workplaces.

I believe that VOSH and the SHCB was not forthcoming with information and the announcement on the revision of this standard and the proposed amendments. There was no announcement of the SHCB meeting to address the changes and the notification on the VOSH News page was hidden below an older entry, and is difficult to find looking through the VOSH webpage.

In the SHCB meeting Mr. Withrow alluded to the fact that this amended standard can be used as a tool to get employees to get vaccinated or force employers to require vaccinations, which is not, and should not, be the focus of ANY workplace regulation. This oversteps what the focus of a workplace standard should be about.

Regardless of your stance on vaccinations and covid, that even being said as a statement for a reason to continue a standard that is outdated, and has been since it came out in June 2020, has lagged well behind the CDC in guidance and recommendations. If you are not the one creating the guidance on a Heath issue than you shouldn't be trying to keep up with those who do. This leads to lagging standards and outdated recommendations that the state cannot, in any way, keep up with. This also leads to an expectation that any other communicable diseases will be treated the same way. Federal OSHA does not try to do this and they simply have regulations that are incorporated by reference to other industry standards, this should also be the case for communicable diseases, let the health experts provide the guidance and VOSH stick with workplace guidance.

This is also the only standard that I am aware of that has had required employers to provide 3 different trainings within a year based on amendments to the standard. We trained all employees on the first Temporary standard, then had to change the training once it was the final permanent standard, and now, with the amended standard will require another training to cover the changing regulations. This puts undue burden on the employers, their staff, and any of us that are safety professionals to provide training that is constantly changing. This leads to employee unrest, confusion, and ultimately, unwillingness to comply. As far as an economical impact on employers throughout the state, COVID has cost employers enough money to provide barriers, cleaning, and other measures to protect our employees, and continuing to move the mark is fiscally irresponsible.

Changing the requirements of the standard every three months based on the latest guidance from the CDC creates a lack of trust and willingness to comply with the changes. We constantly get asked why regulations are changing and it causes confusion amongst the employee base. One week we tell them one thing and come back the next wth a change to the regulation. This builds distrust between the employers, the employees and their safety personnel.

VOSH has lagged in replying to employee questions on the ETS, and the FPS and used the FAQ page to only answer those questions they deemed worthy of placing on the page. Personally I submitted at least 5-8 questions through the email box or to various Compliance personnel in the state and was met with either no answer to my question or one of two other responses which were, we need a consolidated answer from Richmond, or you can use our consultation services. Consultation is not geared toward helping large businesses in the state and there are not currently enough of them to handle a crisis such as COVID.

Expecting employers to constantly check a FAQ page in order to comply with a standard should tell you that the standard was not well written. More time and effort should have been put into the creation of the standard so that on release it was a fully functioning/executable/enforceable standard instead of focusing on having the "first in nation" status.

VOSH requiring a mask mandate for those that are unvaccinated and require training for them only is just going to lead to employees providing false information about their vax status, it will not serve to drive employees to get vaccinated.

VOSH addresses this in the standard by stating that an employer can rely on an employees representation that they are vaccinated, but then also states nothing can stop the employer from asking for proof. If, as a business in the Commonwealth, VOSH can fine a business for employees not wearing masks if they are not vaccinated and face citations and fines from 13k to over 130k, then you cannot simply rely on an employees representation. If you want to make a statement with the standard, put

some onus on the employee and require that they provide proof of vaccination, put some language in that defines the employee responsibility as they do in other federal standards like respiratory protection. Employees need to have skin in the game for a standard like this to work.

This one line (employee representation) in the proposed standard is setting businesses up for failure, and also puts strain on employer/employee relationships. Tensions, political opinion, fear, and knowing that employees can lie about their vax status leaves employers vulnerable to exposures in the workplace, and open to confrontations when asking employees of their status or asking to see their vaccination card.

For these reasons please revoke the Final Permanent Standard and allow employers to follow guidance from the CDC. As this is a HEALTH emergency the state, as well as the nation should follow the guidance of those who deal with the health of all.

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SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99617 Small Business in Virginia 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99617

Please Lift Further COVID Related work-place restrictions For the sake of small businesses in our commonwealth who are already struggling to recover from many harmful effects of COVID, or of economy depression instigated by it (some of which have been caused by Government intervention). Please Cancel and lift all COVID related non-medical-work-place restrictions. For those in the Medical fields, there may clearly be need for some further guidance for which I propose we follow WHO and CDC guidance.

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SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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99618 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99618

Remove all Covid restrictions! I am a Virginia resident vehemently opposed to the segregation of vaccinated and unvaccinated individuals, the masking of healthy individuals, and the removal of bodily autonomy and informed consent that current Covid-19 policies impose. I WILL be voting for any representatives running for any office that support the right to bodily autonomy, and who strike down/ vote “no” on any legislation or policy that enforces further government meddling in private individuals’ health decisions. The decision to accept medical treatment is for an individual to decide with the guidance of their physician. It is not to be decided by an employer, the government, or any other agency or person. Again, these are the only issues I’ll be voting on for the foreseeable future regardless of party affiliation or other candidate platform issues. We are no longer in a state of emergency, and acting as though we are is disingenuous and deceitful. The people of Virginia demand that this farce come to and end.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99619 Patricia 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99619
This must end! I vote against enacting these restrictions.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99620 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99620
guidelines for child care facilities. We are totally confused about the updated instructions from VDOE, that states that staff in child care facilities need to wear a face covering regardless of vaccination status. VDOE cites a mandate from DOLI, but about from the 'final' guidelines from January, I cannot seem to find it anywhere.
We just allowed our vaccinated staff to not wear the masks any longer, and it is a big incentive for the non-vaccinated people to get vaccinated!
I think we should be able to follow general rules as designed by CDC and VDH, just like the general public.

SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484

SEE DOLI §40, FAQ 57 which is based on CDC provisions:

57. ARE CHILD CARE PROVIDERS AND STAFF REQUIRED TO WEAR FACE MASKS AT WORK, REGARDLESS OF VACCINATION STATUS?
Yes. The Final Permanent Standard (FPS) for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, has mandatory requirements for all employers in 16VAC25-220-40 and specific requirements for employees exposed to “medium exposure risk” hazards in 16VAC25-220-60, which is the category that would apply to most child care settings.

Section 16VAC25-220-60.C.11 requires the following:

Employers shall provide and require employees in customer or other person facing jobs to wear face coverings.

The CDC’s “Guidance for Operating Child Care Programs during COVID-19,” which was last updated July 9, 2021, provides:

“Most ECE programs serve children under the age of 12 who are not yet eligible for vaccination at this time. Therefore, this guidance emphasizes implementing layered COVID-19 prevention strategies (e.g., using multiple prevention strategies together) to protect children and adults who are not fully vaccinated.”

https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html

Because the CDC states that masks should be worn indoors by all individuals (ages 2 and older) who are not fully vaccinated and that early care/child care settings may implement universal mask use in some situations, such as if they serve a population not yet eligible for vaccination or if they have increasing, substantial, or high COVID-19 transmission in their ECE program or community, employers cannot take advantage of the provision in 16VAC25-220-10.E, which provides:

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….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.

https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

99621 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99621

Medical Segregation & Fear. How scary that we have to submit anonymous comments for fear of persecution, death threats, child protective services, or other discriminatory factors because we desire to keep our bodies without interference.

As a Jewish woman and a student of history, it was not just an onslaught of killing Jews during the Holocaust. It started with planting seeds of fear over differences. Then it became restrictions of services. Then it turned into closing of businesses and segregation. Then identification. Then the boxcars.

I will not allow myself or my children be part of a health experiment, especially one with such varied outcomes and without recourse. And to segregate me and my family because we opt out is simple: it puts us no better than the racial segregation from our US history or the path towards murder from my family's history in the Holocaust. This needs to end now.

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SEE RESPONSE TO COMMENT 99377
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99622 C.H. 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99622

The End of Nonsense I will not wear in on my faceI will not wear in any placeI will not wear it on my earI will not wear it because of your fear.We will not give upWe will not give inWe will not wear itOn our chinsWe will not takeThis bogus shotMy medical infoAdvertised on my face will NOTBe happening hereBecause of your fearWake up wake upBefore it's too lateRenounce the false religion of

COVIDChange the direction of your fateSatan is laughingTo see you give inAnd he will devour you tooIn the End.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99623 Tina Beauchain 7/26/2021
Masking: A Careful Review of the Evidence. Masking: A Careful Review of the Evidence
"The evidence that masks are effective IS NOT supported by actual science. We need to end the medical tyranny. This article comes from The American Institute for Economic Research https://www.aier.org/article/masking-a-careful-review-of-the-evidence/

The question on whether to wear a face mask or not during the Covid-19 pandemic remains emotional and contentious. Why? This question about the utility of face coverings (which has taken on a talisman-like life) is now overwrought with steep politicization regardless of political affiliation (e.g. republican or liberal/democrat).

Importantly, the evidence just is and was not there to support mask use for asymptomatic people to stop viral spread during a pandemic. While the evidence may seem conflicted, the evidence (including the peer-reviewed evidence) actually does not support its use and leans heavily toward masks having no significant impact in stopping spread of the Covid virus.

In fact, it is not unreasonable at this time to conclude that surgical and cloth masks, used as they currently are, have absolutely no impact on controlling the transmission of Covid-19 virus, and current evidence implies that face masks can be actually harmful. All this to say and as so comprehensively documented by Dr. Roger W. Koops in a recent American Institute of Economic Research (AIER) publication, there is no clear scientific evidence that masks (surgical or cloth) work to mitigate risk to the wearer or to those coming into contact with the wearer, as they are currently worn in everyday life and specifically as we refer to Covid-19.

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99624 Grace 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99624
100% no, we want freedom Please stop with mandates and medical segregation. Our child and grandmother have a vaccine injury. It is not one size fits all. I honor my bodily autonomy. Thank you.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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99625 The Truth! 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99625
Medical Depopulation ?? A deleted Bill Gates Documentary has been revised
" "remember follow the money ?? “It was the best investment I ever made”- Bill Gates ??$10B investment in vaccines grew to an ROI $200B. A 20-1 ROI ??”..Generically Modified Organisms and injecting them in to the little kids arms and shoot them into the vain”- Bill Gates ??????496,000 Indians had paralyzed from the Gates Gene Therapy Polo Vaccine from 2000-2017 ??????2009. 24,000 Indian girls were given a Gates HPP Vaccine (wellness shots) without any consent from a parent or guardian. Many were severely injured Sourced NIH website -????Correlation between Non-Polio Acute Flaccid Paralysis Rates with Pulse Polio Frequency in Indiahttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC6121585/??African’s are the Gate’s lab rats for the world.??...” this is not the last pandemic we will face. We will have to prepare for the next one..aaaaaa...We will get attention this time” -Bill GatesWTF? ??and both he and his wife smiled over that comment. Are they evil? We will find out shortly I am guessing https://t.me/themelkshow/54225https://www.bitchute.com/video/rAVbQ63Wb0vZ/??1986 law signed by President Regan sign the National Childhood vaccine injury act . WTF? Granting totally immunity to vaccine manufacturers. Legally shielded and the American tax to payers pay the damageshttps://www.congress.gov/bill/99th-congress/house-bill/5546

SEE RESPONSE TO COMMENT 99342
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99626 Gaston Brothers Utilities, LLC 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99626
Proposed Amendments to the Final Permanent Standard for Infectious Disease Prevention To date there have been185 comments...184 do not support the proposed amendments; granted some are far-fetching, but most have reasonable and substantive logic for not only opposing the proposed amendment, moreover rescinding the the standard.

I too oppose the proposed amendment and think the standard should be rescinded. While I do believe the Board acted in good faith (and under political pressure), it is not an employer's duty (regulatory or otherwise) to govern public health issues. An employer can be a good resource for promoting healthy choices, but the line is drawn there.

There are many unanswered questions relative to how an employer can implement most of the measures contained in the standard without violating employee privacy laws, creating hostile workplaces, HIPAA violations, various anti-discrimination laws, etc.

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SEE RESPONSE TO COMMENT 99484
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99627 More Truths 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99627

The FDA announced today that the CDC PCR test for COVID-19 has failed its full review "The FDA announced today that the CDC PCR test for COVID-19 has failed its full review. Its Emergency Use Authorization has been REVOKED. It is a Class I recall. The most serious type of recall. Too many false POSITIVES! This is the test that started the pandemic.
The test used in all the nursing homes in Washington and New York. This was the ONLY test in use until May of 2020. THE VACCINE CAUSES THE DELTA VARIANT! THIS IS THE SINGLE MOST HORRIFIC CRIME AGAINST HUMANITY SINCE THE DAWN OF MANKIND.https://www.fda.gov/medical-devices/medical-device-recalls/innova-medical-group-recalls-unauthorized-sars-cov-2-antigen-rapid-qualitative-test-risk-false-test

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99671

99628 anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99628
no way take this to china where it belongs!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
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99629 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99629
End the FPS! Employers were led to believe that the standard would be rescinded when the governor ended the state of emergency. Federal OSHA regulations are in place and should be enough for employers to follow.

SEE RESPONSE TO COMMENT 99342
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99630 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99630
No no no!We need less government in our lives FREEDOM!!!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99631 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99631
Nanny states. Hey Master Governor , won't you be our Nanny?

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99632 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99632
DEMOCRATS to the free and brave: FEAR !FEAR ! FEAR FOR YOUR LIVES!!!? I AM YOUR FATHER!! Luke, I am your protector children!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
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99633 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99633
We the people do not consent to you authority! NO OR GET RECALLED
We the people do not consent to you authority! NO OR GET RECALLED
STAND UP VA! Recall NORTHAM and HERRING!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99634 Cnoden 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99634
Vaccines should always be a choice Vaccines should always be our choice, strengthening the immune system should be our first choice because if our immune system doesn't work properly we can't expect it to be able to fight off viruses and bacteria. The right Education is so important here.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99635 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99635
ABSOLUTELY NOT!!!!!! This is ridiculous and an over-stepping of governmental power. Let the people choose for themselves. This is AMERICA!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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99636 Unknown 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99636
BREAKING HIPPA CODES/LAWS IS NOT GOOD! NO_NO_and more NO!!! This is ridiculous and an over-stepping of governmental power. Let the people choose for themselves. This is AMERICA!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671
The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

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99637 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99637
Vote NO to abuse of power with expanding restrictions If the CDC's stance is that vaccinated people do not have to wear masks then why is Virginia moving backwards? This is no longer about science but about politics, and is now absolute madness. Our motto, Sic Semper Tyrannis, thus always to tyrants, explains how VA responds to abuse of power by politicians. WE THE PEOPLE have the power to tell our government how to function, and expanding COVID restrictions indefinitely is an abuse of power.

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The CDC updated their guidance on July 27, 2021 (fully vaccinated people should wear face masks indoors). https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

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99638 Anonymous 7/26/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99638
We need to return to freedom Covid is not the plague. The death rates have been inflated since day one. We need no permanent laws dealing with this, it will pass just like all others that have come and gone before. It wouldn't even have been an issue if it wasn't a planned release from a lab to help support the left gain power in as much of the world as possible. Vaccinations, wearing of masks and such should be a personal choice, not one forced upon people by governments state or federal that are trying to push us into some form of Socialism.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99639 Concerned Virginia Citizen 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99639
This is egregious government overreach! I implore you to end this egregious government overreach that has already unduly overburdened businesses!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99640 Anonymous 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99640
Vaccines are always a choice mandatory vaccines is unconstitutional! I has always and should always be the person's choice, even more so when they are NOT FDA approved!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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99641 Anonymous 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99641
Government Overreach This is government over reach! We will peacefully resist!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99642 Anonymous 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99642
No more restrictions No more restrictions let everyone make a decision for themselves. What gives you the right to force your choices on us.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99643 Virginian 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99643
NO!!! We the People say NO!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99644 zzzzzzzzzzzz 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99644
VOTE NO. " Keep your Marxist ideals out of my Freedoms.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99645 Billy Duffy, President and owner of Duffy's repair Service, Inc Duffy's repair Service, Inc
7/27/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99645
Making the Emergency Temporary Standards Permanent. It is my opinion that since Governor Northam lifted the state of emergency, the ETS should also be lifted. I think we should only be required to follow the CDC guidelines. The ETS has been a burden on my small business financially and at this stage of the pandemic I think we should only have to follow the CDC guidelines. Additional restrictions and burdens will only be counter productive in my financial recovery.
With employee vaccinations I do not feel the ETS is still necessary.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99646 Ruby, RN 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99646
masks don't work Masks do not work because any face covering is considered a mask. They are not equal. There are microscopic holes even in surgical masks that viruses, that are much small than those microscopic holes can go through. There are treatments for COVID that need to be utilized instead of being stopped by big pharma and the government. We The People have RIGHTS!! I am a grown adult and can make my own choices. I don't need the government to make decisions for me, that is called dictatorship!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99647 Anonymous 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99647
TyrannyThe Govts attempt to "slow the spread" has done just that. The economic depravity endured by LOCAL businesses is already irreparable. The mental health pandemic is the next wave on the back side, which will be far more elusive than any physical virus. "Slowing the spread" has resulted in unfathomable consequences that will ripple through society for years to come. Mother nature is displeased with our stewardship and is exacting her might. We are the parasite and the planet is attempting equilibrium. Its time to get busy living again and stop being afraid to die over something that us puny humans have no control over...A virus will have its way regardless. Northam and his cronies are fossils and are grasping at the last vestiges of their control...Our elected officials should be ashamed as they do not represent the people they were elected to represent...One sided, double standard, pedantic, obsequious, pandering peons. Step out or get stepped on

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99648 David 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99648
No more restrictions We need less government. Businesses should have freedom to choose how they want to run their Businesses. This is abuse of government power.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99649 T Price 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99649
Government Overreach This is pure and simple government overreach. Businesses are fully capable of determining the best course of action for themselves. Government efforts to insert itself are efforts to destroy liberty and freedom for the masses while the govt. expands and accumulates more centralized control and power. A more effective use of taxpayer funds would have been to thoroughly investigate any/all Virginia bio-labs to access their safety protocols.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99650 Unknown 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99650
VACCINES ALWAYS A PERSONAL CHOICE_VIOLATIONS OF NURENBURG CODES " This to even get ON A RADAR for a State in our United States just says HOW FAR down the State of Virginia has gone in terms of supporting our business owner's within the state, and a persons' on PRIVATE CHOICE to choose or not to choose taking a Vaccines.

The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a new code that is now accepted worldwide.

This judgment established a new standard of ethical medical behavior for the post World War II human rights era. Amongst other requirements, this document enunciates the requirement of voluntary informed consent of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body.

This code also recognizes that the risk must be weighed against the expected benefit, and that unnecessary pain and suffering must be avoided.

This code recognizes that doctors should avoid actions that injure human patients.

The principles established by this code for medical practice now have been extened into general codes of medical ethics.

There are no proven clinical trials on these vaccines- it's EXPERIMENTAL!!!!
You will all be thrown in the camps/prisons if this is approved and passed- Think about what you are doing up there in Richmond, VA folks!! It's so absurd or incongruous as to be laughable. synonym: foolish! So READ the below link!!! The Nuremberg Code (cirp.org)

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99671
SEE RESPONSE TO COMMENT 99484

The standard does not require employees to be vaccinated.

99652 Sam Brillant 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99652
Why don't we follow the science None of the proposed regulations are backed by any real scientific evidence. We know the masks have little or no effect on the spread of the virus. The regulation also states that there is no proof that prior exposure to the virus prevents future infection which is easily proven to be false in several studies. Natural antibodies have been shown to be at least as effective as the vaccines and possibly even more effective. This is nothing more than trying to use the regulatory process to get around existing laws because the governor is well aware that even with Democratic control of the legislature none of this would be passed into law. I expect a court challenge on day one and if it gets to the Supreme Court the state will lose.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99653 Gordon G 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99653
follow science. Mask do nothing to protect you or someone else. Lock downs do not work and do more harm than any good.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99654 John 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99654
Masks were not legal now mandatory? Masks don't prevent the spread of the virus. The pours between the thread are too wide. Why do we not use science? A virus going through a mask is equal to a gnat going through a hole the size of the moon! Why are we even debating this? Read the experts paper on the WHO site. Dr. Juan Juranitis. DeaTH RATE OF THIS VIRUS IS TOO LOW TO WORRY ABOUT!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99520
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99655 Virginia Resident 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99655
Stop The Corruption These proposed changes are unconstitutional. It will ruin not only lives, but businesses. People's livelihoods are at stake with these proposed changes. The money it will cost for businesses to implement these changes is beyond reason. The demands that the 'powers that be' in the state of Virginia have over stepped their boundaries. I think many have forgotten THEY work for US, WE the PEOPLE! We refuse to be dependent on the teat of government, for the government to take care of us from cradle to grave. THAT is NOT what our nation was founded on, it is NOT how we intend to live our lives and prosper. No one can prosper under these changes except for the elite. I and my family are against these proposed changes. Stop the corruption.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99656 anonymous 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99656Revolt the time is NOW
We do not consent... you will have a major revolt on your hands!!!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99657 Debbie Berkowitz, National Employment Law Project National Employment Law Project
7/27/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99657
We support adoption of final permanent standard with certain recommended changes
The National Employment Law Project (NELP) submits the following comments in support of the final adoption of the proposed Final Permanent Standard for COVID-19 adopted by the Virginia Safety and Health Codes Board on June 29, 2021, with certain recommended changes proposed below.

NELP is a non-profit law and policy organization with 50 years of experience providing research, advocacy, and public education to advance the employment and labor rights of the nation's workers. NELP seeks to ensure that all employees, and especially the most vulnerable ones, receive the full protection of employment laws, including health and safety protections. NELP's Worker Health & Safety Program Director, Deborah Berkowitz, is a former OSHA official and an expert in OSHA enforcement and

health and safety standards. NELP works with unions in Virginia, as well as community and worker rights organizations such as the Virginia Legal Aid Justice Center, to improve worker safety.

NELP supports the adoption by the Board of the recently promulgated Federal OSHA ETS for the health care industry. We also strongly support the Board's recommendation that if this Federal ETS is stayed, or otherwise revoked or repealed or declared unenforceable, then the Virginia Final permanent standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19 shall immediately apply to all such health care employers. There should be no debate about this at all. The workers in health care industry covered by the ETS face among the highest risk of exposure to COVID and must be protected.

NELP urges the board to adopt the Final Permanent Standard for COVID-19 with the following proposed changes:

Section 10: We support the proposed amendments adopted by the board in section 16VAC25-220-10.E (which maintains the current language) and oppose the substitute language proposed in the July 1, 2021 Notice. First, a great deal of the CDC language is weaker than what is contained in the Final Permanent standard. Further, the substitute language would allow employers to avoid compliance with the standard, and to meet their obligations by simply considering protecting workers. That is because CDC guidance is written as suggestions. The CDC guidance actually states that employers only have to consider their recommendations—the employer does not actually have to implement the recommendations. For example, the CDC recommendations to the meat and poultry industry say they should consider implementing their recommendations" if possible." Thus an employer is in compliance—in actual compliance—if they only consider providing protections. They don't actually have to do anything. We support the current language that states that to the extent that an employer actually complies with a recommendation contained in CDC guidelines, whether mandatory or non-mandatory, to mitigateSARS-CoV-2 virus and COVID-19 disease related hazards or job tasks addressed by this standard, and provided that the CDC recommendations provides equivalent or greater protection than provisions of this standard, the employer's actions shall be considered in compliance with the related provisions of this standard.

Section 40: We urge the board to reject the language in Section 16VAC25-220-40.A. We oppose this amendment to Section 40 because it allows employers to avoid compliance with the standards requirements if they self-declare that they have a policy in place to receive and address complaints by employees of violations. Employers should not be relieved of their legal obligation to comply with the mandatory requirements of the standard simply because they have a policy that resolves complaints. We strongly urge the board to restore the original language such that it reads: 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.

Section 60: B: Engineering Controls 3: We recommend a small amendment to this section, 16VAC25-220-60.B, that adds language to define the "appropriate use of barriers" in food processing plants.
This section addresses risks to workers in food processing plants and ends with this line: "Employers shall ensure proper spacing of employee who are not fully vaccinated or otherwise at-risk employees (or if not possible, appropriate use of barriers)." This language was taken from Federal OSHA's new updated COVID 19 guidance, but the board omitted the definition of 'appropriate use of barriers.' We urge the board to add the following language to this section from the same updated guidance issued by Federal OSHA-that states: "Barriers should block face-to-face pathways between individuals in order to prevent direct transmission of respiratory droplets, and any openings should be placed at the bottom and made as small as possible. The posture (sitting or standing) of users and the safety of the work

environment should be considered when designing and installing barriers, as should the need for enhanced ventilation.
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

The language in the 16VAC25-220-40.A the commenter is referring to is as follows:

> A. Employers shall have a policy in place to ensure compliance with the requirements in this section to protect employees from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease. Such policy shall have a method to receive anonymous complaints of violations. An employer that enforces its policy in good faith and resolves filed complaints shall be considered in compliance with this subsection.

Please note that the underlined language above only refers to "subsection" 16VAC25-220-40.A – it does not apply to any other requirements in the standard.

With regard to the language on "barriers" that the commenter requests adding to 16VAC25-220-60.B, uses nonmandatory "should" language, which is only advisory in nature and not enforceable in its current form.

99658 Joshua Johnson 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99658
Vaccines protect the vaccinated...if not, then mandate is useless "We have been told that a fully vaccinated person cannot be symptomatic or transmit the Covid-19 virus. We have been told the vaccines are 99% effective. If, fully vaccinated people are now becoming infected with the coronavirus, then in fact the vaccines are not as effective as we have been lead to believe, and a mandate is absurd, ineffective, divisive, and contrary to human rights, individual liberty, bodily autonomy, and public policy.

To take or not to take the vaccine is a personal risk decision, particularly if they are not effective. There are less invasive and more effective prophylactic and therapeutic methods of combatting the virus.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The commenter appears to be confused about vaccine effectiveness levels - there has been no such report of a vaccine that is 99% effective.

99659 Tara Eveland, Freedom Keeper 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99659
The Mark of the Beast system is being implemented. A warning for Christians. "The Lord is coming soon. Read my full thoughts here on my blog. Don't take their vx and don't put the mask back on! "
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99660 Brittany 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99660
Freedom of Control NO. No more control. No more fear enforced by government and media.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99661 April 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99661
Stop govenrment overreach This is unconstitutional. Stop government overreach. Leave these decisions to the employers. This is unconstitutional.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99662 The Holland Family 7/27/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99662
This is absolute insanity? NO! This has to stop. This is tyranny. This cannot be tolerated. I beg of you to stop this madness. The true science and data doesn't warrant any of this! We have highly effective treatments! We know how to protect the vulnerable. We cannot continue to place unnecessary burdens on businesses. This is beyond infuriating!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99663 Anonymous 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99663
Too much regulation & restriction kills our spirit & our way of life. More Businesses will die, too Too much regulation & restriction kills our spirit & our way of life. More Businesses will die, too

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99664 Stop the Insanity 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99664
This is Authoritarian control and it MUST STOP! We the people can make our own health decisions and we refuse to be herded like sheep. NO MORE COVID RESTRICTIONS ANY LONGER ARE NEEDED. Is that clear enough? Do you understand? Lift all restrictions NOW and let us get back to our lives. The SCIENCE AND DATA do NOT support continued restrictions. This is a pure authoritarian power grab and has nothing to do with health! We will not comply.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99665 Unhappy Virginian 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99665
Two weeks to slow the spread? I strongly oppose these authoritarian measures continuing permanently. It reeks of political power grabbing. You elected officials work for we the people. Small businesses have suffered the brunt while large box stores had a record year. Long term masking has conflicting evidence behind it. It is heinous to even suggest a medical product as new or questionable as the covid vaccine be mandated for ANYONE. What forced medical procedure is next? What ever happened to my body my choice? I'm disappointed in those running Virginia.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99666 Anonymous 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99666
Repeal the FPS The standard needs to be terminated. This can in no way keep up with the science. (and at least one board member ranted about following the science on one of the electronic meetings).
The standard is overly burdensome for small businesses that are already struggling.
The standard encourages dishonesty. Employers are encouraged to lie in order to have to do less to comply. Employees are encouraged to lie so they aren't discriminated against. They are also encouraged to lie so they don't lose weeks worth of pay that they can't afford.
The state of emergency is over. Since or Governor also says we are following the science and the science says we don't need a state of emergency, then we don't need the FPS.

Perception is reality. It seems that from reading through the comments that the perception of many is that keeping this standard is just a power move. It is also a way to cause businesses to have to shut down. I am sure that DOLI and the Board will say that is not the case but again, it is the perception. DOLI and the Board are perceived to be pushing vaccination on employees in Virginia. That would be fine if all of these people were proven scientists that can verify that there will be no adverse affects to anyone from the vaccine but none of these people fit that description.
The electronic meetings make a mockery of this process. Board members do not treat each other with respect and several members like to make it well known that they don't like it when someone disagrees with their POV. The number of sighs and groans from board members who forget to mute themselves is utterly ridiculous. The best was when Ms. Jolly blurted out an expletive in response to a board member she disagreed with, or should we call that the worst. In listening to all of the meetings it seems like Ms. Jolly is just on the board to try to boost her consultation business and not really there for a meaningful reason. (just my perception)
Where is the documentation that justifies continuing the FPS? Please do not point to any mainstream new outlet. Let's see actual published scientific documentation. Why do we only hear from Mr. Withrow. (Often Mr. Withrow seems to be mocking board members and public commenters) What about the DOLI staff that actually have health and safety knowledge? What about the staff that see the struggles that employees and employers alike are going through? Where are the independent experts that can verify the need to continue the standard?
Here is another big question; why does DOLI make it so hard to find out when these meetings and comment periods are happening? Posting notices at the last minute and hiding them on separate pages make it very hard for an average person to see what is going on. The perception here is that DOLI wants to have as little comment and interaction from the public as possible. That way they can just push through their own agenda.
I know that none of these comments are going to make a difference. Mr. Withrow will minimize most of them and say how the commenters don't understand what they are talking about because they still refer to the standard as the ETS. Many of the board members will also disregard the comments and even the employees that they are supposed to be representing just because they want to prove how right that their opinion is. At the end of the day employees like myself will be stuck following pointless restrictions that our employers are forced to enact upon us. That is unless I decide that I can just lie everyday so I don't have to do as much.
Repeal the standard. The amendments are garbage and will only cause discord and chaos in the workplace."

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
Commenters can sign up on the Virginia Regulatory Townhall to receive notices about upcoming Board activities at: https://townhall.virginia.gov/L/Register.cfm

99667 Anonymous 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99667
Absolutely NO! We all see through the lies now. End these restrictions on our liberty NOW! We have treatments, we know the real data, time to stop with the propoganda/fake narrative.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99668 Ignore Unlawful Orders 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99668
Sic Semper Tyrannus. The wicked flee when none pursue.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99669 Ruth Meredith 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99669
The FPS needs to be completely repealed not just amended. I'm sure Virginia thought they were doing a good thing to protect workers in the food processing sector when they put this document together, but it is over burdensome for small business owners.
Emergency authorization has been granted to biologic products that offer some protection against the covid 19 disease symptoms and are free to anyone that wants to get it.
There is no reason for Virginia Businesses to be underneath this authoritarian guideline and it needs to be removed completely from the books, not just amended to create further division between those that took the shot and those that did not.
There are prophylatics and theraputics out there for each individual to care for their own health, personally. We do not need a nanny-state telling us how we can live our lives.
{one of the least talked about prophylatics is bee propolis. Here is a recent scientific article how it can help. The Importance of Propolis in Combating COVID 19}

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

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99670 Robyn Middleton Lieutenant Colonel (retired)
U.S. Air Force Medical Service Corps 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99670
Revoke the FPS.I agree with the Virginia Department of Labor and Industry's Division of Legal Support to REVOKE the FPS. The justification to revoke is well-articulated here:
https://www.doli.virginia.gov/wp-content/uploads/2021/07/NRWC-Committee-Comments-on-Final-Permanent-Standard-Proposed-Amendments.pdf

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377

SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99671 "Philip Boykin
President & CEO, Virginia Beer Wholesalers Association" Virginia Beer Wholesalers Association
7/28/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99671
Request to Repeal the FPS
Dear Chairwoman Rodriguez:

On behalf of the Virginia Beer Wholesalers Association (VBWA), I provide the following comment on proposed amendments to the Final Permanent Standard (FPS) and respectfully request a full repeal of the FPS. If the Board is unable to support a full repeal of the FPS, the Board should, at a minimum, adopt Governor Northam's substitute language for 16VAC25-220-10(E) to allow more flexibility for compliance with the FPS.

Since the beginning of the pandemic, VBWA members and their employees have gone above and beyond the call to ensure safe distribution of beer to the Commonwealth's restaurants, grocery stores, and convenience stores. VBWA members have worked extremely hard to monitor and comply with the myriad of guidance, rules, regulations, and executive orders since the beginning of the pandemic. Beer distributors also have a significant business incentive to continue safe practices as our employees and customers rely on us.

The majority of our employees are now vaccinated against COVID-19. VBWA Members and their employees continue to stay apprised of and follow CDC guidelines. Fortunately, and as a result, instances of workplace spread amongst our member companies are virtually non-existent. As such, the FPS is not necessary to protect the health and safety of our workforce and serves as an unnecessary burden of compliance for our members.

Secondly, in an appreciated attempt to be flexible, the FPS deems an employer compliant with the standard provided it actually complies with CDC guidelines. However, the qualification that the CDC guidance must provide equivalent or greater protection than the FPS essentially eliminates any flexibility this provision was designed to provide. Furthermore, it begs the question of who determines the level of protection in CDC guidance versus the level of protection provided by the FPS.

Although DOLI continues to update its Frequently Asked Questions in accordance with CDC guidelines, the black letter of the regulation requiring that the CDC guidance provide at least equivalent protection remains the same. As soon as CDC guidance changes to provide less protection than the FPS, Virginia businesses are stuck complying with overly strict and unnecessary restrictions.

Accordingly, the VBWA respectfully requests that the Board repeal the FPS. The FPS is inflexible and unable to account for the changing dynamic of the virus and the CDC recommendations that follow. In the alternative, the Board should adopt Governor Northam's proposed amendment that an employer's actual compliance with applicable CDC guidelines shall be considered compliance with the FPS.

Thank you for your consideration, and should you have any questions or if the VBWA may be of further assistance, please do not hesitate to contact me."

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99671

The VOSH Standard specifically states in 16VAC25-220-10.E that: 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.

Description of how DOLI and VDH apply 16VAC25-220-10.E.

16VAC25-220-10.E provides:

> 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 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. 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 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. (Emphasis added).

The intent of 10.E is to give employers the option to either comply with the requirements of the VOSH Standard or demonstrate as an alternative that they have complied with recommendations in a CDC publication addressing hazards, issues, requirements, etc., that are also addressed in a specific provision of the VOSH Standard.
In order for an employer to take advantage of 10.E, it has to demonstrate that it is 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”, "encouraged", etc.). In other words, an employer would have to comply with a CDC “recommended” practice even if the CDC publication doesn't “require” it.

The Department’s interpretation of 10.E 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 VOSH Standard (e.g., the employer “should” do “this”, or “that”, or “the other”), then the employer is required to implement at least one of the options in order for §10.E to apply.

An employer will not be subject to citation or penalty if they comply with the requirements of the VOSH Standard, even if a CDC publication were to include a more stringent requirement or “recommendation” than is provided for in the VOSH Standard.

The VOSH 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. The focus of the VOSH Standard is employee safety and health, and the focus of §10.E is only CDC publications’ language that addresses employee safety and health, and occupationally-related hazards, issues, mitigation efforts, etc.
Here is an example of application of 10.E to language in Section 3 of the current CDC Guidance for Institutions of Higher Education (IHEs):

> "Administrators should encourage people who are not fully vaccinated and those who might need to take extra precautions to wear a mask consistently and correctly:
>
> > Indoors. Mask use is recommended for people who are not fully vaccinated including children.

Answer: The Department considers use of the phrases "Administrators should encourage" and "Mask use is recommended" to be non-mandatory language that must be actually complied with under 10.E to be considered to provide employees equivalent protection to a provision in the VOSH Standard. This means the phrases will be read as "Administrators shall require" and "Mask use is required." Accordingly, IHE employees who are not fully vaccinated must wear face coverings when so required under the VOSH Standard. IHE compliance with the CDC Guidance as interpreted by the Department above would provide employees equivalent protection to the VOSH Standard provisions regarding the wearing of face coverings in 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11.

99673 Jack Dyer 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99673

DOLI COVID Regulations

Dear Members of the Safety and Health Codes Board,

I write to you today in regards to the proposed changes to the COVID permanent workplace standards. We simply do not feel that permanent regulations are necessary for temporary measures required under emergency conditions or circumstances.

A person would think after more than a year of changes, missteps and wandering gyrations associated with this pandemic, how do you go about mandating permanent regulations for something you all cannot assess or figure out from one day to the next?

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99674 Another dissenter 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99674

Governor, DOLI and Safety and Health Codes Board Promote Racism. The title of my comment should be the next headline in the Richmond Times Dispatch.

The proposed amendments to the FPS greatly favor employees that have been vaccinated. A quick check of the VDH website shows that the vaccination count for white people out numbers the vaccination count of all other races listed by about 2 million vaccinations for each listed race.

So in reality what we have now is a new form of segregation and government approved racism. Way to go to everyone involved in the process to get these amendments pushed through. You should all be proud of yourselves. Undoing decades of struggle in one final VOSH standard. This was not something that I would have expected from all of the far left leaning people in positions of power.

Where is the out cry that would have come if a right leaning governor, board and department of labor had suggested this?

I can't wait to read about all the legal challenges that are submitted over this blatant act of racism. Save us all the trouble and repeal the FPS. Maybe then you can all save a little face and not seem as much of the racists that you are.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99675 Susan Campbell 7/28/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99675
Covid I think all Covid restrictions should be removed and WE THE PEOPLE have the freedom to decide what is best for us!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99678 Anonymous 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99678
Strongly opposed!!!! I am strongly opposed to permanently maintaining these restrictions.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99679 David 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99679
Supplement and enhancement of VOSH laws. Page 4 section c
"Access to employee exposure and MEDICAL RECORDS"
Last time I checked its illegal for any person or entity to request access to a persons medical records??
Therefore vosh is in current violation of HIPAA laws
I'm genuinely curious as to why this stuff is being pushed over a virus with a 99.8% survival rate. "

SEE RESPONSE TO COMMENT 99342
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HIPAA does not apply to occupational safety and health agencies such as the federal Occupational Safety and Health Administration (OSHA) and the Virginia Occupational Safety and Health (VOSH) program in its enforcement operations.

The Health Insurance Portability and Accountability Act (HIPAA) applies to “covered entities” and “business associates,” and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For

further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

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99680 Anonymous 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99680

No mandates It is completely absurd that we are even entertaining this. The government has zero business in the health care of citizens. You are overstepping by threatening to make these mandates permanent fixtures of Virginia's legislation. Are you going to mandate overweight people to lose the excess, or force people to quit smoking, or drinking? We see how well prohibition worked out right? Are we going to mandate eating clean, organic, healthy whole foods? No? Then you have ZERO RIGHT to try and implement these measures. This is America and we have freedoms. Your political agenda and the favors you owe up the chain of command are not our concern. That is not why you were appointed. You CAN NOT do this. The science does not support it, whatsoever.

SEE RESPONSE TO COMMENT 99342
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SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99681 Sean T. Connaughton, President & CEO, Virginia Hospital & Healthcare Association sent Direct to DOLI also Virginia Hospital & Healthcare Association 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99681

Proposed Amendments to the Final Permanent Standard, Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, as Adopted by the Virginia Safety and Health Codes Board on June 29, 2021."On behalf of the Virginia Hospital & Healthcare+D22 Association's ("VHHA") 26 member health systems, with more than 125,000 employees, thank you for the opportunity to comment on the Department of Labor and Industry's (the "Department") proposed amendments to the Final Standard regarding Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 (hereafter referred to as the "Amended Regulations"). Since March 2020, Virginia's hospitals and health systems have been on the frontline treating patients infected with the COVID-19 virus and playing a leading role in the Commonwealth's response to the pandemic. Throughout these efforts, Virginia hospitals have remained steadfastly committed to our top priority – the safety of our patients, visitors, employees, and the communities we serve.

We continue to question whether adopting a permanent regulation specific to COVID-19 is necessary or appropriate. The Commonwealth will undoubtedly face other pandemics or public health threats from communicable disease that involve different safety precautions than those indicated for COVID-19. Accordingly, we believe that a more general standard that sets forth a high-level framework rather than disease-specific criteria should be considered for permanent regulations. For example, the permanent regulations could be simplified in a manner that recognizes the threat posed by COVID-19, but more generally provides a basic series of steps employers would undertake for any pandemic or communicable disease of public health threat (e.g., risk assessment, environmental and administrative controls, infection control plans). That is, the regulations need not be disease specific and could simply require best practices for disease infection and control that apply generally.

Additionally, regardless of whether a permanent standard is specific to COVID-19 or communicable disease more generally, its applicability and enforcement should be tied to an executive order or an order of public health emergency declaring a state of emergency due to a communicable disease of public health threat. Similarly, in the event of a few cases or a localized outbreak of a highly contagious disease that does not amount to public health emergency on a statewide basis, the regulations should

not be applicable to an employer located in an area where there are no cases and where there is not a recognized public health threat in the region.

Any regulations such as these should be limited in duration. As proposed, the Amended Regulations would remain in effect in perpetuity with no clear objective or measures by which they will be rescinded or revoked. The lack of a clear objective or measure for rescission of the Amended Regulations would lead to protracted uncertainty for employers making good faith efforts to comply with the Amended Regulations despite a foreseeable future with zero or minimal positive COVID-19 cases in the Commonwealth or only localized outbreaks.

While we applaud the Amended Regulations' deference to and conformity with the Occupational Safety and Health Administration's COVID-19 Emergency Temporary Standard (29 C.F.R. 1910.502 et seq.) (the "OSHA ETS"), we have concerns about the application of two different sets of COVID-19 workplace regulations to hospitals and health systems. The Amended Regulations at 16VAC25-220-10.B.1-4 provide that applications of nearly all of the Amended Regulations' requirements are suspended "where any employee provides healthcare services or healthcare support services" absent an intervening suspension, stay, invalidation by a state or federal court, revocation, repeal, declaration of unenforceability, or expiration of the OSHA ETS. 16VAC25-220-30 defines "healthcare support services" to mean "services that facilitate the provisions of healthcare services. Healthcare support services include [but are not limited to] patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/processing services." 16VAC25-220-50.A.6.f states that "[t]his section does not apply to the following… healthcare support services not performed in a healthcare setting (.e.g., off-site laundry, off-site medical billing)…"

Presumably, the intent of the Amended Regulations was to have the Amended Regulations apply to "off-site" healthcare support services and the OSHA ETS apply to "on-site" healthcare support services. This result would require hospitals, health systems, and other healthcare employers to implement two different regulatory schemes by attempting to determine what it means to be an "off-site" healthcare support service. Furthermore, employees providing "off-site" services who enter a facility that would be considered "on-site" would be required to follow different procedures than in their usual workplace and would also be subject to the training requirements within the Amended Regulations and the OSHA ETS – among other duplicative or conflicting requirements making implementation of the Amended Regulations onerous and complex.

Similar to "off-site" healthcare support services, employees in "well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present" (16VAC25-220-50.A.6.d.) are not subject to 16VAC25-220.50. As a result, employees within the same facility could find themselves subject to the Amended Regulations in one workspace but would be subject to the OSHA ETS by simply walking to another section of the same facility.

We respectfully request that the Amended Regulations eliminate the confusion this would cause employers and employees by amending 16VAC25-220-10.B.1-3 and 16VAC25-220-50.A.1-3. to state that the Amended Regulations do not apply to hospitals or health systems rather than adopting the OSHA ETS definitions of "healthcare services" and "healthcare support services." This would enable hospitals and health systems to develop employer-wide policies that are consistent among its work force and in compliance with the OSHA ETS in certain settings while adhering to the obligations placed on employers by the General Duty Clause of the OSH Act (29 U.S.C. § 654, 5(a)1) in settings not covered by the OSHA ETS. Hospital and health system employees would also have clear standards by which they are required to operate regardless of whether they happen to be "on-site," "off-site," or in a "well-defined hospital ambulatory care setting where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings" throughout the workday.

In addition to these overarching concerns, there are several technical issues with the regulations that we have previously commented on and that should be considered in this and any future rulemaking:

As noted in our public comment on the permanent regulations, infection prevention and control is a daily, ongoing focus within Virginia hospitals and health systems. Operating under the oversight of the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Virginia Department of Health (VDH), and various other accreditation and regulatory authorities, hospitals and our ancillary facilities are required to consistently demonstrate that their patients and staff receive and provide care in a safe environment. This includes development and implementation of comprehensive infection control plans, quality improvement programs, managing supply chain, training employees and caregivers, ensuring employees have the resources they need, planning for future health emergencies, and working with congregate care settings to institute strong infection control practices, among other activities.

In other words, infection prevention and control and ensuring the safety of our patients and employees are not a new focus for Virginia hospitals and health systems. They are ingrained components of our daily operations. Imposing new and separate regulatory requirements, many of which duplicate the policies and protocols already in place within our facilities, will unnecessarily result in burdensome new compliance costs without meaningfully improving our ongoing efforts to protect our patients and employees. Consequently, we recommend that Subsection E of § 10 – which states that an employer in compliance with CDC publications regarding COVID-19 will be considered in compliance with the standard/regulation – be amended to acknowledge these requirements and explicitly state that hospitals, health systems, and other facilities under their control that are in compliance with the broader industry standards set forth by state and federal health care regulatory entities are deemed in compliance with the permanent regulation and not subject to enforcement actions for failure to comply with any specific requirement under the permanent regulation that is already addressed in these broader industry standards.

Subsection B.5 of § 40 prohibits employers from permitting known or suspected COVID-19 employees or others to report to or be allowed to remain at work. While the intent of this prohibition is clear, as a practical matter it is problematic to require ongoing monitoring of all employees who may be experiencing symptoms that are not visible without examination or inquiry. Furthermore, it is difficult or impossible to enforce where the employee or other person does not physically report to a facility or building under the surveillance and control of the employer as distinct from a teleworking arrangement. To address this, the prohibition could be limited to not "knowingly" permitting the employee to report to or be allowed to remain at work. Alternatively, the prohibition could be limited to those employees who report COVID-19 to the employer under Subsection B.3 of § 40.

The requirement in Subsection B.7 of § 40 is unnecessary and inappropriate to impose on employers. Those subcontractors and companies that provide contract or temporary employees are presumably subject to these regulations by virtue of being an employer in their own right and an upstream employer should not bear this burden. Furthermore, such encouragement is more appropriate coming from the Department.

Subsection B.7. of § 40 requires employers to notify their employees within 24 hours if an employee, subcontractor, contractor, temporary employee, or other person who was present at the place of employment within the previous 14 days tests positive for COVID-19. This requirement poses a challenge for hospitals. Given the inherently higher risk of exposure in the health care setting, notifying every employee of a hospital or health system each time an employee tests positive will require an unreasonable level of ongoing notification. Even assuming a blast e-mail or similar broad communication meets the requirement, notifying every employee – clinical or non-clinical – upon a positive test of essentially anyone entering the facility within "2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test)" is unrealistic and could have Health Insurance Portability and Accountability Act (HIPAA) privacy implications.

In addition to our previous comments, several of the changes to the permanent regulations present new technical issues that we believe should be addressed in this and any future rulemakings:

Subsection C. of § 40 requires employers to "immediately remove" employees from a worksite if the employee has suspected or confirmed to have COVID-19. "Immediate removal" of an employee from a worksite may not be feasible in some circumstances. To address this issue, removal could be "immediately or, if circumstances present a danger to the employee or others, as soon as practicable."

Subsection C.1. of § 50 require employers, to the extent feasible, to prescreen or survey each covered employee to verify the employee does not have signs or symptoms of COVID-19 prior to the commencement of each work shift. However, the Amended Regulations do not clearly define what it means to "prescreen or survey" each employee. The OSHA ETS resolves this ambiguity by defining "screen" to mean "asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19." (29 C.F.R. 1910(b)) The OSHA ETS further addresses patient screening and management (29 C.F.R. 1910(d)) as well as employee screening (29 C.F.R. 1910(l)). Therefore, we recommend mirroring these sections of the OSHA ETS in the Amended Regulations to avoid any confusion regarding the required processes. Similarly, this recommendation would resolve the ambiguous use of "screen" in 16VAC25-220-50.A.6.c-e.

In closing, while COVID-19 may be the first pandemic in recent years to broadly impact the Commonwealth, Virginia's hospitals and health systems deal with issues surrounding infection prevention and control, patient and workforce safety, and employee wellness on a daily basis. We have long-established policies and protocols governing these aspects of our operations and work closely with a variety of regulatory authorities to promote a safe care environment for our patients and our employees. Our utmost priority always has been and always will be the safety of our patients, visitors, employees, and the communities we serve.

The potential confusion surrounding whether the Amended Regulations or OSHA ETS apply to a workplace – or even to specific areas within a facility – as well as additional and duplicative requirements are unnecessary for hospitals and health systems and will have numerous burdensome and costly implications for them. Furthermore, the permanent regulations contain ambiguities that open hospitals and health systems to an uncertain and/or inconsistent interpretations by Department officials despite good faith efforts of hospitals and health systems to comply. We also continue to question whether the permanent regulation should be specific to COVID-19 and believe that any such regulation should only be in effect for the duration of the public health emergency or, at a minimum, contain an objective standard by which any such regulation would no longer be in effect.

Thank you again for the opportunity to comment on the permanent regulation. Please do not hesitate to contact Brent Rawlings (brawlings@vhha.com, 804-965-1228) or me at your convenience if we can provide any additional information regarding our suggested modifications.

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SEE RESPONSE TO COMMENT 10013

The Department notes that as of August 18, 2021, healthcare worker cases in Virginia totaled 32,001, with 952 hospitalizations and 59 deaths. https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

The commenter is correct that where the OSHA ETS does not apply to the healthcare services and healthcare support systems, 16VAC25-220 applies. The Department notes that it is not uncommon for

employers to have to deal with different occupational safety and health standards and regulations depending on the workplaces involved and the hazards present. 16VAC25-220-10.C recognizes this:
C. 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, Va. Code §40.1-51.A, etc.
There are many businesses that have departments/divisions that must operate under different OSHA regulations even though the hazard presented is the same (e.g., companies that have two different departments/divisions that have employees exposed to electrical hazards but must either conform to the General Industry or Construction Industry electrical regulations contained in Part 1910.301, et seq. and Part 1926.400 et seq.)
In addition, the Department notes that in a number of respects, the OSHA ETS contains provisions that could be considered to be more stringent (i.e. more protective of employees) than corresponding requirements in 16VAC25-220. There is no prohibition against an employer from choosing to comply more stringent regulatory requirements to protect its employees.

With regard to the situation raised by the commenter, such employers can apply the requirements of the OSHA ETS to healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing), and employees in well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present, without running afoul of the overwhelming majority of the provisions in 16VAC25-220. The one exception that the Department has identified are the notification provisions in 16VAC25-220-40.B.7, which would still have to be complied with.
Finally, following is a summary of the VOSH policy on de minimis violations from the VOSH Field Operations Manual:

5. De Minimis Violation Policy.

> Va. Code §40.1-49.4.A.2 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.”
>
> The Virginia Occupational Safety and Health (VOSH) Field Operations Manual (FOM) 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:
> ….
> 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.

The VOSH FOM 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.

With regard to the commenter's concern about 16VAC25-220-40.B.5 (prohibits employers from permitting known or suspected COVID-19 employees or others to report to or be allowed to remain at work), a prerequisite for the issuance of a VOSH violation is a demonstration that the employer knew or should have known of the violation. Accordingly, no change to the wording of the provision to include the word "knowingly" is needed.

With regard to the commenter's concern about 16VAC25-220-40.B.7 dealing with issues of contractors and temporary employees, OSHA and VOSH have longstanding policies addressing the respective responsibilities of employers, subcontractors and temporary employment agencies in a multi-employer situation. The referenced section is consistent with those policies. See 16VAC25-60-260.F and G for VOSH multi-employer worksite regulation.
https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section260

See DOLI §10, FAQ 12 for a discussion of host employer and temporary employment agency responsibilities. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

With regard to the commenter's concern about 16VAC25-220-40.B.7 dealing with notification of employees, 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 requirement can be satisfied by a blast email. The referenced provision specifically is qualified by the phrase "To the extent permitted by law, including HIPAA." A blast email to employees would satisfy the requirement and the provision does not require providing identifying information about the infected employee.

With regard to the commenter's concern about 16VAC25-220-40.C about the phrase "immediate removal" and the possibility of an emergency or danger to others interfering with the ability to comply, the Department has a longstanding policy of considering exigent circumstances, such as emergencies or dangerous situations, in assessing whether violations of VOSH standards will or will not be cited. Accordingly, not special language is needed to address the commenter's concern. See VOSH Field Operations Manual (FOM), Chapter 8.A.6, Emergency Situations, and 8.B, Voluntary Rescue Operations Performed by Employees.
https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v8.pdf

With regard to the commenter's concern about 16VAC25-220-50.C 1., that provision provides "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. The use of the word "surveying" encompasses the commenter's request to define screening as “asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19.

99682 Anonymous 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99682
FPS comments "Hello Members of the Safety and Health Codes Board,

I work for a large municipal organization, and have played a key role in developing, designing, and implementing our COVID response in compliance with the temporary standard, and then the Final permanent standard. Trying to get 15,000 employees across 50+ agencies all into compliance with every aspect of the FPS has been a full time job, which was made more complicated by the conflicting information that was coming out from the various regulatory and health bodies. Our Health Dept was following the science of the CDC, while we were responsible for informing and reminding that the final permanent standard was the law we must adhere to, or risk fines.

The most difficult part of that was that the science changed much more often, the guidance from the CDC was updated often, whereas the FPS, as you know, must go through a much lengthier process to make changes and amendments. It became harder and harder to tell employees they must comply with laws that did not match the science, but the law was the law. In some instances where employees would refuse to comply, it led to employees being terminated for non-compliance. At a time when people needed jobs the most, ours were losing their jobs because the law did not match the science, and we were, and are, bound by the law.

It is for these reasons, and the reality that the science changes much more rapidly than the law can keep up, that I urge the board to adopt new language that clearly mandates the FPS mirror the guidance of the CDC, or that the FPS be rescinded altogether. This will give employers the agility they need to meet the demands of a rapidly changing situation.

Thank you for your time and consideration.

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SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99684 M. Clark Barrineau, Asst VP of Govt Affairs & Public Policy sent Direct to DOLI also The Medical Society of Virginia 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99684
Request to Repeal the FPS
I am writing as Assistant Vice President of Government Affairs and Public Policy for the Medical Society of Virginia (MSV) to respectfully comment on the Final Permanent Standard (FPS) and to request a repeal of that standard. If the Board is unable to support a full repeal of the FPS, the Board should, at a minimum, adopt Governor Northam's substitute language for 16VAC25-220-10(E) to allow moe flexibility for compliance with the FPS.

MSV is grateful for the many hours of work the Safety and Health Codes Board has devoted to this issue over last year. This is a complicated virus, and the Board's work has been admirable.

Since the beginning of the outbreak, physicians have served on the front lines of the pandemic. MSV members and their staffs have answered the call to provide for testing, diagnosis, and treatment of COVID-19. We have also led the charge on vaccinations, leading to a significant curb in the infection rate.

Even though cases and community spread are down significantly right now, the health care community remains vigilant.as new variants enter the community. As such, CDC guidelines and the OSHA ETS mandate continued distancing, capacity, and PPE guidelines for health care settings.

Unfortunately, the FPS is unable to account for the changing dynamic of the virus and the chnging recommendations from the CDC. For example, language in the FPS that deems compliance with the FPS

if the employer complies with CDC guidelines is qualified with the requirement that CDC guidance provide equivalent or greater protection than the FPS. This qualification essentially eliminates any flexibility this provision was designed to provide. It also raises the question of who determines the level of protection in CDC guidance versus the level of protection provided by the FPS.
Recognizing this, DOLI continues to update its Frequently Asked Questions in accordance with CDC guidelines. While the clarification in the FAQs is appreciated, our concern is that a court would still lean on the strict qualifying language in the FPS itself rather than information in the FAQs.
Accordingly, the MSV respectfully requests the Board repeal the FPSIn the alternative, the Board should adopt Governor Northam's substitute language that an employer's actual compliance with CDC guidance shall be considered compliance with the FPS. Thank you for your consideration and should you have any questions or if the MSV may be of further assistance, please do not hesitate to contact me.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
SEE RESPONSE TO COMMENT 10013
The Department notes that as of August 18, 2021, healthcare worker cases in Virginia totaled 32,001, with 952 hospitalizations and 59 deaths. https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

99685 "Stephanie Peters, CAE
President & CEO
Virginia Society of CPAs" Virginia Society of CPAs 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99685
Comments on Final Permanent Standard (FPS)
Dear Commissioner Davenport:

On behalf of the more than 13,000 members of the Virginia Society of CPAs (VSCPA), the VSCPA Executive Committee is writing to comment on the Final Permanent Standard (FPS) for Infectious Disease Prevention of the SARS-CoV-2 Virus. We request revocation.

The VSCPA appreciates the attention and careful consideration the Safety and Health Codes Board has devoted to this issue over the past year and a half. CPAs in public practice, as well as those in private industry and government roles, quickly pivoted and adapted their business practices to allow for remote work at the beginning of the pandemic in order to keep their staff, clients and other business associates safe. By the very nature of their work, CPAs are accustomed to following uniform guidelines and standards to ensure consistency. As the Centers for Disease Control (CDC), the Occupational Safety and Health Administration (OSHA), and others continue to update their guidance and recommendations based on the changing dynamic of the virus, it is critical for Virginia's guidelines to have the flexibility to quickly evolve as well. Even with the proposed amendments, the FPS does not adequately account for the constantly evolving virus and ongoing revisions to federal guidance. It is our recommendation that Virginia rely solely on the federal guidance available as the standard for workplace safety measures. Adoption of separate standards makes compliance challenging for all businesses and institutions and may very well lead to failure to comply simply due to conflicting guidance.

The VSCPA is the leading professional association in the Commonwealth dedicated to empowering CPAs to thrive. Founded in 1909, the VSCPA has more than 13,000 members who work in public accounting, industry, government and education. Please feel free to contact me or VSCPA Vice President, Advocacy Emily Walker, CAE, at (804) 612-9428 or ewalker@vscpa.com if we can be of further assistance.

Sincerely,

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99687 Anonymous 7/29/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99687
Concerned Virginia Resident! I am totally against the continued restrictions and mask wearing we have endured for the past two years. We are not stupid, we get it and we should have the freedom to make choices for ourselves. We know so much about the virus now. In spite of what the news media tells us, it is very treatable (if we are allowed the drugs available that have been proven helpful).

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99689 Lourice Thonas Ii 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99689
NO MORE UNCONSTITUTIONAL OVERREACH Continuing to perpetuate this agenda of control, fear mongering and frankly Cultish Covid obsession with the false pretense of health and infectious disease management is unconstitutional federal and state wise and completely contrary to the economic capitalistic freedoms that are the very foundation of the United States' and our Commonwealth's strengths. There is nothing but destruction to be had for Virginia and Virginians by perpetuation and terrifying the suggestion of permanence of this insanely extreme response to a 99% recovering flu. The burden of compliance is unwarranted and extreme. This is sealing the coffin of small business success, destroying the economy of the Commonwealth and for those that support this stupidity please take your agenda to CA or Ny and get out of my home!

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99691 Augusta County Augusta County 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99691

Comments on the Draft Standard It appears to that the CDC recommends masks for those not vaccinated. The draft revisions to the Standards indicate masks are required for those not vaccinated. News outlets indicate the Governor wants to follow CDC guidelines. There appears to be a conflict in the requirements.

The revised Standard appears to discriminate against those not vaccinated. Some have good reasons for not being vaccinated whether medical or not. The choice to vaccinate should be of the individual person. The standard appears to require employers to know if an employee is not vaccinated and then enforce the standard appropriately. What about HIPPA and other code requirements that keep medical information personal? Those not vaccinated should have the choice on whether or not to wear a mask. Employers should not be required to police who is vaccinated or not. Follow CDC as a recommendation, not a requirement.

It's the same with the physical distancing requirements in the Standard. Those not vaccinated can choose to distance themselves from others. We do not need to post signs in designated common areas, breakrooms, lunchroom, etc. on the number of people allowed in a room and then police it. Vaccination is a choice. Those not vaccinated should have the choice to distance from others.

It appears that we are going from "masks protect others" to "masks protect yourself" and now to "vaccinated people wear masks to protect those not vaccinated". Again, is should be a personal choice of those not vaccinated.

The Standard is written in a way to guilt people into being vaccinated so they are not singled out. Medical information will not be private, and those not vaccinated will feel pressure from others to be vaccinated.

We realize there may be parts of the State that have higher positivity rates, and there may need to be additional measures, but don't penalize the areas that do not have a problem.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The VOSH Standard addresses medical situations that prevent a person from wearing a face covering:

J. 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:

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.

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

3. 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.

4. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.
5. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.

99692 Don Bright
President, Virginia Forest Products Association Submitted Electronically
Virginia Department of Labor and Industry" Virginia Forest Products Association 7/30/2021
https://townhall.virginia.gov/L/viewcomments.cfm?commentid=99692
Remove Permanent Standard

The Virginia Forest Products Association ("VFPA") appreciates the opportunity to comment on the Virginia Department of Labor and Industry's Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16 VAC 25-220 (collectively, the "Regulations"). The VFPA has previously commented on the Emergency Temporary Standard; we urge you once again to align any standard with CDC and OSHA guidance, and not exceed that guidance. We remain opposed to the permanent regulation that has adopted a rigid standard for a constantly evolving pandemic.

CDC and OSHA have provided practical, science-based guidance that are suitable to low risk work environments like ours. Specifically, VFPA respectfully requests that:

Original agency language providing "safe harbor" for employers who follow CDC and OSHA guidance be included in any revision of the permanent standard;

Any language regarding "Return to Work" mirror the latest CDC Guidance on time-based return-to-work. Again, this regulation should be consistent in all ways with CDC medical guidance;

Language in Section 40F regarding "N95 filtering face piece respirator" be stricken. As the pandemic evolves, the availability of these masks may again become scarce and be distributed first to healthcare workers. The language of this section states that in ride sharing scenarios, employees "shall be" provided with these masks, with no language that protects employers if the supply of these respirators becomes limited and they are not available to non-healthcare workers; and

All of the language in Section 90 regarding discrimination against employees who raise concerns to the public through social media be stricken. There is no other similar protection we are aware of for employees to distribute potentially damaging and unfounded information against an employer with impunity.

In closing, we would like to reiterate our opposition to a permanent Virginia regulation for COVID-19. Our opposition from the outset to this regulation was rooted in its static nature; the virus is now mutating to the Delta variant and the science is changing daily. The regulatory process simply cannot move fast enough to adapt, particularly in regard to masking policies. Virginia's employers and employees would be better served by adhering to uniform guidance from CDC and OSHA that changes as appropriate with science and is independent of the Board. Thank you for this opportunity to comment.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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With regard to the commenter's concern about return to work requirements being consistent with CDC guidelines, the standard is consistent.
With regard to the commenter's concern about the availability of N95 respirators under 16VAC25-220-40.F, that proposed amendment provision provides:

Notwithstanding anything to the contrary in this standard, the Secretary of Labor may exercise discretion in the enforcement of an employer's failure to provide PPE required by this standard, if the employer demonstrates that the employer:
a. Is exercising due diligence to come into compliance with such requirement; and
b. Is implementing alternative methods and measures to protect employees that are satisfactory to the Secretary of Labor after consultation with the commissioner and the Secretary of Health and Human Services.

With regard to the commenter's concern with the anti-discrimination provisions of 16VAC25-220-90, those provisions are consistent with current statutes, regulations and case law. See DOLI §90, FAQ 1. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

99693 Brandon Robinson, Associated General Contractors of Virginia Associated General Contractors of Virginia 7/30/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99693
Construction Industry Concerns with a Permanent Standard
On behalf of the Associated General Contractors of Virginia (AGCVA), Virginia's largest and most influential construction trade organization, we urge you to rescind the Permanent Safety Standard for Infectious Disease Prevention: SARS-CoV-2 / 16VAC25-220, which is a permanent regulatory burden for businesses based on a pandemic that will eventually end.

Throughout the COVID-19 pandemic, Virginia's construction companies invested heavily to keep employees and jobsites safe. While millions of fellow Americans faced unemployment and the consequences of such, many AGCVA members were able to keep employees working and do so safely. Further, the industry has complied with all government mandates and followed the science and recommendations of the Centers for Disease Control.

However, the current Permanent Standard goes beyond the science-based CDC recommendations. If the board feels a full repeal is not in order, AGCVA would at a minimum urge the board to adopt the governor's suggested amendment. This amendment will provide safeguards for employers who follow CDC guidelines, which change frequently as evidenced by this week's updated guidance.

AGCVA represents an industry with a concerted focus on the safety and health of its workforce. Providing these companies the flexibility to adopt safety and health policies and procedures that fit each individual situation is the best way to ensure the safety of Virginia's workers. Ensuring that employers can implement safety measures that follow CDC recommendations and in the best interest of the particular business and its employers is the safest and best path forward.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99694 Anonymous 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99694
Too Much VA should have businesses align with CDC guidance, that's it. Anything beyond that is overly cumbersome and confusing for employers and employees. It is not a one size fits all for safety regulations, especially when the landscape of Covid changes so quickly.

What happens a different variant comes out, and it takes VOSH and VDOLI another 6 months to update this standard? We will have the same situation like we had previously, with outdated and non-

meaningful requirements. Businesses need to be able to be flexible and adapt quickly, and putting strict rules in a Final Permanent Standard is not helpful for anyone.

Align with CDC and drop the Final Permanent Standard. Time, effort, and resources would be better spent in other ways than trying to keep updating these guidelines.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99695 Anonymous 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99695

Mandatory Covid Shots FDA stated the Covid shot is gene therapy used to alter one's DNA. The animal study is HUMAN. This is experimental never before used technology on human beings. It is unconstitutional to force anyone to take this shot. It is Not a vaccine. I am against forced vaccination. Put back liability on drug companies so they will stop maiming and killing people. There are over 6000 deaths from the shot and hundreds of thousands of adverse reactions after getting the shot. Enough is enough. Stop the madness. Stop lying to the public. Once you've had the Sars Co V 2 infection, you cannot be reinfected. You have immunity. The spike protein in this shot is a bio weapon, a prion, which causes brain and heart damage. It was put in on purpose. Gain of Function from the Wuhan lab was used to make this virus more infective to people. It was done on purpose for nefarious reasons. It is illegal to mandate this shot. There are many FDA approved drugs that treat Covid that the government and media have suppressed. Emergency Use Authorization documents show us the shots don't work. This is unethical research doing research on people without animal models and without informed consent. You are in violation of Hippocratic oaths, international treaties, and Nuremberg.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671
Reports of death after COVID-19 vaccination are rare. More than 351 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through August 9, 2021. During this time, VAERS received 6,631 reports of death (0.0019%) among people who received a COVID-19 vaccine. FDA requires healthcare providers to report any death after COVID-19 vaccination to VAERS, even if it's unclear whether the vaccine was the cause. Reports of adverse events to VAERS following vaccination, including deaths, do not necessarily mean that a vaccine caused a health problem. A review of available clinical information, including death certificates, autopsy, and medical records, has not established a causal link to COVID-19 vaccines. However, recent reports indicate a plausible causal relationship between the J&J/Janssen COVID-19 Vaccine and TTS, a rare and serious adverse event—blood clots with low platelets—which has caused deaths.
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html

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99696 Virginia's Electric Cooperatives (Sam Brumberg, Vice President, VMDAEC) Virginia's Electric Cooperatives (VMDAEC) 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99696

Comments regarding Amendments to the Final Permanent Standard ("FPS") for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19
Comments of Virginia's Electric Cooperatives
VIA ELECTRONIC FILING
Dear Ladies and Gentlemen:

The purpose of this letter is to briefly comment in the interests of Virginia's rural electric utilities, the electric cooperatives, and the communities they serve. Virginia's thirteen electric distribution cooperatives have struggled under the FPS, especially as it has conflicted with federal industry safety regulations applicable to the electric industry and COVID-19 guidance from the Centers from Disease Control and Prevention ("CDC"). Although assurances received from the agency's staff indicate that enforcement discretion would be exercised in a common-sense way, the regulatory text should reflect the realities of the fast-changing nature of the COVID-19 pandemic. In particular, please refer to comments submitted June 22, 2020, on the Emergency Temporary Standard, and September 25, 2020, on the FPS. Basic clarifications along these lines are necessary in order to preserve and protect the lives of employees. If the Board is to issue broad, sweeping regulations, such as the FPS, the Board should also reexamine its "long-standing policy" of regulating "regardless of industry" due to the special and essential nature of our work.

We have seen—just this week—a change in CDC guidance regarding the Delta variant of the SARS-CoV-2 virus. With the pace of changes and the variation in community transmission among localities, the amended FPS should be more flexible, nimble, and adaptable to changes as the new Delta variant spreads and other variants, possibly, emerge.

Further, the recommendation of the Governor which would make compliance with CDC guidance tantamount to compliance with the amended FPS is a commonsense approach and would remove the ambiguity around the FPS' ostensible requirement of individualized, case-by-case analysis of whether a particular protective measure within the CDC guidance was "equal to or greater than" the protection required by the FPS. We strongly support the Board's integration of the Governor's recommendation into the amended FPS.

The Board's proposal of an anonymous complaint procedure and a requirement to "resolve" those anonymous complaints with no other details about how that system would work or be monitored portends to create an environment of division and difficulty between employers and employees; such a complaint system should be voluntary.

Finally, there also appear to be no mechanisms in the amended FPS for it to expire, for the Board to convene again to examine changing conditions, or for the Board in any other way to exercise its continuing oversight responsibility over the amended FPS. We urge the Board to add provisions to require meetings at intervals, or to add an expiration date.

We appreciate the opportunity to comment. Thank you for your kind attention to this matter, and if you have any questions, please do not hesitate to contact me.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The Proposed Amendments provide a specific timetable for review of the VOSH Standard:
B. 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.

1. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and
16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.
2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final
Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.
3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia’s 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be maintained, modified, or revoked.

99697 Dennis A Edwards, CHST, OHST 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99697

Rescind the final standard The overwhelming majority of the commenters do not support a continuation of the FPS much less support the proposed amendments.

The standard can't keep pace with the constant evolution of the virus.

The standard was not and is still not needed.

DOLI has not shown how the FPS has been successful. DOLI has not shown a need for the standard to continue.

Just this week the CDC guidance has once again changed. So now, several parts of the amended standard would no longer be in line with current guidance. Just like the previous iteration of the standard.

This can't continue. Rescind the FPS. There is enough information out there for working adults to make their own decisions about the protections that they need for their own health issues. COVID is not a workplace issue. It is unfair to make employers responsible for employees when they aren't on the job.

It is unfair for DOLI and the SHCB to promote divisiveness and discrimination amongst workers. DOLI and the SHCB are not medical professionals or scientists and should in no way be trying to force vaccinations on the work force.

It is time to move on. Rescind the FPS and let's get back to the business of real worker protections."

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

99698 Bruce T. Whitehurst
President & CEO, Virginia Bankers Association" Virginia Bankers Association 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99698
Repeal the FPS Chairwoman Rodriguez,
Thank you for the opportunity to comment on the Final Permanent Standard (FPS). The Virginia Bankers Association (VBA) serves as the organized voice for Virginia's $615 billion banking industry and its 42 thousand employees. We appreciate the efforts of the Safety and Health Codes Board on this important issue. With the expiration of the Governor's pandemic-related Executive Orders, the end of the state of emergency, and the proliferation of COVID-19 vaccines, the VBA supports the repeal of the FPS. Alternatively, if the Board decides that the FPS should remain in place, the VBA supports the proposed amendments as well as the Governor's substitute language for 16VAC25-220-10(E).
Please free free to contact me if you have any questions at 804-819-4701 or bwhitehurst@vabankers.org.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99699 Olin Kinney, Metropolitan Washington Airports Authority Metropolitan Washington Airports Authority 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99699
Final Permanent Standard for Infectious Disease Prevention 16VAC25-220-50/60 B. Engineering Controls
Final Permanent Standard for Infectious Disease Prevention 16VAC25-220-50/60 B. Engineering Controls
The engineering controls as stipulated represent and extreme overreach of the regulatory process since it is impractical for Owners of existing buildings, absent of any pending major renovations, to comply with standards that preceded the time when the facilities were designed and constructed. Equipment originally installed and appropriate to the building occupancy should be required to function as intended and was inspected during construction or last significant renovation.

Building HVAC systems in use have been designed, constructed, and commissioned in accordance strict building code requirements in effect at the time of issuing the Certificate of Occupancy. The engineering controls should only require systems to be maintained and operated in accordance with their system design and related manufacturer requirements such that the mandatory minimum level of protection of the workforce is ensured. Engineering controls in part B should be revised and limited to the ASHRAE 62.1 edition in effect at the time of building design or last significant renovation.

It is still yet to be determined by the industry trade groups as to the most effective design performance requirements for existing and new HVAC systems and any permanent regulations should follow existing processes contained in the Virginia Uniform Statewide Building Code (USBC).

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

The HVAC provisions in the VOSH Standard referenced by the commenter were specifically reviewed by the Virginia Department of Housing and Community Development (DHCD) and found to conform to Virginia Statewide Building Code requirements.

99701 Laura Karr, ATU Associate General Counsel lkarr@atu.org or (240) 461-7199.
Amalgamated Transit Union 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99701

The Amalgamated Transit Union (the "ATU") submits the following Comments regarding the amendments proposed to the final permanent standard regarding infectious disease protection, SARS-CoV-2, and Covid-19 that are under consideration by the Virginia Safety and Health Codes Board (the "Board"). As the labor union representing over 2,200 bus, rail, and paratransit workers employed throughout Virginia, the ATU comes before the Board to present these workers' pressing safety concerns regarding the proposed amendments – just as the ATU did in October 2020 and January 2021 concerning the final permanent standard.

Further, the ATU stands with its labor movement allies – represented by the AFL-CIO – in supporting certain proposed amendments while urging the Board to strike others, as enumerated in the comments filed by the AFL-CIO. The Board should not construe the decision by the ATU not to expand here upon certain AFL-CIO requests as indicating a lack of support for those points. Instead, the ATU will use its limited comment space to highlight only the following concerns that are most pressing to our Virginia members.

The ATU strongly supports the following amendments that enhance protections for transit workers:

16 VAC 25-220-40(F)-(G): The ATU commends the Board for proposing to expand the scope of protections for workers who must travel with others in vehicles so that those protections encompass not only coworkers who travel together but also workers who travel with any "other persons." Importantly, this category of "other persons" reasonably would include members of the transit-riding public. The proposed amendment is a common-sense improvement to the final permanent standard because it recognizes that it is the presence of potentially infected people, not those people's status as coworkers or members of the public, that determines a worker's infection risk. Because all people are potentially infected, regardless of their vaccination status – due to the rise of the Delta variant of SARS-CoV-2, the accompanying increase in breakthrough infections, and the expected future emergence of more virulent variants – the only way to promote worker safety in vehicles is to require effective and targeted protections for all workers who must ride with others.

If amended, the final permanent standard would do this by requiring transit employers to provide fresh air ventilation; eliminate air recirculation; separate transit vehicle operators from passengers, including by limiting vehicle occupancy; and provide respiratory protection to vehicle operators. These measures are consistent with the ATU's own conclusions regarding vehicle operator safety during the SARS-CoV-2 pandemic, based on over a century of transit safety expertise and on research specific to SARS-CoV-2.[1] Equally important is the fact that the protections that the Board proposes to extend to transit workers are readily feasible for transit employers, with the necessary vehicle components available on the market today.[2] In fact, employers of ATU members in Virginia and across the United States have implemented many of these protections successfully at various times during the pandemic. Although transit employers incur costs in doing so, they have received generous pandemic-related support from the federal government. Those funds should mitigate the impact of any additional expenditures that would result from compliance with these proposed amendments, which the ATU urges the Board to adopt without delay.

16 VAC 25-220-60(A): The ATU also commends the Board for proposing to list transit among the "higher-risk workplaces" that are subject to the enhanced protections contained in this section. Importantly, transit workers' coverage under 16 VAC 25-220-60 also ensures that their employers are required to train them in SARS-CoV-2 safety pursuant to 16 VAC 25-220-80. The experience of the ATU throughout the pandemic has confirmed that transit workers face substantial risks on the job; to date,

tragically, we have lost over 150 members to Covid-19, and many more have suffered through the illness.

Likewise, a New York University study found that as of August 2020, nearly a quarter of New York City transit workers reported having been infected with Covid-19.[3] While most Virginia transit workers serve areas that are less densely populated than New York, their cumulative risk now likely exceeds that of New York transit workers in August 2020, since the pandemic has persisted for an additional year. Meanwhile, researchers have found that in the United Kingdom, transit workers have died from Covid-19 at rates more than double those of the general working population;[4] in Norway, they are among those with the highest risk of contracting Covid-19;[5] and across six Asian countries, they had the second highest number of occupational SARS-CoV-2 exposures of all groups of workers studied.[6] There is nothing unique to these countries that puts transit workers there at greater risk from SARS-CoV-2 than they are in Virginia. Instead, the threat arises – universally – from transit workers' frequent and prolonged contact with the public in confined, often poorly-ventilated spaces. The ATU, therefore, urges the Board to adopt the amendment clarifying that transit workers face enhanced risks and are entitled to correspondingly enhanced protections.

The ATU urges the Board to reject the following amendments that would reduce worker protections:

The ATU is alarmed to find that the Board has proposed several amendments that would reduce protections substantially for workers who are fully vaccinated against SARS-CoV-2. If adopted, these amendments would eliminate an employer's obligation to provide physical barriers, administrative and work practice controls, personal protective equipment, and SARS-CoV-2 training to protect vaccinated workers. (See 16 VAC 25-220-60(B)(2), (C)-(D) and 16-VAC-25-220-80(A)(2).) Likewise, an employer would be free to disregard vaccinated workers when determining whether its workforce is large enough to require a written infectious disease preparedness and response plan. (See 16 VAC 25-220-70(A)(2).) To the extent that the standard still would require the employer to develop such a plan, neither the plan itself nor its training requirements would apply to vaccinated workers. (See 16 VAC 25-220-70(B)(2).)

The present state of scientific knowledge regarding SARS-CoV-2 does not support these amendments. Since December 1, 2020, testing labs have detected 644 cases of the Delta variant in Virginia.[7] This number represents over seventeen percent of the total cases in the state during the week ending July 30, 2021, and due to limitations on labs' virus sequencing abilities, the actual number of Virginia Delta cases is likely much higher.[8] Further, Delta cases are increasing in Virginia, having doubled in the two weeks prior to July 9, 2021. By the end of June 2021, Delta cases represented eighty percent of all SARS-CoV-2 specimens sequenced in Virginia. Researchers predict that Delta will become the dominant viral strain in the state. [9]

Delta's increasing prevalence is important because, as the U.S. Centers for Disease Control and Prevention announced on July 29, 2021, it appears that vaccinated people who become infected with Delta can transmit the infection to others.[10] This was not thought to be the case with other SARS-CoV-2 variants. The difference might be due to the fact that people infected with Delta tend to have high viral loads, regardless of whether they have been vaccinated.[11] Therefore, while breakthrough infections remain rare in Virginia, with 1,566 detected since January 1, 2021 (although due to the widespread practice of not reporting breakthrough cases that do not result in hospitalization, the true number is likely much higher), those that do occur are now more dangerous because they can feed outbreaks among unvaccinated people.[12] With thirty-five percent of Virginia's adult population still unvaccinated, the danger of Delta-driven viral spread is real, as is the potential for vaccinated people to help drive that spread.[13]

Under these circumstances, it is essential that the Board continues to require employers to protect both vaccinated and unvaccinated (and otherwise at risk) workers alike. It is well understood that SARS-CoV-2 spreads in workplaces. Vaccinated workers are not necessarily immune, and they can infect their unvaccinated colleagues. Therefore, the only way to stop the occupational spread of the virus is to protect all workers. Doing so will have the added benefit of sparing employers the administrative burden of keeping constant track of who is vaccinated and who is not, along with which

protections apply to whom. For these reasons, the ATU urges the Board to reject the aforementioned amendments and preserve the full protections of the final permanent standard for all workers.

16 VAC 25-220-60(C)(10)-(11): The ATU is likewise dismayed that the Board is considering amending these sections to eliminate an employer's obligation to provide masks to workers (and require those workers to wear them) when the workers' jobs make physical distancing impossible or when the workers hold customer-facing positions. Most transit workers fit into these categories. An executive order and accompanying U.S. Transportation Security Administration directive currently protect transit workers by requiring universal masking in indoor areas of transit systems.[14] However, these rules expire on September 13, 2021, and the federal government might not renew them.[15] Virginia transit workers would then have no assurance that their employer would provide masks – the absolute minimum level of viral protection that workers need in confined spaces with members of the public, any one of whom could be infected. Therefore, the ATU calls on the Board to preserve mask protections for these vulnerable workers.

The ATU appreciates the opportunity to comment on the proposed amendments, and we thank the Board for its consideration. For further information regarding the matters discussed herein, please contact ATU Associate General Counsel Laura Karr at lkarr@atu.org or (240) 461-7199.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484

"The Transportation Security Administration on Tuesday extended a federal requirement that travelers [and employees] wear masks on commercial flights, buses and trains through Jan. 18, 2022." https://www.cnbc.com/2021/08/17/biden-administration-set-to-extend-mask-mandate-for-travel-through-mid-january.html

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.
(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).
The Dept. invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

99703 Petrina Jones Wrobleski, Columbia Gas of Virginia Columbia Gas of Virginia
7/30/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99703
Comments on Final Permanent Standard and Proposed Amendments Columbia Gas of Virginia respectfully offers the following comments to the proposed amendments to the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus, 16 VAC25-220, ("FPS"). We join with other commenters in asking that the FPS be revoked or, at a minimum, amended to provide better clarity for Virginians.

The FPS was born of an emergency involving a virus, COVID-19, about which little was known. Since the first cases of COVID-19 were reported, the knowledge, expertise, and experience as to how to limit the spread and treat the illness has grown rapidly. In addition, a growing percentage of the population has been vaccinated against the illness or otherwise has some level of natural immunity following infection and recovery. For these reasons, the emergency measures put into place are no longer necessary. Indeed, many are no longer relevant or in accordance with current best practices.

Should the FPS amendments proceed despite the lack of necessity, the Company objects to the difficult position the proposed amendments continue to place on employers and, by extension, employees.

At the outset, the goal of most employment-related government regulations is to prevent employers from treating employees disparately. This is not true of the FPS. The FPS potentially requires employers to draw distinctions between employees based on vaccination status. While some employees may be willing to share that information, others will not. And while an employee may choose not to reveal their vaccination status, that employee will be required by the FPS to self-identify by wearing a face covering and observing other social distancing requirements. Certainly, employers may, after careful consideration, choose to either require vaccination or proof thereof, but that decision should only be undertaken after careful consideration of all relevant laws and research related to COVID-19 and its vaccines, not in response to an emergency standard that is not capable of responding to new developments.

Second, the proposed amendments do nothing to address the myriad of operational inefficiencies and impossibilities created by the FPS. For example, the FPS requires restrooms to be cleaned once per shift. For employers with remote employees who use remote-stationed portable restrooms, the unworkable, and perhaps unnecessary given current guidance related to hygiene, cleaning requirements necessitated the removal of the portable restrooms or other onerous cleaning solutions. Additionally, the requirement that employers provide N-95 face masks for employees traveling together in vehicles led to confusion regarding compliance with OSHA fit testing requirements and ignored other mitigating measures or circumstances. Indeed, the amendments ignore the impact of employees who have some level of natural immunity as a result of having contracted and recovered from COVID-19.

Should the agency choose not to repeal the FPS, at a minimum, we would request the Board adopt substitute language to 16VAC25-220 to deem compliance with the FPS if the employer complies with the CDC guidance to mitigate the spread of the SARS-CoV-2 virus, which continues to responsibly evolve in response to the changing dynamic of COVID-19.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

With regard to the commenter's concerns about employees being treated differently based on their vaccination status, the Department notes that, as many employers and organizations representing employers have requested, the proposed amendments are designed to address updated CDC guidance on the issue. If the employer has concerns about employees being treated differently based on vaccination status, they can legally implement face covering and other safety and health rules for their employees that are more stringent than 16VAC25-220.

Note: The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance

for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.
(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).

The Department invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

With regard to N-95 issues raised by the commenter, the Department has issued §40, FAQs 37 and 38 on those issues. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

99704 Sara Kitt, Anheuser-Busch Anheuser-Busch 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99704
Requested Updates and Clarifications 220-10.E CDC guidelines can only be followed in lieu of DOLI requirements if they offer equivalent or greater protection

During past revisions of the DOLI regulation this requirement has led to confusion as new information about the pandemic becomes available. CDC guidelines are continuously evolving and a hierarchy of standards to follow would be more effective for long term implementation than a separate set of FAQ guidelines that don't align with the original regulation.

220-40.E.4 Requires respiratory protection in shared vehicles.

It remains unclear whether medical clearance and fit testing is required for N95 use in this application. This was previously clarified in a FAQ to not require medical clearance and fit testing if a N95 was selected. Can this be included in the standard?

220-40.F.1.f Provides face covering exceptions.

How does this apply to contractors working at a facility that has different rules than their employer?

220-40.L.5.a Required frequencies for cleaning and disinfection of common spaces.

Add provision for supplying cleaning and disinfection equipment in the area that can be used to clean and disinfect prior to accessing the common space

220-50 Need additional clarification under A.6.a around what is considered a licensed healthcare provider.

It appears this section is not intended to apply to first aid provided by an employee. Seeking to clarify that an employee licensed as an EMT would not be considered a licensed healthcare provider.

220-20 The definition of "otherwise at-risk" includes an employee's personal health conditions that the employer may not be aware of. Sections 220-40.D and 220-40.G require the employer to require these employees to take certain actions.

Update sections that reference "otherwise at-risk employees" so that the employer is required to provide protective measures but not required to enforce the requirement since employers are not aware of what employees may be in this category.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

As the commenter noted, the Department has FAQs dealing with the voluntary use of respirators. See §40, FAQs 37 and 38. https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/ If proposed amendments to the standard are adopted, DOLI will update its FAQs accordingly.

With regard to multi-employer worksites and different approaches to employee safety and health taken by subcontractors on a host employer's worksite, first, each employer must comply with the requirements in VOSH standards to protect their own employees. Host employers can establish safety and health work rules for companies it contracts with that meet or exceed VOSH requirements. Such rules are normally included in contractual agreements. The Department recommends the commenter consult with legal counsel about including such language contracts with subcontractors who will be entering the host worksite.

With regard to the commenter's question about employees who are licensed EMTs, if an employer hires a licensed EMT for the purposes of providing medical assistance to employees, the EMT would be considered a "licensed healthcare provider" under the standard. However, if the employee is a licensed EMT but that designation has no relation to her job duties and that employee provides first aid to another employee on a "good Samaritan" basis, the licensed EMT would not be considered a "licensed healthcare provider."

99705 Anonymous 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99705

REPEAL THE FPS The FPS and proposed amendments typify a hurried and ill conceived administrative process that has saved no one while imposing near impossible burdens on thousands of individuals, businesses and organizations. Creating sedimentary layers of duplicative, discordant and scientifically unsupportable shoulds on the Commonwealth's businesses and employers has brought only confusion and noncompliance, not an orderly informed path toward worker safety. The amendments are out of step with swiftly changing CDC guidance and even conflict with executive orders and various state and federal safety enactments. The Standard cannot keep pace with medical developments. Its central flaw of perpetual obsolescence cannot be papered over.

The attempt to impose burdens and benefits based on employee vaccination status invades well established zones of constitutional privacy. It effectively creates a caste system that coerces employees into making decisions about their body, health and family based on the State's preferences rather than respecting the medical self determination of its citizens. The vaccination apartheid proposed by DOLI also has a disparate impact on Blacks and Latinos who are less likely to obtain vaccines and therefore more likely to be blackballed, marginalized and harassed. The DOLI approach of medical status haves and have nots compels employers to violate the ADA, informational privacy laws as well as civil rights laws.

Regarding PPEs, simply read the mask disclaimers. They affirm what everybody already knows; masks do not reduce virus transmission, so why are public officials persisting in this cruel charade devoid of scientific merit?

The regs were a trainwreck from the beginning. They were enacted without public input, without expertise in contagious diseases and without the careful measured approach owed to the People of Virginia. Repeal is the only logical and ethical solution. Public officials who tinker with the lives of the citizenry should at least honor the principles of Hippocrates, the father of medicine, who presciently warned medical professionals to first, DO NO HARM. The FPS and its proposed amendments work substantial harm to both employers and employees and should therefore be repealed. No amount of wordsmithing can salvage this bureaucratic debacle.

SEE RESPONSE TO COMMENT 99342

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The Standard was the subject of extensive public input including multiple written comment periods and multiple public hearings which can be accessed www.doli.virginia.gov.

99706 VIRGINIA BUSINESS COALITION
Associated Builders and Contractors -Virginia
Associated General Contractors of Virginia
Delmarva Chicken Association
Hampton Roads Chamber of Commerce
Harrisonburg – Rockingham Chamber of Commerce
Heavy Construction Contractors Association
National Federation of Independent Business
Northern Virginia Chamber of Commerce
Northern Virginia Transportation Alliance
Precast Concrete Association of Virginia
Richmond Area Municipal Contractors Association
Shellfish Growers of Virginia
Thomas Jefferson Institute for Public Policy
Virginia Agribusiness Council
Virginia Assisted Living Association
Virginia Association of Roofing Professionals
Virginia Association of Surveyors
Virginia Association for Home Care & Hospice
Virginia Automatic Merchandising Association
Virginia Contractor Procurement Alliance
Virginia Food Industry Association
Virginia Forestry Association
Virginia Forest Products Association
Virginia Loggers Association
Virginia Manufactured & Modular Housing Association
Virginia Manufacturers Association
Virginia Peninsula Chamber of Commerce
Virginia Poultry Federation
Virginia Retail Federation
Virginia Seafood Council
Virginia Trucking Association
Virginia Veterinary Medical Association
Virginia Wholesalers & Distributors Association
Virginia Wineries Association 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99706

Repeal Permanent Standard
Dear Safety and Health Codes Board Members:
On behalf of the Business Coalition (“Coalition”) which is comprised of 34 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 amend the Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations").

For the last year and half, Virginia employers have committed themselves to protecting their employees, contractors, suppliers, customers, and communities from COVID-19 infection. They have done this by continually updating their COVID-19 protocols to ensure they are complying with the latest regulations and guidance imposed by federal, state, and local regulators. Despite the additional stress, costs and time related to compliance, business leaders and owners understood how critically important it was to do their part to reduce the risk of exposure and spread of the virus.

Understanding Virginia businesses need clarity and consistency in any regulatory program and the permanent standard is a static regulatory burden for a pandemic that is temporary, our Coalition respectfully asks the Board to repeal the permanent standard.

However, if the Board feels a standard should remain in effect as the pandemic winds down, we strongly encourage the Board to adopt Governor Northam's recommendation to amend Section 16VAC25-220-10.E to provide employers with safeguards should they comply with the most recent CDC guidance. We hope the Board will reconsider and approve the following language change.

E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.

By approving the Governor's recommendation to 16VAC25-220-10.E, you will enable employers to return their focus where it belongs — on best practices as they are recommended in real time by the CDC.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99707 "Scott Killian

7/30/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99707

Opposition Statement to Permanent Standards "Dear Members of the Safety and Health Codes Board:

I am writing today to express my opposition to the Covid-19 permanent workplace standards – whether the January version or the new proposed amended version. I believe that the amended version should not be adopted and the existing version should be abrogated.

In reviewing the amended order, I fail to see any rational basis for it. Instead, it seems designed to make life more difficult for people who have made a different medical choice than you would like.

To illustrate my point, let's take a two-person example – Person A is vaccinated; Person B is not. Under the amended standards, Person B would be required to wear a mask and maintain social distance at his place of employment (presumably forever since there is no end date in the standards). Person A would not need to wear a mask and does not need to maintain social distance.

If the theory is that this policy protects Person A, it does not hold up. In order for this theory to be correct, Person A would have to be able to catch Covid-19 from an unvaccinated person but not be able to catch Covid-19 from a vaccinated person. Such a contention defies not only logic, but evidence. Even the premise of the theory underlies it. The theory assumes that despite being vaccinated, Person A can catch Covid-19. So if Person A can catch it, then any other vaccinated person can catch it. And if Person A is around such a vaccinated person that has caught it, then this only protects Person A if it's not possible to transmit Covid-19 from a vaccinated person. But recent cases (such as the New York Yankees, the Texas Democrat delegation, the wedding written about in Forbes, and even recent documents released by the CDC) show that even among fully vaccinated individuals, Covid-19 can spread. So distinguishing between vaccinated and unvaccinated makes no difference in protecting Person A and makes it an arbitrary distinction. Person A's protection comes not from being distant from unvaccinated people, Person A's protection comes from the vaccine. This vaccine, like virtually all vaccines, is designed to protect the person who receives it. If Person A does catch Covid-19, that person is almost certainly not going to have any serious outcome because of the vaccine (again, making any additional protections unnecessary).

If the theory is that this policy protects Person B, it is unnecessary, paternalistic and overreaching. The vast majority of people who are not vaccinated have made a choice not to be vaccinated. Some do so because they have already had Covid and have natural immunity; some have concerns about the safety of the vaccines (including unknown long-term effects); some have concerns that the vaccines are not fully approved, but only have been given emergency use authorization; some have determined that given their age and medical situation (e.g., lack of comorbidities) that it is unnecessary. If the theory is this policy protects Person B, then that leads to the conclusion that you are mandating this because you don't agree with a medical choice someone made for themselves (since, as discussed in the previous paragraph, the vaccine is not about protecting others). This is absolutely not the place of the government period, but certainly not this agency.

These regulations also have no end date. When the pandemic first started, the restrictions that were put in place were done so under the guise of "two weeks to flatten the curve." The idea was to avoid the hospital system from being overwhelmed. Then when that was achieved, the restrictions did not go away, but instead the goalpost shifted. The restrictions were then recast as necessary until all adults have had the opportunity to get vaccinated. That has been achieved. And yet again, we are faced with a moving goalpost, but this time, there is not even a pretense of when Covid restrictions will go away. It is intended to be a permanent change. This is unwarranted and ignores reality. Our hospital systems are not in danger of being overwhelmed; every adult has the ability to obtain a vaccine if they so choose; the daily death rate from Covid is low (something like Alzheimer's at this point). Covid has become a livable disease that everyone has the ability to protect themselves from. The government should step back and allow people their freedoms.

As further evidence that these regulations are designed just to punish those with whom you disagree, it makes no distinction about when a person is vaccinated. Evidence is coming out that the vaccine's effectiveness drops off (by some measures fairly significantly) after some period of time (around 6 months). The drug companies and federal agencies are already talking about the need for booster shots. Yet these regulations define a person as someone who received the vaccine at least 2 weeks prior. So if someone gets the vaccine in January 2021, under these regulations in July 2022, they would still be classified as "vaccinated" even though the effectiveness of that vaccine at that point (18 months after it was received) may be on the level of someone who never got it. And yet no restrictions are placed on that person. This distinction is arbitrary and without any rational basis.

These regulations also make no allowance for those who have natural immunity from Covid because they had it. Some indications are that the immunity one gets from having Covid is better and lasts longer than the immunity received from the vaccines (including with the Delta variant). Yet those individuals under these regulations are put into the class that needs to be protected. Again, such a delineation is arbitrary.

And finally, these regulations impose additional and unnecessary burdens on Virginia businesses. These standards are different than other states and the federal guidelines. So companies would now have an additional set of possibly conflicting guidelines to navigate and implement. It also takes time and effort for their compliance employees to track the status of each employee and their actions. These additional burdens are not what Virginia businesses need after over a year of being hampered in their ability to conduct business. They need to be allowed to reopen and resume their normal activities.

For all these reasons, I strongly oppose the proposed amendment and believe that the existing permanent regulation should be abrogated.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99708 Jenn

7/30/2021 https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99708

comments "Does zthe fact that the COVID vaccine is still in an experimental vaccine and in emergency use authorization make a difference? There are medications out there to treat COVID. All persons in the state of Virginia were offered the vaccine. It is available. If they choose to take the vaccine it is their own risk and if they choose not to get the vaccine it is their own risk. My choice my body. People have made an informed decision and should have the freedom to make that choice without being discriminated against.

16VAC25-220-10 Purpose, scope, and accessibility

Sections C

If there is a failure on the employers part of not having proper PPE. Employers should be held responsible and could have action brought against them. If there is not the proper PPE available, employee should not be asked to work.

16VAC25-220-40 Mandatory requirements for all employees

D. 3. “provide that such requirements do not apply to fully vaccinated employees”

This looks like segregation. Also is this subjective if the requirement of having boosters of the COVID vaccine, when will someone be onsidered to be fully vaccination.

E. Access to common area…

Again this looks like segregation. What happens to the person who is allergic to ingredients in the vaccine? Is that person going to be punished and not allowed in the common areas, etc.? Also what about consideration of vaccinated people who are shedding from the vaccine?

E. 1. All employees should follow the same guideline of sanitizing and cleaning, regardless of the vaccination status, as recommend in universal precaution training.

E. 2. All employees should follow the same occupancy limits, not discrimination.

G. Making an employee that is non vaccinated wear a mask singles them out, violates HIPAA, and marks them with visual discrimination such as a scarlet letter.

16VAC25-220-50 requirements for healthcare…

6. g.

Remove “are not fully vaccinated” throughout the entire text. All employees should be assumed to be contagious whether it is a person who was vaccinated and is shedding or unvaccinated. Just like all police officers should be CIT trained so everyone is treated with respect.

Having un-vaccinated employees wear masks is an outward display of a health status and HIPAA breech.

16VAC25-220-70 infectious disease…

7.b. Employers would not have to know of these health conditions if it does not affect the employees' job performance and they have not asked for a reasonable accommodation.
16VAC25-220-80 Training
A section 2
All employees need to have training just as all employees need universal precautions. No employee should be exempt from having training.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.
If employers do not provide employees with either respiratory protection equipment or personal protective equipment required by a VOSH standard or regulation, they are subject to citation and penalty.

99709 Anonymous 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99709
No more mandates Do not attempt to divide our great state anymore! Vaccination is a personal choice not a law. CDC, unelected individuals who are complicit, provides recommendations, not laws. There is no science to prove that these mandates have made our state safer. Other states had no mandates and did just fine. This has been a year of hell for the citizens and employers with again no science to justify the requirements. Masks do not protect from viruses. Look at the box. Look at a newspaper from 1918; we knew it then and the facts have not changed. How are you going to detect Covid since now the CDC and FDA advise that the PCR tests are faulty? They cannot detect between the flu and Covid. Even the inventor of the test said that they should not be used in Covid testing. This cost him his life. Why didn't the total deaths last year increase overall if we were in a pandemic? Total deaths are nearly the same as they have been for the past 5 years, per the CDC website. End all mandates and allow every one to chose for themselves how they want to protect their family. Stop dividing us. Stop putting ridiculous and unproven requirements on employers. We are free and will not be manipulated and lied to.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
The standard does not require employees to be vaccinated.

99710 KK German 7/30/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99710
Only 420 covid deaths total in a city of 437,000 (2010 census) The PCR tests are bunk. And after a year of shutting down and causing irreparable harm to the citizenry, now the FDA is admitting they were in error to recommend 40 cycles that results in millions of FALSE POSITIVE covid results.
My city has had 420 covid deaths since the beginning of the pandemic, March 2020 to July 2021.

In a population of 437,000 (2010 census) that equals a death rate of .096% PER CENT for the entire population of the city.

This medical tyranny needs to cease immediately. It is killing commerce and livelihoods. Children are being suffocated and no child has died from covid.

WHAT IS WRONG WITH YOU PEOPLE? IS CHINA PAYING YOU OFF?

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99711 Vanessa L Patterson, Executive Director RAMCA, Executive Director PCAV Submitted Electronically
RAMCA & Precast Concrete Association of Virginia 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99711
Repeal Permanent Standard for Infectious Disease Prevention: 16VAC25-220 Standard "RAMCA & Precast Concrete Association of Virginia

Dear Safety and Health Codes Board Members:

On behalf of the Richmond Area Municipal Contractors Association (RAMCA) and the Precast Concrete Association of Virginia (PCAV), I respectfully request a full repeal of the Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 standard. If the Safety and Health Codes Board is unable to support a full repeal of the Final Permanent Standard, the Board should adopt Governor Northam's substitute language for 16VAC25-220-10(E):

E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.

Thank you for the opportunity to comment.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99712 Anonymous 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99712
This Rule Divides US and Doesn't Protect Us As an essential worker who has gone to work everyday vaccine or no, I am opposed to this regulation. Across the country, we are seeing a divide of citizens based on their willingness to take a vaccine that is not approved by the FDA. There are many reasons an individual might not get the vaccine and separation of them vs those who have it is leading to

discrimination in the workplace. I understand the need to keep workers safe, but if high risk people are vaccinated and deaths are down let us move forward together.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99713 Muhamad Soros Wang 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99713
Absolutely Opposed to Government Control-My body-My Choice!! This is an obvious result of your unquenchable lust for power. You will never win trying to play God. God is watching and taking notes. Psalm 105:15 "Touch not my anointed ones and do my prophets no harm.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99714 Anonymous (with letter reference on behalf of AFL-CIO) AFL-CIO 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99714 Comments of the Virginia AFL-CIO on the VOSH Proposed Revised Final Permanent COVID-19 The Virginia AFL-CIO, a state federation of the national AFL-CIO, represents over 300,000 union members and their families. With over 300 affiliated local unions in the Commonwealth, unions represent workers in a broad range of industries including healthcare, first response, food processing, manufacturing, hospitality, construction, transportation, utilities, grocery and retail service, education, and others; in private and public sectors; in stationary and mobile workplaces. Our members work side-by-side millions of non-unionized workers.

In 2020, the Commonwealth of Virginia was the first in the nation to recognize the need for enforceable workplace protections from COVID-19 and implement a strong clear standard to prevent the virus from spreading and save lives. Recognizing that COVID-19 is not a temporary workplace hazard, the Commonwealth issued a permanent standard in January 2021. Workplace outbreaks have been a key indicator of virus spread throughout the pandemic and continue to be a major source of COVID-19 exposure and outbreaks. This makes workplaces the key point of intervention where the strongest mitigation measures are needed. Comprehensive workplace protections are necessary for Virginia workplaces to remain open as we continue to address waves of infections and hospitalizations surging through communities.

We strongly urge the Safety and Health Codes Board to maintain strong provisions in the final permanent standard for COVID-19 that reflect the aerosol nature of this virus and ensure all workers are adequately protected from exposure to COVID-19 on the job. In light of the highly contagious Delta variant, rapid increase in cases and CDC's latest guidance issued on July 27, 2021, which recommends stronger protections for vaccinated individuals, DOLI should present the Board with a new draft of the revised standard as many of the proposed revisions are no longer relevant at this stage in the pandemic.

Workplace protections continue to be vital to preventing the spread of COVID-19.

Sixteen months into the pandemic, we know much more about the SARS-CoV-2 virus, COVID-19 and the continued need for protections for all workers. During this time, it has been soundly established that the virus is aerosolized and can spread through the air distances beyond six feet through talking, breathing, coughing or sneezing. Indoor, poorly ventilated spaces where individuals share the same air—workplaces—continue to be where the virus easily spreads, one case rapidly turning into an outbreak. Vaccinations are widely available throughout the nation and are a critical long term measure to end the pandemic, but vaccination rates remain low among working age adults in the U.S., breakthrough infections continue to rise where transmission is high, and evidence shows that vaccinated people carry the same viral load as unvaccinated individuals, making vaccinations insufficient to control the virus spread and mitigation measures critical.

The United States and Virginia are experiencing few hospitalizations and deaths among the vaccinated; however, the risk for unvaccinated individuals is increasing with the spread of more transmissible variants. The percentage of adults vaccinated in Virginia varies widely by locality. As of mid-July, many Virginian localities still have less than 50% of adults fully vaccinated, largely in south and southwest Virginia. The Delta variant is sweeping through areas with low vaccination rates and the number of cases is rising in all 50 states, compared to the all-time lows in June and early July. Daily COVID-19 cases in Virginia are now six times more than they were in May.[1] The situation is worsening.

On July 27, 2021, the CDC revised their guidance again due to the high rates of transmission of the Delta variant, once again recommending masking in indoor public spaces for all individuals, regardless of vaccination status, in areas of high or substantial transmission.[2] To date, more than 70 counties in Virginia are areas of high or substantial transmission, a number that is increasing rapidly.[3] This guidance also was issued as new data from outbreak clusters showed that infected vaccinated individuals carry the same viral load as infected unvaccinated individuals, even though breakthrough infections usually do not result in severe symptoms.[4] Breakthrough infections are not uncommon and it is unclear the long term effect of breakthrough infections, especially as the Delta variant surges and additional variants of unknown transmissibility and morbidity develop. In places with especially high exposures, breakthrough infections are more common; recent CMS data show that 68% of infections in nursing home residents are among vaccinated individuals.[5]

While the vaccine is extremely effective at reducing severe symptoms, hospitalization and death, vaccines alone are not sufficient to adequately control the spread of COVID-19. A recent study confirms that even with vaccinations, new variants will continue to spread and that even with high levels of vaccination, relaxation of other mitigation measures will enhance transmission.[6] The authors' recommended maintaining non-pharmaceutical interventions and transmission-reducing behaviors throughout the entire vaccination period.

In the current state of the pandemic, comprehensive protections that include multiple exposure prevention strategies reflective of current transmission science must continue to be implemented in workplaces—vaccines and masks are not enough to protect individuals from the high rates of transmission and airborne nature of this virus. Comprehensive protections include strong ventilation requirements, adequate respiratory protection, adequate distancing, worker training, immediate removal of cases from the workplace, and early identification, reporting and employee notification of cases and outbreaks, regardless of vaccination status.

As workers continue to be at increased risk of exposure to COVID-19 and in light of the new CDC guidance, we support the Safety and Health Codes Board (the Board) continuing to ensure that all workers have protections from exposure to COVID-19. The Board should examine the new CDC guidance which accounts for the current emergency situation, the transmissibility of the Delta variant and the viral load that can be carried by vaccinated individuals and ensure that any amendments to the Virginia Final Permanent Standard reflect this guidance.

In adopting the federal emergency temporary standard (ETS) for health care and support workers, they should amend the language to reflect the current CDC guidance in addition to the ETS. The guidance now recommends that vaccinated individuals with a known exposure to an infected person

with COVID-19 should isolate and be tested. This is a change from the federal ETS and in light of the new data, Virginia should ensure that all vaccinated and unvaccinated workers are removed from work to prevent the spread of the virus. Additionally, we support the Board ensuring that health care worker protections from COVID-19 do not lapse even if something changes in the federal ETS. These workers have been on the frontline of the pandemic from the first days, are currently fighting to save lives against the Delta variant and will continue to be exposed to COVID-19 even when the risks for others outside of health care might be reduced.

Any amendments to the standard must ensure workers remain protected in the workplace from COVID-19 exposures, illness and death.

We support many of the Board's proposed amendments to the Virginia Final Permanent Standard for COVID-19 as it ensures all employers must work together with workers and their representatives to conduct a hazard assessment to identify and mitigate the risks of exposure. The Board should work diligently to incorporate principles from the most recent CDC guidance that supports multiple prevention strategies that the standard requires based on the risk level and not solely vaccination status. However, several proposed revisions would significantly weaken worker protections from COVID-19, placing them at grave risk from the Delta variant, and must be addressed before any revised standard is issued.

The standard must continue to be the minimum level of COVID-19 protection in workplaces and not permit voluntary public-based CDC guidance as a substitute for workplace protections.

The proposed revised final permanent standard maintains the final permanent standard language that allows employers to follow CDC guidance instead of the standard, but only when the guidance provides equivalent or greater protection than provided by the standard. This ensures that employers have to follow a similar set of baseline workplace requirements throughout the standard, while having flexibility to adhere to updated protective guidance as necessary.

However, a new amendment proposed by the state would eliminate the language that maintains strong baseline protections from an airborne virus, permitting employers to follow CDC guidance even if it is weaker than Virginia's standard. This not only undermines the intent of the standard to protect all workers with clear enforceable workplace safety measure-s, but allows federal guidance to supersede state OSHA authority, which is wrong.

It is vital that employers are not allowed to follow any CDC guidance instead of the standard as the CDC has hundreds of guidelines and many have not been updated to include current science and are weaker than the proposed revisions to the final permanent standard. On May 7, 2021, the CDC issued a scientific brief on airborne transmission, yet many of their COVID-19 workplace guidelines have not been updated to reflect this information. For example, the meatpacking guidance hasn't been updated since it's creation in May 2020, does not recognize airborne exposure and is filled with unenforceable language of "if possible." The final permanent standard recognizes airborne transmission and the significance of ventilation, air filtration and appropriate respiratory protection. If the Board were to vote to accept the new amendment, it would allow employers to follow CDC guidance that does not recognize the significance of airborne transmission or recommend control measures to address this transmission route, leaving workers at significant risk.

The current language in the proposed revised standard stating, "provided that the CDC recommendation provides equivalent or greater protection than provided by a provision of this standard," has been supported and voted on by the Board multiple times as the emergency temporary standard and final permanent standard language was promulgated and adopted. VOSH also has stated that this language has been useful to the agency and they have been able to address CDC guidance that offers greater protections through their FAQs. The current language, quoted above, has been in effect since July 2020 and must be maintained and not be weakened by the Board or the Governor's office.

The state must remove the arbitrary distinction of vaccination status as a basis of employer size for the written plan requirement.

The final permanent standard requires all employers in higher risk, non-healthcare, workplaces with 11 or more employees to have a written plan. However, the revised final permanent standard includes exempting language "[i]n counting the number of employees, the employer may exclude fully vaccinated employees." This exempting clause must be eliminated from the final revised standard.

The requirement to have a written plan must be based solely on exposure risk and the business size exclusion should remain based solely on the number of total employees since all employees are still at risk of being infected and spreading the virus to others, whether or not they are vaccinated. The exception clause would allow for large employers in workplaces with high risk factors of COVID-19 exposure to claim that their workforce is fully vaccinated and therefore not required to have a written plan. There is nothing in the standard that requires employers to determine vaccination status, and states that employers can rely on what employees present. If the standard included this exemption clause, and employers did take action to determine if they have fewer than 11 employees unvaccinated, it would create a recordkeeping nightmare for employers to collect and store information covered under HIPAA and be especially difficult for employers in high-turnover industries.

The data released with the July 27, 2021 CDC guidance shows that vaccinated people carry the same viral load as unvaccinated individuals, making vaccinations alone insufficient to control the virus spread and additional mitigation measures are critical. Using vaccination status, even if verified by the employer, to exempt employers from having a written plan will allow the virus to continue to spread in workplaces, as it would allow employers not to implement all the additional mitigation measures in the standard.

The exception clause leaves workers at significant risk by not requiring a written plan, no matter the size of the employer or significance of the risk of COVID-19 exposure to these workers. A written plan is essential because it is used to identify tasks where there is exposure to COVID-19, identify the specific control measures that will be used and how they will be implemented, and to have procedures in place to assess that controls are being properly utilized and maintained. Without a written plan there is no assurance that there will be a systematic and comprehensive approach to identifying and controlling COVID-19 exposures at the workplace.

It has been suggested that this provision will encourage vaccination. However, allowing an employer not to provide protections does not incentivize vaccination of workers—it only leaves them without protections.

The standard must be continuously in effect to avoid breaks in protections for workers, rather than delaying effective dates for the training and written plan provisions.

The training and written plan provisions have been in effect for almost a year and employers should already be in compliance with those provisions of the standard. Any delay in enforcement dates is effectively a halting of essential provisions and there is no reason to give employers who have already been subject to compliance with these provisions more time to comply. Starting and stopping the provisions of the standard as the pandemic continues and surges due to the Delta variant will encourage the virus to spread more rapidly.

It has been suggested that newly opened businesses need additional time to come into compliance with these provisions. This argument allows employers who haven't been following the law weeks of a free pass while other employers have ensured that they are following the law and protecting their workers. Additionally, VOSH already has a process in place for helping new businesses come into compliance with current regulations that would be utilized for COVID-19 as in any workplace hazard. Maintaining all the provisions and being clear that employers must have a plan to prevent exposure to COVID-19 on the job and train their workers will keep all workers protected and does not create gaps in protections from employers who are attempting to follow the rules. Viriginia must maintain the standard set of procedures that keep businesses open and safe—the provisions of the Virginia final permanent standard ensures both.

A "good faith" safe harbor provision would weaken workplace protections from COVID-19 exposures and move dangerously beyond the standard practice of OSHA's discretion through enforcement.

The final permanent standard required clear and basic mitigation measures for workplace exposures to COVID-19. These provisions included significant, standardized measures such as exposure assessment and determination, notification requirements, and employee access to exposure and medical records, return to work criteria, and sanitation and disinfection. These provisions have been in place without an expressed issue by the agency for more than a year and have contributed to the reduction of COVID-19 cases in workplaces.

The proposed good faith safe harbor amendment relieves employers of the obligation to comply with these mandatory basic and vital requirements in exchange for an employer policy that includes an anonymous complaint system if all complaints are resolved. Enforcement of the employer's policy that may be weaker than the standard and resolving complaints should not be a substitute for compliance with the standard's provisions. Additionally, there are no recordkeeping requirements for the complaint system and creating those requirements would be complex and burdensome and workers often are incentivized not to issue complaints or report issues. Without requirements of how complaints are being addressed, it is the word of the employer versus the worker.

VOSH already has the ability to use enforcement discretion if an employer is acting in good faith to follow the standard and resolve any complaints or concerns their employees have about their safety. The agency should continue to use their enforcement discretion, but a clause that allows employers to not follow the standard for vague and arbitrary reasons must not be included in the revised final permanent standard for all.

Language addressing PPE shortages is no longer in line with federal authoritative bodies, weakens the protections in the standard, and must be removed.

Respirator and other PPE supplies, stockpiles, and production have increased and are now widely available, and future manufacturing capacity of these supplies is on an upward trajectory in July 2021, compared to 2020. The CDC, FDA and federal OSHA have removed all of their PPE crisis guidance and recommend all employers return to conventional PPE practices.[7]

However, Virginia’s proposed revisions to its final permanent standard includes two provisions that allow the use of face masks instead of appropriate respiratory protection due to PPE shortages. All employers should have provided the necessary PPE to workers and continue to do so when the hazard assessment determines respiratory protection is required. This provision must be completely eliminated from consideration.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99671
DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC’s updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask (“face covering” in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:
https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.
The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:
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.

Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021, which resulted in the CDC update:
Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).
The Dept. invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021. https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

99715 "Kate Baker Jodi Roth
Government Affairs
Virginia Retail Federation
Submitted Electronically
Virginia Department of Labor and Industry Virginia Retail Federation 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99715
Repeal Permanent Standard

On behalf of Virginia Retail Federation, representing retailers large and small across the Commonwealth, we would like to thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to amend the Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations").

For the last year and half, Virginia employers have committed themselves to protecting their employees, contractors, suppliers, customers, and communities from COVID-19 infection. They have done this by continually updating their COVID-19 protocols to ensure they are complying with the latest regulations and guidance imposed by federal, state, and local regulators. Despite the additional stress, costs and time related to compliance, business leaders and owners understood how critically important it was to do their part to reduce the risk of exposure and spread of the virus.

Virginia retailers need clarity and consistency in any regulatory program and the permanent standard is a static regulatory burden for a pandemic that is temporary, therefore Virginia Retail Federation respectfully asks the Board to repeal the permanent standard.

However, if the Board feels a standard should remain in effect as the pandemic winds down, we strongly encourage the Board to adopt Governor Northam's recommendation to amend Section 16VAC25-220-10.E to provide employers with safeguards should they comply with the most recent CDC guidance. We hope the Board will reconsider and approve the following language change.

E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.

By approving the Governor's recommendation to 16VAC25-220-10.E, you will enable employers to return their focus where it belongs — on best practices as they are recommended in real time by the CDC.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

99716 anonymous 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99716

Repeal 16VAC25-220 in its entirety Repeal Permanent Standard for Infectious Disease Prevention: 16VAC25-220 Standard in it's entirety. People and employers are capable of handling their own health matters.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

99717 anonymous 7/31/2021
https://townhall.virginia.gov/L/ViewComments.cfm?CommentID=99717

Repeal all mandates Repeal all these mandates which are targeted at dividing us and have absolutely no proof of keeping anyone safe. There are many scientific studies which are peer reviewed and prove that masks do not protect from viruses. The jab is experimental. We are not guinea pigs. The Constitution is still in effect and provides freedom in all situations. What we chose to do for our families is our choice not a government mandate. Repeal these mandates immediately!

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SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99520

SEE RESPONSE TO COMMENT 99671

10001 Phillip Boykin Virginia Beer Wholesalers Association 6/28/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/06/06-28-21-VBWA-COMMENTS.pdf

I am writing as the President and CEO of the Virginia Beer Wholesalers Association (VBWA) to respectfully comment on the Final Permanent Standard (FPS) and to request revocation.
The VBMA appreciates the tall task presented to the Safety and Health Codes Board lst year and the diffuculty in piecing together a regulation on such a complicated situation.
Since the being of the pandemic, VBMWA members and their employees have gone above and beyond the call to provide safe ad responsible distribution of beer to the Commonwealth's restaurants, grocery stores, and convenience stores. VBWA members have worked hard to monitor and comply with the myriad of guidance, rules, regulations and executive orders since the beginning of the pandemic. Now, thanks to the advances in scientific research on the COVID-19 vaccines and the hard work put in by Virginians to reduce and prevent the spread of COID-19, the threat of the virus is at an all-time low. The majority of VBWA member employees are now vaccinated against COVID-19. VBWA members and their employees continue to follow the revised and current CDC guidelines which have been relaxed significantly, especially for vaccinated individuals. Instances of community and wrokplace spread are minimal to non-existent in the Commonwealth. The FPS is inflexible and unable to account for the changing dynamic of the virus and the revised CDC recommendations that have issued. In his letter to SAfety and HEalth COdes Board Chairwoman Milagro Rodriguez on June 14, Governor Northam states similarly that the FPS "unfortunately does not evolve with the improving conditions across the Commonwealth." Accordingly, the VBWA respectfully requests the FPS be revoked. Thank you for your consideration and should you have any questions or if the VBWA may be of further assistance, please do not hesitate to contact me.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

10002 Keith Hare Virginia Healthcare Association and Virginia Center for Assisted Living (Keith Hare) 6/28/2021 "https://www.doli.virginia.gov/wp-content/uploads/2021/06/VHCA-VCAL-6.28.2021.pdf

DUPLICATE: https://www.doli.virginia.gov/wp-content/uploads/2021/07/Virginia-Health-Care-Association-and-Virginia-Center-for-Assisted-Living-VHCA-VCAL-.pdf

I am writing as President and CEO of the Virginia Health Care Association and Virginia Center for Assisted Living (VHCA-VCAL) to respectfully comment on the Final Permanent Standard (FPS) and to request revocation. VHCA-CAL represents over 95% of the nursing homes in the Commonwealth and nearly 100 assisted living facilities.

Since the beginning of the pandemic, nursing homes and assisted living facilities have been “ground zero” on the front lines of the pandemic. Our members and their staffs have answered the call and performed under the most extreme circumstances anyone could imagine. Now, thanks to the vaccines and the dedication of many Virginians to reduce and prevent community spread of COVID-19, the threat of the virus is at a reported all-time low.

Even though cases and community spread are down significantly right now, the health care community remains vigilant and vulnerable. Recognizing this, CDC revised guidelines and the OSHA ETS, soon to be in effect, mandate continued distancing, capacity, and PPE guidelines for health care settings. It is the CDC and OSHA guidance that should govern our responses.

The FPS is out of step with the changing dynamic of the virus and the revised CDC recommendations that have been issued. In his letter to Safety and Health Codes Board Chairwoman Milagro Rodriguez on June 14th, Governor Northam states similarly that the FPS “unfortunately does not evolve with the improving conditions across the Commonwealth.”

Accordingly, VHCA-VCAL respectfully requests the FPS be revoked. for your consideration and should you have any questions or if VHCA-VCAL may be of further assistance, please do not hesitate to contact me.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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SEE RESPONSE TO COMMENT 99671
As of August 18, 2021, healthcare worker cases in Virginia totaled 32,001, with 952 hospitalizations and 59 deaths. https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

10003 M. Clark Barrineau Medical Soceity of Virginia 6/28/2021
"https://www.doli.virginia.gov/wp-content/uploads/2021/06/MSV-DOLI-Comments-06.28.21.pdf

DUPLICATE: https://www.doli.virginia.gov/wp-content/uploads/2021/07/DM_LIBRARY-1190714-v1-MSV_Comments_on_FPS_Amendments.pdf

I am writing as Assistant Vice President of Government Affairs and Public Policy for the Medical Society of Virginia (MSV) to respectfully comment on the Final Permanent Standard (FPS) and to request revocation.

MSV is grateful for the many hours of work the Safety and Health Codes Board has devoted to this issue over last year.

Since the beginning of the outbreak, physicians have served on the front lines of the pandemic. MSV members and their staffs have answered the call to provide for testing, diagnosis, and treatment of COVID-19.

Even though cases and community spread are down significantly right now, the health care community remains vigilant. Recognizing this, CDC guidelines and the OSHA ETS, soon to be in effect, mandate continued distancing, capacity, and PPE guidelines for health care settings.

The FPS does not account for the changing dynamic of the virus and the revised CDC recommendations that have issued. In his letter to Safety and Health Codes Board Chairwoman Milagro Rodriguez on June 14th, Governor Northam states similarly that the FPS "unfortunately does not evolve with the improving conditions across the Commonwealth.

Accordingly, the MSV respectfully requests the FPS be revoked. Thank you for your consideration and should you have any questions or if MSV may be of further assistance, please do not hesitate to contact me.

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SEE RESPONSE TO COMMENT 99671

10004 Manuel Gago Legal Aid Justice Center 6/28/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/06/LAJC-comment-COVID-standards-6.29.2021.pdf

On behalf of our low-income Virginian clients, the Legal Aid Justice Center (LAJC) submits these comments in response to the Virginia Department of Labor and Industry/Safety and Health Codes Board related to the Final Permanent Standards(FPS), for Infectious Disease Prevention of the SARS-CoV-2 Virus that causes COVID-19, 16VAC25-22.

LAJC is a statewide organization that provides free legal representation to low-income people throughout the Commonwealth of Virginia. Through a combination of direct representation, organizing, education, and advocacy, we aim to address the root causes of injustice and poverty that our clients face. Among other things, LAJC provides representation to individuals in their efforts to maintain safe and healthy workplaces where their dignity is recognized and upheld.

Virginia was the first in the nation to adopt these standards, and they helped to create similar regulations around the US, and even across the globe. These standards have helped to protect workers and keep Virginia safe and productive. As we enter into a new phase, we need to have thoughtful consideration of the way we are going back to a new normal that keeps us safe.

COVID-19 has already killed more than 600,000 Americans, but Virginia's standards have helped keep Virginians safe. We need to ask ourselves, what is the economic impact of a sick worker or the death of a family member who contracted COVID-19 in the workplace? It's priceless; the value of a worker's life must always come first.

The pandemic still ongoing, and things have not yet stabilized. For instance, the season for farmworkers in Virginia is about to begin with hundreds of workers coming from abroad every week. These workers may be coming from areas where vaccinations are not as widely available as Virginia and areas where the new, and more deadly, variants of COVID-19 are present. Additionally, many children are not yet eligible for vaccination and may be at risk of contracting COVID-19 from their parents. What is more, we do not yet know much about the new variants, included the Delta variant, and the impact they will have. Finally, many immunocompromised persons are not as protected by the vaccine.

This standard has been in effect for almost year with business not suffering negative impacts. It is better to be safe than sorry, especially when the lives of thousands of essential workers and their families are at risk. Again, we at Legal Aid Justice Center ask you to extend the Final Permanent Standards for Prevention of COVID-19.

SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99671

10005 Brett Vassey Virginia Manufacturer's Association 6/28/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/06/VMA-6.29.2021.pdf The VMA is pleased that the permanent regulation is being modified but still thinks it is overly burdensome, has limited efficacy beyond CDC & OSHA guidance, and should be repealed. Perpetuating a flawed permanent standard by continually updating FAQs (although appreciated), and convening regularly to amend it is not sustainable.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

10006 Jerry Sheets Utility Trailer Mfg 7/4/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/07/Comment-by-Jerry-Sheets-of-Utility-Trailer-Manufacturing.pdf

I'm reaching out to you on behalf of Utility Trailer Mfg in Atkins, VA. With over 1,000 employees at our location, we are one of the largest private employers in Southwest Virginia. Since the very beginning of the pandemic, Utility has been steadfast in our commitment to follow each guideline established by the CDC as well as Virginia's Final Permanent Standard. Respectfully now though, we find ourselves feeling the proposed FPS is too restrictive on employers as well as employees. Utility would like to see the FPS revoked so that proper changes can be made in workplace protocols as conditions surrounding COVID-19 continue to improve in our region. But if revocation of the FPS proves unlikely, we urge the Board to at least reconsider its amendments and remove the requirement for daily prescreening of nonvaccinated employees. Employees are longing for anything that might be a sign of returning to a more normal and familiar workplace life. Life outside the workplace in Virginia is quickly returning to a sense of normalcy since the governor ended the state of emergency. You can feel the excitement everywhere you go. Having the workplace remain so rigid in its COVID-19 restrictions serves to exacerbate frustrations and anxieties people are feeling at work. With each passing week revealing less and less virus spread across Virginia, the value of prescreening comes into question in comparison to the frustrations employees feel about its continuing to be a requirement. While having differing protocols in place for the vaccinated and the non-vaccinated employee might serve to motivate a person to get the vaccine, we would be remised not to recognize that it also creates an environment where tensions and divisiveness grows within the workplace. That is not an environment conducive to successful operations or peacefulness in the workplace, Utility Trailer respectfully asks that the Board please consider removing the requirement for daily prescreening of non-vaccinated employees.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

10007 Joseph Bloom 7/26/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/07/Forwarded-message-Comments-by-Joe-Bloom.pdf

My name is Joseph Bloom. I am a resident of Frederick County, Virginia and a constituent of House of Delegates District 33 and State Senate District 27.

I am writing to voice my strong objection to provisions of the Proposed Amendments to the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220

Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220 which establish differential standards of workplace treatment for employees who are fully vaccinated for COVID-19 and those who are not.

These requirements, while presumably intended to provide a greater level of protection from exposure to unvaccinated individuals, impose a de facto requirement upon these individuals to divulge private health information. This is a patent erosion of an individual's right to privacy and the right of patients to accept or decline medical intervention freely and without inducement or coercion. The establishment of standards that in spirit and in practice serve to segregate employees based on vaccination status obliterates the crucial right of Virginians to choose when, to whom, and to what extent they share personal health information. My view is that these provisions in the proposed Standard are a travesty against the commitment to individual liberties that is paramount to Virginia values, and will be injurious to the social cohesion and civic

harmony of our communities if adopted.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

10008 Vicky Shoupe 7/24/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/07/Forwarded-message-Comments-by-Vicky-Shoupe.pdf "I reject all unnecessary restrictions on Virginia businesses and contend that all practices should return to normal prior to COVID restrictions. Our state business owners have suffered enough loss by this administrations onerous administrative burdens that neither helped contain the transmission of COVID nor prevented the disease.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

10009 Mark A. Mix 7/26/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/07/NRWC-Committee-Comments-on-Final-Permanent-Standard-Proposed-Amendments.pdf

The National Right to Work Committee offers these comments to the proposed amendments to the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16 VAC25-220, as Adopted by the Virginia Safety and Health Codes Board on June 29, 2021 ("FPS"). We join other commenters in asking that the FPS be revoked.

The FPS arose out of a government declared emergency involving a virus that health care providers did not yet know how to treat. The situation thankfully is quite different today. With developing knowledge, expertise and resources and with a large and growing portion of the population vaccinated or having immunity following infection and recovery, emergency measures are no longer necessary. Indeed, the Governor allowed his emergency declaration to expire on June 30, 2021, removing even that "emergency" foundation from the FPS. Should the FPS amendments still proceed despite the lack of necessity, the Committee objects to the untenable position those proposed amenfments place on employees and employers. The Committee has always operated with the belief that its employees' health affairs are their personal business. While employees sometimes voluntarily share that information, especially if it explains a performance issue or constitutes a disability needing an accommodation, we do not pry and our employees are not required to tell. We respect their personal privacy. In stark contract, the FPS dos not. ALthough the FPS amendmentd do not explicitly require an employer to document whether employees are fully vaccinated, they do require employers to take multiple preventive actions on that very basis, thereby impelling employers to force employees to publicly disclose their vaccination status - making employers do what DOLI does not mandate. The result forces employees to publicly disclose their vaccination status - regardless of the employee's personal basis for that status - not only to their employers but also to their fellow employees by wearing a face covering, maintaining physical distancing, etc. - this despite the fact they prefer to keep vaccination status private. Government regulations should not force employers to discriminate against and divide their employees in such a manner and should not force employees to publicly self-label themselves, especiall when the labeling conerns private health information. Doing so fosters an unhealthy workplace environment for all involved. Finally, we join with those commenters who have said, "[t]he FPS is out of step with the changing dynamic of the virus and the revised CDC recommendations that have been issues." (Letters of the Medical Society of Virginina and the Virginia Health Care Association and Virginia Center for Assisted Living.) Indeed, the amendments ignore the impact of employees who have immunity as a result of having contracted and recovered from COVID-19, which is just one of many developing research areas. Governor Northam, in a jun 14th letter to the Safety and Health Codes Board Chairwoman Milagro Rodriguez, "states similarly that the FPS 'unfortunately does not evolve with the improving conditions across the Commonwealth.'" (Letters.) Rather than continuing out of step, we urge DOLI to rescind the FPS. As a society, we need to revert to leaving health conditions, prevention and treatment - includinf an infectious dosease like COVID-19 that is a constantly evolving situation - as private matters between individual employees and their physicians. Employers and employees are quite capable of following the developing and changing guidance from

the CDC and the medical community, which surely the Virginia Department of Labor and Industry likewise supports.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671
SEE RESPONSE TO COMMENT 99681

10010 Sean T. Connaughton Virginia Hospital and Healthcare Association 7/29/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/07/VHHA-Comment-Letter-DOLI-Revised-COVID-19-Regulations-Comment-Letter-7.29.21-1.pdf

On behalf of the Virginia Hospital & Healthcare Association's ("VHHA") 26 member health systems, with more than 125,000 employees, thank you for the opportunity to comment on the Department of Labor and Industry's (the "Department") proposed amendments to the Final Standard regarding Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 (hereafter referred to as the "Amended Regulations"). Since March 2020, Virginia's hospitals and health systems have been on the frontline treating patients infected with the COVID-19 virus and playing a leading role in the Commonwealth's response to the pandemic. Throughout these efforts, Virginia hospitals have remained steadfastly committed to our top priority – the safety of our patients, visitors, employees, and the communities we serve.

We continue to question whether adopting a permanent regulation specific to COVID-19 is necessary or appropriate. The Commonwealth will undoubtedly face other pandemics or public health threats from communicable disease that involve different safety precautions than those indicated for COVID-19. Accordingly, we believe that a more general standard that sets forth a high-level framework rather than disease-specific criteria should be considered for permanent regulations. For example, the permanent regulations could be simplified in a manner that recognizes the threat posed by COVID-19, but more generally provides a basic series of steps employers would undertake for any pandemic or communicable disease of public health threat (e.g., risk assessment, environmental and administrative controls, infection control plans). That is, the regulations need not be disease specific and could simply require best practices for disease infection and control that apply generally.

Additionally, regardless of whether a permanent standard is specific to COVID-19 or communicable disease more generally, its applicability and enforcement should be tied to an executive order or an order of public health emergency declaring a state of emergency due to a communicable disease of public health threat. Similarly, in the event of a few cases or a localized outbreak of a highly contagious disease that does not amount to public health emergency on a statewide basis, the regulations should not be applicable to an employer located in an area where there are no cases and where there is not a recognized public health threat in the region.

Any regulations such as these should be limited in duration. As proposed, the Amended Regulations would remain in effect in perpetuity with no clear objective or measures by which they will be rescinded or revoked. The lack of a clear objective or measure for rescission of the Amended Regulations would lead to protracted uncertainty for employers making good faith efforts to comply with the Amended

Regulations despite a foreseeable future with zero or minimal positive COVID-19 cases in the Commonwealth or only localized outbreaks.

While we applaud the Amended Regulations' deference to and conformity with the Occupational Safety and Health Administration's COVID-19 Emergency Temporary Standard (29 C.F.R. 1910.502 et seq.) (the "OSHA ETS"), we have concerns about the application of two different sets of COVID-19 workplace regulations to hospitals and health systems. The Amended Regulations at 16VAC25-220-10.B.1-4 provide that applications of nearly all of the Amended Regulations' requirements are suspended "where any employee provides healthcare services or healthcare support services" absent an intervening suspension, stay, invalidation by a state or federal court, revocation, repeal, declaration of unenforceability, or expiration of the OSHA ETS. 16VAC25-220-30 defines "healthcare support services" to mean "services that facilitate the provisions of healthcare services. Healthcare support services include [but are not limited to] patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/processing services." 16VAC25-220-50.A.6.f states that "[t]his section does not apply to the following… healthcare support services not performed in a healthcare setting (.e.g., off-site laundry, off-site medical billing)…"

Presumably, the intent of the Amended Regulations was to have the Amended Regulations apply to "off-site" healthcare support services and the OSHA ETS apply to "on-site" healthcare support services. This result would require hospitals, health systems, and other healthcare employers to implement two different regulatory schemes by attempting to determine what it means to be an "off-site" healthcare support service. Furthermore, employees providing "offsite" services who enter a facility that would be considered "on-site" would be required to follow different procedures than in their usual workplace and would also be subject to the training requirements within the Amended Regulations and the OSHA ETS – among other duplicative or conflicting requirements making implementation of the Amended Regulations onerous and complex.

Similar to "off-site" healthcare support services, employees in "well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present" (16VAC25-220-50.A.6.d.) are not subject to 16VAC25-220.50. As a result, employees within the same facility could find themselves subject to the Amended Regulations in one workspace but would be subject to the OSHA ETS by simply walking to another section of the same facility.

We respectfully request that the Amended Regulations eliminate the confusion this would cause employers and employees by amending 16VAC25-220-10.B.1-3 and 16VAC25-220-50.A.1-3. to state that the Amended Regulations do not apply to hospitals or health systems rather than adopting the OSHA ETS definitions of "healthcare services" and "healthcare support services."

This would enable hospitals and health systems to develop employer-wide policies that are consistent among its work force and in compliance with the OSHA ETS in certain settings while adhering to the obligations placed on employers by the General Duty Clause of the OSH Act (29 U.S.C. § 654, 5(a)1) in settings not covered by the OSHA ETS. Hospital and health system employees would also have clear standards by which they are required to operate regardless of whether they happen to be "on-site," "off-site," or in a "well-defined hospital ambulatory care setting where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings" throughout the workday.

In addition to these overarching concerns, there are several technical issues with the regulations that we have previously commented on and that should be considered in this and any future rulemaking:

As noted in our public comment on the permanent regulations, infection prevention and control is a daily, ongoing focus within Virginia hospitals and health systems. Operating under the oversight of the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Virginia Department of Health (VDH), and various other accreditation and regulatory authorities, hospitals and our ancillary facilities are required to consistently demonstrate that their patients and staff receive and provide care in a safe environment. This includes development and implementation of comprehensive infection control plans, quality improvement programs, managing supply chain, training employees and caregivers, ensuring employees have the resources they need, planning for future health emergencies, and working with congregate care settings to institute strong infection control practices, among other activities.

In other words, infection prevention and control and ensuring the safety of our patients and employees are not a new focus for Virginia hospitals and health systems. They are ingrained components of our daily operations. Imposing new and separate regulatory requirements, many of which duplicate the policies and protocols already in place within our facilities, will unnecessarily result in burdensome new compliance costs without meaningfully improving our ongoing efforts to protect our patients and employees.

Consequently, we recommend that Subsection E of § 10 – which states that an employer in compliance with CDC publications regarding COVID-19 will be considered in compliance with the standard/regulation – be amended to acknowledge these requirements and explicitly state that hospitals, health systems, and other facilities under their control that are in compliance with the broader industry standards set forth by state and federal health care regulatory entities are deemed in compliance with the permanent regulation and not subject to enforcement actions for failure to comply with any specific requirement under the permanent regulation that is already addressed in these broader industry standards.

Subsection B.5 of § 40 prohibits employers from permitting known or suspected COVID19 employees or others to report to or be allowed to remain at work. While the intent of this prohibition is clear, as a practical matter it is problematic to require ongoing monitoring of all employees who may be experiencing symptoms that are not visible without examination or inquiry. Furthermore, it is difficult or impossible to enforce where the employee or other person does not physically report to a facility or building under the surveillance and control of the employer as distinct from a teleworking arrangement. To address this, the prohibition could be limited to not “knowingly” permitting the employee to report to or be allowed to remain at work. Alternatively, the prohibition could be limited to those employees who report COVID-19 to the employer under Subsection B.3 of § 40.

The requirement in Subsection B.7 of § 40 is unnecessary and inappropriate to impose on employers. Those subcontractors and companies that provide contract or temporary employees are presumably subject to these regulations by virtue of being an employer in their own right and an upstream employer should not bear this burden. Furthermore, such encouragement is more appropriate coming from the Department.

Subsection B.7. of § 40 requires employers to notify their employees within 24 hours if an employee, subcontractor, contractor, temporary employee, or other person who was present at the place of employment within the previous 14 days tests positive for COVID19. This requirement poses a challenge

for hospitals. Given the inherently higher risk of exposure in the health care setting, notifying every employee of a hospital or health system each time an employee tests positive will require an unreasonable level of ongoing notification. Even assuming a blast e-mail or similar broad communication meets the requirement, notifying every employee – clinical or non-clinical – upon a positive test of essentially anyone entering the facility within "2 days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test)" is unrealistic and could have Health Insurance Portability and Accountability Act (HIPAA) privacy implications.

In addition to our previous comments, several of the changes to the permanent regulations present new technical issues that we believe should be addressed in this and any future rulemakings:

Subsection C. of § 40 requires employers to "immediately remove" employees from a worksite if the employee has suspected or confirmed to have COVID-19. "Immediate removal" of an employee from a worksite may not be feasible in some circumstances. To address this issue, removal could be "immediately or, if circumstances present a danger to the employee or others, as soon as practicable."

Subsection C.1. of § 50 require employers, to the extent feasible, to prescreen or survey each covered employee to verify the employee does not have signs or symptoms of COVID-19 prior to the commencement of each work shift. However, the Amended Regulations do not clearly define what it means to "prescreen or survey" each employee.

The OSHA ETS resolves this ambiguity by defining "screen" to mean "asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19." (29 C.F.R. 1910(b)) The OSHA ETS further addresses patient screening and management (29 C.F.R. 1910(d)) as well as employee screening (29 C.F.R. 1910(l)). Therefore, we recommend mirroring these sections of the OSHA ETS in the Amended Regulations to avoid any confusion regarding the required processes. Similarly, this recommendation would resolve the ambiguous use of "screen" in 16VAC25-220-50.A.6.c-e.

In closing, while COVID-19 may be the first pandemic in recent years to broadly impact the Commonwealth, Virginia's hospitals and health systems deal with issues surrounding infection prevention and control, patient and workforce safety, and employee wellness on a daily basis. We have long-established policies and protocols governing these aspects of our operations and work closely with a variety of regulatory authorities to promote a safe care environment for our patients and our employees. Our utmost priority always has been and always will be the safety of our patients, visitors, employees, and the communities we serve.

The potential confusion surrounding whether the Amended Regulations or OSHA ETS apply to a workplace – or even to specific areas within a facility – as well as additional and duplicative requirements are unnecessary for hospitals and health systems and will have numerous burdensome and costly implications for them. Furthermore, the permanent regulations contain ambiguities that open hospitals and health systems to an uncertain and/or inconsistent interpretations by Department officials despite good faith efforts of hospitals and health systems to question whether the permanent regulation should be specific to COVID-19 and believe that any such regulation should only be in effect for the duration of the public health emergency or, at a minimum, contain an objective standard by which any such regulation would no longer be in effect.

Thank you again for the opportunity to comment on the permanent regulation. Please do not hesitate to contact Brent Rawlings (brawlings@vhha.com, 804-965-1228) or me at your convenience if we can provide any additional information regarding our suggested modifications.

SEE RESPONSE TO COMMENT 99681
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 10013
SEE RESPONSE TO COMMENT 99671

10011 Randy F. Jouben Fairfax County Department of Finance, Risk Management Division 7/27/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/07/Matthew-Larkin.pdf

Comments for the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19. The Emergency Temporary standard and the Final Permanent Standard, since their inception,

have lagged behind the CDC guidance issued. As the guidance changed employers across the state have had to visit the FAQ page on a daily basis to find the VOSH interpretations of the standard as it deals with the workplace. Not all questions sent to DOLI addressed the workplace concerns of employers and left them to make determinations based on their interpretation of items contained within it. Some definitions that were critical to notification of cases was not addressed in the FAQS and answers from VOSH reps was very limited. A common reply to questions was " … seek the consultation services offered by VOSH" (paraphrased). This is not applicable to large organizations, using VOSH consultation services is an option and a choice for employers but should not be the only method VOSH uses to address/respond to questions that address inadequacies/difficult determinations inherit to the standard.

In the revised Final Permanent and amendments Section 16VAC25-220-40, Mandatory requirements for all employers, Paragraph B(1) states that employers can rely on an employee's representation of being fully vaccinated and that there is nothing that prohibits the employer from asking for proof of vaccination. This begs the question: How can VOSH state that an employer can rely on the employee's representation of vaccination status and then within the same standard stress instances where the employer can be cited if an employee is not following the standards for those that are unvaccinated. For fines that range from $13K to $130K, reliance on an employee's word is not acceptable and, in our opinion, is not value-added to this standard.

In the SHCB meeting Mr. Withrow alluded to the fact that the standard issued by VOSH could be/should be used as a tool to get more people vaccinated. We disagree with this approach and do not believe the standard should be used to motivate employees to get vaccinated (although we agree with the premise of all employees getting vaccinated). Regardless, this is an individual's personal decision. We do not believe creating harsher standards and requirements for those that are not vaccinated will be what drives people to get vaccinated. Education on the SARS-CoV-2 disease and vaccines and a final full approval from the FDA will help to drive the number of vaccinated individuals, not a VOSH Standard. In Virginia the percentage of individuals that are vaccinated is over 70% so the state should be able to follow CDC/OSHA recommended guidance for employers.

If the VOSH Standard places the emphasis on relying on the employee's representation of vaccination status as acceptable, the standard must contain verbiage that emphatically states that and should also

state, in such instances, there would be no citation issued to the employer if the employee has misrepresented themselves.

If VOSH wants to set the bar and make a name for a higher standard then put some expectation on the employee, not just the employers. There are many requirements for the employer to follow but the standard is lacking strong verbiage on Employee responsibilities. There should be an equal responsibility for the employee.

Due to personal, individual interpretations and rights, asking employers to verify vaccination status potentially puts employers, supervisors, and coworkers at risk of unnecessary confrontation and possibly workplace violence due to the angst and high stress of this specific issue (people thinking individuals believe their vaccination status is protected HIPAA information, others are not entitled to ask about their status, etc.). Also stating that the employer can require employees to get vaccinated is also crossing the boundary of what VOSH should be expecting an employer to do. The standard does not say that specifically but during the SHCB meeting that perspective was expressed by Mr. Withrow as well as other members of the SHCB.

In addition, the revised amended standard includes the third change to reporting cases to VDH and to VOSH. This has led to difficulties with tying to provide consistent compliance, communication, training, and direction to a 16,000+ employee base. We recommend going forward that VOSH select, and remain consistent, with what they determine to be reportable cases.

It would benefit all employers if there was only one reporting requirement. VOSH and VDH should combine their web resources and make one consolidated portal to report the cases. Having two different forms, one with a report number and one without, is too cumbersome and certainly not intuitive or user friendly.

It is our belief that the Virginia Final Permanent Standard be revoked and that any further guidance and interpretation on SARS-CoV-2 or other infectious diseases come from the CDC and OSHA.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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VOSH Consultation Services are available to all State and Local Government employers, regardless of size. In addition, VOSH Consultations Services have three Consultant positions that can provide services to private sector employers, regardless of size.

With regard to the commenter's concern about employees providing false information concerning vaccination status, the “Employee Misconduct” affirmative defense to VOSH citations and penalties is codified in VOSH regulation 16 VAC 25-60-260.B and C:

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.

C. For the purposes of subsection B of this section only, the term ""employee"" shall not include any officer, management official, or supervisor having direction, management control, or custody of any place of employment that was the subject of the violative condition cited.

https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section260

With regard to the commenter's concerns about asking employees their vaccination status, the Department has issued FAQs on what employers can and cannot do under federal and state regulations:

https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

§20, FAQ 21. CAN MY EMPLOYER LEGALLY ASK IF I RECEIVED THE COVID-19 VACCINE AND AM FULLY VACCINATED?

The Department is not aware of any Virginia law, standard or regulation that prohibits employers from asking employees if they have received the COVID-19 vaccine and are fully vaccinated, and if so, requiring employees to show proof of full vaccination.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) applies to “covered entities” and “business associates,” and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

EEOC

The Equal Employment Opportunity Commission (EEOC) indicates that employers may require employees to show proof of full vaccination, but notes certain issues associated with such a mandate:

https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

K.3. Is asking or requiring an employee to show proof of receipt of a COVID-19 vaccination a disability-related inquiry? (December 16, 2020)

No. There are many reasons that may explain why an employee has not been vaccinated, which may or may not be disability-related. Simply requesting proof of receipt of a COVID-19 vaccination is not likely to elicit information about a disability and, therefore, is not a disability-related inquiry. However, subsequent employer questions, such as asking why an individual did not receive a vaccination, may elicit information about a disability and would be subject to the pertinent ADA standard that they be “job-related and consistent with business necessity.” If an employer requires employees to provide proof that they have received a COVID-19 vaccination from a pharmacy or their own health care

provider, the employer may want to warn the employee not to provide any medical information as part of the proof in order to avoid implicating the ADA.

10012 Beck Stanley Virginia Agribusiness Council 7/30/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/07/VAC-Comments-on-Proposed-Changes-to-PS-COVID-7-30-21.pdf

I am writing you today on behalf of the Virginia Agribusiness Council to provide comments regarding the proposed changes to the Permanent Standard for COVID-19 mitigation. While we acknowledge the proposed revisions bring Virginia more closely aligned with the recommended guidance from the CDC, we still believe a static, one-size fits all standard does not offer the flexibility of changing to the existing science of the pandemic. We further believe the regulation is not necessary and puts our members in an impossible compliance position as conditions continue to change.

However, if the Board moves forward with the proposed revisions, we ask that the Board remove the qualifier "equivalent or greater than" located in Section 10.E. Council members were put in an impossible compliance situation this Spring in which the CDC changed its recommendation regarding vaccinated individuals. The Governor's announcement of a changed Executive Order and a static Permanent Standard created an incredibly confusing regulatory structure. Should a similar situation arise in the future, the regulation must be as clear as possible that if our members are following the most up to date science as stated by the CDC, they are in compliance with the standard. Removing the qualifying language would remove this confusion and create an easier standard with which to comply.

A further suggested edit by the Council would be to strike Section F.4 from the16VAC25-220-40, the requirements for mandatory for all employers. Section F.5 requires employers to provide Personal Protective Equipment up to the standards of their industry for unvaccinated employees traveling in the same vehicle, which is the standard currently. However, F.4 requires employees traveling in the same vehicle to a higher standard, such as N95 respirators. The inclusion of both sections is confusing and could lead employers to be required to provide expensive and unnecessary protection. Multiple employees riding in a vehicle should be subject to the PPE requirements of that given field. Section F.4 is unnecessary and should be removed.

We applaud the administration for removing the risk assessments for each employee and job status. However, the Council is concerned changing the former "medium" section of the Permanent Standard to "higher risk employer" will lead to confusion. We understand that terminology is referenced in the federal employer guidance issued by OSHA. However, given Virginia's Emergency Temporary Standard and Permanent Standard, Virginia's employers are already used to the terminology of "low", "medium", "high" and "very high" risk categories.

The section could lead to employer confusion, especially small businesses that do not have regulatory compliance officers, and mistakenly believe they do not need to comply. We recommend changing the section to "unavoidable areas of employment with prolonged close contact."

The industry has already invested millions of dollars and implemented unprecedented safety measures to protect their workforce and maintain the food supply. More importantly, our members have been robust in their support for vaccinations. We continue to believe that further vaccinations efforts will continue to change the science behind mitigation of COVID-19. It is therefore imperative that our

industry has a regulatory structure able to adapt to the changing science. As always, we are grateful for this opportunity to comment and would be happy to answer any questions the Department has.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

10013 Hobey Bauhan Virginia Poultry Federation 7/30/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/07/Virginia-Poultry-Federation-Comments-on-Amendments-to-Permanent-COVID-19-Standard-July-2021.pdf "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. 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) last summer, 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 2020, 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 and, subsequently, the Permanent Standard for COVID for Infectious Disease Prevention.

As you know, VPF previously urged the Virginia Department of Labor and Industry (DOLI) not to promulgate these standards, setting forth our reasons 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 COVID19, 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. With the proliferation of vaccinations, reduced rates of infections, and termination of the state of emergency, we believe that DOLI and its Safety and Health Codes Board should eliminate, rather than amend, the permanent standard.

Alternatively, DOLI and the Board should consider eliminating everything in the existing permanent standard except a simple requirement that employers follow CDC guidelines. At the very least, it is paramount that any standard retained should contain the substitute language for 16VAC25-220-10.E concerning CDC compliance as requested by the Governor in his July 1, 2021 Review of the Proposed Amendments to the Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19, §16 VAC 25-220, Adopted by the Virginia Safety and Health Codes Board (Board) on June 29, 2021.

Additionally, at 16VAC25-220-60, the Board proposes to replace the section for existing requirements for "medium" risk workplaces with the following titled section: "Requirements for higher-risk workplaces." It lists poultry plants among those workplaces covered under the new section. In the existing standard, poultry plants are considered "medium risk." We are concerned about the negative perception and potential confusion your proposal creates by reclassifying sectors currently designated "medium" risk as "higher-risk." In the case of poultry plants, the data on COVID cases among workers would suggest that these worksites now present a fairly low risk. We request that you label this section something other than "higher-risk." We would suggest something like, "Workplaces of unavoidable close contact."

Please let me know if you have any questions or would like any additional information. Thank you for your consideration of our views.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
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Limitations on the use of the general duty clause.

Va. Code §40.1-51(a), otherwise known as the "general duty clause" (the Virginia equivalent to §5(a)(1) 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 standards, 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 (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. 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.

10014 P. Dale Bennett Virginia Trucking Association 7/30/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/08/COVID-19-Amendments-Comments-Va-Trucking-Assn.pdf

Thank you for the opportunity to comment on the Proposed Amendments to the Final Permanent Standard for Infectious Disease Prevention of the 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, including vaccines, test kits and medical supplies, to sustain the population and the economy.

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.

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 a rigid and burdensome regulation such as the current Emergency Temporary Standard (ETS) that is being considered as a permanent standard.

The Permanent Standard

We believe that the current permanent standard is a static regulatory approach to a pandemic that is temporary and ever-changing as we have this past week with the CDC's latest changes in their guidance in response the Delta variant. Therefore we believe that the Board should act to repeal the permanent standard.

However, if the Board feels the permanent standard should remain in effect, we strongly urge the Board to adopt Governor Northam's recommendation to amend Section 16VAC25-220-10.E to provide employers with safeguards should they comply with the most recent CDC guidance. We hope the Board will reconsider their earlier rejection of the Governor's recommendation and approve the following language change.

E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of this standard. An employer's actual compliance with a recommendation contained in CDC guidelines, whether mandatory or nonmandatory, 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.

By approving the Governor's recommendation to 16VAC25-220-10.E, the Board will enable employers to focus on and follow the best practices and guidance - and subsequent changes thereto - issued by the CDC as it reacts to ever changing science regarding spread of the virus. For an interstate industry like trucking, it is even more important to have one set of regulations and guidance to simplify compliance and promote uniform understanding of the requirements.

Multiple Employees Occupying the Same Work Vehicle Although support outright repeal of the permanent standard, or at least approval of the Governor's recommendation, we greatly appreciate the proposed new paragraph 16VAC25-220-40.F.7. We strongly support this amendment that follows NIOSH/CDC guidelines regarding respiratory protection/face coverings for commercial drivers who live in the same household and are the only persons in the vehicle, while occupying the same work vehicle.

However, we do have concerns about Section 16VAC25-220-40.F.4 that requires employers to provide unvaccinated employee(s) occupying a work vehicle with another employee(s) or person(s) with "respiratory protection, such as an N95 filtering face piece respirator." To the best of our knowledge this is a more prescriptive requirement than the federal or any other state government for non-medical and non-first responder employers and employees. For example, the CDC requires face masks but has not seen the need to prescribe N95 masks to protect persons on public transportation or at transportation hubs throughout the country.

Additionally, with the spread of the Delta variant and potential for an increase in hospitalizations, the demand for N95 masks will increase, which is likely to decrease availability and increases costs for businesses to comply with 16VAC25-220-40.F.4.

We believe that 16VAC25-220-40.F.4 is overly prescriptive and costly and should be deleted from the permanent standard. Section 16VAC25-220-40.F.5 would continue to provide protection for employees by requiring employers to comply with respiratory protection and personal protective equipment standards applicable to the employer's industry.

Conclusion. Thank you for your consideration of our comments and please contact me if you need any additional information or have any questions regarding these comments or how trucking industry is working to protect the health and safety of its workers during the pandemic.

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99671

10015 Amy S. Sebring William and Mary University 7/31/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/08/WM-Comments-on-DOLI-FPS-07-31-21.pdf

I am writing as Chief Operating Officer and COVID Director for William & Mary (W&M) to respectfully comment on the Final Permanent Standard (FPS) for Infectious Disease Prevention of the SARS-CoV02 that causes COVID-19, § 16 VAC 25-220, as adopted on June 29, 2021. W&M is grateful for the many hours of work the Safety and Health Codes Board has devoted to this issue over the last year and takes seriously the responsibility of ensuring the safety and wellbeing of our faculty, staff, students, and community.

Since March 2020, W&M has implemented policies and procedures to protect our employees and students which adhere to the guidance from the CDC, VDH, Governor Northam, and others. We are committed to the health and safety of both our university community and our broader community.

Given the evolving landscape, we urge the adoption of Governor Northam's proposed substitute language for 16VAC25-220-10.E which would allow us to use CDC guidelines in concert with the FPS standards to be in compliance with the Department's regulations as the CDC guidance continues to evolve.

Thank you for your consideration

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

10016 Julie Zobel George Mason University 7/31/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/08/Mason-comments-to-FPS_7.31.21.pdf

I am writing as Associate Vice President and COVID Director for George Mason University (Mason) to respectfully comment on the Final Permanent Standard (FPS) for Infectious Disease Prevention of the

SARS-CoV02 that causes COVID-19, § 16 VAC 25-220, as adopted on June 29, 2021. Mason is grateful for the many hours of work the Safety and Health Codes Board has devoted to this issue over the last year and takes seriously the responsibility of ensuring the safety and wellbeing of our faculty, staff, students, and community.

Since March 2020, Mason has implemented policies and procedures to protect our community (employees, students, contractors, visitors, and the surrounding community) which adhere to the guidance from the CDC, VDH, our local health departments, Governor Northam, and others. We are committed to the health and safety of our community.

We urge the adoption of Governor Northam's proposed substitute language for 16VAC25-220-10.E which would allow institutions of higher education to follow CDC guidelines in concert with the FPS standards to be in compliance with the Department's regulations as the CDC guidance continues to evolve.

Thank you for your consideration.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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SEE RESPONSE TO COMMENT 99671

10017 Jennifer Latour Christopher Newport University 7/31/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/08/CNU-Comments-on-FPS.pdf

Thank you for the opportunity to comment on the Final Permanent Standard (FPS) for Infectious Disease Prevention of the SARS-CoV02 that causes COVID-19, § 16 VAC 25-220, as adopted on June 29, 2021. Christopher Newport University appreciates the careful consideration and attention the Safety and Health Codes Board has given to this issue over the last 18 months. Our university has implemented many policies and procedures to protect our students and employees that are in line with guidance from the CDC, VDH, and Governor Northam.

Christopher Newport respectfully requests the Board adopt Governor Northam's proposed substitute language for 16VAC25-220-10.E which would allow us to use CDC guidelines in concert with the FPS standards to be in compliance with the Department's regulations as the CDC guidance continues to evolve.

SEE RESPONSE TO COMMENT 99342
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SEE RESPONSE TO COMMENT 99671

10018 Colette Sheehy University of Virginia 7/31/2021 https://www.doli.virginia.gov/wp-content/uploads/2021/08/UVA.pdf

We appreciate the opportunity to comment on the Final Permanent Standard (FPS) for Infectious

Disease Prevention of the SARS-CoV02 that causes COVID-19, § 16 VAC 25-220, as adopted on

June 29, 2021. University of Virginia (UVA) takes seriouslyt the responsibility of ensuring the safety and well being of our faculty, staff, students, and our entire community. Over the last 18 months, UVA and other institutions of higher education have implemented many policies and procedures designed to protect both employees and students, adhering to the guidance from the CDC, VDH, and Governor Northam, and others, and we remain steadfast in our commitment to the health and safety of all in our community and across the Commonwealth.

Given the rapid evolving landscape, we urge adoption of Governor Northam's proposed substitute language for 16VAC25-220-10.E which would provide that employers in compliance with CDC guidelines would be considered in compliance with the FPS and would allow CDC guidelines to be the guiding standard for workplace safety in the Commonwealth. Additionally, the CDC guidelines specific to institutions of higher education take into account the different nature of our ""business"" and are intended to protect our communities and mitigate spread of COVID on our campuses.

Thank you for your consideration.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
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SEE RESPONSE TO COMMENT 99671

10019 Wayne Pryor Virginia Farm Bureau Federation 7/31/2021
https://www.doli.virginia.gov/wp-content/uploads/2021/08/Comments-of-the-Virginia-Farm-Bureau-Federation.pdf

The Virginia Farm Bureau Federation (VFBF) appreciates the opportunity to provide comments on the Proposed Amendments to 16VAC25-220, Permanent Standard for Infectious Disease Prevention of the SARS-CoV2 Virus That Causes COVID-19. Our organization previously commented on the Standard, and we remain opposed to the permanent regulation that has adopted a static standard for an evolving pandemic.

The health and safety of our 35,000 farm family members continues to be our top priority today, as it was at the start of the pandemic. As essential workers, Virginia's farmers and their employees have gone above and beyond their charge to maintain a safe and abundant food supply, while complying and monitoring the complex and ever-changing guidance, rules, regulations, and executive orders since the beginning of the pandemic.

On at least three previous occasions, VFBF outlined our reasons for opposing the Standard in detailed comments, and proposed revisions that would make the Standard 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.

It is our hope that the board will consider repealing the permanent standard, and will instead rely on OSHA and CDC guidelines, and place trust in their resources, research, and flexible nature. We have seen

three “waves” of COVID since the start of the pandemic. We have seen global Alpha, Beta, Gamma, and Delta variants of concern. We know that this virus can move and evolve faster than this regulatory process, so we must stop placing permanent standards in place to respond to this ever-changing pandemic.

Thank you for your consideration of these comments.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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20001 Hobey Bauhan Virginia Poultry Federation 8/5/2021
Virginia Poultry Federation Testimony before the Virginia Safety and Health Codes Board, August 5, 2021

Good morning. I am Hobey Bauhan, President of Virginia Poultry Federation, a statewide trade association that represents all sectors of the poultry industry in Virginia. In previous testimony and written comments on these issues, I have emphasized the poultry industry's successful measures to protect our workforce from COVID-19 and argued that CDC guidelines are the best, scientifically sound mechanism to govern protective measures, and that 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.

Our position has not changed. The Board should eliminate the state standard and let the Department address any failures to implement protective measures through the general duty clause. Alternatively, DOLI and the Board should consider eliminating everything in the existing permanent standard except a simple requirement that employers follow CDC guidelines. At the very least, it is paramount that any standard retained should contain the substitute language for 16VAC25-220-10.E concerning CDC compliance as requested by the Governor. We have submitted additional written comments which address some other aspects of this proposal. Thank you for the opportunity to participate today.

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SEE RESPONSE TO COMMENT 10013

20002 Robert B. Melvin Virginia Restaurant, Lodging & Travel Association 8/5/2021
Comments on Proposed Amendments to the FPS for Infectious Disease Prevention – August 5, 2021
Good Morning Members of the Board,
My name is Robert Melvin, and I am the Director of Government Affairs for the Virginia Restaurant, Lodging & Travel Association. I would like to take this opportunity to share the remarks of our organization as it relates to the DOLI COVID-19 FPS. Our organization believes that the existing standard should be repealed as there are now treatments and vaccines that can prevent the spread of COVID-19. Moreover, the inflexibility of this standard has demonstrated it is unable to keep up with the ever changing science as it relates to the virus.
That being said, in light of the Governor's proposed amendments, we believe that should the board not repeal the FPS that it should adopt the Governor's recommendations as they relate to CDC guidance.

SEE RESPONSE TO COMMENT 99342
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20003 Brett Vassey Virginia Manufacturers Association" 8/5/2021

VMA Testimony - Safety and Health Codes Board intent to amend Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220"

Dear Safety and Health Codes Board Members:

My name is Brett Vassey. I am the President & CEO of the Virginia Manufacturers Association. Thank you for the opportunity to address you today. I also want to express my appreciation for the extra effort made by the staff, Jay Withrow and Princy Doss in particular, to communicate with the business community over the last eight months.

The Virginia Manufacturers Association ("VMA") represents more than 6,750 manufacturing facilities and suppliers that employ over 238,000 individuals, contribute $45 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 are directly affected by the "one size fits all" VA COVID-19 Regulations. We thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to amend the Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations").

Virginia manufacturers and suppliers have protected their employees, contractors, suppliers, customers, and communities from COVID-19 infection by continually updating their COVID-19 protocols to ensure compliance with the latest regulations and guidance imposed by federal, state, and local governments. Despite the additional stress, costs, and time related to compliance, manufacturing leaders accepted their role in reducing the risk of exposure and spread of the virus as well as continuing operations to produce medicine, PPE, food, and invent new products to meet public health needs such as UV sanitation devices and vaccines.

However, the permanent standard is a static regulation for a temporary pandemic. There is no evidence that employers are in full compliance with this standard, nor is their evidence that compliance with OSHA Guidance, CDC Guidance, and Governor's Executive Orders are not protective. 45 states are proof that the Board is over-regulating. As such, we respectfully ask the Board to repeal the permanent standard.

In the event that you do not repeal the permanent standard, I want to resubmit our comments from January 8, 2021 that included dozens of concerns and nearly 30 unanswered questions but today I want to highlight a few specific standards for your consideration:

1. 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 Regulations. In addition, the language does not account for older facilities, as upgrading the ventilation in those facilities may be infeasible.

NOTE: Governor proposed $250 million for HVAC compliance costs for only 197 schools. The VDOLI economic impact assessment of this cost to industry is completely inaccurate and inadequate.

Instead, 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.
2. Requiring "respiratory protection" and "personal protective equipment standards applicable to the employer's industry" in vehicles with more than 1 person is impractical and vague. There are other controls, when used together, that should be considered, and the Regulations should reflect so. The Regulations should not incorporate this provision. Employers should be allowed to only require face coverings while in the vehicle provided the occupants follow CDC guidelines.
3. §16VAC25-220-90 unreasonably expands protections for employee complaints to the news media and social media without due process for the employer. The Regulations exceed federal OSHA protections. Some employers have policies restricting statements to the press or statements reflecting poorly on their employers. Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. The language "or to the public such as through print, online, social, or any other media" should be struck from the Regulations and protections should be limited only to notification to the responsible government regulatory agency. Further, if a person is proven to have provided false statements on social media and never raised the concerns with the responsible government regulatory agency or management of the company, they should not be insulated from action.

There should be no enforcement without prior notice to and "due process" for an employer. The Regulations have 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 in cases involving these Regulations – 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 Regulations.

Finally, we strongly encourage the Board to adopt Governor Northam's recommendation to amend Section 16VAC25-220-10. E to provide employers with a CDC compliance "safe harbor." We hope the Board will adopt the following language change.
E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.
Thank you for your consideration.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
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20004 M. K. Fletcher AFL-CIO8/5/2021
Oral Testimony of the AFL-CIO at the Public Hearing of the Virginia Safety and Health Codes Board—August 5, 2021

The AFL-CIO represents millions of workers, many in VA, all of whom have been directly impacted by the COVID-19 pandemic. The Commonwealth became the first state to issue an ETS and permanent standard, recognizing that guidelines were not enough and that COVID-19 would be a serious risk to people in workplaces for a long time.

Right now, we are at a pivotal moment in the pandemic. The Delta variant is rapidly spreading across the nation, cases are spiking, hospitals are reopening dedicated COVID-19 wards and some employers are delaying in-person work plans. In Virginia, the number of outbreaks reported jumped from 5 per week in early July, to 29 outbreaks 2 weeks ago and 49 outbreaks last week—outbreak numbers not seen since April 2021.

Last week, the CDC updated their guidance for fully vaccinated people to recommend that all individuals regardless of vaccination status wear a mask indoors in areas of high or substantial transmission—which is the majority of VA right now—and for all symptomatic individuals who are exposed to quarantine until they test negative for the virus. The updated CDC guidance is a significant step in the opposite direction from the May 13 CDC guidance that recommended that vaccinated individuals no longer needed to wear masks, socially distance, or quarantine—the guidance that resulted in the emergency S&H codes board meeting in June and the justification behind the majority of the proposed amendments to the Virginia final permanent standard.

The CDC revised their guidance for two significant reasons: 1) The viral load in vaccinated people when infected is the same as unvaccinated; 2) When they compared 2 settings where individuals were vaccinated, an outbreak occurred in the setting where other mitigation measures were not in place, while in the setting with other mitigation measures added to vaccination, the virus did not spread.

In light of the new CDC guidance, which looks at current risk instead of solely vaccination status, we strongly urge the Board to re-evaluate the proposed amendments and ensure that all workers are kept from being exposed to the virus at work. We know that vaccines are essential, and while we continue to get working people vaccinated, the science shows that it is critical to continue strong workplace mitigation measures that address airborne transmission until the population as a whole achieves immunity through vaccines and transmission is low. This includes maintaining the critical provisions in the final permanent standard without amendments that weaken the standard.

The standard must continue to be the floor level of protections, not the ceiling, and the amendment proposed by the Governor to allow employers to follow CDC guidance that is not at least as protective as the standard should not be approved by the Board. This undermines and weakens the strong standard that you have used your sound expertise to develop. The AFL-CIO has testified to you all multiple times on how there are hundreds of CDC guidelines—many outdated, weaker than the standard, and they are confusing to keep up with and unenforceable. In addition, the Board has voted many times on this issue and always chosen to have the standard be the baseline of protections and clear authority in VA—we strongly urge you to continue to do so. Where CDC guidance is weaker than the standard, it should not be able to override the enforceable standard.

Employers must not be able to be exempted from any requirements to implement any of the protective mitigation measures based on the vaccination status of employees, including exempting employers from

having a written plan. An employer must have a written plan for how they will protect all of their employees from being exposed to the virus at work.

In addition, any good faith employers have taken to follow the standard should be considered on a case-by-case basis through enforcement discretion by the agency, as it always does. No good faith language should be codified in a standard, especially for an entire section of a standard

Finally, any changes to the standard must go into effect immediately upon issuance. There is no reason for any provisions that have been in effect for over a year, should be halted through delayed effective dates.

Thank you and once again we support the Board and the Commonwealth continuing to ensure employers protect all workers from COVID-19 exposure at work. We strongly urge them to re-evaluate the proposed changes in light of the newest CDC guidance for fully vaccinated individuals and surging Delta variant and increasing outbreaks in Virginia. We all want all workers to be safe and Virginia businesses to be able to remain open safely.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

20005 Dr. Jeffrey McClurken University of Mary Washington 8/5/2021

Comments on Proposed Amendments to the FPS for Infectious Disease Prevention – August 5, 2021
Jeffrey McClurken, University of Mary Washington

I. Introduction
a. Good morning. I'm Dr. Jeffrey McClurken. I am Chief of Staff to President Troy Paino at the University of Mary Washington, where I also serve as director of our COVID response efforts. I am also here as the Chair of the Public Higher Education COVID Directors Working Group.
b. In addition to representing UMW, I represent CNU, GMU, UVA, VT, VSU, JMU, W&M, and the VCCS
c. I am here to follow up on and endorse a number of the written comments my fellow institutional COVID Directors submitted as part of public comment.
d. Thank you for the opportunity to comment of the proposed amendments to the FPS for Infectious Disease Prevention of the SARS-CoV02 that Causes COVID-19, Section 16 VAC 25-220.

II. Let me start by being absolutely clear that UMW and the other institutions I represent here today care deeply about the safety of our universities and our communities. For over the last year and half, our institutions have been committed to creating places for students to learn and live and for employees to work in the midst of a pandemic. We have created and implemented an array of policies and procedures crafted to protect the safety and wellbeing of students, faculty, staff, and community members. We have worked with guidance from, and in partnership with, the CDC, VDH and our local health districts, the Governor and many other Commonwealth institutions. As we head into our fourth semester of pandemic-inflected teaching and learning we are dedicated to that commitment of health and safety for all.

III. As we look to that fall, amidst the rapidly changing landscape of the Delta variant and uneven vaccination rates, I appear before you today to urge the adoption of the Governor's proposed substitute language for Section 16 VAC 25-220-20.E, which would allow that employers who are in compliance with the CDC guidelines would be considered in compliance with the Final Permanent Standard and would further permit CDC guidelines to be the guiding standard of care for workplace safety in the Commonwealth more broadly. As institutions of higher education, we are also attentive to the CDC Guidance specific to Higher Education which takes into account the different, even unique, aspects of our business which are intended to protect workers, students, and the community alike as we work to mitigate the spread of COVID 19 on our campuses.

IV. Thank you for your time and consideration, and for the opportunity to speak before you today.

SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99671

20006 Nicole Riley National Federation of Independent Business. 8/5/2021
Comments on Proposed Amendments to the FPS for Infectious Disease Prevention – August 5, 2021

Good morning. My name is Nicole Riley and I'm the Virginia State Director for the National Federation of Independent Business. We represent over 6000 small businesses across the Commonwealth. Our members average less than 20 employees and represent all sectors of Virginia's economy.
I'm also here on behalf of the Virginia Business Coalition which is comprised of over 30 leading business associations representing thousands of employers in the manufacturing, retail, construction, agriculture, health care and professional services industries.

First, we want to thank you for the opportunity to comment on the Safety and Health Codes Board's intent to amend the Permanent Standard related to COVID- 19 Workplace Safety regulations.
For the last year and half, Virginia employers have committed themselves to protecting their employees, contractors, suppliers, customers, and communities from COVID-19 infection. They have done this by continually updating their COVID-19 protocols to ensure they are complying with the latest regulations and guidance imposed by federal, state, and local regulators. Despite the additional stress, costs and time related to compliance, business leaders and owners understood how critically important it was to do their part to reduce the risk of exposure and spread of the virus.

Understanding Virginia businesses need clarity, consistency and flexibility in any regulatory program and the permanent standard is a static regulatory burden for a pandemic that is temporary, our Coalition respectfully asks the Board to repeal the permanent standard. Virginia's Permanent Standard adds another layer of regulation that complicates things for small business owners – who are more likely NOT to have a full-time compliance officer or human resources manager to assist in complying with the Permanent Standard.

Also, the Biden Administration has recently released an Emergency Temporary Standard related to COVID-19 workplace safety regulations which includes clarification that OSHA and state programs such as Virginia's may use the General Duty clause to hold employers who flagrantly disregard CDC and OSHA guidance to protect their workers and customers from exposure to the coronavirus.

SEE RESPONSE TO COMMENT 99520
SEE RESPONSE TO COMMENT 99342
SEE RESPONSE TO COMMENT 99371
SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99671
SEE RESPONSE TO COMMENT 10013

20007 Manuel Gago Legal Aid Justice Center 8/5/2021
Comments on Proposed Amendments to the FPS for Infectious Disease Prevention – August 5, 2021

My name is Manuel Gago, and I'm organizer with the Legal Aid Justice Center. I want to make a comment on behalf of our low-income Virginian clients, the Legal Aid Justice Center.
When COVID-19 first began sweeping across the nation as a part of a still ongoing global pandemic, Virginia was the first state to adopt workplace standards to protect workers and their families from the deadly virus. These standards helped to create similar regulations around the US, and even across the globe. Locally, these standards protected workers and have kept Virginia safe and productive. Although much of Virginia is now vaccinated, not only do many people remain unvaccinated (including many migrant farmworkers currently in the midst of the high agricultural season coming from areas where vaccinations are not as widely available as Virginia and areas where the new, and more deadly, variants of COVID-19 are present), children younger than 12 are not yet eligible, and many people who are immunocompromised do not have as adequate of protection.

Furthermore, the Delta variant is currently wreaking havoc across the country, impacting both fully vaccinated and unvaccinated individuals.3 In fact, just last week, the Center for Disease Control issued new guidance recommending vaccinated individuals return to wearing masks indoors in certain areas. As we navigate this new phase, we must carefully consider the way we return to a new normal that continues to keep us safe.

COVID-19 has already killed more than 615,000 Americans including 11,541 Virginians like Maurice Purnell, John Harlow, Ellen Marie Douglas, Fidel Ibarra, Celia Mayo Gutierrez, Rafael Hernan Gonzalez Zamudio, all workers who contracted COVID in their workplace in a poultry plant in the Virginia's Eastern Shore.

We strongly urge the Board to not adopt the Governor's amendment to 16VAC25-220-10(E) to remove the requirement that in order for employers to follow CDC guidance instead of these standards, the CDC standard must provide equal to or greater than protection than these standards. This requirement is essential to provide continuity and adequate protection. The CDC standards change with such great frequency that it would create confusion to abide solely by them. Furthermore, this Board has given very careful consideration to what is important for Virginians and allowing businesses to disregard those choices for a CDC recommendation that is less protective undermines this Board's authority and decision-making. The Board voted to keep the language at the June 29, 2021, meeting, a choice we whole-heartedly support. They should do the same at the next meeting.

Virginia's standards have helped keep Virginians safe. We need to ask ourselves, what is the economic impact of a sick worker or the death of a family member who contracted COVID-19 in the workplace? It's priceless; the value of a worker's life must always come first.

Thanks so much for your time and for giving us the opportunity to make this comment.

SEE RESPONSE TO COMMENT 99371

SEE RESPONSE TO COMMENT 99377
SEE RESPONSE TO COMMENT 99484
SEE RESPONSE TO COMMENT 99671

COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

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AUGUST 19, 2021

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY

VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM

PROPOSED AMENDMENTS TO VOSH STANDARD FOR INFECTIOUS DISEASE PREVENTION OF THE SARS-COV-2 WHICH CAUSES COVID-19, AS ADOPTED BY THE BOARD ON JUNE 29, 2021

16VAC25-220

DEPARTMENT STANDARD RESPONSES TO ISSUES RAISED BY PUBLIC COMMENTERS

Background

The Department received 268 written comments through the Virginia Regulatory Townhall for the 30 day written comment period from July 1, 2021 to July 31, 2021.

There were 19 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 7 oral comments received during the public hearing on August 5, 2021.

Following are Department standard responses to issues raised by public commenters.

1. <u>Ability of VOSH Standard to stay current with CDC guidance.</u>

Many comments appear to be under a misunderstanding about the ability of the Final Permanent Standard (VOSH Standard) to respond to changes in CDC guidance. While it is true that the text of the Final Permanent Standard remains as it was when first adopted effective January 27, 2021, please note that 16VAC25-220-10.E provides:

> 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 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. 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 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.

Contrary to many commenters stating that the VOSH Standard is inflexible and unable to account for the changing dynamic of the virus and the revised CDC recommendations that have issued, 16VAC25-220-10.E specifically does allow the Department's VOSH Standard to account for revised CDC recommendations which are issued in response to the changing dynamic of the virus.

As an example, in §40, FAQ 55[1] regarding CDC guidance changes for fully vaccinated persons, the Department consulted with the Virginia Department of Health (VDH) and concluded the following within a matter of days of the issuance of the updated CDC guidance on fully vaccinated people:

> As the CDC comes out with revised guidelines for fully vaccinated employees in a public workplace setting, the Department reviews the changes with the Virginia Department of Health (VDH) and addresses any changes in compliance requirements in an FAQ.
>
> The Department and VDH agree that based on the CDC's science-based determination that, with the exceptions previously noted, these FAQs, including §40, FAQs 46 to 57, fully vaccinated non-healthcare employees can safely resume indoor and outdoor workplace duties without wearing a face covering or physically distancing in public indoor settings if the place of employment is in an area of moderate or low COVID-19 transmission. Such activities would be in compliance with and provide employees equivalent protection to 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11. Face coverings must continue to be worn in public

[1] https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

indoor settings if the place of employment is in an area of substantial or high COVID-19 transmission.

Unlike the states of California and Oregon, for instance, who issued Emergency Temporary Standards (that did not contain language similar to 16VAC25-220-10.E) and later had to convene their regulatory rulemakers to reissue updated regulatory text to reflect CDC changes, Virginia did not have to do so because it could address them within days of CDC changes through interpretative responses to questions asked by the regulated community and employee representatives.

In closing, 16VAC25-220-10.E, has turned out to be a very effective method for the Virginia to deal with "the changing dynamic of the virus and the revised CDC recommendations that have issued"

The Department has issued FAQs addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).

The FAQs can be found at: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

2. Differences in the way fully vaccinated persons and those who are not fully vaccinated are treated by the CDC and the VOSH Standard.

An employer commenter expressed concerns about employees being treated differently based on their vaccination status. The Department notes that, as many employers and organizations representing employers have requested, the proposed amendments are designed to address updated CDC guidance on the issue. If the employer has concerns about employees being treated differently based on vaccination status, they can legally implement face covering and other safety and health rules for their employees that are more stringent than 16VAC25-220.

On July 9, 2021, the CDC has estimated that ""Preliminary data from several states over the last few months suggest that 99.5% of deaths from COVID-19 in the United States were in unvaccinated people."[2]

"CDC Director Rochelle Walensky said that cases, hospitalizations and deaths from the coronavirus are increasing nationwide, adding that over 97% of new hospitalizations are in patients who are unvaccinated."[3]

The Department has relied heavily on guidance from the CDC and federal OSHA in developing the VOSH Standard because they are the two primary national authorities on infectious disease transmission in the workplace.

[2] https://www.businessinsider.com/us-coronavirus-deaths-nearly-all-among-unvaccinated-cdc-head-2021-7
[3] https://www.usnews.com/news/national-news/articles/2021-07-16/cdc-head-covid-19-becoming-pandemic-of-the-unvaccinated

The CDC has provided detailed guidance on the need for and efficacy of COVID-19 vaccines[4] and what mitigation strategies should be used by persons[5] and businesses[6] to slow the spread of the virus. They have also issued guidance on what precautions should be observed by those who have been fully vaccinated.[7]

As is evident from the recent surge around the nation and in Virginia from the Delta variant poses another significant challenge to the wellbeing of employees and employers:

"On July 27, 2021, CDC released updated guidance on the need for urgently increasing COVID-19 vaccination coverage and a recommendation for everyone in areas of substantial or high transmission to wear a mask in public indoor places, even if they are fully vaccinated. CDC issued this new guidance due to several concerning developments and newly emerging data signals. First is a reversal in the downward trajectory of cases. In the days leading up to our guidance update, CDC saw a rapid and alarming rise in the COVID case and hospitalization rates around the country.

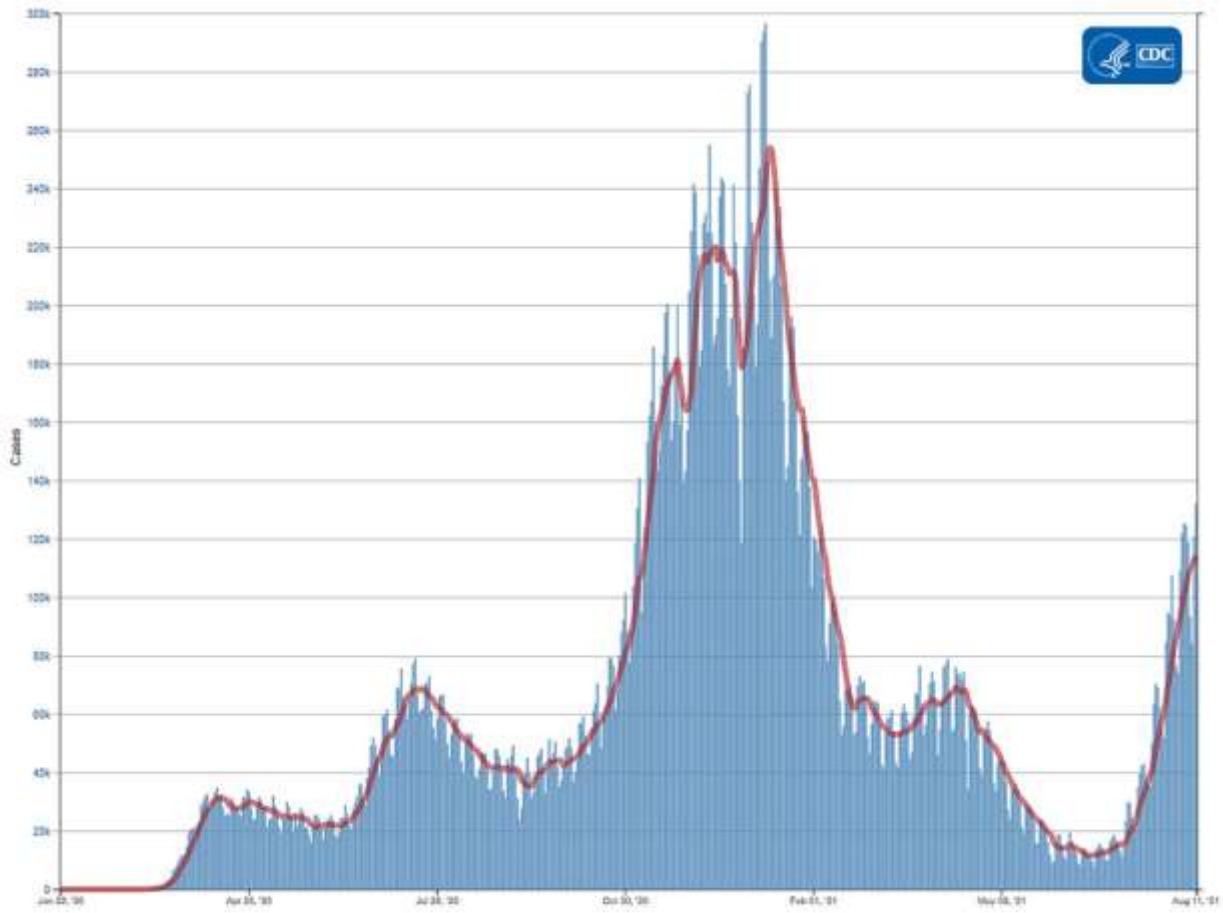
- In late June, our 7-day moving average of reported cases was around 12,000. On July 27, the 7-day moving average of cases reached over 60,000. This case rate looked more like the rate of cases we had seen before the vaccine was widely available.

  [As of August 11, 2021, "the current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619)."[8]]

Second, new data began to emerge that the Delta variant was more infectious and was leading to increased transmissibility when compared to other variants, even in vaccinated individuals. This includes recently published data from CDC and our public health partners, unpublished surveillance data that will be publicly available in the coming weeks, information included in CDC's updated Science Brief on COVID-19 Vaccines and Vaccination, and ongoing outbreak investigations linked to the Delta variant.

Delta is currently the predominant strain of the virus in the United States."

[4] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html
[5] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
[6] https://www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/index.html
[7] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html
[8] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html



USA Today, August 19, 2021, "Vaccine effectiveness declines over time, studies say"[9]

> Protection provided by COVID-19 vaccines declines over time, **but protection against the most severe effects of the disease — including hospitalization and death — remains strong**, according to three studies published Wednesday by the Centers for Disease Control and Prevention. (Emphasis added).

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "Sustained Effectiveness of Pfizer-BioNTech and Moderna Vaccines Against COVID-19 Associated Hospitalizations Among Adults — United States, March–July 2021"[10]

> In a multistate network that enrolled adults hospitalized during March–July 2021, effectiveness of 2 doses of mRNA vaccine against COVID-19–associated hospitalization was sustained over a follow-up period of 24 weeks (approximately 6 months). These findings of sustained VE were consistent among subgroups at

[9] https://www.usatoday.com/story/news/health/2021/08/19/covid-vaccine-mask-mandates-biden-administration/8189622002/
[10] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e2.htm?s_cid=mm7034e2_w

highest risk for severe outcomes from COVID-19, including older adults, adults with three or more chronic medical conditions, and those with immunocompromising conditions. Overall VE in adults with immunocompromising conditions was lower than that in those without immunocompromising conditions but was sustained over time in both populations.

These data provide evidence for sustained high protection from severe COVID-19 requiring hospitalization for up to 24 weeks among fully vaccinated adults, which is consistent with data demonstrating mRNA COVID-19 vaccines have the capacity to induce durable immunity, particularly in limiting the severity of disease. Alpha variants were the predominant viruses sequenced, although Delta variants became dominant starting in mid-June, consistent with national surveillance data (8). Because of limited sequenced virus, Delta-specific VE was not assessed. VE was similar during June–July when circulation of Delta increased in the United States compared with VE during March–May when Alpha variants predominated, although further surveillance is needed.

3. Limitations on the use of the general duty clause.

Va. Code §40.1-51(a), otherwise known as the "general duty clause" (the Virginia equivalent to §5(a)(1)[11] 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 standards[12], 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 (CDC), or an employer's safety and health rules. Other than serious hazards cannot be addressed by the general

[11] https://www.osha.gov/laws-regs/oshact/section_5, 29 U.S.C. § 654(a)(1).
[12] *The Law of Occupational Safety and Health,* Nothstein, 1981, page 259.

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.[13] 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.[14]

4. Why are previously infected persons with COVID-19 anti-bodies (aka "natural immunity") not treated the same by the CDC and the VOSH Standard as those persons who are fully vaccinated?

It continues to remain the CDC's position that persons who have previously have COVID-19 should get vaccinated[15] "because experts do not yet know how long you are protected from getting sick again after recovering from COVID-19." In addition, "Studies have shown that vaccination provides a strong boost in protection in people who have recovered from COVID-19."

A recent study[16] published in the CDC's Morbidity and Mortality Weekly Report on August 13, 2021 found that:

> Although laboratory evidence suggests that antibody responses following COVID-19 vaccination provide better neutralization of some circulating variants than does natural infection, few real-world epidemiologic studies exist to support the benefit of vaccination for previously infected persons. This report details the findings of a case-

[13] 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)

[14]" 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."

[15] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/prepare-for-vaccination.html

[16] https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm

control evaluation of the association between vaccination and SARS-CoV-2 reinfection in Kentucky during May–June 2021….

….

Among Kentucky residents infected with SARS-CoV-2 in 2020, vaccination status of those reinfected during May–June 2021 was compared with that of residents who were not reinfected. In this case-control study, being unvaccinated was associated with 2.34 times the odds of reinfection compared with being fully vaccinated.

5. <u>Permanence of the standard.</u>

Some commenters raised concerns about the standard 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. 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. Va. Code § 40.1-22.

6. DOLI should not be regulating COVID-19 in the workplace.

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. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission of the virus, particularly the Delta variant, and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. While highly effective vaccines against the disease are widely available at no cost, there is still a considerable percentage of the population nationally and in Virginia that is not fully vaccinated.

It is the Department's position that the VOSH Standard remains 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 VOSH Standard ultimately helps 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.

The Department notes that the VOSH 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."

7. Commenter's statements expressing a refusal to wear face coverings.

With regard to the efficacy of face masks/face coverings, the CDC states:[17]

"SARS-CoV-2 infection is transmitted predominately by inhalation of respiratory droplets generated when people cough, sneeze, sing, talk, or breathe. CDC recommends community use of masks, specifically non-valved multi-layer cloth masks, to prevent transmission of SARS-CoV-2. Masks are primarily intended to reduce the emission of virus-laden droplets ("source control"), which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than 50% of transmissions.1,2 Masks also help reduce inhalation of these droplets by the wearer ("filtration for wearer protection"). The community benefit of masking for SARS-CoV-2 control is due to the combination of these effects; individual prevention benefit increases with increasing numbers of people using masks consistently and correctly.

Source Control to Block Exhaled Virus

Multi-layer cloth masks block release of exhaled respiratory particles into the environment,3-6 along with the microorganisms these particles carry.7,8 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 ;3,5 which increase in number with the volume of speech10-12 and specific types of phonation.13 Multi-layer cloth masks can both block

[17] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html

up to 50-70% of these fine droplets and particles3,14 and limit the forward spread of those that are not captured.5,6,15,16 Upwards of 80% blockage has been achieved in human experiments that have measured blocking of all respiratory droplets,4 with cloth masks in some studies performing on par with surgical masks as barriers for source control.

Filtration for Wearer Protection

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. The relative filtration effectiveness of various masks has varied widely across studies, in large part due to variation in experimental design and particle sizes analyzed. Multiple layers of cloth with higher thread counts have demonstrated superior performance compared to single layers of cloth with lower thread counts, in some cases filtering nearly 50% of fine particles less than 1 micron .14,17-29 Some materials (e.g., polypropylene) may enhance filtering effectiveness by generating triboelectric charge (a form of static electricity) that enhances capture of charged particles18,30 while others (e.g., silk) may help repel moist droplets31 and reduce fabric wetting and thus maintain breathability and comfort. In addition to the number of layers and choice of materials, other techniques can improve wearer protection by improving fit and thereby filtration capacity. Examples include but are not limited to mask fitters, knotting-and-tucking the ear loops of medical procedures masks, using a cloth mask placed over a medical procedure mask, and nylon hosiery sleeves."

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 VOSH Standard and the Emergency Temporary Standard (ETS), 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.

8. Applicability of HIPAA.

The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

9. Constitutionality of the VOSH Standard.

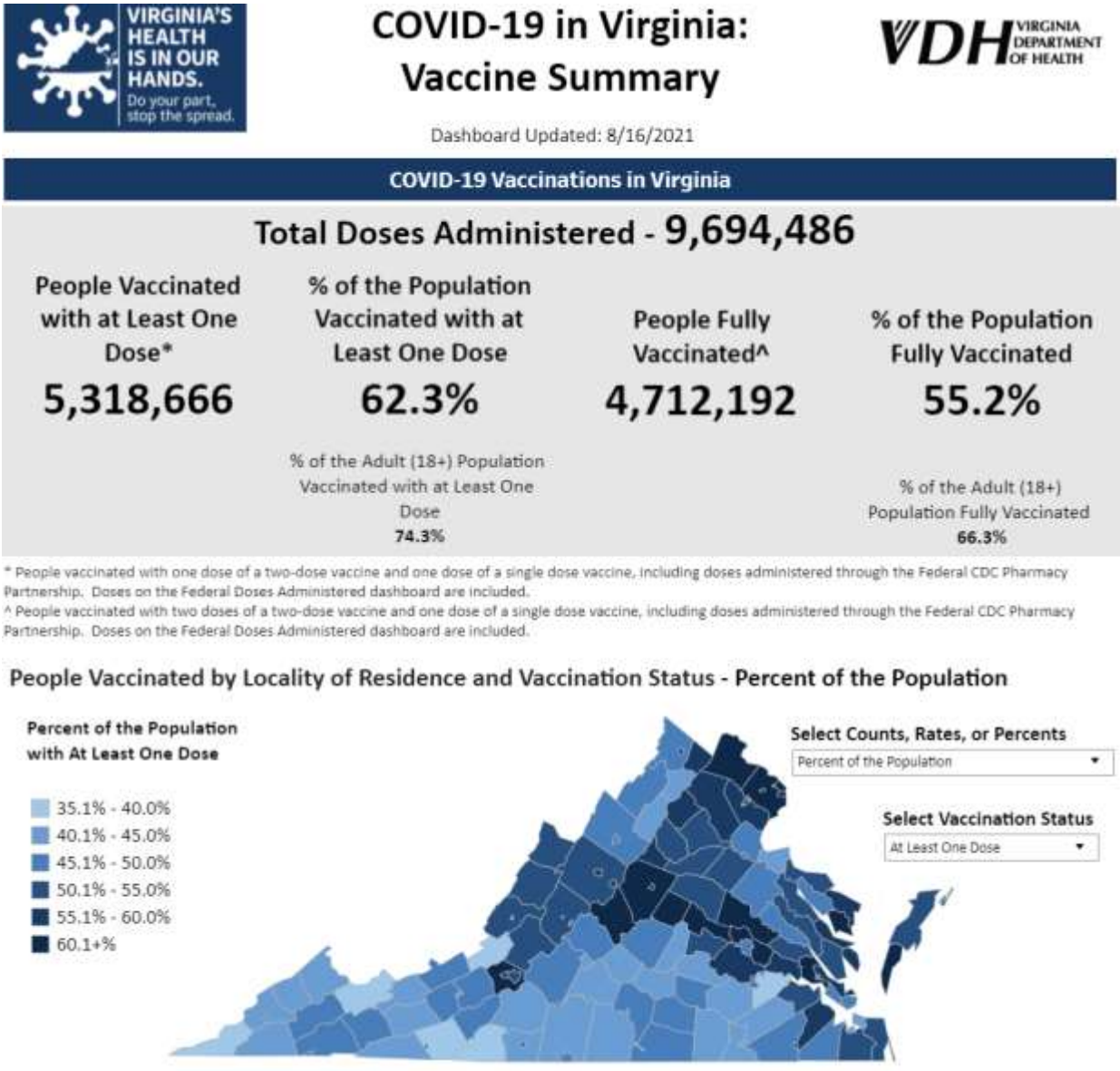
The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer's Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

10. Current statistics on COVID-19 in Virginia.

As of August 16, 2021:

55.2% of the Virginia population is fully vaccinated. 66.3% of the adult Virginia population is fully vaccinated. 62.3% of the Virginia populations is vaccinated with at least one dose of the vaccine. [18]

[18] https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/

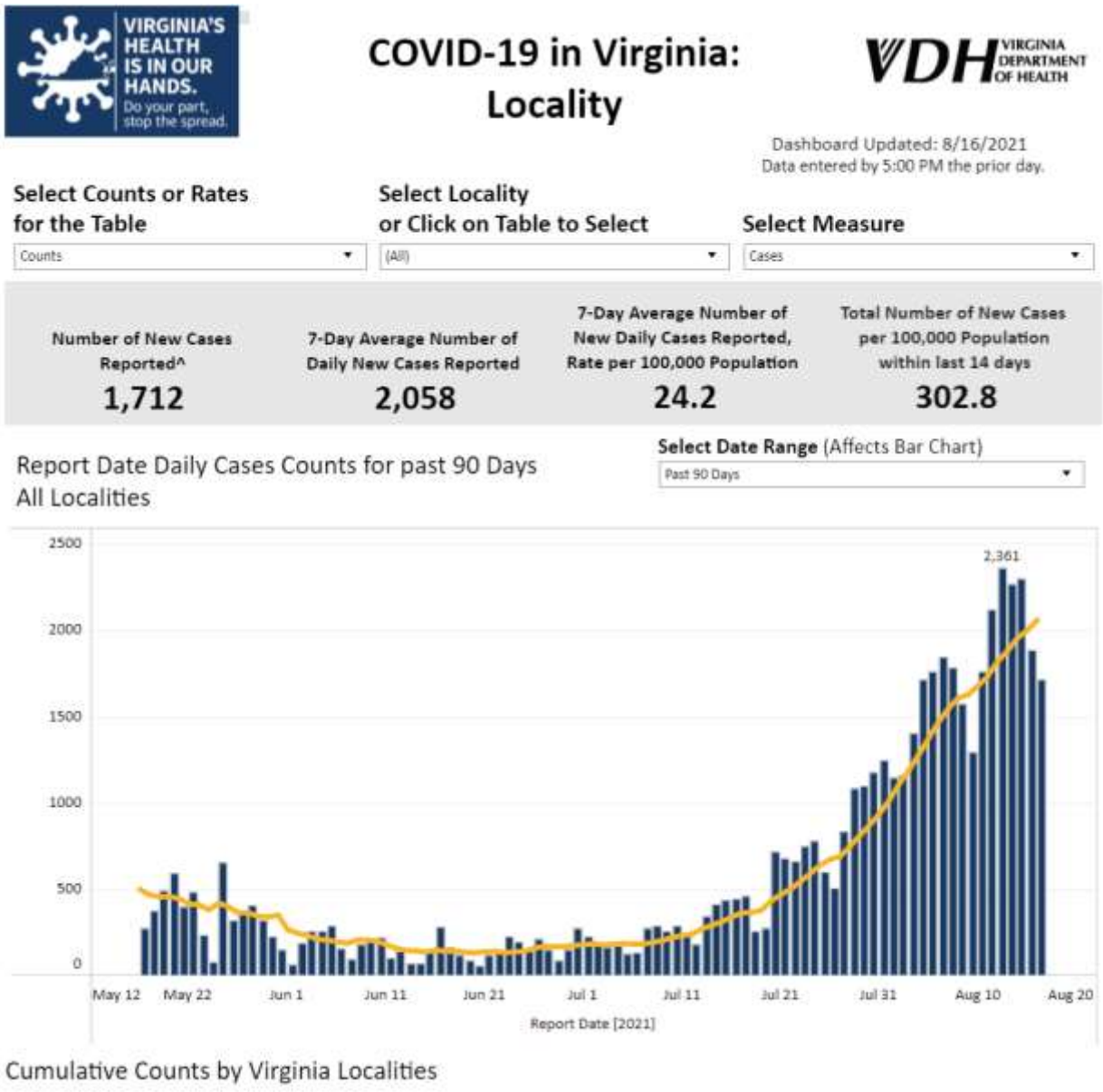


The current 7-day positivity rate PCR only in Virginia is 8.2%.[19]

The 7-day average of number of new cases reported in Virginia is 2,058.

As of August 16, 2021:

[19] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/



11. Current CDC national statistics on COVID-19.

As of August 11, 2021:[20]

SARS-CoV-2 Variants

Multiple variants of the virus that causes COVID-19 are circulating globally, including within the United States. Currently, four variants are classified as a variant of concern (VOC). Nowcast estimates* of COVID-19 cases caused by these VOCs for the week ending August 7 are summarized here. Nationally, the combined proportion of cases attributed to Delta (B.1.617.2, AY.1, AY.2, AY.3) is estimated to increase to 97.4%; Alpha (B.1.1.7) proportion is estimated to decrease to 0.9%; Gamma (P.1) proportion is estimated to decrease to 0.5%; and Beta (B.1.351) is estimated to be less than 0.1%.

[20] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

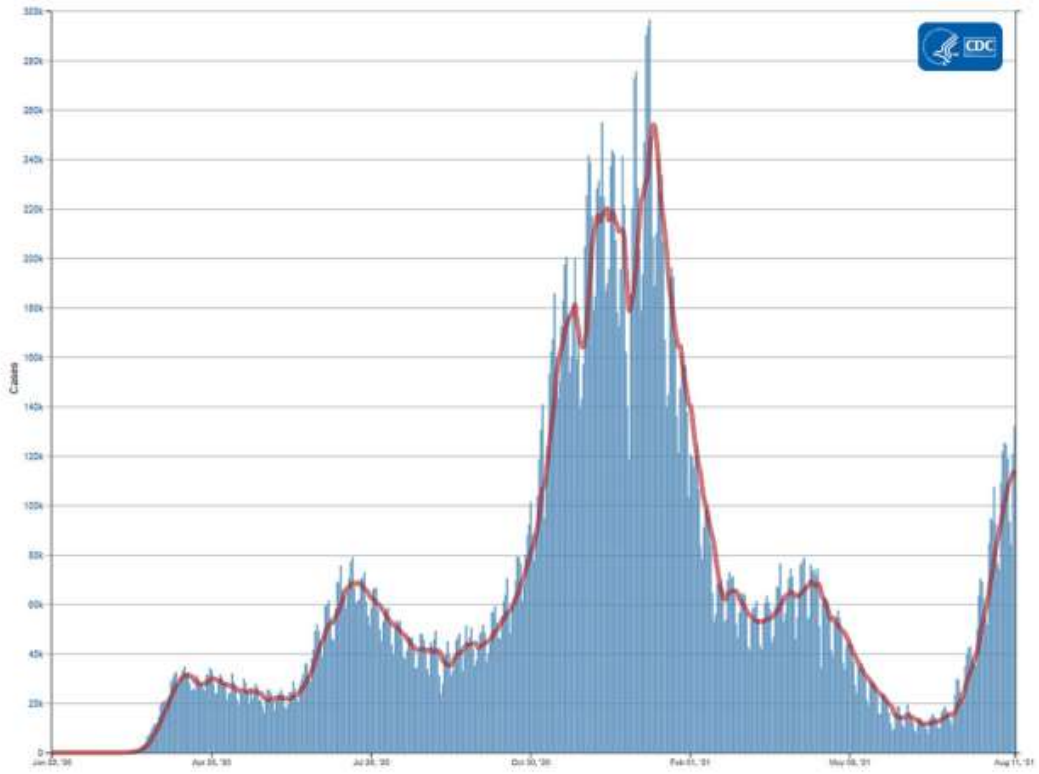
Nowcast estimates that Delta (B.1.617.2, AY.1, AY.2, and AY.3) will continue to be the predominant variant circulating in all 10 HHS regions. Alpha (B.1.1.7) is estimated to be 1.6% or less in all HHS regions. Gamma (P.1) is estimated to be 1.2% or less in all HHS regions; and Beta (B.1.351) is estimated to be less than 0.1% in all HHS regions.

Reported Cases

The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619). A total of 36,268,057 COVID-19 cases have been reported as of August 11.

Daily Trends in COVID-19 Cases in the United States Reported to CDC

7-Day moving average



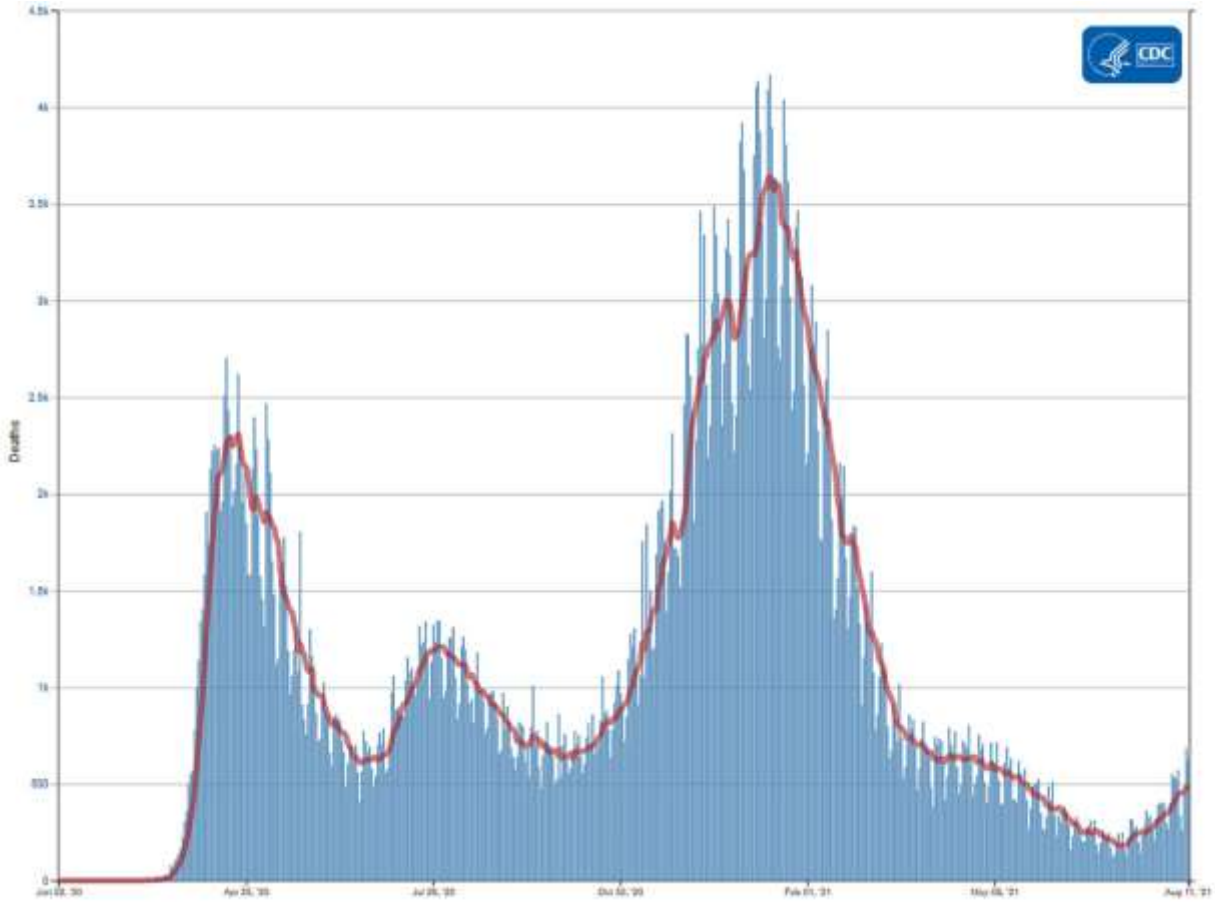
Deaths

The current 7-day moving average of new deaths (492) has increased 21.0% compared with the previous 7-day moving average (407). The current 7-day moving average is 59.3% lower compared to the peak observed on August 2, 2020 (1,210). The current 7-day moving average is 86.5% lower than the peak observed on January 13, 2021 (3,640)

and is 170.4% higher than the lowest value observed on July 10, 2021 (182). As of August 11, a total of 617,096 COVID-19 deaths have been reported in the United States.

Daily Trends in Number of COVID-19 Deaths in the United States Reported to CDC

7-Day moving average

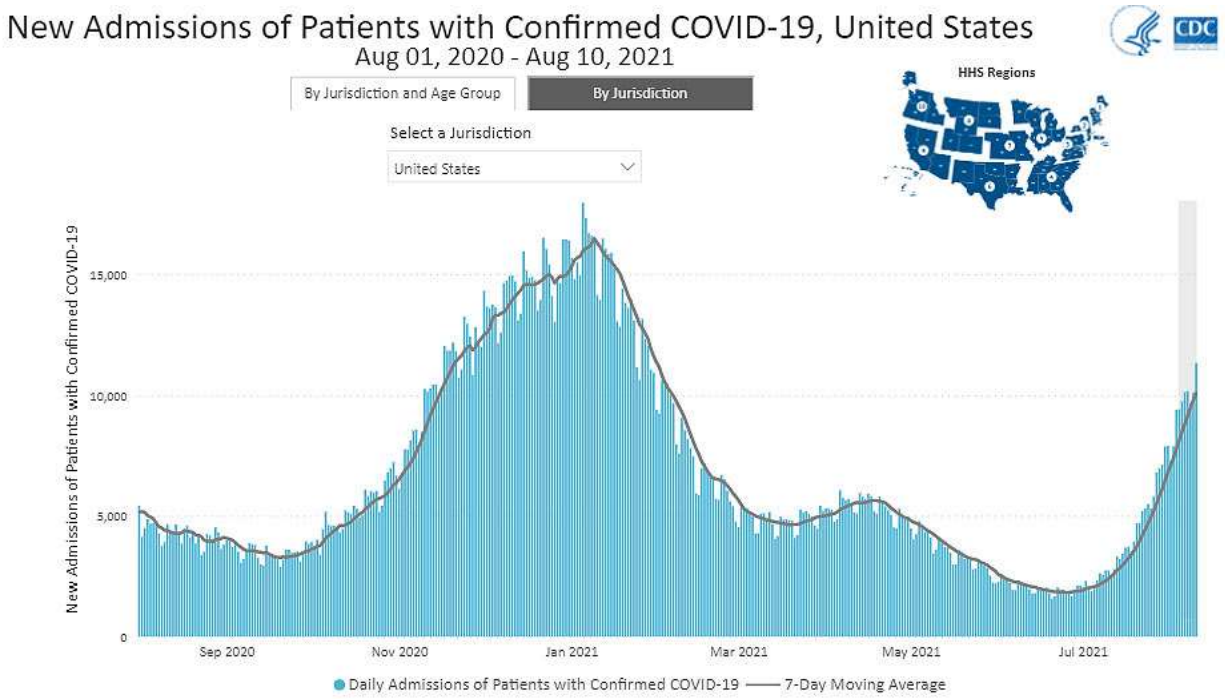


Hospitalizations

New Hospital Admissions

The current 7-day average for August 4–August 10 was 10,072. This is a 29.6% increase from the prior 7-day average (7,771) from July 28–August 3. The 7-day moving average for new admissions has consistently increased since June 25, 2021. New admissions of patients with confirmed COVID-19 are currently at their highest levels since the start of the pandemic in Florida, Louisiana, and Oregon.

Daily Trends in Number of New COVID-19 Hospital Admissions in the United States



Vaccinations

The U.S. COVID-19 Vaccination Program began December 14, 2020. As of August 12, 353.9 million vaccine doses have been administered. Overall, about 196.5 million people, or 59.2% of the total U.S. population, have received at least one dose of vaccine. About 167.4 million people, or 50.4% of the total U.S. population, have been fully vaccinated.* As of August 12, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 699,068, a 0.03% decrease from the previous week.

CDC's COVID Data Tracker Vaccination Demographic Trends tab shows vaccination trends by age group. As of August 12, 90.6% of people ages 65 or older have received at least one dose of vaccine and 80.6% are fully vaccinated. Over two-thirds (71.5%) of people ages 18 or older have received at least one dose of vaccine and 61.3% are fully vaccinated. For people ages 12 or older, 69.2% have received at least one dose of vaccine and 59% are fully vaccinated.

12. <u>Operation Warp Speed.</u>

The Trump Administration initiated Operation Warp Speed to combat the spread of the SARS-CoV-2 virus and the initiative has resulted in significant reductions in U. S. deaths, hospitalizations, and long term illnesses. Per the Government Accounting Office "Operation Warp Speed (OWS)—a partnership between the Departments of Health and Human Services (HHS) and Defense (DOD)—aimed to help accelerate the development of a COVID-19 vaccine. GAO found that OWS and vaccine companies adopted several strategies to accelerate vaccine development and mitigate risk. For example, OWS selected vaccine candidates that use different mechanisms to stimulate an immune response (i.e., platform technologies; see figure). Vaccine companies also took steps,

such as starting large-scale manufacturing during clinical trials and combining clinical trial phases or running them concurrently. Clinical trials gather data on safety and efficacy, with more participants in each successive phase (e.g., phase 3 has more participants than phase 2).

....

As of January 30, 2021, five of the six OWS vaccine candidates have entered phase 3 clinical trials, two of which—Moderna's and Pfizer/BioNTech's vaccines—have received an emergency use authorization (EUA) from the Food and Drug Administration (FDA). For vaccines that received EUA, additional data on vaccine effectiveness will be generated from further follow-up of participants in clinical trials already underway before the EUA was issued.

Technology readiness. GAO's analysis of the OWS vaccine candidates' technology readiness levels (TRL)—an indicator of technology maturity— showed that COVID-19 vaccine development under OWS generally followed traditional practices, with some adaptations. FDA issued specific guidance that identified ways that vaccine development may be accelerated during the pandemic. Vaccine companies told GAO that the primary difference from a non-pandemic environment was the compressed timelines. To meet OWS timelines, some vaccine companies relied on data from other vaccines using the same platforms, where available, or conducted certain animal studies at the same time as clinical trials. However, as is done in a non-pandemic environment, all vaccine companies gathered initial safety and antibody response data with a small number of participants before proceeding into large-scale human studies (e.g., phase 3 clinical trials). The two EUAs issued in December 2020 were based on analyses of clinical trial participants and showed about 95 percent efficacy for each vaccine. These analyses included assessments of efficacy after individuals were given two doses of vaccine and after they were monitored for about 2 months for adverse events.

https://www.gao.gov/products/gao-21-319

13. Children.

The VOSH Standard does not apply to children unless they are employed.

14. Are deaths linked to the COVID-19 vaccines?

Reports of death after COVID-19 vaccination are rare. More than 351 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through August 9, 2021. During this time, VAERS received 6,631 reports of death (0.0019%) among people who received a COVID-19 vaccine. FDA requires healthcare providers to report any death after COVID-19 vaccination to VAERS, even if it's unclear whether the vaccine was the cause. Reports of adverse events to VAERS following vaccination, including deaths, do not necessarily mean that a vaccine caused a health problem. A review of available clinical information, including death certificates, autopsy, and medical records, has not established a causal link to COVID-19 vaccines. However,

recent reports indicate a plausible causal relationship between the J&J/Janssen COVID-19 Vaccine and TTS, a rare and serious adverse event—blood clots with low platelets—which has caused deaths.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html

15. Description of how DOLI and VDH apply 16VAC25-220-10.E.

16VAC25-220-10.E provides:

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 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. 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 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.** (Emphasis added).

The intent of 10.E is to give employers the option to either comply with the requirements of the VOSH Standard or demonstrate as an alternative that they have complied with recommendations in a CDC publication addressing hazards, issues, requirements, etc., that are also addressed in a specific provision of the VOSH Standard.

In order for an employer to take advantage of 10.E, it has to demonstrate that it is 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", "encouraged", etc.). In other words, an employer would have to comply with a CDC "recommended" practice even if the CDC publication doesn't "require" it.

The Department's interpretation of 10.E 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 VOSH Standard (e.g., the employer "should" do "this", or "that", or "the other"), then the employer is required to implement at least one of the options in order for §10.E to apply.

An employer will not be subject to citation or penalty if they comply with the requirements of the VOSH Standard, even if a CDC publication were to include a more stringent requirement or "recommendation" than is provided for in the VOSH Standard.

The VOSH 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. The focus of the VOSH Standard is employee safety and health, and the focus of §10.E is only CDC publications' language that addresses employee safety and health, and occupationally-related hazards, issues, mitigation efforts, etc.

Here is an example of application of 10.E to language in Section 3 of the current CDC Guidance[21] for Institutions of Higher Education (IHEs):

> "Administrators should encourage people who are not fully vaccinated and those who might need to take extra precautions to wear a mask consistently and correctly:
>
> Indoors. Mask use is recommended for people who are not fully vaccinated including children.
>
> Answer: The Department considers use of the phrases "Administrators should encourage" and "Mask use is recommended" to be non-mandatory language that must be actually complied with under 10.E to be considered to provide employees equivalent protection to a provision in the VOSH Standard. This means the phrases will be read as "Administrators shall require" and "Mask use is required."
>
> Accordingly, IHE employees who are not fully vaccinated must wear face coverings when so required under the VOSH Standard. IHE compliance with the CDC Guidance as interpreted by the Department above would provide employees equivalent protection to the VOSH Standard provisions regarding the wearing of face coverings in 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11.

16. <u>July 27, 2021 CDC updated guidance for fully vaccinated persons.</u>

DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC's updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask ("face covering" in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:

https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.

The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:

[21] https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/considerations.html

> 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.

Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled *Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021*, which resulted in the CDC update:

> Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons.... Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported....[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."

https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

17. VOSH Consultation Services.

VOSH Consultation Services are available to all State and Local Government employers, regardless of size. In addition, VOSH Consultations Services have three Consultant positions that can provide services to private sector employers, regardless of size.

https://www.doli.virginia.gov/vosh-programs/consultation/

18. Employee misconduct defense.

The "Employee Misconduct" affirmative defense to VOSH citations and penalties is codified in VOSH regulation 16 VAC 25-60-260.B and C:[22]

> 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

[22] https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section260

4. Reasonable steps have been taken by such employer to discover any such violation.

C. For the purposes of subsection B of this section only, the term "employee" shall not include any officer, management official, or supervisor having direction, management control, or custody of any place of employment that was the subject of the violative condition cited.

19. <u>Employers can require safety and health protections for employees that exceed VOSH standards.</u>

See §40, FAQ 50: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

50. IF[23] AN EMPLOYER DETERMINES THAT FULLY VACCINATED EMPLOYEES MUST STILL WEAR FACE COVERINGS AND/OR PHYSICAL DISTANCE WHILE AT WORK, MUST EMPLOYEES COMPLY?

Yes. Va. Code §40.1-51.2(a), rights and duties of employees provides as follows:

(a) It shall be the duty of each employee to comply with all occupational safety and health rules and regulations issued pursuant to this chapter and any orders issued thereunder which are applicable to his own action and conduct.

Employers have the duty to "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," Va. Code §40.1-51.1.A; and the right to establish workplace safety and health rules and to enforce them, 16VAC25-60-260.B.

NOTE 1: For the purposes of this guidance, people are considered fully vaccinated for COVID-19 ≥2 weeks after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or ≥2 weeks after they have received a single-dose vaccine (Johnson & Johnson [J&J]/Janssen)±; there is currently no post-vaccination time limit on fully vaccinated status. This guidance can also be applied to COVID-19 vaccines that have been authorized for emergency use by the World Health Organization (e.g. AstraZeneca/Oxford). Unvaccinated people refers to individuals of all ages, including children, that have not completed a vaccination series or received a single-dose vaccine.

However, at this time, there are limited data on vaccine protection in people who are immunocompromised. People with immunocompromising conditions, including those taking immunosuppressive medications (for instance drugs, such as mycophenolate and rituximab, to suppress rejection of transplanted organs or to treat rheumatologic conditions), should discuss the need for personal protective measures with their healthcare provider after vaccination.

[23] https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

Reference: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

20. Healthcare industry concern about having to comply with the OSHA ETS for most healthcare settings and 16VAC25-220 for healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); and employees in well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present.

The commenter is correct that where the OSHA ETS does not apply to the healthcare services and healthcare support systems, 16VAC25-220 applies. The Department notes that it is not uncommon for employers to have to deal with different occupational safety and health standards and regulations depending on the workplaces involved and the hazards present. 16VAC25-220-10.C recognizes this:

> C. 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, Va. Code §40.1-51.A, etc.

There are many businesses that have departments/divisions that must operate under different OSHA regulations even though the hazard presented is the same (e.g., companies that have two different departments/divisions that have employees exposed to electrical hazards but must either conform to the General Industry or Construction Industry electrical regulations contained in Part 1910.301, et seq. and Part 1926.400 et seq.)

In addition, the Department notes that in a number of respects, the OSHA ETS contains provisions that could be considered to be more stringent (i.e. more protective of employees) than corresponding requirements in 16VAC25-220. There is no prohibition against an employer from choosing to comply more stringent regulatory requirements to protect its employees.

With regard to the situation raised by the commenter, such employers can apply the requirements of the OSHA ETS to healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing), and employees in well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present, without running afoul of the overwhelming majority of the provisions in 16VAC25-220. The one exception that the Department has identified are the notification provisions in 16VAC25-220-40.B.7, which would still have to be complied with.

Finally, following is a summary of the VOSH policy on de minimis violations from the VOSH Field Operations Manual:[24]

5. De Minimis Violation Policy.

   Va. Code §40.1-49.4.A.2[25] 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)[26] 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:
   >
   > ....
   > 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.

   The FOM[27] 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.

[24] Chapter 5, p. 76. https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf

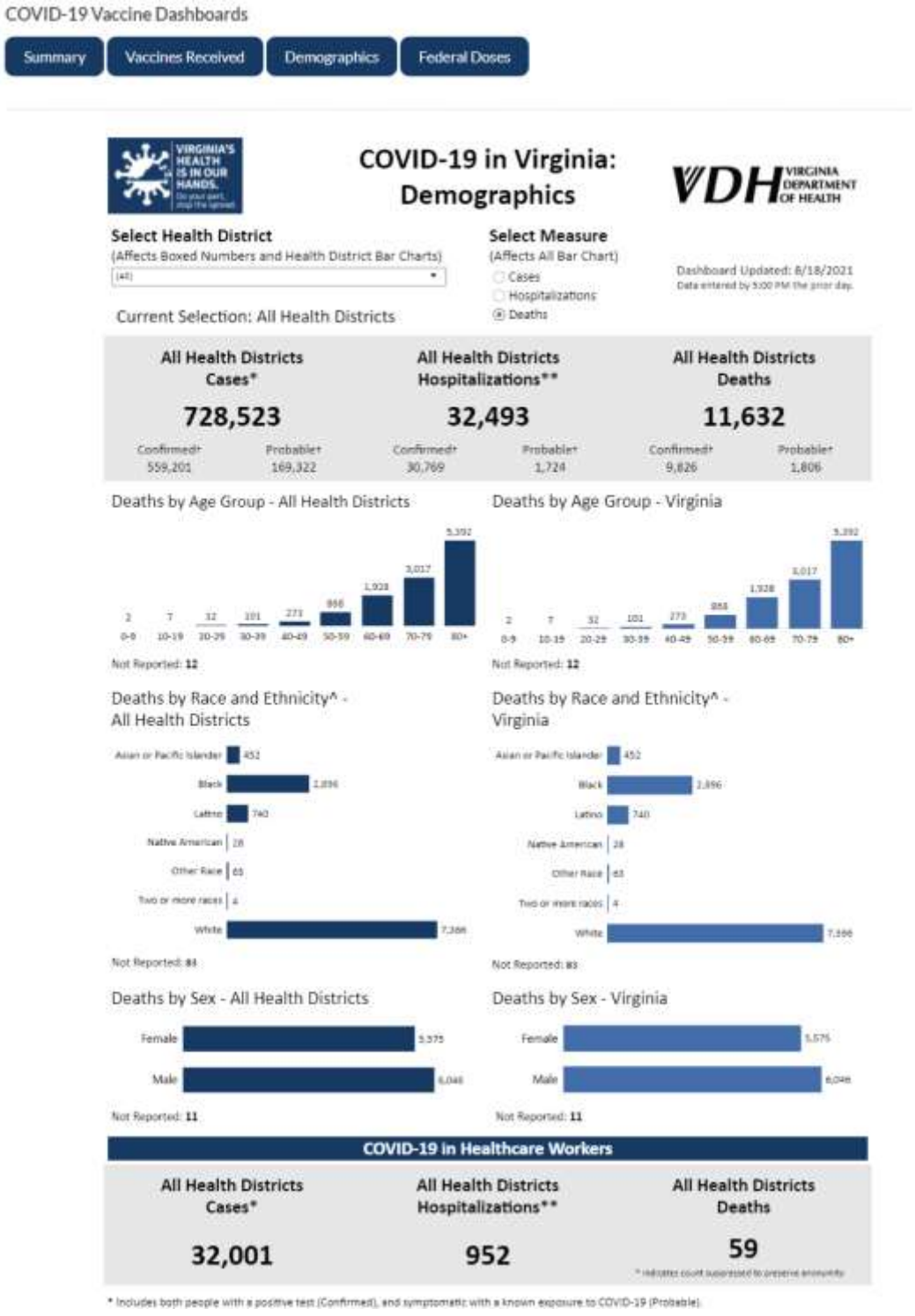
[25] https://law.lis.virginia.gov/vacode/40.1-49.4/

[26] https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf

[27] *Id.* at Chapter 5, p. 76.

21. Virginia Healthcare worker statistics.

As of August 18, 2021, healthcare worker cases in Virginia totaled 32,001, with 952 hospitalizations and 59 deaths.[28]



[28] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-in-virginia-demographics/

22. DOLI Recommended revisions to proposed amendments to 16VAC25-220.

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.(https://www.doli.virginia.gov/wpcontent/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendmentsto-16VAC25-220-7.1.2021.pdf).

The Dept. invites the public to comment on the Revised Proposed Amendments to the VOSH Standard by using the Townhall Comment Forum here. The forum will be open for 7 days from August 16, 2021 to August 23, 2021.
https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309

23. On multi-employer worksites, can the host employer require subcontractors to meet or exceed VOSH safety and health standard requirements?

With regard to multi-employer worksites and different approaches to employee safety and health taken by subcontractors on a host employer's worksite, first, each employer must comply with the requirements in VOSH standards to protect their own employees. Host employers can establish safety and health work rules for companies it contracts with that meet or exceed VOSH requirements. Such rules are normally included in contractual agreements. The Department recommends the commenter consult with legal counsel about including such language contracts with subcontractors who will be entering the host worksite.

24. Meaning of language in proposed amendment 16VAC25-220-50.A.6.a.

With regard to the commenter's question about employees who are licensed EMTs and application of proposed amendment 16VAC25-220-50.A.6.a, if an employer hires a licensed EMT for the purposes of providing medical assistance to employees, the EMT would be considered a "licensed healthcare provider" under the standard. However, if the employee is a licensed EMT but that designation has no relation to her job duties and that employee provides first aid to another employee on a "good Samaritan" basis, the licensed EMT would not be considered a "licensed healthcare provider."

25. OSHA Emergency Temporary Standard.

On June 21, 2021 Federal OSHA issued an emergency temporary standard (ETS) to protect healthcare and healthcare support service workers from occupational exposure

to COVID-19 in settings where people with COVID-19 are reasonably expected to be present.

On June 29, 2021, the Safety and Health Codes Board (Board) adopted the federal COVID19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, with an effective date of August 2, 2021 and which shall expire within six months or when repealed by the Board, whichever occurs first.

The effective date of the ETS as adopted by the Board is August 2, 2021. Virginia employers must comply with all the requirements of the COVID-19 ETS except paragraphs §1910.502 (i), (k) and (n) by August 17, 2021. Employers must comply with paragraphs § 1910.502(i), (k), and (n) by September 1, 2021.

In its motion to adopt the Emergency Temporary Standard, the Safety and Health Codes Board also accepted the recommendation of the Department that:

1. Application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services be later stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services be later stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be maintained, modified, or revoked.

To access the final rule see Occupational Exposure to COVID–19; Emergency Temporary Standard, Interim Final Rule. https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf

For Federal OSHA Outreach Materials, see COVID-19 Healthcare ETS Outreach.
https://www.osha.gov/coronavirus/ets

26. How Long Does Vaccine Immunity Last?

USAToday.com, August 19, 2021, "Vaccine effectiveness declines over time, studies say"

> Protection provided by COVID-19 vaccines declines over time, but protection against the most severe effects of the disease — including hospitalization and death — remains strong, according to three studies published Wednesday by the Centers for Disease Control and Prevention.

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "New COVID-19 Cases and Hospitalizations Among Adults, by Vaccination Status — New York, May 3–July 25, 2021"[29]

> In this study, current COVID-19 vaccines were highly effective against hospitalization ([vaccine effectiveness] VE >90%) for fully vaccinated New York residents, even during a period during which prevalence of the Delta variant increased from <2% to >80% in the U.S. region that includes New York, societal public health restrictions eased,§§ and adult full-vaccine coverage in New York neared 65%. However, during the assessed period, rates of new cases increased among both unvaccinated and fully vaccinated adults, with lower relative rates among fully vaccinated persons. Moreover, VE against new infection declined from 91.7% to 79.8%. To reduce new COVID-19 cases and hospitalizations, these findings support the implementation of a layered approach centered on vaccination, as well as other prevention strategies.

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, " Effectiveness of Pfizer-BioNTech and Moderna Vaccines in Preventing SARS-CoV-2 Infection Among Nursing Home Residents Before and During Widespread Circulation of the SARS-CoV-2 B.1.617.2 (Delta) Variant — National Healthcare Safety Network, March 1–August 1, 2021"[30]

> Analysis of nursing home COVID-19 data from NHSN indicated a significant decline in effectiveness of full mRNA COVID-19 vaccination against laboratory-confirmed SARS-CoV-2 infection, from 74.7% during the pre-Delta period (March 1–May 9, 2021) to 53.1% during the period when the Delta variant predominated in the United States. This study could not differentiate the independent impact of the Delta variant from other factors, such as potential waning of vaccine-induced immunity. Further research on the possible impact of both factors on VE among nursing home residents is warranted. Because nursing home residents might remain at some risk for SARS-CoV-2 infection despite vaccination, multipronged COVID-19 prevention strategies, including infection control, testing, and vaccination of nursing home staff members, residents, and visitors are critical.

Medrxiv.org, August 8, 2021, "Comparison of two highly-effective mRNA vaccines for

[29] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e1.htm?s_cid=mm7034e1_w
[30] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e3.htm?s_cid=mm7034e3_w

COVID-19 during periods of Alpha and Delta variant prevalence"[31]

> Although clinical trials and real-world studies have affirmed the effectiveness and safety of the FDA-authorized COVID-19 vaccines, reports of breakthrough infections and persistent emergence of new variants highlight the need to vigilantly monitor the effectiveness of these vaccines. Here we compare the effectiveness of two full-length Spike protein-encoding mRNA vaccines from Moderna (mRNA-1273) and Pfizer/BioNTech (BNT162b2) in the Mayo Clinic Health System over time from January to July 2021, during which either the Alpha or Delta variant was highly prevalent. We defined cohorts of vaccinated and unvaccinated individuals from Minnesota (n = 25,589 each) matched on age, sex, race, history of prior SARS-CoV-2 PCR testing, and date of full vaccination.
>
> Both vaccines were highly effective during this study period against SARS-CoV-2 infection (mRNA-1273: 86%, 95%CI: 81-90.6%; BNT162b2: 76%, 95%CI: 69-81%) and COVID-19 associated hospitalization (mRNA-1273: 91.6%, 95% CI: 81-97%; BNT162b2: 85%, 95% CI: 73-93%).
>
> However, in July, the effectiveness against infection was considerably lower for mRNA-1273 (76%, 95% CI: 58-87%) with an even more pronounced reduction in effectiveness for BNT162b2 (42%, 95% CI: 13-62%).

[31] https://www.medrxiv.org/content/10.1101/2021.08.06.21261707v1

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. <u>Pandemic Statistics.</u>

The Department respectfully disagrees with the Commenter's assertion that the pandemic is much less impactful then originally feared. As of January 1, 2021, the pandemic 341,199 deaths have been attributed to COVID-19 in the U.S.[32] and 5,117 in Virginia.[33]

<u>2. Notification to VDH – Reporting of Two or More Cases.</u>

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).

<u>3. Employer requirement to assess risk exposure for hazards and job tasks.</u>

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:

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[32] https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

[33] 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/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."[34]

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

[34] 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. <u>Employees wearing face coverings with political statements</u>.

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. <u>Surgical masks versus face coverings</u>.

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. <u>Rapid Testing</u>.

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.[35]

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. <u>VOSH Enforcement.</u>

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.

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[35] 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."[36]

Study: More Than 125,000 Farmworkers Have Contracted Covid-19:[37]

> "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[38] beginning on page 36:

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[36] https://www.agweek.com/business/agriculture/6819831-USDA-report-studies-pandemics-effect-on-rural-America

[37] https://www.ewg.org/news-and-analysis/2020/09/study-more-125000-farmworkers-have-contracted-covid-19

[38] 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. <u>Economic Impact Analysis.</u>

An economic impact analysis (EIA) based on the requirements of Va. Code §2.2-4007.04[39] will be issued no later than January 11, 2021. The EIA is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.[40]

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

[39] https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/
[40] 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. <u>PPE Shortages</u>.

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. <u>Reuse of Respirators.</u>

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")."[41]

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."[42]

19. <u>Impact of Vaccines.</u>

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."[43]

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.

....

<u>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.</u> 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.

....

[41] https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus

[42] https://www.osha.gov/memos/2020-04-24/enforcement-guidance-decontamination-filtering-facepiece-respirators-healthcare

[43] 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).
[44]

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."[45]

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:

[44] https://www.forbes.com/sites/joewalsh/2021/12/29/first-us-case-of-new-covid-mutation-discovered-in-colorado/?sh=5560175e1d79
[45] 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 crumby 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/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

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 COVD-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/conronavirus-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 63[46]).

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.[47] Two of these specifically challenged the face covering requirements. *Schilling et al. v. Northam*, CL20-799 (Albemarle Co. Cir. Ct. July 20, 2020)[48]; *Strother, et al. v. Northam*, CL20-260 (Fauquier Co. Cir. Ct. June 29, 2020).[49]

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)[50] 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.

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[46] 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.pd

[47] 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).

[48] Accessible at https://oag.state.va.us/files/2020/Schilling-et-al-v-Northam.pdf.

[49] Accessible at https://www.oag.state.va.us/files/2020/maskRequirementsCase.pdf.

[50] 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%[51] 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-

[51] 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." [52]

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.[53]

....

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 masks[54] is also based on high risk for transmission from asymptomatic or presymptomatic persons.[55] 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.[56] 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.[57] Correctly putting on and taking off cloth masks improves

[52] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[53] http://www.ijic.info/article/view/11366
[54] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
[55] https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-019-4109-x
[56] MacIntyre CR, Chughtai AA. Facemasks for the prevention of infection in healthcare and community settings. BMJ. 2015;350(apr09 1):h694.
[57] Institute of Medicine. Reusability of facemasks during an influenza pandemic: facing the flu. Washington (DC): The National Academies Press; 2006.

protection.[58] Taking a mask off is a high-risk process[59] because pathogens may be present on the outer surface of the mask and may result in self-contamination during removal.[60]

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),[61] 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

[58] https://wwwnc.cdc.gov/eid/article/26/10/20-0948-t1
[59] https://www.sciencedirect.com/science/article/pii/S0196655318306801?via%3Dihub
[60] https://bmcinfectdis.biomedcentral.com/articles/10.1186/s12879-019-4109-x
[61] 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 COVD-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/conronavirus-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.

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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.

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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/conronavirus-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/conronavirus-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/conronavirus-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/conronavirus-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 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_0.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.

COMMONWEALTH of VIRGINIA

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August 24, 2021

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY

VIRGINIA OCCUPATIONAL SAFETY AND HEALTH PROGRAM

RECOMMENDED REVISIONS TO PROPOSED AMENDMENTS

TO THE VOSH 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 27 written comments through the Virginia Regulatory Townhall for the 7 day written comment period from August 16-23, 2021.

There were 4 written comments sent directly to the Department during the 7 day written comment period.

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 99342).

Standard responses are highlighted in yellow.

99762 Buddy Omohundro 8/17/2021 DO NOT FOLLOW CDC Our governor should look at our specific challenges and make informed decisions based on Virginia data, not general CDC recommendations. Further, the people of Virginia want the ability to make choices about wearing masks and attending events. If you want to take an action, penalize those who choose not to be vaccinated for no valid reason. If everyone was vaccinated, the problem would be minimal.

The following is an example of Virginia specific data is included in the Briefing Package to the Virginia Safety and Health Codes Board for it August 26, 2021 meeting:

As of June 14, 2021, cases in Virginia totaled 677,812 (7-day average 140 cases), 30,182 hospitalizations (7-day average of 10 hospitalizations), with 11,318 deaths (7-day average of 3 deaths).

As of August 10, 2021, cases in Virginia totaled 725,971 (7-day average 1,700 cases), 32,399 hospitalizations (7-day average of 37 hospitalizations), with 11,625 deaths (7-day average of 5 deaths).

The Virginia standard only applies to employees and employers, not the general public.

99779 Anonymous 8/18/2021 Repeal much and studies needed for further restrictions

Regarding the Masks: Data still does not support mask wearing by vaccinated folks as helpful; DOLI or any agency/authority should not make further decisions or restrictions based on the tide of public opinion and fear without a proven and relevant study referenced.

Regarding the rest: The DOLI is still operating on January assumptive data, reviewing since June, while the governor continues to act independently of DOLI for executive orders; with at least some differences with the CDC recommendations. There are too many conflicts. DOLI should exit these considerations; discussions, forums, and procedures of DOLI are not going to be able to keep up with the moving targets of other guidance and orders.

Remove yourselves as much as possible from this confusing heap. Specifically for office buildings and other lower-risk businesses. Let the governor provide the guidance and orders alone for lower-risk business activities and general public safety until the state of emergency is removed

SEE RESPONSE TO COMMENTER 99762

With regard to the efficacy of face masks/face coverings, the CDC states:

"SARS-CoV-2 infection is transmitted predominately by inhalation of respiratory droplets generated when people cough, sneeze, sing, talk, or breathe. CDC recommends community use of masks, specifically non-valved multi-layer cloth masks, to prevent transmission of SARS-CoV-2. Masks are primarily intended to reduce the emission of virus-laden droplets ("source control"), which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than 50% of transmissions.1,2 Masks also help reduce inhalation of these droplets by the wearer ("filtration for wearer protection"). The community benefit of masking for SARS-CoV-2 control is due to the combination of these effects; individual prevention benefit increases with increasing numbers of people using masks consistently and correctly.

Source Control to Block Exhaled Virus

Multi-layer cloth masks block release of exhaled respiratory particles into the environment,3-6 along with the microorganisms these particles carry.7,8 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 ;3,5 which increase in number with the volume of speech10-12 and specific types of phonation.13 Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles3,14 and limit the forward spread of those that are not captured.5,6,15,16 Upwards of 80% blockage has been achieved in human experiments that have measured blocking of all respiratory droplets,4 with cloth masks in some studies performing on par with surgical masks as barriers for source control.

Filtration for Wearer Protection

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. The relative filtration effectiveness of various masks has varied widely across studies, in large part due to variation in experimental design and particle sizes analyzed. Multiple layers of cloth with higher thread counts have demonstrated superior performance compared to single layers of cloth with lower thread counts, in some cases filtering nearly 50% of fine particles less than 1 micron .14,17-29 Some materials (e.g., polypropylene) may enhance filtering effectiveness by generating triboelectric charge (a form of static electricity) that enhances capture of charged particles18,30 while others (e.g., silk) may help repel moist droplets31 and reduce fabric wetting and thus maintain breathability and comfort. In addition to the number of layers and choice of materials, other techniques can improve wearer protection by improving fit and thereby filtration capacity. Examples include but are not limited to mask fitters, knotting-and-tucking the ear loops of medical procedures masks, using a cloth mask placed over a medical procedure mask, and nylon hosiery sleeves.

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 FPS and the Emergency Temporary Standard (ETS), 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.

99799 Anonymous 8/20/2021 Fully Vaccinated vs. Unvaccinated Confusion/Difficulties

Given that the CDC has indicated a booster will likely be required after 8 months, and that it will be ongoing, it seems as if no one would ever be fully vaccinated. This leads to confusion. Additionally separating individuals either by protective requirements or distance based on the status of a vaccine is not practical in all environments and leads to confusion. Additionally the CDC indicates the Delta variant can be transmitted for those who are currently defined as fully vaccinated just as much as those who are not. All of this leads to confusion and it would make the standard difficult to manage. A consistent approach to protective measures for all employees (not related to vaccines) is an approach that is more

practical. With regard to the commenter's concerns about employees being treated differently based on their vaccination status, the Department notes that, as many employers and organizations representing employers have requested, the proposed amendments are designed to address updated CDC guidance on the issue. If the commenter has concerns about employees being treated differently based on vaccination status, the Department notes that employers can legally implement face covering and other safety and health rules for their employees that are more stringent than 16VAC25-220.

99801 Anonymous Mandated Vaccine Adverse Effects Recordkeeping

If an employer mandates vaccines, it should be outlined that the employer document when an adverse event to a vaccine occurs, just as is required with recordable incidents (medical treatment, hospitalizations, death).

The Standard does not require employers to mandate vaccines.

With regard to the recording of adverse reactions to COVID-19 vaccines, federal OSHA sets national policy on recordkeeping requirements, which state plans for occupational safety and health, such as Virginia, are required to comply with. They have issued the following Frequently Asked Question on the Issue:

Are adverse reactions to the COVID-19 vaccine recordable on the OSHA recordkeeping log?

DOL and OSHA, as well as other federal agencies, are working diligently to encourage COVID-19 vaccinations. OSHA does not wish to have any appearance of discouraging workers from receiving COVID-19 vaccination, and also does not wish to disincentivize employers' vaccination efforts. As a result, OSHA will not enforce 29 CFR 1904's recording requirements to require any employers to record worker side effects from COVID-19 vaccination through May 2022. We will reevaluate the agency's position at that time to determine the best course of action moving forward.

https://www.osha.gov/coronavirus/faqs#vaccine

99802 Scott Killian 8/20/2021 Opposition to Regulations During the 30-day public comment period for the previous proposed amendment, many (including myself) voiced opposition to the amended regulation and indeed any further regulation. Now, in response to the CDC's revised recommendations regarding masking (which has a highly questionable basis itself), a revised version of the proposed amendment has been put forth with only a 7-day comment period. I would refer you to my previous comment and all of the comments submitted during the 30-day period. It is my sincere hope that you review those and take them into honest, good faith consideration now as well, and don't just treat them as "comments to the prior amendment but not to this". To summarize my prior comment, I do not think any regulation at this point makes sense, is over-reaching, and creates additional hurdles that are burdensome for Virginia businesses.

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. The number of COVID-19 daily infections in Virginia and the United States continue to support the conclusion of ongoing widespread community transmission of the virus, particularly the Delta variant, and the continuing possibility of the introduction of SARS-CoV-2 into Virginia's workplaces for many months to come. While highly effective vaccines against the disease are widely available at no cost, there is still a considerable percentage of the population nationally and in Virginia that is not fully vaccinated.

It is the Department's position that the VOSH Standard remains 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 VOSH Standard ultimately helps 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.

The Department notes that the VOSH 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.

Some commenters raised concerns about the standard 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. 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. Va. Code § 40.1-22.

DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC's updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask ("face covering" in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:

https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.

The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:

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.

Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021, which resulted in the CDC update:

Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."

https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

The CDC reports the following as of August 11, 2021:

Reported Cases

The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619). A total of 36,268,057 COVID-19 cases have been reported as of August 11.

Deaths

The current 7-day moving average of new deaths (492) has increased 21.0% compared with the previous 7-day moving average (407). The current 7-day moving average is 59.3% lower compared to the peak observed on August 2, 2020 (1,210). The current 7-day moving average is 86.5% lower than the peak observed on January 13, 2021 (3,640) and is 170.4% higher than the lowest value observed on July 10, 2021 (182). As of August 11, a total of 617,096 COVID-19 deaths have been reported in the United

States.

Hospitalizations, New Hospital Admissions

The current 7-day average for August 4–August 10 was 10,072. This is a 29.6% increase from the prior 7-day average (7,771) from July 28–August 3. The 7-day moving average for new admissions has consistently increased since June 25, 2021. New admissions of patients with confirmed COVID-19 are currently at their highest levels since the start of the pandemic in Florida, Louisiana, and Oregon.

Vaccinations

The U.S. COVID-19 Vaccination Program began December 14, 2020. As of August 12, 353.9 million vaccine doses have been administered. Overall, about 196.5 million people, or 59.2% of the total U.S. population, have received at least one dose of vaccine. About 167.4 million people, or 50.4% of the total U.S. population, have been fully vaccinated.* As of August 12, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 699,068, a 0.03% decrease from the previous week.

CDC's COVID Data Tracker Vaccination Demographic Trends tab shows vaccination trends by age group. As of August 12, 90.6% of people ages 65 or older have received at least one dose of vaccine and 80.6% are fully vaccinated. Over two-thirds (71.5%) of people ages 18 or older have received at least one dose of vaccine and 61.3% are fully vaccinated. For people ages 12 or older, 69.2% have received at least one dose of vaccine and 59% are fully vaccinated.

99809 Anonymous 8/20/2021 COVID Testing--Medical Procedure

With regards to COVID testing, with many employers now mandating vaccines or regular COVID testing, it should be indicated that the testing should not create an undue hardship or inconvenience for employees to the testing. This type of testing should be provided, at no cost and unrelated to medical insurance. Additionally, any injury as a result of this type of medical procedure that may require medical attention, should be considered a recordable injury.

SEE RESPONSE TO COMMENT 99801

The Standard does not require employers to mandate vaccines.

It is the Department's understanding that COVID-19 vaccines are still provided free of charge.

How do I get an authorized COVID-19 vaccine?

Search vaccines.gov, text your ZIP code to 438829, or call 1-800-232-0233 to find COVID-19 vaccine locations near you in the U.S. In some states, information may be limited while vaccination providers and pharmacies are being added. Contact your state health department to find additional vaccination locations in your area.

FDA-authorized COVID-19 vaccines are distributed for free by states and local communities. You cannot buy COVID-19 vaccines online. You do not need to pay any out-of-pocket costs to get an authorized COVID-19 vaccine — not before, during, or after your appointment. If someone asks you to pay for your vaccine, it is either a scam or a mistake.

https://www.fda.gov/consumers/consumer-updates/learn-more-about-covid-19-vaccines-fda

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99814 Dennis A. Edwards, CHST, OHST 8/20/2021 Repeal the FPS So another couple of weeks goes by and here we are again. More changes have been proposed and more information has come out since those proposals were made. Regulation can't keep up with the constant evolution of the situation. End the standard. Require businesses to follow all current CDC guidelines. Use the general duty clause. Stop the madness.

Most people can see how this has become an extremely political situation. VOSH owes it to all businesses in the Commonwealth to step out of the political game and stick to keeping workers safe.

Many comments appear to be under a misunderstanding about the ability of the VOSH Standard to respond to changes in CDC guidance. While it is true that the text of the VOSH Standard remains as it was when first adopted effective January 27, 2021, please note that 16VAC25-220-10.E provides:

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 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. 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 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.

Contrary to many commenters stating that the VOSH Standard is inflexible and unable to account for the changing dynamic of the virus and the revised CDC recommendations that have issued, 16VAC25-220-10.E specifically does allow the Department's VOSH Standard to account for revised CDC recommendations which are issued in response to the changing dynamic of the virus.

As an example, in §40, FAQ 55 regarding CDC guidance changes for fully vaccinated persons, the Department consulted with the Virginia Department of Health (VDH) and concluded the following within a matter of days of the issuance of the updated CDC guidance on fully vaccinated people:

As the CDC comes out with revised guidelines for fully vaccinated employees in a public workplace setting, the Department reviews the changes with the Virginia Department of Health (VDH) and addresses any changes in compliance requirements in an FAQ.

The Department and VDH agree that based on the CDC's science-based determination that, with the exceptions previously noted, these FAQs, including §40, FAQs 46 to 57, fully vaccinated non-healthcare employees can safely resume indoor and outdoor workplace duties without wearing a face covering or physically distancing in public indoor settings if the place of employment is in an area of moderate or low COVID-19 transmission. Such activities would be in compliance with and provide employees equivalent protection to 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11. Face coverings must continue to be worn in public indoor settings if the place of employment is in an area of substantial or high COVID-19 transmission.

Unlike the states of California and Oregon, for instance, who issued Emergency Temporary Standards (that did not contain language similar to 16VAC25-220-10.E) and later had to convene their regulatory rulemakers to reissue updated regulatory text to reflect CDC changes, Virginia did not have to do so

because it could address them within days of CDC changes through interpretative responses to questions asked by the regulated community and employee representatives.

In closing, 16VAC25-220-10.E, has turned out to be a very effective method for the Virginia to deal with the changing dynamic of the virus and the revised CDC recommendations that have issued.

The Department has issued FAQs addressing the CDC's updates concerning persons who are fully vaccinated (see §10, FAQs 19-22, and §40, FAQs 46-54).

The FAQs can be found at: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

DOLI updated its Frequently Asked Questions (FAQ) for the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, in response to the CDC's updated guidance issued on July 27, 2021. The CDC update resulted in changes to face mask ("face covering" in the VOSH Standard) recommendations for fully vaccinated people in public indoor settings in areas with high and substantial COVID-19 transmission rates:

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

VDH is updating its transmission metrics which can be found at:

https://www.vdh.virginia.gov/coronavirus/key-measures/pandemic-metrics/

See §40, FAQs 54 and 55, which were directly impacted by the updated CDC guidance.

The FAQs were the result of a review by DOLI and VDH in accordance with 16VAC25-220-10.E, which provides in part:

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.

Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021 titled Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021, which resulted in the CDC update:

Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."

https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

99815 Anonymous 8/20/2021 Statements Such as Provide that such requirements do not apply to fully vaccinated employees.

Statements and criteria such as "Provide that such requirements do not apply to fully vaccinated employees" creates confusion and in some large operations, such as construction sites, it is not feasible.

If the standard is in place, it should apply to all individuals, especially given that the vaccine is not 100% effective, boosters may be required, and even those who are vaccinated can transmit some variants just as much as unvaccinated individuals.

SEE RESPONSE TO COMMENT 99799

With regard to the issue of face covering requirements, the recommended revisions to the proposed amendments to the standard, in accordance with CDC guidance, treat vaccinated and unvaccinated employees the same in areas of substantial and high community transmission.

99816 Stephen Craig No mechanism to notify regulated community of substantive changes through FAQ edits! DOLI has adopted the use of FAQ's as their preferred method of adjusting the FPS to fit current CDC guidance. I understand the need for flexibility in response to an ever changing situation, and although I believe it is of questionable legality, I am willing to accept this method of regulatory updates for lack of a better alternative. What I find completely unacceptable though, is the lack of a mechanism by which the regulated community is informed of such changes. I have become a nearly obsessive in checking the FAQs to look for new additions. I thought I was really on top of the game. And then I discovered that changes are being made by DOLI to the wording within their previous answers to FAQ's!!! How in the world can we find time to figure out how to comply with the rules if we have to spend every waking minute performing comparative analysis of the entire content of the FAQ web page? PLEASE PLEASE PLEASE establish some obvious system of notification when there are changes being made to the standard by way of FAQ. I'd love to be on an e-mail mailing list or get notifications through an app... something other than dumb luck of stumbling into new words.

The commenter can contact the Department and request to be place on a list of stakeholders that the Department regularly sends out notices to: webmaster@doli.virginia.gov

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99827 Anonymous 8/20/2021 IDRP The IDRP for an employer should be included for all employees, not just those who have not received a vaccine.

The Department assumes that when the commenter refers to "IDRP" they are referring to an Internal Dispute Resolution Procedure. The Standard does not have a provision addressing IDRPs.

99835 Chris Cook 8/20/2021 Objection to proposed standard

The proposal, as revised, continues to be deeply flawed. The two most glaring issues:

1) It places an unreasonable burden on businesses both in terms of monitoring, placing demand on employers to create two classes of workers; essentially requiring employers disclose employees medical choices to all employees. Could that then trigger A.D.A. violation claims? Would the potential for employees feeling harassed by the employer and/or other employees as "The problem around here", make them feel vulnerable to harassment, bias? Would it place "undue emotional stress" creating a perception of the employer creating a hostile, unsafe work environment? Could that be viewed, ironically as a violation of OSHA's General Duty Clause.

2) The standard implies that COVID-19 is a workplace hazard; it is not. It is an airborne virus, It can be contracted anywhere. There is no way to determine an employee caught COVID-19 at the workplace. Period. It is not a workplace hazard that can mitigated like a chemical, or tripping hazard, etc.

As Governor Northam has stated, the focus needs to be on vaccinating the population. It will not be fixed by more legislation that is disconnected from any practical understanding of how businesses actually operate in the real world. Businesses across the Commonwealth, already traumatized by the events of the past year don't need or want this. We want our employees, customers, and the public at large to get vaccinated.

SEE RESPONSE TO COMMENT 99799
SEE RESPONSE TO COMMENT 99802

For information on ADA, HIPAA, etc., See DOLI §10, FAQ 21: https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/

21. CAN MY EMPLOYER LEGALLY ASK IF I RECEIVED THE COVID-19 VACCINE AND AM FULLY VACCINATED?

The Department is not aware of any Virginia law, standard or regulation that prohibits employers from asking employees if they have received the COVID-19 vaccine and are fully vaccinated, and if so, requiring employees to show proof of full vaccination.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) applies to "covered entities" and "business associates," and in most cases does not apply to employers. Accordingly, the patient privacy protections contained in HIPAA do not apply to employers who ask employees if they have received the COVID-19 vaccine and are fully vaccinated or require employees to show proof of full vaccination. For further information on HIPAA see: https://www.hhs.gov/hipaa/for-individuals/employers-health-information-workplace/index.html

EEOC

The Equal Employment Opportunity Commission (EEOC) indicates that employers may require employees to show proof of full vaccination, but notes certain issues associated with such a mandate:

https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

K.3. Is asking or requiring an employee to show proof of receipt of a COVID-19 vaccination a disability-related inquiry? (December 16, 2020)

No. There are many reasons that may explain why an employee has not been vaccinated, which may or may not be disability-related. Simply requesting proof of receipt of a COVID-19 vaccination is not likely to elicit information about a disability and, therefore, is not a disability-related inquiry. However, subsequent employer questions, such as asking why an individual did not receive a vaccination, may elicit information about a disability and would be subject to the pertinent ADA standard that they be "job-related and consistent with business necessity." If an employer requires employees to provide proof that they have received a COVID-19 vaccination from a pharmacy or their own health care provider, the employer may want to warn the employee not to provide any medical information as part of the proof in order to avoid implicating the ADA.

99848 Anonymous End the Mask Mandates

After reviewing these proposed amendments I was alarmed as an employee of the Commonwealth to discover that DOLI will once again blindly follow CDC recommendations that will have employers in the Commonwealth requiring their employees to wear a mask in the workplace. The distinction between the first mask mandate and this time around is that there is now a vaccine that is (and has been for months) widely available to any who choose to take it. Additionally but no less significant, add to that the fact that there are many who have developed natural immunity after contracting the Covid-19 virus. Despite having immunity to the Covid-19 virus, whether it be natural or through a vaccine, those individuals (now the majority of the population) will be forced soon to don a mask in the workplace if the DOLI proposed amendments to this standard are ratified. Further, I have yet to see a legitimate peer-reviewed scientific study that directly correlates a substantial reduction of Covid-19 cases/deaths to populations that incorporate mask mandates as part of their prophylactic efforts. To be sure, a cloth mask such as those that are typically donned to comply with Covid mask mandates would be ineffective in protecting an individual in a basic wood working shop from inhaling wood dust particles that are orders of magnitudes larger in size than the Covid-19 virus.

The foundation for DOLI's proposal to implement mask mandates is based on the latest CDC recommendations. Unfortunately, one can no longer claim that as a result those recommendations are based on actual science. Once it was discovered that the CDC was consulting with the National Education Association (NEA) to determine whether or not teachers should return to the classroom instead of relying on legitimate peer reviewed scientific studies, they lost all credibility as an agency that was supposed to make objective recommendations that are unimpeded by political motivation.

Absent legitimate data that would clearly and objectively demonstrate that cloth masks significantly reduce the transmission of Covid-19, coupled with the clearly evident political motivation of the CDC to recommend mask mandates, it is clear to me that the primary and sole reason at this point in time to reimplement mask mandates in the workplace is for political theater. Masks on faces function to perpetuate the initial fear caused by the Covid pandemic, which in turn causes individuals to offer less resistance when asked to surrender individual freedoms under the guise of combating a public health emergency.

Covid-19 is here to stay now, just like the flu virus and the cold virus before it. It is utter madness to suggest that mask mandates, social distancing, and shutdowns will continue until Covid-19 has been completely eradicated. Sadly that is exactly the path that we as a Commonwealth find ourselves on right now. I would therefore implore DOLI to turn a deaf ear to political pressures and demonstrate the fortitude needed to rely instead on objective science based evidence to draft amendment proposals to this Standard. Enough is enough - end the mask mandate permanently and allow individuals in the workforce to make health related decisions for themselves based on guidance received from their own medical doctor. If that means they choose to wear a mask in the workplace, so be it. If that means they opt to forgo a mask, that should be equally acceptable to the employer and supported by the DOLI standard.

SEE RESPONSE TO COMMENT 99779
SEE RESPONSE TO COMMENT 99799

A recent study published in the CDC's Morbidity and Mortality Weekly Report on August 13, 2021 found that:

Although laboratory evidence suggests that antibody responses following COVID-19 vaccination provide better neutralization of some circulating variants than does natural infection, few real-world epidemiologic studies exist to support the benefit of vaccination for previously infected persons. This report details the findings of a case-control evaluation of the association between vaccination and SARS-CoV-2 reinfection in Kentucky during May–June 2021….

Among Kentucky residents infected with SARS-CoV-2 in 2020, vaccination status of those reinfected during May–June 2021 was compared with that of residents who were not reinfected. In this case-control study, being unvaccinated was associated with 2.34 times the odds of reinfection compared with being fully vaccinated.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm

How Long Does Vaccine Immunity Last?

USAToday.com, August 19, 2021, "Vaccine effectiveness declines over time, studies say"

Protection provided by COVID-19 vaccines declines over time, but protection against the most severe effects of the disease — including hospitalization and death — remains strong, according to three studies published Wednesday by the Centers for Disease Control and Prevention.

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "New COVID-19 Cases and Hospitalizations Among Adults, by Vaccination Status — New York, May 3–July 25, 2021"

In this study, current COVID-19 vaccines were highly effective against hospitalization ([vaccine effectiveness] VE >90%) for fully vaccinated New York residents, even during a period during which prevalence of the Delta variant increased from <2% to >80% in the U.S. region that includes New York, societal public health restrictions eased,§§ and adult full-vaccine coverage in New York neared 65%. However, during the assessed period, rates of new cases increased among both unvaccinated and fully vaccinated adults, with lower relative rates among fully vaccinated persons. Moreover, VE against new infection declined from 91.7% to 79.8%. To reduce new COVID-19 cases and hospitalizations, these findings support the implementation of a layered approach centered on vaccination, as well as other prevention strategies.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e1.htm?s_cid=mm7034e1_w

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, " Effectiveness of Pfizer-BioNTech and Moderna Vaccines in Preventing SARS-CoV-2 Infection Among Nursing Home Residents Before and During Widespread Circulation of the SARS-CoV-2 B.1.617.2 (Delta) Variant — National Healthcare Safety Network, March 1–August 1, 2021"

Analysis of nursing home COVID-19 data from NHSN indicated a significant decline in effectiveness of full mRNA COVID-19 vaccination against laboratory-confirmed SARS-CoV-2 infection, from 74.7% during the pre-Delta period (March 1–May 9, 2021) to 53.1% during the period when the Delta variant predominated in the United States. This study could not differentiate the independent impact of the Delta variant from other factors, such as potential waning of vaccine-induced immunity. Further research on the possible impact of both factors on VE among nursing home residents is warranted. Because nursing home residents might remain at some risk for SARS-CoV-2 infection despite vaccination,

multipronged COVID-19 prevention strategies, including infection control,§§ testing, and vaccination of nursing home staff members, residents, and visitors are critical.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e3.htm?s_cid=mm7034e3_w

Medrxiv.org, August 8, 2021, "Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence"

Although clinical trials and real-world studies have affirmed the effectiveness and safety of the FDA-authorized COVID-19 vaccines, reports of breakthrough infections and persistent emergence of new variants highlight the need to vigilantly monitor the effectiveness of these vaccines. Here we compare the effectiveness of two full-length Spike protein-encoding mRNA vaccines from Moderna (mRNA-1273) and Pfizer/BioNTech (BNT162b2) in the Mayo Clinic Health System over time from January to July 2021, during which either the Alpha or Delta variant was highly prevalent. We defined cohorts of vaccinated and unvaccinated individuals from Minnesota (n = 25,589 each) matched on age, sex, race, history of prior SARS-CoV-2 PCR testing, and date of full vaccination.

Both vaccines were highly effective during this study period against SARS-CoV-2 infection (mRNA-1273: 86%, 95%CI: 81-90.6%; BNT162b2: 76%, 95%CI: 69-81%) and COVID-19 associated hospitalization (mRNA-1273: 91.6%, 95% CI: 81-97%; BNT162b2: 85%, 95% CI: 73-93%).

However, in July, the effectiveness against infection was considerably lower for mRNA-1273 (76%, 95% CI: 58-87%) with an even more pronounced reduction in effectiveness for BNT162b2 (42%, 95% CI: 13-62%).

https://www.medrxiv.org/content/10.1101/2021.08.06.21261707v1

Please note that 16VAC25-220-10.B.3 provides:

3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia’s 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be maintained, modified, or revoked.

99849 Jonathan Bottoms 8/21/2021 Falling on deaf ears - yet again.

These next round of "revisions" clearly show the same bias & blatant lack of Virginia's commitment to protect simple freedoms. Unfortunately, this state (as well as many others) will have to learn the hard way - at what point do we, the employees, finally say we've had enough of these restrictions? Given that they are only in place to allow our employers to continue making money, these divisive regulations will undoubtedly have a negative impact on workplace morale, staffing, & solidarity.

Can someone explain to the citizens of this state:

Why is there no mention of "breakthrough" infections of vaccinated persons?

Why is there no mention of individuals who have contracted & since recovered from Covid? Are they not to be considered as protected?

Why hasn't the State mandated/required employers to provide compensation for lost work days due to Covid and/or Covid investigations?

What kind of safeguards is the State offering to those of us who do not wish to cover our faces, nor be singled out/hassled about our vaccination status?

Why would an employee subject themselves to these regulations, when incentives still exist for the unemployed?

What are the leaders of this state prepared to do in response to a mass exodus of its own workforce?

With so many changing narratives in the ever-changing, inconsistent narrative that is Covid-19, why do the leaders of Virginia STILL feel like it is their duty & their right to disregard the freedoms granted to their own citizens?

At some point, we all must realize and accept that we cannot "protect" ourselves by attempting to control others. As with anything in life, we make choices that are best for ourselves & those that we care about. If we lose the freedom to make these choices, we are giving up control of the one thing that inherently ours - our lives.

If you fear the Covid-19 virus - by all means, mask up and/or get vaccinated. It is your right to believe in any threat & make appropriate decisions based on what you feel is best for you. However, that should in no way make you feel empowered nor obligated to oppress others with your own feelings & beliefs. Common courtesy & respect for each other as diverse, free-thinking individuals has gone out the window since the onset of Covid. I urge this state to stop creating more division & adversity among its residents. As I stated in my previous post - all of this has gone on for far too long. Virginia must move forward from Covid-19, in a way that is inclusive of ALL of its residents.

SEE RESPONSE TO COMMENT 99848

The Department does not have jurisdiction over unemployment compensation.

The VOSH Standard addresses medical situations that prevent a person from wearing a face covering:

J. 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:

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.

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

3. 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.

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

5. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.

99850 Anonymous 8/21/2021 End the mask mandate End the mask mandate

SEE RESPONSE TO COMMENT 99779
SEE RESPONSE TO COMMENT 99802

99851 Anonymous 8/21/2021 Faith over fear. Quit putting faith of “safety” in a cloth or paper. Instead TRUST God!

Faith over fear. Quit putting faith of “safety” in a cloth or paper. Instead TRUST God!

SEE RESPONSE TO COMMENT 99779
SEE RESPONSE TO COMMENT 99802

99852 Anonymous 8/21/2021 Stop. Just stop! You are violating the constitution!

The constitutionality of the VOSH Standard was challenged in Richmond Circuit Court and upheld (Virginia Manufacturer’s Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Order Granting Motion to Dismiss, March 4, 2021). The case is on appeal to the Virginia Court of Appeals (Virginia Manufacturer’s Association, et al. v. Ralph S. Northam, et al, Case Number CL20004521, Notice of Appeal, March 31, 2021).

99853 Anonymous 8/21/2021 STOP the madness! I'm sure this is all for fun and you don't consider anyone's opinion but your own. However, on a wing and a prayer, I'll just say this: you are the blind leading the blind. What about people who have recovered from covid and carry antibodies? And for the love of pete, there should be an exception to all vaccinations until it is fully approved by the FDA. As of today, this is still in emergency approval status. Finally, these masks you want to mandate... have you checked the side of a box recently? Unless it's a N95 mask, the manufacturer has a disclaimer that it doesn't protect against covid micron particles. And while I doubt the person sewing cotton masks on Etsy may not have a warning, I'll just assume that 100% breathable cotton mask with your favorite NFL team logo on it doesn't stop a virus that escaped from a level 5 biolab. But hey... what do I know?

SEE RESPONSE TO COMMENT 99779
SEE RESPONSE TO COMMENT 99802
SEE RESPONSE TO COMMENT 99848

On August 23, 2021, the FDA approved the first COVID-19 vaccine, known as the Pfizer-BioNTech COVID-19 Vaccine, now known as Comirnaty (koe-mir'-na-tee), for the prevention of the disease in individuals 16 years of age and older. The vaccine also continues to be available under emergency use authorization (EUA), including for people 12 through 15 years of age and for the administration of a third dose in certain immunocompromised individuals.

https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/comirnaty-and-pfizer-biontech-covid-19-vaccine-frequently-asked-questions

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99854 Alison Creamer 8/22/2021 Mask mandates

CDC discounted the Denmark study siting 3k people were not enough to determine an outcome yet they use anecdotal stories about hairdressers as case for masking.

There is reports from dentist noting mouth disease , called mask mouth now that causes issues and decay happening because of the use of mask for long periods of time. This does show mask are causing harm. The Mayo Clinic lays out proper masking - I expect my school teacher to ensure my child is following these guidelines since the school is mandating my child wear a medical divide.

Children are not at risk and are able to build natural immunity if exposed at this time with minimal risk. It's time to allow our kids to breath free- build immunity and break the cycle of drug induced antibody that will only prop up big pharmaceuticals and the elite. sincerely, a mother of an 8 year old

SEE RESPONSE TO COMMENT 99779

The standard does not apply to children unless they are employed.

99855 Anonymous 8/22/2021 Mask mandates Medical freedom is the right choice not mandate.

Masking up will have/has had some long term physiological effects on the mental health of our children and ourselves. We still don't know what the long term total affects will be physically on our health especially our children. We've been doing this for almost 18 months and it does not look good for our children's physiological and physical health. Please do your own research.

SEE RESPONSE TO COMMENT 99779

The standard does not apply to children unless they are employed.

99856 Sam Janney 8/22/2021 End the masking - Violating Title 12 These mask mandates violate Title 12 around Restraint and Seclusion. Forced masking is a restraint and leads to a feeling of seclusion - you are opening yourself up to many a lawsuit.

SEE RESPONSE TO COMMENT 99779

There are many VOSH and OSHA standards are regulations that require various forms of protective clothing or equipment. The Department is not aware of any legal prohibition against requiring the wearing of face coverings.

99857 Resilientmom 8/22/2021 Mask don't work, PCR test doesn't differentiate between sars cov2 and influenza

I’m not understanding why there is a mask mandate when they do more harm than good and the PCR rapid test was phase 1 recall, the other PCR test has the EUA pulled as of December 2021 due to the lack of differentiation between sars cov2 and influenza and there are no isolates found for Covid that makes Covid a hoax. Do your research and shame on you!!

SEE RESPONSE TO COMMENT 99779

99859 Concerned Citizen 8/23/2021 Support for these changes Most of the comments on this issue are complete nonsense by some very dramatic keyboard warriors. I applaud DOLI's efforts to keep workers safe despite the rising tide of misinformation and absurdly placed outrage over simple mitigation efforts.

As a citizen working in a mental health clinic that has remained open during the entirety of this pandemic, providing needed services for our vulnerable populations, I can say with absolute certainty that these standards are not difficult to implement and have contributed to our ability to remain on the front lines.

Please continue to amend the standard as the science progresses and ignore the tantrums of our Social Media Scientists.

SEE RESPONSE TO COMMENT 99802

99860 Anonymous 8/23/2021 Edits and Updates Confusing: Please Scrap Original and Start from Scratch

Since July 2020, there have been many edits to this document. There have so many edits that there are parts of the standard that contradicts itself. This has made it nearly impossible to follow the intent of the standard. Instead of editing again and again, please start from scratch, just identifying that employers should follow CDC guidelines and include some guidance to go along with that. Other safety standards do not get into the "how" of implementing in the workplace, the updated standard is getting into this too much, which should be left up to employers and outlined in an employers IDRP. The vaccination status should not be included in the standard because this places an undue burden on workplace supervisors/managers to track and implement this sort of division among staff members/workforce. Instead, the protective measures should be all inclusive for both protection and implementation of the standard. The current standard is too convoluted and would be better for employers if it were more straightforward while also allowing employers to customize implementation of the standard in their own IDRP.

SEE RESPONSE TO COMMENT 99799

99861 Sara Kitt, Anheuser-Busch 8/23/2021 Requested Updates and Clarifications

Thank you for the many updates to the proposed regulation. Below are comments on the updated proposed amendments.

· Additional guidance is needed on exactly what area’s metrics are to be used to make the determination on community transmission (county, region, state, etc.).

· The process of finding the metrics required to determine the transmission level should be streamlined on the VDH website to allow for accurate and efficient determination of community transmission.

· There needs to be an implementation timeline for rolling out the additional requirements for vaccinated employees once the data indicates community transmission has become substantial or high. The change in expectations for vaccinated employees when this happens will need to be communicated and understood by hundreds of people throughout the facility. We recommend at least 24 normal business hours to implement.

The commenter can use the CDC's county level community transmission map: https://covid.cdc.gov/covid-data-tracker/#county-view

As of August 23, 2021, all of Virginia is classified as either substantial or high. The Department is aware that county level transmission rates can theoretically change on a daily basis and will use its enforcement discretion in assessing whether an employer has acted in a reasonable and timely manner to protect its employees.

99862 Laura Karr, Assoc. General Counsel Comments by the Amalgamated Transit Union, International President John Costa

8/23/2021 Reject Recommended Revisions to Preserve Worker Protections

The Amalgamated Transit Union (the "ATU") submits the following Comments regarding the recommended revisions to the proposed amendments to the VOSH Standard for Infectious Disease Protection of the SARS-CoV-2 Virus that Causes COVID-19 (the "Standard"), which are under consideration by the Virginia Safety and Health Codes Board (the "Board"). As the labor union representing over 2,200 bus, rail, and paratransit workers employed throughout Virginia, the ATU comes before the Board to present these workers' pressing safety concerns regarding the recommended revisions – just as the ATU did in October 2020, January 2021, and July 2021 concerning the Standard and the proposed amendments thereto.

The ATU strongly opposes the revision to 16 VAC 25-220-10(E), which would allow an employer to disregard the final permanent standard and adhere to CDC guidance, even when doing so puts workers in greater danger. Since VOSH implemented its Emergency Temporary Standard Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19 (the "ETS") and as that rule evolved to become the Standard, VOSH has allowed an employer to substitute compliance with the agency's rules with compliance with "CDC guidelines" only when those guidelines "provide[ ] equivalent or greater protection than provided by a provision of the relevant VOSH rule.[1] Now, however, the state recommends removing this clause, thereby allowing an employer to substitute CDC compliance regardless of the worker protections that the CDC provides relative to those in the Standard. Such a revision is unacceptable to transit workers for both practical and logistical reasons.

Regarding practicalities, the recommended revision to 16 VAC 25-220-10(E) would allow an employer to void many of the Standard's most significant protections for transit workers: employer requirements for protecting workers who ride in vehicles with others.[2] These provisions require a transit employer to provide fresh air ventilation to such workers, to separate them from others as much as possible (such as by limiting transit vehicle capacities), and to provide them with respirators. Current

CDC guidance regarding workplace protections from SARS-CoV-2 and Covid-19 does not include any provisions accounting for or mitigating the specific exposure threats that are present in shared vehicles. In fact, the CDC has wholly abandoned its insufficient and ineffective prior efforts to provide workplace safety guidance to transit employers. Its "COVID-19 Employer Information for Bus Transit Operators" (last updated May 7, 2021) and "COVID-19 Employer Information for Transit Maintenance Workers" (last updated June 9, 2021) pages are archived.[3] Further, the agency's guidance for "specific industries and occupations" includes nothing regarding transit.[4]

Therefore, a transit employer permitted to choose compliance with the Standard or with CDC guidance, regardless of the relative protections offered, would look to the CDC's general guidance for all workplaces and businesses.[5] This guidance is far from comprehensive, and it omits many of the Standard's core provisions that are essential to transit workers. First, it neglects to identify transit workers among those who work in high-risk environments and who therefore require high levels of protection.[6] By extension, the CDC – unlike the Standard – does not require transit employers to provide maximum air filtration, including MERV-13 filters where possible, or virus-blocking barriers.[7] Certain of these measures appear in the CDC's guidance regarding "Tools to Improve Ventilation," but by its terms, this guidance applies only to buildings, and not to the vehicles in which many transit workers spend their days.[8]

Likewise, the CDC's workplace guidance does not require an employer to establish an infectious disease preparedness and response plan; to train workers regarding that plan, and regarding SARS-CoV-2 and Covid-19; to report Covid-19 cases and outbreaks to state public health authorities; or to protect workers from retaliation for reporting concerns related to SARS-CoV-2 and Covid-19.[9] Instead, the CDC refers parties interested in such matters to OSHA, which has produced more wide-ranging – but still far from comprehensive – workplace safety guidance regarding SARS-CoV-2 and Covid-19.[10] OSHA guidance, however, is not CDC guidance – and per the recommended revision to 16 VAC 25-220-10(E), VOSH would permit an employer to abandon the Standard for CDC guidance alone, without reference to OSHA. Importantly, even if VOSH were to deem employer compliance with OSHA guidance to be equivalent to compliance with the Standard, such a provision would not resolve transit workers' safety concerns. Like the CDC, OSHA also would not require transit employers to provide respirators, nor would the agency require the detailed infectious disease preparedness and response plan and comprehensive worker training that the Standard demands.[11]

The recommended revision to 16 VAC 25-220-10(E) also poses several logistical problems. First, the terms "CDC recommendation" and "CDC guidelines," as used in this provision, are nonspecific and do not direct an employer to any CDC document(s) that the employer might follow in lieu of the Standard. This is a challenge for an employer looking to make a good-faith effort to comply with VOSH's directives. It is an even bigger problem for workers, who have no way to know what rules their employer is supposed to be following, nor where to find them. Under these circumstances, it would be impossible for workers to monitor their employer's compliance and to know when a VOSH complaint might be justified.

Second, and relatedly, VOSH has declined to include in the Standard the mechanics of its plan to enforce the proposed option for an employer to follow CDC guidance without regard to the protections that it offers. Instead, the agency has buried this vital information in its "Department Standard Responses to Issues Raised by Public Commenters" regarding the proposed amendments to the Standard. There, VOSH explains:

In order for an employer to take advantage of 10.E, it has to demonstrate that it is 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”, ""encouraged"", etc.). In other words, an employer would have to comply with a CDC “recommended” practice even if the CDC publication doesn't “require” it.[12]

Neither employers nor workers are likely to know that they need to look to an obscure VOSH document to discover that the agency proposes to require employers to abide by both “mandatory” and “non-mandatory” language in whatever CDC guidance an employer might select as its SARS-CoV-2 safety standard. Once again, workers would be left in the dark regarding the nature of their employer’s responsibilities, and they would be unable to hold employers accountable. Further, as long as VOSH’s enforcement approach remains outside of the Standard, it is vulnerable to changing institutional attitudes and priorities, which – if altered in a way that is unfavorable to workers – would leave workers even more vulnerable to any employer seeking to minimize the effort and expense put toward SARS-CoV-2 safety.

Third, the recommended revision to 16 VAC 25-220-10(E) would put VOSH in the position of interpreting and enforcing CDC recommendations that the agency did not develop and does not control. There is no guarantee that VOSH’s interpretation of CDC documents would be consistent with the CDC’s interpretation. If and when such discrepancies occur, which they almost certainly will, they will pose challenges to enforcement as employers attempt to avoid citations by appealing to CDC pronouncements that they believe to be favorable. CDC guidance documents are also subject to continual revision, and they change frequently and without notice. Were the Board to adopt the recommended revision, VOSH would have to keep abreast continually of these developments and their application to the many industries under the agency’s jurisdiction – while workers struggle to stay up to date on what their employers are required to do. It would be far simpler and more transparent for Virginia to hold employers to a Standard developed by Virginia’s own occupational safety and health experts – not by federal public health authorities with no expertise in or jurisdiction over workplace safety.

Above all, the recommended revision poses an existential threat to the entirety of the Standard. Since VOSH implemented the ETS, employers have been required to abide by the most protective of the safety directives that the agency made available to them. Under the revision, however, employers would be empowered to choose the least protective option. VOSH makes this clear in its “Department Standard Responses to Issues Raised by Public Commenters,” stating, “An employer will not be subject to citation or penalty if they comply with the requirements of the VOSH Standard, even if a CDC publication were to include a more stringent requirement or ‘recommendation’ than is provided for in the VOSH Standard.”[13] With this approach, VOSH is inviting employers to engage in a race to the bottom regarding SARS-CoV-2 safety – and because safety is expensive and time-consuming, many employers are sure to accept the agency’s invitation. Therefore, the recommended revision would constitute not only a rollback of 16 VAC 25-220-10(E) but of the entire Standard. As Covid-19 case counts rise and workplace outbreaks increase in Virginia, this is not the time to diminish workplace protections. For these reasons, the ATU calls on the Board to reject the recommended revision and to preserve the Standard that workers and their allies have fought to achieve.[14]

The ATU strongly opposes the recommended revision to 16 VAC 25-220-40(F)(4), which would reduce an employer’s responsibility for providing respirators to transit workers.

If the Board accepts the initially proposed amendment to 16 VAC 25-220-40(F)(4), VOSH would require transit employers (and the employers of other workers who ride in vehicles with others) to provide respirators to those workers. Now, the state recommends revising the amendment to limit this protection only to workers who are not fully vaccinated. For vaccinated workers, an employer would have to provide only a face covering, regardless of the level of SARS-CoV-2 transmission in the community.

Transit vehicle operators face the same SARS-CoV-2 exposure risks, regardless of their vaccination status. Meanwhile, the CDC has determined that fully vaccinated people can contract and spread the Delta variant of SARS-CoV-2.[15] In light of the agency's findings regarding fully vaccinated people's declining immunity to SARS-CoV-2, the CDC is also making plans to begin offering booster shots in a matter of weeks.[16] Under these circumstances, it is unreasonable to reduce transit workers' access to respirators, when they continue to be in close contact with the unvaccinated public in small, often poorly ventilated spaces. These workers continue to need respiratory protection for themselves and to prevent SARS-CoV-2 from spreading in their workplaces. The ATU, therefore, urges the Board to reject the revision to 16 VAC 25-220-40(F)(4) and to preserve maximum protections for a vulnerable workforce.

The ATU appreciates the opportunity to comment on the recommended revisions to the proposed amendments to the Standard, and we thank the Board for its consideration. For further information regarding the matters discussed herein, please contact ATU Associate General Counsel Laura Karr at lkarr@atu.org or (240) 461-7199. See LINK to Townhall comment post for footnotes

SEE RESPONSE TO COMMENT 99799

It is the Department's position that when a CDC guidance document does not address an issue that is addressed in the VOSH Standard (e.g., infectious diseases preparedness and response plan, requirements regarding employees riding in vehicles), the VOSH Standard requirement applies.

99863 Virginia Business Coalition 8/23/2021 Repeal Permanent Standard - Or Address Business Coalition's Concerns

On behalf of the Business Coalition ("Coalition") which is comprised of 34 leading business associations across the Commonwealth, we thank you for the opportunity to comment on the Virginia Department of Labor and Industry's proposed amendments to the Final Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220. (collectively, the "Regulations").

Since the beginning of the pandemic, Virginia employers diligently kept their businesses and workplaces updated with the most current COVID-19 protocols to ensure they were doing everything possible to protect their employees, customers, and clients. Despite the stressful time Virginia businesses experienced working through the various layers of government regulations while struggling to keep their doors open for business, they understood how critically important it was to do their part to reduce the risk of exposure and spread of the virus.

The Virginia Business Coalition would like to reiterate our position that the Board should repeal the Permanent Standard and remove a static regulatory burden for a pandemic that is temporary. There is no evidence that these regulations provided any additional protections that current CDC and OSHA guidance already provided. 45 states are proof that the Board is over-regulating.

However, if the Board feels a standard should remain in effect as the pandemic winds down, we strongly encourage the Board to address the following five (5) areas of concern:

Adopt Governor Northam's recommendation to amend Section 16VAC25-220-10.E to provide employers with safeguards should they comply with the most recent CDC guidance. We hope the Board will reconsider and approve the following language change.

E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.

Simplify "respiratory protection" in vehicles with more than 1 person to be a face covering. The current proposed language is impractical and could put employers in a bind should there be a supply shortage of certain types of face coverings. Employers should be allowed to only require face coverings while in the vehicle provided the occupants follow CDC guidelines. Also, the amended standard places a difficult burden on employees to know when to comply with the face covering requirement when traveling between areas that are of varying exposure rates. Our recommended amendments are below:

16VAC25-220-40. F (PAGE 29)

4. When an employee who is not fully vaccinated must share a work vehicles or other transportation with one or more employees or other persons because no other alternatives are available, such employees shall be provided with and wear respiratory protection, such as an N95 filtering face piece respirator, or a face covering at the option of the employee. When an employee who is fully vaccinated must share work vehicles or other transportation with one or more employees or other persons in areas of substantial or high community transmission because no other alternatives are available, such employees when feasible shall be provided with and wear face coverings.

16VAC25-220-40. F (PAGE 29)

6. 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 or other transportation with other employees or persons.

16VAC25-220-40. (PAGE 35)

M. 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.

Remove requirement for "Low" and "Medium" risk facilities to maintain HVAC systems in accordance with manufacturers' instructions since it does not address the potential hazard (if any) as it relates to

ventilation. In addition, the language does not account for older facilities, as upgrading the ventilation in those facilities may be infeasible.

NOTE: Governor proposed $250 million for HVAC compliance costs for only 197 schools. The VDOLI economic impact assessment of this cost to industry is completely inaccurate and inadequate.

Instead, the Coalition recommends that the Board adopt the recommendations put forth by the Virginia Manufacturers Association in their comments related to the CDC guidelines on HVAC systems.

Strike "social media" employee complaints from §16VAC25-220-90. This particular regulation exceeds federal OSHA protections removes any due process for the employer to address the complaints. Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. If a person is proven to have provided false statements on social media and never raised the concerns with the appropriate government agency or management of the company, they should not be insulated from action. Our recommended amendments are below:

16VAC25-220-90 (page 57)

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.

Remove new language in the "Return to Work" section (16VAC25-220-40 C(3.) which requires an employer to follow any testing or quarantine guidance provided by a VDH public health professional. This is in direct conflict with the CDC guidance safe harbor language in 16VAC25-220-10 E. There is a strong possibility VDH could institute procedures that are beyond CDC guidance and place employers in a confusing situation on which guidance to follow. Our Coalition's recommendation is below:

16VAC25-220-40 C(3)- (PAGE 26-27)

3. The employer must make decisions regarding an employee's return to work after a COVID-19-related workplace removal in accordance with guidance from a licensed healthcare provider, a VDH public health professional, or CDC's "Isolation Guidance" (hereby incorporated by reference); and CDC's "Return to Work Healthcare Guidance" (hereby incorporated by reference). If an employee has a known exposure to someone with COVID-19, the employee must follow any testing or quarantine guidance provided by a VDH public health professional.

By approving the Governor's recommendation to 16VAC25-220-10.E and addressing the other areas of concern the Virginia employers have with the Permanent Standard, you will enable employers to return their focus where it belongs — complying with the best practices as they are recommended in real time by the CDC while rehiring their employees and rebuilding their businesses.

SEE RESPONSE TO COMMENT 99802

The CDC reports the following as of August 11, 2021:

Reported Cases

The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to

the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619). A total of 36,268,057 COVID-19 cases have been reported as of August 11.

Deaths

The current 7-day moving average of new deaths (492) has increased 21.0% compared with the previous 7-day moving average (407). The current 7-day moving average is 59.3% lower compared to the peak observed on August 2, 2020 (1,210). The current 7-day moving average is 86.5% lower than the peak observed on January 13, 2021 (3,640) and is 170.4% higher than the lowest value observed on July 10, 2021 (182). As of August 11, a total of 617,096 COVID-19 deaths have been reported in the United

States.

Hospitalizations

New Hospital Admissions

The current 7-day average for August 4–August 10 was 10,072. This is a 29.6% increase from the prior 7-day average (7,771) from July 28–August 3. The 7-day moving average for new admissions has consistently increased since June 25, 2021. New admissions of patients with confirmed COVID-19 are currently at their highest levels since the start of the pandemic in Florida, Louisiana, and Oregon.

Vaccinations

The U.S. COVID-19 Vaccination Program began December 14, 2020. As of August 12, 353.9 million vaccine doses have been administered. Overall, about 196.5 million people, or 59.2% of the total U.S. population, have received at least one dose of vaccine. About 167.4 million people, or 50.4% of the total U.S. population, have been fully vaccinated.* As of August 12, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 699,068, a 0.03% decrease from the previous week.

CDC's COVID Data Tracker Vaccination Demographic Trends tab shows vaccination trends by age group. As of August 12, 90.6% of people ages 65 or older have received at least one dose of vaccine and 80.6% are fully vaccinated. Over two-thirds (71.5%) of people ages 18 or older have received at least one dose of vaccine and 61.3% are fully vaccinated. For people ages 12 or older, 69.2% have received at least one dose of vaccine and 59% are fully vaccinated.

With regard to potential respirator shortages, 16VAC25-220-40.F.6 provides:

6. 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 or other transportation with other employees or persons.

With regard to potential respirator shortages, 16VAC25-220-40.G.2 provides:
Notwithstanding anything to the contrary in this standard, the Secretary of Labor may exercise discretion in the enforcement of an employer's failure to provide PPE required by this standard, if the employer demonstrates that the employer:

a. (1). Is exercising due diligence to come into compliance with such requirement; and

b. (2). Is implementing alternative methods and measures to protect employees that are satisfactory to the Secretary of Labor after consultation with the Commissioner of Labor and Industry and the Secretary of Health and Human Services.

With regard to employers complying with manufacturer's instructions for HVAC systems, VOSH has a long standing set of regulations at 16VAC25-60-120, -130, -140 and -150 that already require employer compliance in such a situation.

With regard to the commenter's concerns about requirements in 16VAC25-220-90, the provisions in that section reflect current statutes, regulations and case law.

The Department does not incorporate by reference CDC guidance because every time the CDC updates its guidance, the Department would be legally required to also go through the process of updating the VOSH Standard (i.e., incorporating a document by reference in a regulation only incorporates the version of the document that was in effect on the date the regulation was adopted).

99864 Dale Bennett, President & CEO Va Trucking Association Comments

Thank you for the opportunity to comment on the Recommended Revisions to the Proposed Amendments of the VOSH Standard for Infectious Disease Prevention of the 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, including vaccines, test kits and medical supplies, to sustain the population and the economy.

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.

The Permanent Standard

We believe that the current permanent standard does not provide the flexibility needed for a pandemic that is temporary and ever-changing. Therefore we believe that the Board should act to repeal the permanent standard.

However, should the Board determine to continue the permanent standard, we strongly support the recommendation to adopt the Governor's proposed amendment to 16VAC25-220-10.E. By approving the Governor's recommended amendment, the Board will enable employers to focus on and follow the best practices and guidance - and subsequent changes thereto - issued by the CDC as it reacts to ever changing science regarding spread of the virus.

For an interstate industry like trucking, it is extremely important to have one set of regulations and guidance to simplify compliance and promote uniform understanding of the requirements as our drivers travel in Virginia and across the country.

Multiple Employees Occupying the Same Work Vehicle (16VAC25-220-40.F)

We appreciate the effort to address our concern about the requirement that employers provide and require employees occupying the same work vehicle with "respiratory protection, such as an N95 filtering face piece respirator," which we believe would be overly prescriptive and costly.

While the proposed amendment adding face coverings as an option is an improvement, it will have the effect of requiring employers to incur additional costs to purchase and keep in stock both N95 filtering face piece respirators and face coverings in order to provide whichever option an employee may choose on any particular day.

We believe this section should be amended to require employers to provide and require employees to wear face coverings only. To the best of our knowledge neither the federal or any other state government requires non-medical and non-first responder employers to provide N95 filtering face piece respirators and require employees to wear them. To protect persons on public transportation or at transportation hubs throughout the country, the CDC requires face masks, but not N95 masks. We believe the Board should follow CDC guidelines and require face coverings only.

We are concerned that the amended standard places a difficult burden on truck drivers to know when they must comply with the face covering requirement when, on a daily basis, they are traveling between and working in areas with varying transmission rates

We recommend that the wording of this section be clarified by inserting the word "additional" between the words "more" and "employees" in the first sentence of the first paragraph of 16VAC25-220-40.F and the first and second sentences of 16VAC25-220-40.F.4.

As stated in previous comments, we strongly support adoption of the proposed new 16VAC25-220-40.F.7.

Virginia Business Coalition Comments

We share the concerns and support the recommendations outlined in the comments filed on behalf of the Virginia Business Coalition, especially those regarding the "social media" employee complaints in §16VAC25-220-90 and the proposed new language the "Return to Work" section (16VAC25-220-40 C(3.) that requires an employer to follow any testing or quarantine guidance provided by a VDH public health professional.

Conclusion

Thank you for your consideration of our comments and please contact me if you need any additional information or have any questions regarding these comments or how trucking industry is working to protect the health and safety of its workers during the pandemic.

SEE RESPONSE TO COMMENT 99802
SEE RESPONSE TO COMMENT 99863

The reference to N95s in the 16VAC25-220-40.F was the result of a Board member amendment based on the concern that the ability of employees to physical distance in a vehicle was often severely limited, along with potential inability to have windows open during adverse weather conditions, and a concern that some employees would be required to occupy vehicles with others for extended periods of time; all of which increase the risk of potential exposure to the SARS-CoV-2 virus.

COMMENTS SENT DIRECT TO DOLI

10001 Brett A. Vassey President & CEO (VMA) Virginia Manufacturers Assn
8/23/2021
Safety and Health Codes Board intent to amend Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220

The VMA thanks you for the opportunity to comment on the Virginia Department of Labor and Industry's proposed amendments to the Final Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.

Virginia manufacturers and suppliers have protected their employees, contractors, suppliers, customers, and communities from COVID-19 infection by continually updating their COVID-19 protocols to ensure compliance with the latest regulations and guidance imposed by federal, state, and local governments. Despite the additional stress, costs, and time related to compliance, manufacturing leaders accepted their role in reducing the risk of exposure and spread of the virus as well as continuing operations to produce medicine, PPE, food, and invent new products to meet public health needs such as UV sanitation devices and vaccines.

However, the permanent standard is a static regulation for a temporary pandemic. There is no evidence that employers are in full compliance with this standard, nor is their evidence that compliance with OSHA Guidance, CDC Guidance, and Governor's Executive Orders are not protective. 45 states are proof that the Board is over-regulating. As such, we respectfully ask the Board to repeal the permanent standard.

We would like to reiterate our relevant complaints stated in prior formal comments filed on January 8, 2021 and in January and August 5 of this year. Many questions posed in those comments have still not been answered. However, for today's purposes, we have three principal comments that we would like to reiterate:

1. 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. This section should be struck entirely from Regulations. In addition, the language does not account for older facilities, as upgrading the ventilation in those facilities may be infeasible.

NOTE: Governor proposed $250 million for HVAC compliance costs for only 197 schools. The VDOLI economic impact assessment of this cost to industry is completely inaccurate and inadequate.

Instead, 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.

2. Requiring "respiratory protection" in vehicles with more than 1 person is impractical. There are other controls, when used together, that should be considered, and the Regulations should reflect so. The

Regulations should not incorporate this provision. Employers should be allowed to only require face coverings while in the vehicle provided the occupants follow CDC guidelines. Our recommended amendments are below:

16VAC25-220-40. F (PAGE 29)

4. When an employee who is not fully vaccinated must share a work vehicles or other transportation with one or more employees or other persons because no other alternatives are available, such employees shall be provided with and wear respiratory protection, such as an N95 filtering face piece respirator, or a face covering at the option of the employee. When an employee who is fully vaccinated must share work vehicles or other transportation with one or more employees or other persons in areas of substantial or high community transmission because no other alternatives are available, such employees shall be provided with and wear face coverings.

16VAC25-220-40. F (PAGE 29)

6. 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 or other transportation with other employees or persons

16VAC25-220-40. (PAGE 35)

M. 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.

3. §16VAC25-220-90 unreasonably expands protections for employee complaints to the news media and social media without due process for the employer. The Regulations exceed federal OSHA protections. Some employers have policies restricting statements to the press or statements reflecting poorly on their employers. Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. The language “or to the public such as through print, online, social, or any other media” should be struck from the Regulations and protections should be limited only to notification to the responsible government regulatory agency. Further, if a person is proven to have provided false statements on social media and never raised the concerns with the responsible government regulatory agency or management of the company, they should not be insulated from action. Our recommended amendments are below:

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.

There should be no enforcement without prior notice to and “due process” for an employer. The Regulations have 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 in cases involving these Regulations – 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 Regulations.

4. The Economic Impact Analysis (EIA) was provided to stakeholders at 5:20 pm on
August 20, 2021. There was inadequate time given to the public to review the document

and make comments in time for the August 23, 2021 deadline. Considering the significant errors involving the estimated impact on employers for the HVAC regulations in the last EIA, the VMA recommends that the timeline for consideration and comment be extended two weeks.
5. Finally, we strongly encourage the Board to adopt Governor Northam's recommendation to amend Section 16VAC25-220-10. E to provide employers with a CDC compliance "safe harbor." We hope the Board will adopt the following language change.
E. To the extent that 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, the employer's actions shall be considered in compliance with the related provisions of 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 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.

SEE RESPONSE TO COMMENT 99802
SEE RESPONSE TO COMMENT 99863
SEE RESPONSE TO COMMENT 99864

With regard to the change to 16VAC25-220-40.C.3, that was by specific request of the Virginia Department of Health.

The air handling provisions in the VOSH Standard are only referenced in 16VAC25-220-50 and -60.

The Department no longer uses designations of "low" or "medium" in the VOSH Standard.

With regard to employers complying with manufacturer's instructions for HVAC systems, VOSH has a long standing set of regulations at 16VAC25-60-120, -130, -140 and -150 that already require employer compliance in such a situation.

10002 Hobey Bauhan, President Virginia Poultry Federation (VPF) 8/23/2021

Please accept the following as Virginia Poultry Federation's comments on the proposed additions to the revisions to the permanent COVID-19 standard. Our stance on the proposal remains generally the same as reflected in the comments we previously submitted (attached). LINK TO COMMENTS SUBMITTED JUNE 29, 2021: https://www.doli.virginia.gov/wp-content/uploads/2021/07/Virginia-Poultry-Federation-Comments-on-Amendments-to-Permanent-COVID-19-Standard-July-2021.pdf

In this regard, we want to reiterate our support for the Governor's proposed language concerning compliance with CDC guidelines.

Secondly, we are concerned about the provision on page 27 of the most recently published proposal, which states:
"If an employee has a known exposure to someone with COVID-19, the employee must follow any testing or quarantine guidance provided by a VDH public health professional."
We believe it could be problematic to give individual VDH representatives the power to dictate to an employer testing and quarantine requirements. This is too much discretion for an individual health

official to use their professional judgement, without any parameters, to require protocols that could have a dramatic impact on the operations of a private business. We ask that you reconsider this provision.

SEE RESPONSE TO COMMENT 99802
SEE RESPONSE TO COMMENT 99863

With regard to the change to 16VAC25-220-40.C.3, that was by specific request of the Virginia Department of Health.

10003 Dale Bennett, President & CEO Va Trucking Association Comments 8/23/2021

Thank you for the opportunity to comment on the Recommended Revisions to the Proposed Amendments of the VOSH Standard for Infectious Disease Prevention of the 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, including vaccines, test kits and medical supplies, to sustain the population and the economy.

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.

The Permanent Standard

We believe that the current permanent standard does not provide the flexibility needed for a pandemic that is temporary and ever-changing. Therefore we believe that the Board should act to repeal the permanent standard.

However, should the Board determine to continue the permanent standard, we strongly support the recommendation to adopt the Governor's proposed amendment to 16VAC25-220-10.E. By approving the Governor's recommended amendment, the Board will enable employers to focus on and follow the best practices and guidance - and subsequent changes thereto - issued by the CDC as it reacts to ever changing science regarding spread of the virus.

For an interstate industry like trucking, it is extremely important to have one set of regulations and guidance to simplify compliance and promote uniform understanding of the requirements as our drivers travel in Virginia and across the country.

Multiple Employees Occupying the Same Work Vehicle (16VAC25-220-40.F)

We appreciate the effort to address our concern about the requirement that employers provide and require employees occupying the same work vehicle with "respiratory protection, such as an N95 filtering face piece respirator," which we believe would be overly prescriptive and costly.

While the proposed amendment adding face coverings as an option is an improvement, it will have the effect of requiring employers to incur additional costs to purchase and keep in stock both N95 filtering face piece respirators and face coverings in order to provide whichever option an employee may choose on any particular day.

We believe this section should be amended to require employers to provide and require employees to wear face coverings only. To the best of our knowledge neither the federal or any other state government requires non-medical and non-first responder employers to provide N95 filtering face piece respirators and require employees to wear them. To protect persons on public transportation or at transportation hubs throughout the country, the CDC requires face masks, but not N95 masks. We believe the Board should follow CDC guidelines and require face coverings only.

We are concerned that the amended standard places a difficult burden on truck drivers to know when they must comply with the face covering requirement when, on a daily basis, they are traveling between and working in areas with varying transmission rates

We recommend that the wording of this section be clarified by inserting the word "additional" between the words "more" and "employees" in the first sentence of the first paragraph of 16VAC25-220-40.F and the first and second sentences of 16VAC25-220-40.F.4.

As stated in previous comments, we strongly support adoption of the proposed new 16VAC25-220-40.F.7.

Virginia Business Coalition Comments

We share the concerns and support the recommendations outlined in the comments filed on behalf of the Virginia Business Coalition, especially those regarding the "social media" employee complaints in §16VAC25-220-90 and the proposed new language the "Return to Work" section (16VAC25-220-40 C(3.) that requires an employer to follow any testing or quarantine guidance provided by a VDH public health professional.

Conclusion

Thank you for your consideration of our comments and please contact me if you need any additional information or have any questions regarding these comments or how trucking industry is working to protect the health and safety of its workers during the pandemic.

SEE RESPONSE TO COMMENT 99864

10004 Beck Stanley Director of Government Affairs Virginia Agribusiness Council 8/23/2021

Proposed changes to Permanent Standard regarding COVID-19 Mitigation

I am writing you today on behalf of the Virginia Agribusiness Council to provide comments regarding the new, revised proposed changes to the Permanent Standard for COVID-19 mitigation.

We continue to believe the Permanent Standard is the wrong mechanism to protect employees, as it is a static, one-size fits all policy that is not flexible to the changing conditions of the pandemic. However, should the Board choose to move forward with the proposed revisions, we offer these comments on the Administration's amendments.

We support and appreciate the proposed deletion of the "equivalent or greater" provision in Section 10.E. The revised section will remove any doubt or confusion for an employer regarding compliance. It will also allow an employer to practice the latest science when it pertains to COVID-19 mitigation

without having to choose between the Department and the CDC. We hope the Board will support the clarification as proposed by the Department.

We are strongly opposed to the proposed change to 16VAC25-220-40.C.3, the Return to Work Policy found on pages 26 and 27 of the draft regulation. The proposed language would require an employer to abide by a single VDH employee's recommendations to testing and quarantining with regards to an exposure without any regards to mitigation efforts, vaccination status or extenuating circumstances. It would also not be subject to any regulatory review. This type of authority should not be placed in the hands of one VDH employee and would be a very large shift to quarantining an employee outside of being suspected of being or confirmed COVID-19.

Contacting tracing has been unreliable and tracking exact times of employee exposure with COVID-19 either at the place of employment or outside of the workplace is nearly impossible in a reasonable timeframe. The risk of contracting the disease is greatly diminished if the employee is vaccinated and complying with mitigation efforts. Requiring mandatory quarantining of a simple exposure without the full details of the exposure could result in devastating effects on the industry, especially industries as dependent on timing as the agriculture and forestry industries.

With harvest approaching, this is especially apparent. With certain weather conditions, a harvest window can be extremely narrow. These harvest times can be as short as one or two weeks. If one employee were to be exposed and the VDH professional recommends quarantining an entire work crew, it could undermine that farm's entire harvest. Similarly, if a processing plant needs to quarantine an entire shift causing a shutdown of the facility, regardless of the circumstances of the exposure, agricultural commodities may be stranded on farms and ultimately need be destroyed due to the delay. For these reasons, we respectfully ask the sentence "If an employee has a known exposure to someone with COVID-19, the employee must follow any testing or quarantine guidance provided by a VDH public health professional" be removed from 16VAC25-220-40.C.3.

We would also request clarification around Section 16VAC25-220-40.F regarding employee travel. We would suggest amending the first sentence of section F to read "or other form of transportation with one or more additional employees or other persons.

We are concerned the current language may be interpreted to require face coverings of a single employee traveling in a work vehicle. We would also request the deletion of the employee option for an N95 mask in Number 4 of Section F. N95 masks can be difficult to requisition and can be very cost prohibitive. We certainly have no objection to an employee choosing to utilize an N95 mask should they choose; however, it should not be a necessary requirement of an employer to provide an N95 mask upon request. This would require every employer which provides work vehicles to stock N95 in the event an employee requests. This is unnecessary and a general face covering is sufficient to protect workers traveling in the same vehicle.

We continue to contend that the Permanent Standard is a static, one size fits all program for an ever-evolving health crisis and should be repealed. The regulatory process is ill-equipped to deal with the constantly changing situation. Indeed, the Administration has proposed two different amendments to the standard since the Safety and Health Codes Board last met. Once these new revisions are adopted, the Board will have to meet further to continually update the Standard as needed. However, we hope the Board will seriously consider our suggestions and make every effort to ensure compliance is obtainable should the board adopt the proposed revisions to the Standard.

As always, we are grateful for this opportunity to comment and would be happy to answer any questions the Department or the Board may have.

SEE RESPONSE TO COMMENT 99802

SEE RESPONSE TO COMMENT 99863
SEE RESPONSE TO COMMENT 99864

With regard to the change to 16VAC25-220-40.C.3, that was by specific request of the Virginia Department of Health.

With regard to the commenter's concern that 16VAC25-220-40.F might be interpreted to require a lone employee to wear a face covering, the VOSH Standard is clear that it is only referring to situations where multiple employees are occupying the same vehicle.

COMMONWEALTH of VIRGINIA

DEPARTMENT OF LABOR AND INDUSTRY

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DRAFT:
AUGUST 25, 2021

NEW INFORMATION HIGHLIGHTED IN YELLOW
VIRGINIA SAFETY AND HEALTH CODES BOARD

BRIEFING PACKAGE FOR

for August 26, 2021

Adoption of Final Amendments to the
VOSH 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 final amendments to the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19, §16 VAC 25-220 ("VOSH Standard"). Va. Code §40.1-22(6a).

Any final amendments to or proposed revocation of the VOSH Standard voted upon by the Safety and Health Codes Board at its upcoming meeting will be reviewed by the Governor in accordance with 16VAC25-220-20.A.[1]

[1] 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 subdivision A 1 of this section within 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

On June 29, 2021, the Board adopted proposed amendments to the VOSH Standard which were the subject of a 30 day written comment period.[2]

On August 16, 2021, after consultation with the Virginia Department of Health (VDH), DOLI decided to recommend revisions[3] to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's Updated Guidance for Fully Vaccinated People issued on July 27, 2021[4] (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

The CDC July 27, 2021 updated guidance was based in part on new research. Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021[5] titled *Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021*, which resulted in the CDC update:

> Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."

A. Attachments.

ATTACHMENT A:
INDUSTRY SPECIFIC INFORMATION ASSOCIATED WITH ADOPTION OF THE EMERGENCY TEMPORARY STANDARD AND ORIGINAL VOSH STANDARD

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

published in the City of Richmond, Virginia.
[2] https://www.doli.virginia.gov/proposed-changes-to-fps/
[3] https://www.doli.virginia.gov/wp-content/uploads/2021/08/Revisions-to-Proposed-Amendments-to-the-FPS-for-COVID-19-16VAC25-220-Adopted-06.29.2021.pdf
[4] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
[5] https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

ATTACHMENT D:
FINDING OF "GRAVE DANGER" TO SUPPORT THE ADOPTION OF THE EMERGENCY TEMPORARY STANDARD (ETS) AND VOSH STANDARD FOR INFECTIOUS DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19, 16VAC25-220, EFFECTIVE JULY 27, 2020 AND JANUARY 27, 2021, RESPECTIVELY

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 June 16, 2021

ATTACHMENT I:
January 11, 2021, Economic Impact Proposed Standard For Infectious Disease Prevention Of The Sars-Cov-2 Virus That Causes Covid-19, Prepared by Chmura Economics and Analytics

ATTACHMENT J:
January 11, 2021, DOLI ADDENDUM to January 11, 2021, Economic Impact Proposed Standard for Infectious Disease Prevention Of The Sars-Cov-2 Virus That Causes Covid-19, Prepared by Chmura Economics and Analytics

B. Situation Summary.[6]

- On February 7, 2020, the Commissioner of the Virginia Department of Health (VDH) issued a Declaration of Public Emergency.[7]
- On March 7, 2020 the first case of COVID-19 in Virginia was confirmed.[8]
- On March 11, 2020 the World Health Organization characterized COVID-19 as a pandemic.[9]

[6] https://www.vdh.virginia.gov/coronavirus/ - Situation Summary Taken in Part from the Virginia Department of Health Website
[7] https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf
[8] https://www.vdh.virginia.gov/news/2020-news-releases/first-virginia-case-of-covid-19-confirmed-at-fort-belvoir/
[9] https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

- On March 12, 2020 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.[10]

- On March 13, 2020, President Donald J. Trump declared a national emergency in response to the COVID-19 pandemic.[11]

- On March 17, 2020 Governor Northam and State Health Commissioner M. Norman Oliver, MD, MA issued a Declaration of Public Health Emergency.[12]

- On March 23, 2020 Governor Northam issued Executive Order 53[13] 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, 2020 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.[14]

- On March 30, 2020 Governor Northam issued Executive Order 55[15], 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, 2020 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).[16]

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[10] 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

[11] https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/

[12] https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf

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

[14] https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-Public-Health-Emergency-Two---Order-of-The-Governor-and-State-Health-Commissioner.pdf

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

[16] 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

- On May 12, 2020 Governor Northam issued Executive Order 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.[17]

- On May 14, 2020 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.[18]

- On May 26, 2020 Governor Northam issued a revised Executive Order 63[19] (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.

- On December 10, 2020 Governor Northam issued Executive Order 72[20] (EO 72) "Order of Public Health Emergency Nine, Common Sense Surge Restrictions, Certain Temporary Restrictions Due to Novel Coronavirus (COVIS-19)."

- On May 14, 2021, Governor Northam issued Executive Order 79 (EO79) "Order of Public Health Emergency Ten, Ending of Common Sense Public Health Restrictions Due to Novel Coronavirus (COVIS-19)."

- On May 28, 2021, the CDC issued "Interim Public Health Recommendations for Fully Vaccinated People"[21] which cleared fully vaccinated people to safely resume most normal activities. The CDC continues to recommend preventative measures for unvaccinated people (unvaccinated people refers to individuals of all ages, including children, that have not completed a vaccination series or received a single-dose vaccine) including wearing a face covering and staying six feet apart from people who don't live with you.[22]

  Face coverings continue to be required on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation hubs such as airports and stations.

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[17] 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

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

[19] 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

[20] 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

[21] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

[22] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

- On June 10, 2021, federal OSHA issued an updated version of "Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace."[23] The guidance focuses on safety and health protections and mitigation efforts to protect unvaccinated, not fully vaccinated and otherwise at-risk workers:

    1. Grant paid time off for employees to get vaccinated.
    2. Instruct any workers who are infected, unvaccinated workers who have had close contact with someone who tested positive for SARS-CoV-2, and all workers with COVID-19 symptoms to stay home from work
    3. Implement physical distancing for unvaccinated and otherwise at-risk workers in all communal work areas
    4. Provide unvaccinated and otherwise at-risk workers with face coverings or surgical masks, unless their work task requires a respirator or other PPE
    5. Educate and train workers on your COVID-19 policies and procedures using accessible formats and in language they understand
    6. Suggest that unvaccinated customers, visitors, or guests wear face coverings
    7. Maintain Ventilation Systems
    8. Perform routine cleaning and disinfection
    9. Record and report COVID-19 infections and deaths: Under mandatory OSHA rules in 29 CFR 1904
    10. Implement protections from retaliation and set up an anonymous process for workers to voice concerns about COVID-19-related hazards
    11. Follow other applicable mandatory OSHA standards

- On June 21, 2021, federal OSHA issued an Emergency Temporary Standard for Occupational Exposure to COVID-19 (COVID-19 ETS) applicable to employees engaged in healthcare services and healthcare support services.[24] At its June 29, 2021 meeting, the Board is considering adoption of the COVID-19 ETS in Virginia that would apply to healthcare services and healthcare support services which would expire within six months or when repealed by the Board, whichever occurs first. If adopted, application of the VOSH Standard to healthcare services and healthcare support services would be suspended while the COVID-19 ETS was in effect, and would reapply after the COVID-19 ETS was no longer in effect.

- On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021.[25] The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first.

- On August 12, 2021, Virginia State Health Commissioner M. Norman Oliver, MD, MA issued a Statewide Requirement to Wear Masks in K-12 Schools[26] under his ongoing Order of Public Health Emergency originally issued on February 7, 2020.

[23] https://www.osha.gov/coronavirus/safework
[24] https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf
[25] https://www.doli.virginia.gov/emergency-temporary-standard-interim-final-rule/
[26] https://www.governor.virginia.gov/media/governorvirginiagov/governor-of-virginia/pdf/PHE-Order_K-12-8-12-2021.pdf

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 63[27] (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 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."[28] (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

[27] *Id.*

[28] 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

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."[29] (Emphasis added).

C. Emergency Meetings 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 meeting[30] 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 Forum[31] 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 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,[32] July 7, 2020[33] and July 15, 2020.[34] 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.[35] The ETS expired on January 26, 2021.

D. VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19.

[29] https://www.governor.virginia.gov/newsroom/all-releases/2020/may/headline-857020-en.html
[30] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31004
[31] https://townhall.virginia.gov/L/comments.cfm?GeneralNoticeid=1118
[32] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31037
[33] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31057
[34] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31089
[35] http://register.dls.virginia.gov/emergency_regs.shtml

1. 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.[36]

- The Board held a public hearing on the proposed permanent standard on September 30, 2020.[37]

  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.

- 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.[38]

- A public hearing was held on January 5, 2021.[39]

- An economic impact analysis (EIA)[40] based on the requirements of Va. Code §2.2-4007.04[41] was issued on January 11, 2021. The EIA was prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.[42] The Department issued an Addendum to the EIA[43] on January 11, 2021.

2. Review of Comments Submitted: Initial 60 day Written Comment Period from

[36] https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1137
[37] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31418
[38] https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1177
[39] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31985
[40] https://www.doli.virginia.gov/wp-content/uploads/2021/01/VDOLI-COVID-Regulation-Economic-Impact-Analysis-EIA-20210111.pdf
[41] https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/
[42] http://www.chmuraecon.com/
[43] https://www.doli.virginia.gov/wp-content/uploads/2021/01/DOLI-ADDENDUM-TO-EIA-Final-1.11.2021.pdf

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.[44]

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.[45]

There were 29 oral comments received during the public hearing on September 30, 2020.[46]

3. 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.

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.[47]

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.

4. Adoption of VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19.

A meeting of the Board to consider adoption of a final standard was held January 12, 2021[48] and a continuation of the meeting was held on January 13, 2021,[49] at which time the Board adopted the final standard, 16VAC25-220 with an effective date of January 27, 2021.[50]

16VAC25-220-20.C provides that 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

[44] https://townhall.virginia.gov/L/GetFile.cfm?File=meeting\92\31594\Agenda_DOLI_31594_v6.pdf
[45] *Id.*
[46] https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=1162
[47] https://www.doli.virginia.gov/wp-content/uploads/2021/01/Combined-Townhall-Direct-to-DOLI-and-Oral-Comments-with-Dept-Response-1.10.2021-FOR-PUBLICATION.pdf
[48] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31986
[49] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31987
[50] https://www.doli.virginia.gov/wp-content/uploads/2021/01/Final-Standard-for-Infectious-Disease-Prevention-of-the-Virus-That-Causes-COVID-19-16-VAC25-220-1.27.2021.pdf

regular, special, or emergency meeting to determine whether there is a continued need for the standard.[51]

The state of emergency that Governor Northam declared on March 12, 2020 in response to COVID-19 expired on June 30.[52]

E. Proposed Changes to or Revocation of VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 That Causes COVID-19.

Any proposed changes to or proposed revocation of the VOSH Standard, for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-1916VAC25-220 voted upon by the Safety and Health Codes Board at its upcoming meeting will go through a similar notice and comment process to that used for adoption of the original VOSH Standard. This includes a written comment period for the public and stakeholders to provide written feedback to the Board about the proposed changes or proposed revocation, at least one public hearing, and development of an Economic Impact Analysis (EIA). The Board will then hold a second meeting and vote to accept or reject the proposed changes or proposed revocation as final. During both the proposed and final change stages, the Governor will have the opportunity to review the changes per 16VAC25-220-20.A.

On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021.[53] The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

On June 29, 2021, the Board adopted proposed amendments to the VOSH Standard which were the subject of a 30 day written comment period.[54]

On July 1, 2021, Governor Northam completed his review of the proposed amendments to 16VAC25-220 adopted by the Board on June 29, 2021, and requested the following substitute language for 16VAC25-220-10.E be reconsidered by the Board when it reconvenes to consider final adoption of the proposed amendments to the VOSH Standard:
[LANGUAGE HIGHLIGHTED IN BLUE ADDED BY THE ADMINISTRATION ON AUGUST 25, 2021]

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[51] 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.
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.

[52] https://www.governor.virginia.gov/newsroom/all-releases/2021/june/headline-897920-en.html
[53] https://www.doli.virginia.gov/emergency-temporary-standard-interim-final-rule/
[54] https://www.doli.virginia.gov/proposed-changes-to-fps/

E. To the extent that an employer actually complies with a recommendation contained in current 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 shall be considered in compliance with the related provisions of this standard. An employer's actual compliance with a recommendation contained in current CDC guidelines, 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 current CDC guidelines.

1. Review of Comments Submitted: 30 day Written Comment Period from July 1, 2021 to July 30, 2021; and Public Hearing of August 5, 2021.

   The Department received 268 written comments through the Virginia Regulatory Townhall for the 30 day written comment period from July 1, 2021 to July 31, 2021.[55]

   There were 19 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.[56]

   There were 7 oral comments received during the public hearing on August 5, 2021.[57]

   [The Department's responses to the above comments will be provided to the Board in a separate document.]

2. An economic impact analysis (EIA)[58] on the Proposed Amendments based on the requirements of Va. Code §2.2-4007.04[59] is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.[60]

   [The EIA will be provided to the Board along with the Department's response in separate documents]

3. Written Comment Period from August 16, 2021 to August 23, 2021 opened to

[55] https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1283
[56] Public comments sent direct to DOLI can be found here: https://www.doli.virginia.gov/proposed-changes-to-fps/
[57] https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=32816
A recording of the public hearing can be found here: https://www.doli.virginia.gov/proposed-changes-to-fps/
[58] https://www.doli.virginia.gov/wp-content/uploads/2021/01/VDOLI-COVID-Regulation-Economic-Impact-Analysis-EIA-20210111.pdf
[59] https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/
[60] http://www.chmuraecon.com/

addressed DOLI's Requested Revisions to the Board's Proposed Amendments.

On August 16, 2021, after consultation with the Virginia Department of Health (VDH), DOLI has decided to recommend revisions[61] to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's Updated Guidance for Fully Vaccinated People issued on July 27, 2021[62] (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

The proposed revisions are the subject of a written comment period[63] from August 16, 2021 to August 23, 2021 on the Virginia Regulatory Townhall.

[The Department's responses to the above comments will be provided to the Board in a separate document.]

III. Recommended Revisions to Proposed Amendments to the VOSH Standard.

[RECOMMENDED REVISIONS TO THE PROPOSED AMENDMENTS (ADOPTED ON JUNE 29, 2021) FOR FINAL ADOPTION ARE HIGHLIGHTED IN YELLOW]

The primary purpose of DOLI's recommended revisions to the Board's Proposed Amendments to the VOSH Standard is to address the Governor's proposed amendment to 16VAC25-220-10.E and the CDC's updated guidance for fully vaccinated people issued on July 27, 2021[64] (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

Please note there were a few other relatively minor changes and some non-substantive error corrections included as well.

In reference to the recommended revisions document,[65] the Governor's amendment is located on page 5. The other revisions can be found on pages 9-10, 24-30, 32, 36-39, 43, and 46.

10 Purpose, scope, and applicability.

The purpose of the proposed amendments is to change the focus of the VOSH Standard from the very high/high/medium/lower risk exposure level approach to one that focuses on mitigation strategies directed at protecting employees who are unvaccinated, not fully vaccinated or are otherwise at risk from the grave danger presented by the SARS-C-oV-2 virus (and its variants) and the COVID-19 disease. In doing so the Department and the Virginia Department of Health (VDH) reviewed and identified requirements from:

[61] https://www.doli.virginia.gov/wp-content/uploads/2021/08/Revisions-to-Proposed-Amendments-to-the-FPS-for-COVID-19-16VAC25-220-Adopted-06.29.2021.pdf
[62] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
[63] https://townhall.virginia.gov/L/ViewNotice.cfm?GNid=1309
[64] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
[65] https://www.doli.virginia.gov/wp-content/uploads/2021/08/Revisions-to-Proposed-Amendments-to-the-FPS-for-COVID-19-16VAC25-220-Adopted-06.29.2021.pdf

- OSHA's "Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace," and
- OSHA's COVID-19 ETS (requirements of general application, not dependent on or specific to the healthcare industry).

- 16VAC25-220-10.B is amended as follows:

  1. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

  2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

  3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be revoked.

- 16VAC25-220-10.E is amended as follows: [Governor's amendment]

  [LANGUAGE HIGHLIGHTED IN BLUE ADDED BY THE ADMINISTRATION ON AUGUST 25, 2021]

  E. To the extent that an employer actually complies with a recommendation contained in current 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 the related provisions of

this standard. An employer's actual compliance with a recommendation contained in current CDC guidelines, 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 current CDC guidelines.

NOTE 1: Description of how DOLI and VDH apply 16VAC25-220-10.E.
16VAC25-220-10.E currently provides:

> 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 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. 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 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.** (Emphasis added).

The intent of 10.E is to give employers the option to either comply with the requirements of the FPS or demonstrate as an alternative that they have complied with recommendations in a CDC publication addressing hazards, issues, requirements, etc., that are also addressed in a specific provision of the FPS.

In order for an employer to take advantage of 10.E, it has to demonstrate that it is 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”, "encouraged", etc.). In other words, an employer would have to comply with a CDC “recommended” practice even if the CDC publication doesn't “require” it.

The Department’s interpretation of 10.E 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 FPS (e.g., the employer “should” do “this”, or “that”, or “the other”), then the employer is required to implement at least one of the options in order for §10.E to apply.

An employer will not be subject to citation or penalty if they comply with the requirements of the FPS, even if a CDC publication were to include a more stringent requirement or "recommendation" than is provided for in the FPS.

The FPS 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. The focus of the FPS is employee safety and health, and the focus of §10.E is only CDC publications' language that addresses employee safety and health, and occupationally-related hazards, issues, mitigation efforts, etc.

Here is an example of application of 10.E to language in Section 3 of the current CDC Guidance[66] for Institutions of Higher Education (IHEs):

"Administrators should encourage people who are not fully vaccinated and those who might need to take extra precautions to wear a mask consistently and correctly:

Indoors. Mask use is recommended for people who are not fully vaccinated including children.

Answer: The Department considers use of the phrases "Administrators should encourage" and "Mask use is recommended" to be non-mandatory language that must be actually complied with under 10.E to be considered to provide employees equivalent protection to a provision in the FPS. This means the phrases will be read as "Administrators shall require" and "Mask use is required."

Accordingly, IHE employees who are not fully vaccinated must wear face coverings when so required under the FPS. IHE compliance with the CDC Guidance as interpreted by the Department above would provide employees equivalent protection to the FPS provisions regarding the wearing of face coverings in 16VAC25-220-40.F, -40.G, -40.H, -60.C.10, and -60.C.11.

NOTE 2: VOSH is required by the OSH Act of 1970[67] and OSHA regulations[68] 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.

20 Dates.

- Provides a process for gubernatorial review of proposed and final changes to the final standard prior to the standard becoming effective.

[66] https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/considerations.html
[67] https://www.osha.gov/laws-regs/oshact/section_18
[68] https://www.osha.gov/laws-regs/regulations/standardnumber/1902/1902.4

- Requirements for training would take effect 30 days after the effective date of the VOSH Standard, and the requirement to develop an infectious disease prevention and response plans would take effect 60 days after the effective date of the VOSH Standard.

30 Definitions.

- The definition of "Community transmission" is amended as follows:

  "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 may be obtained from the VDH website and is assessed using, at a minimum, two metrics: new COVID-19 cases per 100,000 persons in the last 7 days and percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days. For each of these metrics, CDC classifies transmission values as low, moderate, substantial, or high. If the values for each of these two metrics differ (e.g., one indicates moderate and the other low), then the higher of the two should be used for decision-making.

  CDC core indicators of and thresholds for community transmission levels of SARS-CoV-2:

Indicator Level	**Low**	**Moderate**	**Substantial**	**High**
New COVID-19 cases per 100,000 persons in the last 7 days	0–9.99	10.00–49.99	50.00–99.99	≥100.00
Percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days	<5.00	5.00–7.99	8.00–9.99	≥10.00

- New or revised definitions are provided for the following terms: "Aerosol-generating procedure," "Airborne infection isolation room" or "AIIR," "Ambulatory care," ASTM," "Cleaning," "Community Transmission," "Confirmed COVID-19" [formerly "know to be infected with the SARS-CoV-2 virus"], "COVID-19 positive and confirmed COVID-19," "COVID-19 test," "Elastomeric respirator," "Face covering," "Face mask," "Face shield," "Fully vaccinated," "Healthcare services," "Healthcare support services," "Otherwise at risk," "Personal Protective Equipment," "Powered air-purifying respirator (PAPR)," "Respirator," "Signs of COVID-19," "Surgical mask,"

"Suspected COVID-19" [formerly "Suspected to be infected with SARS-CoV-2 virus"], and "Symptoms of COVID-19," and "Vaccine."

- Definitions are deleted for the following terms: "Exposure risk level [including "Very high," 'High," Medium," and "Lower"], "May be infected with SARS-CoV-2 virus," "Minimal occupational contact," "Surgical/medical procedure mask."

40 Mandatory requirements for employers in all exposure risk levels.

- Changes are made throughout 16VAC25-220-40 to reflect revised requirements for employees who are fully vaccinated and for those employees who are not fully vaccinated or otherwise at risk.

- Changes are made throughout 16VAC25-220-40 to reflect revised CDC procedures for cleaning and/or disinfecting surfaces.

- 16VAC25-220-40.A is amended as follows:

  A. Employers shall have a policy in place to ensure compliance with the requirements in this section to protect employees from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease. Such policy shall have a method to receive anonymous complaints of violations. An employer that enforces its policy in good faith and resolves filed complaints shall be considered in compliance with this subsection

- References to exposure risk hazards of very high, high, medium and lower are removed and the focus of requirements is shifted to addressing hazards faced by employees who are not fully vaccinated or are otherwise at risk.

- Employers may rely on an employee's representation of being fully vaccinated, as defined herein, without requiring proof of vaccination; however, nothing in this standard shall be construed to preclude an employer from requiring proof that an employee is fully vaccinated.

- The requirement for employers to notify DOLI of three or more cases within a 14 day period is changed to two or more cases to be consistent with a similar requirement to report such cases to the Virginia Department of Health. Such reports can be filed online at:

  https://www.doli.virginia.gov/report-a-workplace-fatality-or-severe-injury-or-covid-19-case/

- 16VAC25-220-40.C is amended to reflect the return to work requirements from the OSHA COVID-19 ETS:

  C. Return to work. Employers shall develop and implement policies and procedures for suspected or confirmed COVID-19 employees to return to work.

1. If the employer knows an employee is COVID-19 positive, then the employer must immediately remove that employee from the worksite and keep the employee removed until they meet the return to work criteria in 16VAC25-220-40 C 3.

2. If the employer knows an employee is suspected COVID-19, then the employer must immediately remove that employee from the worksite and either:

a. Keep the employee removed until they meet the return to work criteria in 16VAC25-220-40 C 3; or

b. Keep the employee removed and provide a COVID-19 polymerase chain reaction (PCR) test at no cost to the employee.

(1) If the test results are negative, the employee may return to work immediately.

(2) If the test results are positive, the employer must comply with 16VAC25-220-40 C 1.

(3) If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with 16VAC25-220-40 C 1. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons. If an employee has a known exposure to someone with COVID-19, the employee must follow any testing or quarantine guidance provided by a VDH public health professional.

3. The employer must make decisions regarding an employee's return to work after a COVID-19-related workplace removal in accordance with guidance from a licensed healthcare provider, a VDH public health professional, or CDC's "Isolation Guidance"[69] (hereby incorporated by reference); and CDC's "Return to Work Healthcare Guidance"[70] (hereby incorporated by reference).

- 16VAC25-220-40.F is amended as follows:

F. When ~~multiple employees are~~ an employee is occupying a vehicle or other form of transportation with one or more employees or other persons for work purposes, employers shall use the hierarchy of hazard controls to mitigate the hazards associated with SARS-CoV-2 and COVID-19 to prevent employee exposures in the following order (NOTE: This subsection does not apply to fully vaccinated employees in areas of low to moderate community transmission, and except as otherwise noted):

[69] https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/isolation.html
[70] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

1. Eliminate the need for employees to share work vehicles or other transportation and arrange for alternative means for additional employees to travel to work sites.
2. Provide access to fresh air ventilation (e.g., windows). Do not recirculate cabin air.
3. When physical distancing cannot be maintained, establish procedures to maximize separation between employees as well as other persons during travel (e.g., setting occupancy limits, sitting in alternate seats, etc.).
4. When an ~~employees~~ employee who is not fully vaccinated must share a work vehicle~~s~~ or other transportation with one or more employees or other persons because no other alternatives are available, such employees shall be provided with and wear respiratory protection, such as an N95 filtering face piece respirator, or a face covering at the option of the employee. When an employee who is fully vaccinated must share work vehicles or other transportation with one or more employees or other persons in areas of substantial or high community transmission because no other alternatives are available, such employees shall be provided with and wear face coverings.
….

- 16VAC25-220-40.G is amended as follows:

G. Employers shall provide and require employees that are not fully vaccinated, fully vaccinated employees in areas of substantial or high community transmission, and otherwise at-risk employees (because of a prior transplant or other medical condition), to wear face coverings or surgical masks while indoors, unless their work task requires a respirator or other PPE. Such employees shall wear a face covering or surgical mask that covers the nose and mouth to contain the wearer's respiratory droplets and help protect others and potentially themselves. ~~Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements, employers shall ensure compliance with respiratory protection and personal protective equipment standards applicable to its industry.~~ This subsection does not apply to fully vaccinated employees in areas of low to moderate community transmission, and except as otherwise noted.

1. The following are exceptions to the requirements for face coverings, facemasks or surgical masks for employees that are not fully vaccinated and fully vaccinated employees in areas of substantial or high community transmission:
….
b. While an employee is eating and drinking at the workplace, provided each employee who is not fully vaccinated is at least 6 feet away from any other person, or separated from other people by a physical barrier.

Exceptions to the requirements for face coverings or surgical masks for employees that are not fully vaccinated are noted (e.g., when an employee is alone in a room; While an employee is eating and drinking at the workplace, provided each employee is at least 6 feet away from any other person, or separated from other people by a physical barrier, etc.).

Requirements related to the wearing of face shields in certain circumstances are provided.

Certain requirements related to cleaning and/or disinfecting are revised to reflect DOLI Frequently Asked Questions and updated in CDC guidance.

NOTE: HIPAA does not apply to apply to VOSH or OSHA.[71]

50 Requirements for healthcare services and healthcare support services.

- A Scope and Application section is added which provides:

1. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of Virginia's 16VAC-25-220, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

2. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

3. Should the federal COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, or whether it should be revoked.

- Coverage of correctional facilities, jails, detention centers, and juvenile detention centers was moved from 16VAC25-220-50 to 16VAC25-220-60, because 16VAC25-220-50 is now limited to coverage of healthcare services and healthcare support services.

[71] https://www.osha.gov/Publications/OSHA-factsheet-HIPPA-whistle.pdf

- A list of activities that the section does not apply to is included (e.g., the provision of first aid by an employee who is not a licensed healthcare provider; the dispensing of prescriptions by pharmacists in retail setting; etc.)

60 Requirements for higher-risk workplaces with mixed-vaccination status employees.

- 16VAC25-220-60 is amended to mitigate the spread of COVID-19 for employees who are not fully vaccinated, and otherwise at-risk employees in workplaces (which include, but are not limited to, manufacturing, meat and poultry processing, high-volume retail and grocery, transit, seafood processing, correctional facilities, jails, detention centers, and juvenile detention centers) where there is heightened risk due to the following types of factors:

  16VAC25-220-60.A.

  1. Where employees who are not fully vaccinated, employees who are fully vaccinated but work in a place of employment with substantial or high community transmission, or otherwise at-risk employees are working close to one another, for example, on production or assembly lines. Such workers may also be near one another at other times, such as when clocking in or out, during breaks, or in locker/changing rooms.

  2. Where employees who are not fully vaccinated or otherwise at-risk workers often have prolonged closeness to coworkers (e.g., for 8–12 hours per shift).

  3. Employees who are not fully vaccinated or otherwise at-risk employees who may be exposed to the infectious virus through respiratory droplets or aerosols in the air—for example, when employees who are not fully vaccinated or otherwise at-risk employees in a manufacturing or factory setting 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.

  4. Other distinctive factors that may increase risk among these employees who are not fully vaccinated or otherwise at-risk employees include:

     a. A common practice at some workplaces of sharing employer-provided transportation such as ride-share vans or shuttle vehicles; and
     b. Communal housing, or living quarters onboard vessels with other unvaccinated or otherwise at-risk individuals.

  16VAC25-220-60.C.7 is amended as follows:

  7. In retail workplaces (or well-defined work areas within retail) where there are employees who are not fully vaccinated, fully vaccinated employees in areas of substantial or high community transmission, or otherwise at-risk employees:

     a. Post signage ~~requesting~~ requiring face coverings for employees who are not fully vaccinated (or unknown-status) and fully vaccinated employees in areas of

substantial or high community transmission; and requesting face coverings for customers and other visitors.

70 Infectious disease preparedness and response plan.

- 16VAC25-220-70 is amended to apply to employers covered by 16VAC25-220-50 and 16VAC25-220-60.

- For employers covered by 16VAC25-220-60, the plan requirements do not apply to employees who are fully vaccinated.

80 Training.

- 16VAC25-220-80 is amended to apply to employers covered by 16VAC25-220-50 and 16VAC25-220-60.

- For employer covered by 16VAC25-220-60 employers may provide fully vaccinated employees with written information meeting the requirements of subsection 16VAC25-220-80 F in lieu of training.

NOTE: Construction employers, regardless of risk category, will be required to provide SARS-C0V-2 and COVID-19 related training, and training on the VOSH Standard 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 amendments proposed.

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)[72] 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

[72] https://law.lis.virginia.gov/vacode/40.1-22/

> 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)[73] 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 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. <u>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,</u> 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 DOLI concludes:

> Virginia Code § 40.1-22(6a) states that the Board shall provide — without regard to the requirements of the APA — for an emergency temporary or permanent standard 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. Section 40.1-22(6a) creates a path to a temporary and/or permanent standard outside of the APA. This creates a

[73] *Id.*

> separate procedure for emergency temporary and/or permanent standards – without regard to the regular processes of the APA. 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. (Emphasis added).

The purpose of the proposed amendments is to change the focus of the VOSH Standard from the very high/high/medium/lower risk exposure level approach to one that focuses on mitigation strategies directed at protecting employees who are unvaccinated, not fully vaccinated or are otherwise at risk from the grave danger presented by the SARS-C-oV-2 virus (and its variants) and the COVID-19 disease. In doing so the Department and the Virginia Department of Health (VDH) reviewed and pulled requirements from:

- OSHA's "Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace," and
- OSHA's COVID-19 ETS of general application.

The purpose of DOLI's recommended revisions to the Board's Proposed Amendments to the VOSH Standard is to address the Governor's proposed amendment to 16VAC25-220-10.E and the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

Please note there were a few other relatively minor changes and some non-substantive error corrections included as well.

2. Requirements More Restrictive than Federal.[74]

On June 21, 2021, federal OSHA adopted a COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to the healthcare industry[75] (COVID-19 ETS) (employees engaged in healthcare services and healthcare support services), but does not have a specific regulation or standard that addresses the SARS-CoV-2 virus that causes COVID-19 for employers in non-healthcare settings.[76]

On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021.[77] The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and

[74] 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.

[75] https://www.osha.gov/sites/default/files/covid-19-healthcare-ets-reg-text.pdf
https://www.govinfo.gov/content/pkg/FR-2021-06-21/pdf/2021-12428.pdf

[76] https://www.osha.gov/coronavirus/ets

[77] https://www.doli.virginia.gov/emergency-temporary-standard-interim-final-rule/

healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

3. Agencies, Localities, and Other Entities Particularly Affected.[78]

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.[79]

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

As previously referenced, on June 21, 2021, federal OSHA adopted a COVID-19 Emergency Temporary Standard, 1910.502, et seq., applicable to the healthcare industry (COVID-19 ETS) but does not have a specific regulation or standard that addresses the SARS-CoV-2 virus that causes COVID-19 for employers in non-healthcare settings.

On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021.[80] The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

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 (with the exception of the COVID-19 ETS referenced above) or standards that would require:

Physical distancing of unvaccinated or not fully vaccinated employees at least six feet where feasible (also known as Social Distancing)

[78] 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.

[79] 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.

[80] https://www.doli.virginia.gov/emergency-temporary-standard-interim-final-rule/

Require unvaccinated, not fully vaccinated, fully vaccinated employees in areas of substantial or high community transmission, or otherwise at risk employees to wear face coverings

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

Employers to develop policies and procedures for employees to report when they are confirmed COVID-19 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 in certain high risk industries 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)[81] 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

[81] https://www.osha.gov/laws-regs/oshact/section_5, 29 U.S.C. § 654(a)(1).

under the OSH Act of 1970 would be through the adoption of occupational safety and health standards[82], 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 (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.[83] 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.[84]

5. Regulatory Flexibility Analysis.[85]

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[82] *The Law of Occupational Safety and Health,* Nothstein, 1981, page 259.

[83] 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)

[84]" 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."

[85] 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

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 in 16VAC25-220-50 for healthcare services or healthcare support services, and 16VAC25-220-60 for higher-risk workplaces with mixed-vaccination status employees centered around mitigation of hazards.

  Proposed amendments are recommended to reduce the compliance burden for employers whose employees are fully vaccinated.

- On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021. The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

- DOLI's recommended revisions to the Board's Proposed Amendments to the VOSH Standard address the Governor's proposed amendment to 16VAC25-220-10.E and the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

- 16VAC25-220-60 is amended to apply to higher-risk workplaces (which include manufacturing, meat and poultry processing, high-volume retail and grocery, seafood processing, transit, correctional facilities, jails, detention centers, and juvenile detention centers) with mixed-vaccination status employees (employees who are not fully vaccinated and other at risk employees).

- Employers covered by 16VAC25-220-50 or -60 would be provided 30 days to train employees and 60 days to develop and implement an Infectious disease preparedness and response plan. All other employers are exempted from training and plan requirements, with the exception that employees must be provided information about COVID-19 hazards (an information document

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.

satisfying this requirement is provided free of charge by the Department). Small employers covered by 16VAC25-220-50 or -60 with 10 or fewer employees would be 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 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 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."

B. Purpose.

The purpose of the proposed amendments is to take into account the latest recommendations of the CDC to mitigate the spread of the SARS-CoV-2 virus for unvaccinated, not fully vaccinated and otherwise at risk employees, and reduce the compliance burden for employers whose employees are fully vaccinated. The recommended changes support the overall purpose of the standard to reduce/eliminate employee injuries, illnesses, and fatalities from SARS-CoV-2 and COVID-19 related hazards and job tasks in all industries under the jurisdiction of the Virginia State Plan.

The purpose of DOLI's recommended revisions to the Board's Proposed Amendments to the VOSH Standard is to address the Governor's proposed amendment to 16VAC25-220-10.E and the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

NOTE: On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021. The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

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).

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."[86]:

In one study, younger adults 20–44 account for 20% of hospitalizations, 12% of ICU admissions."[87]

"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"[88]

"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%

[86] https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963
[87] https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm
[88] https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_

- 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.

In a study of U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 14%. The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 2%, and overall 5% of patients died.[89]

Long-term Effects of COVID-19

"People with moderate-to-severe or uncontrolled asthma are more likely to be hospitalized from COVID-19."
"[90]

'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

[89] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[90] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/asthma.html

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.'"[91] (Emphasis added).

A CDC report on "Characteristics and Clinical Outcomes of Adult Patients Hospitalized with COVID-19 — Georgia, March 2020":[92]

> "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 [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?"[93]

> "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.

[91] https://www.healthline.com/health-news/what-we-know-about-the-long-term-effects-of-covid-19#COVID-19-might-affect-the-brain-stem
[92] https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e1.htm
[93] https://www.medicalnewstoday.com/articles/what-factors-did-people-who-died-with-covid-19-have-in-common#The-majority-were-older-males

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."

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.'"[94]

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, in the U. S. there were 1,248,029 total cases (32,411 new cases

[94] https://www.invasivecardiology.com/news/irish-study-blood-clotting-significant-cause-death-patients-covid-19

compared to June 20, 2020) of COVID-19 and 119,615 deaths (560 new deaths compared to June 20, 2020).[95] Confirmed COVID-19 cases in Virginia totaled 57,994 with 1,611 deaths.

As of December 26, 2020, in the U. S. 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.[96]

As of June 11, 2021, in the U. S. there were 33,246,578 total cases (current 7-day average of 13,997 cases), 2,243,371 hospitalizations (current 7-day average of 2,239), and 596,059 total deaths (current 7-day moving average of 347 deaths).[97]

As of June 14, 2021, cases in Virginia totaled 677,812[98] (7-day average 140 cases), 30,182 hospitalizations (7-day average of 10 hospitalizations),[99] with 11,318 deaths (7-day average of 3 deaths).[100]

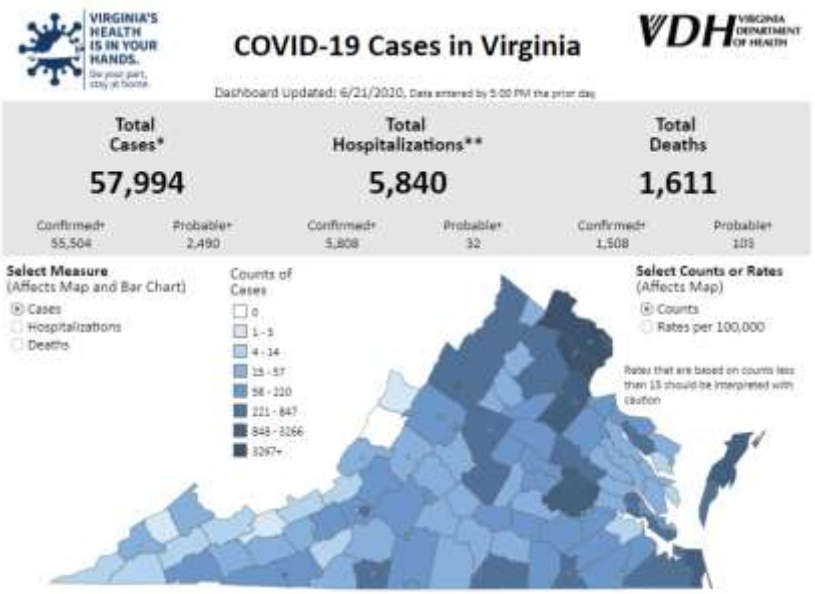
As of August 11, 2021, in the U. S. there were 36,268,057 total cases (current 7-day average of 114,190 cases), 2,507,105 hospitalizations (current 7-day average of 10,072), and 617,096 total deaths (current 7-day moving average of 407 deaths).[101]

As of August 10, 2021, cases in Virginia totaled 725,971[102] (7-day average 1,700 cases), 32,399 hospitalizations (7-day average of 37 hospitalizations),[103] with 11,625 deaths (7-day average of 5 deaths).[104]

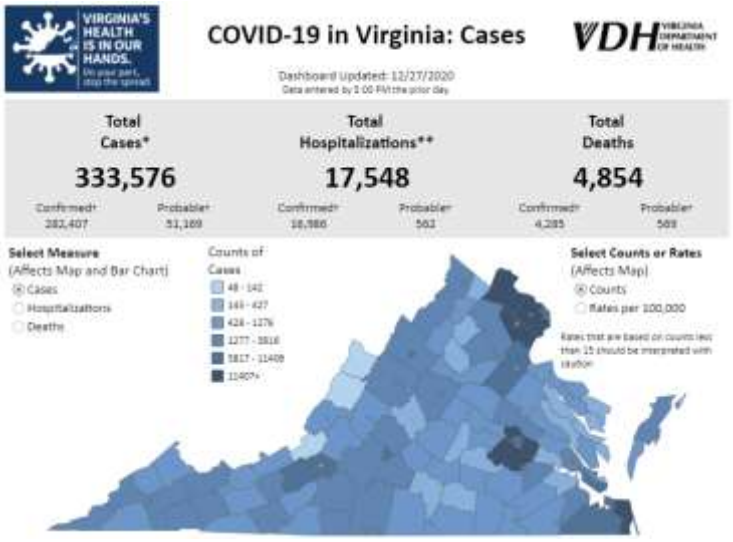
[95] https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf
[96] *Id.*
[97] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[98] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
[99] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[100] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[101] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[102] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
[103] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[104] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/

National and Virginia Charts

Virginia Cases by County as of June 21, 2020.[105]

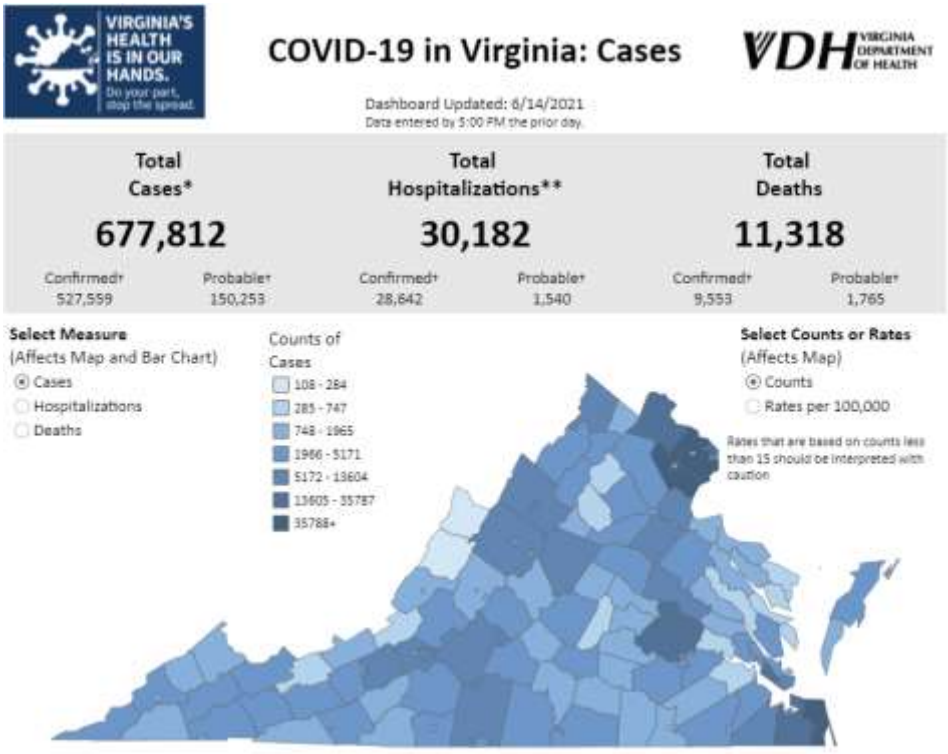


Virginia Cases by County as of December 26, 2020.[106]

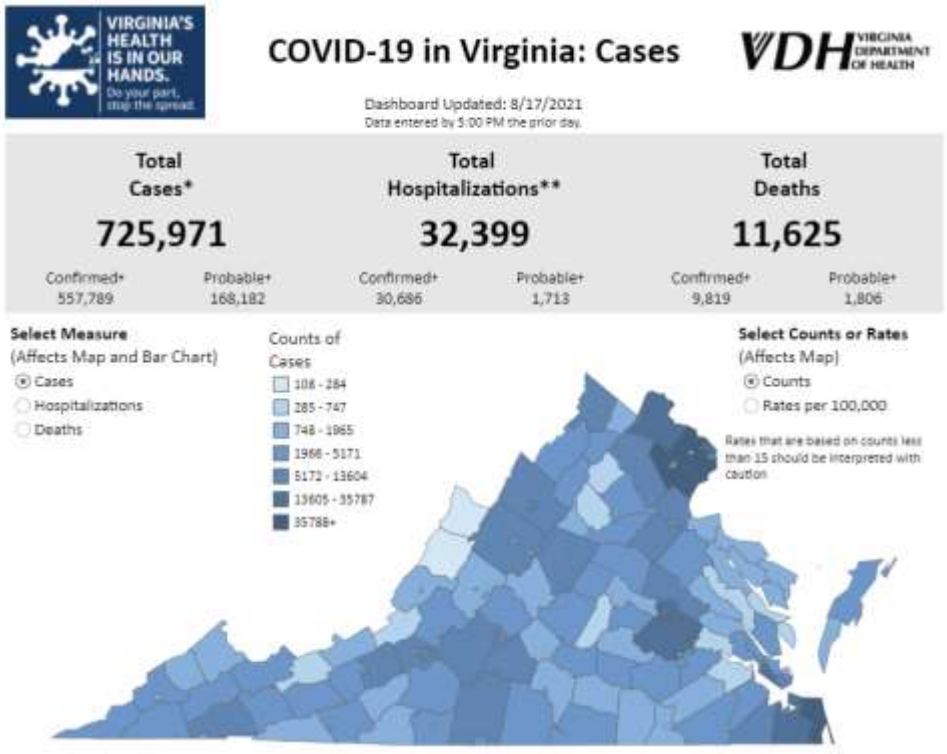


[105] https://www.vdh.virginia.gov/coronavirus/
[106] *Id.*

Virginia Cases by County as of June 14, 2021.[107]

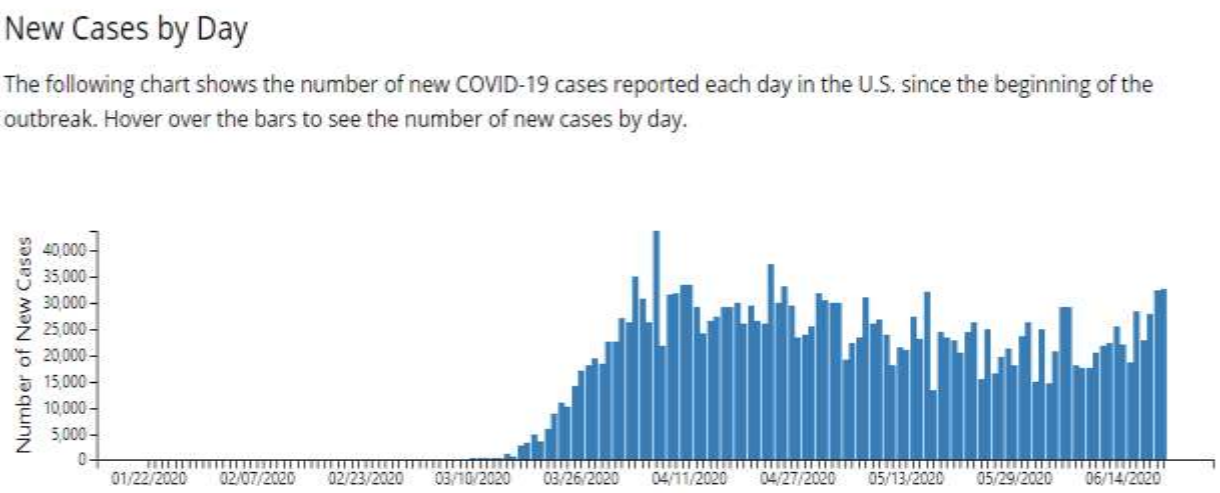


Virginia Cases by County as of August 17, 2021.[108]

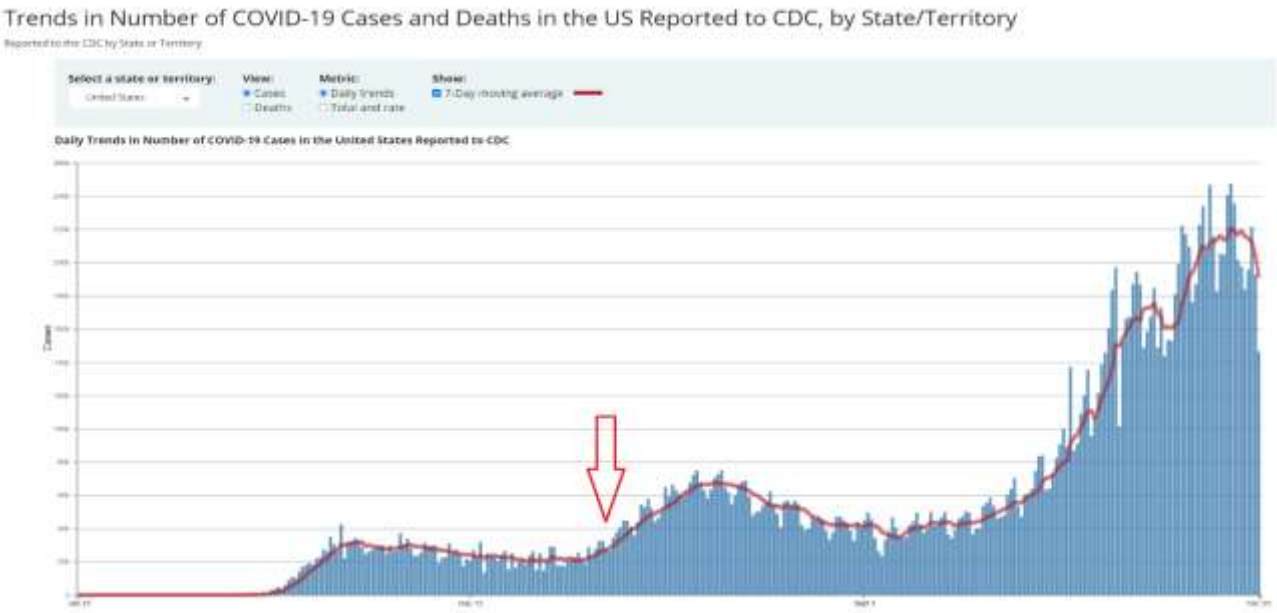


[107] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[108] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/

National COVID-19 Cases as of June 21, 2020[109]

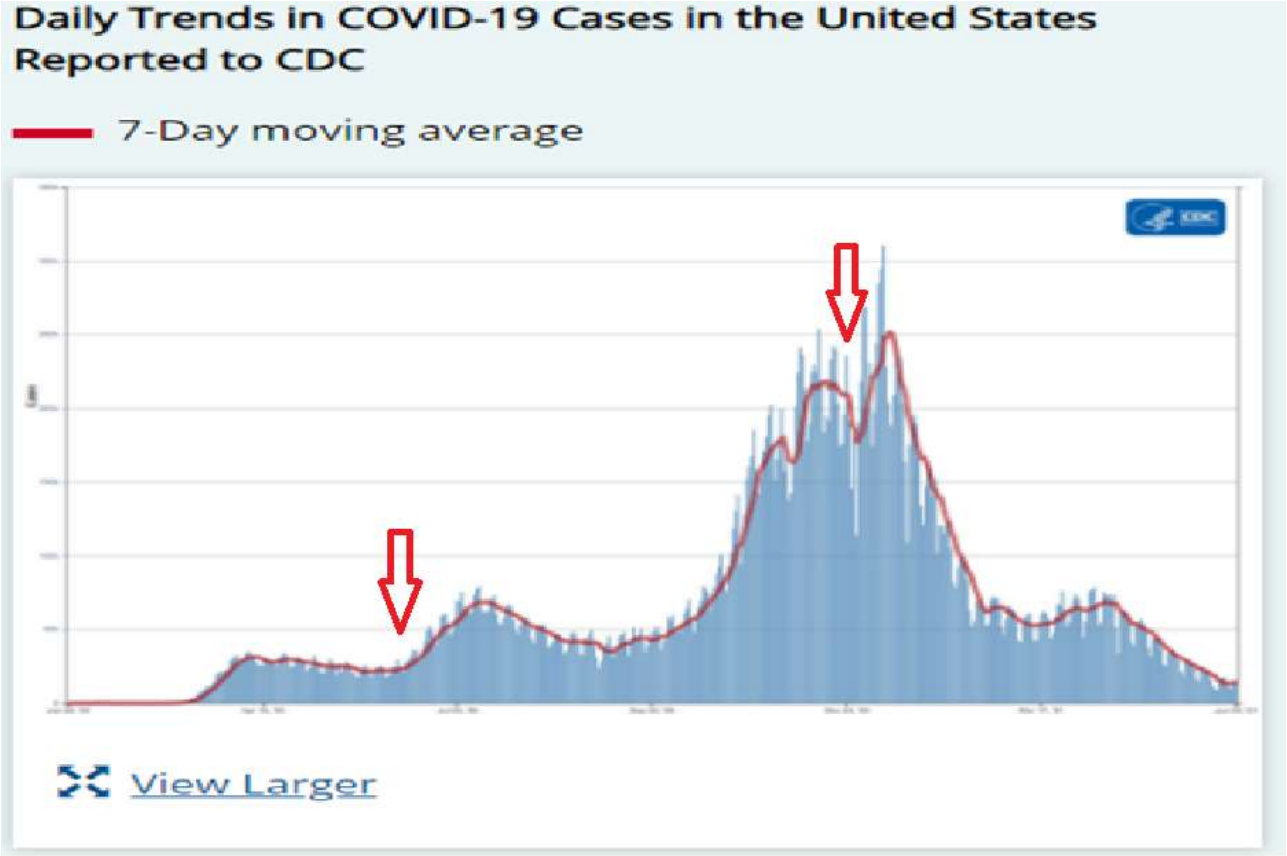


National COVID-19 Cases as of December 26, 2020.[110]



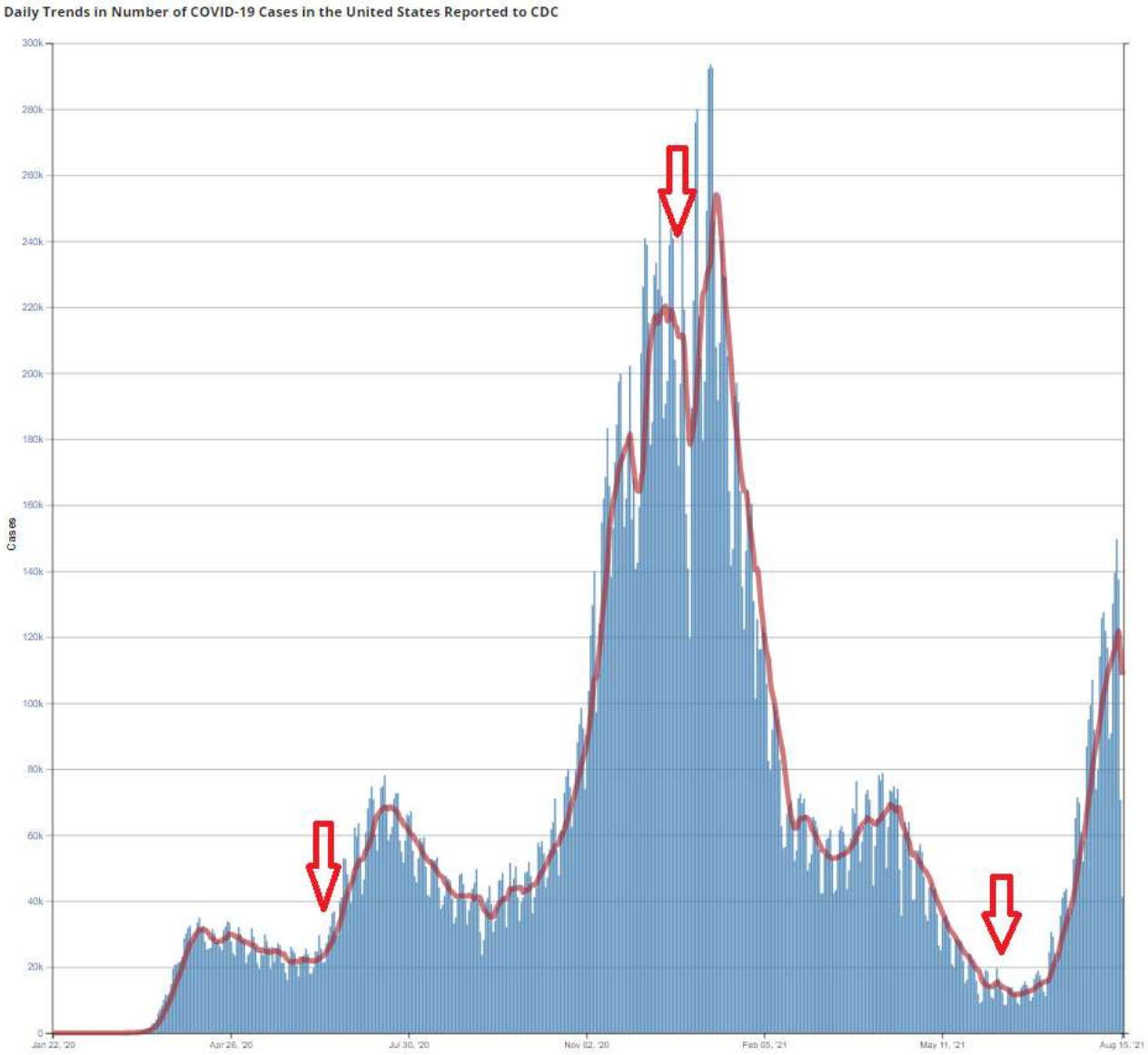
[109] https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf
[110] *Id.*

National COVID-19 Cases as of June 11, 2021[111]



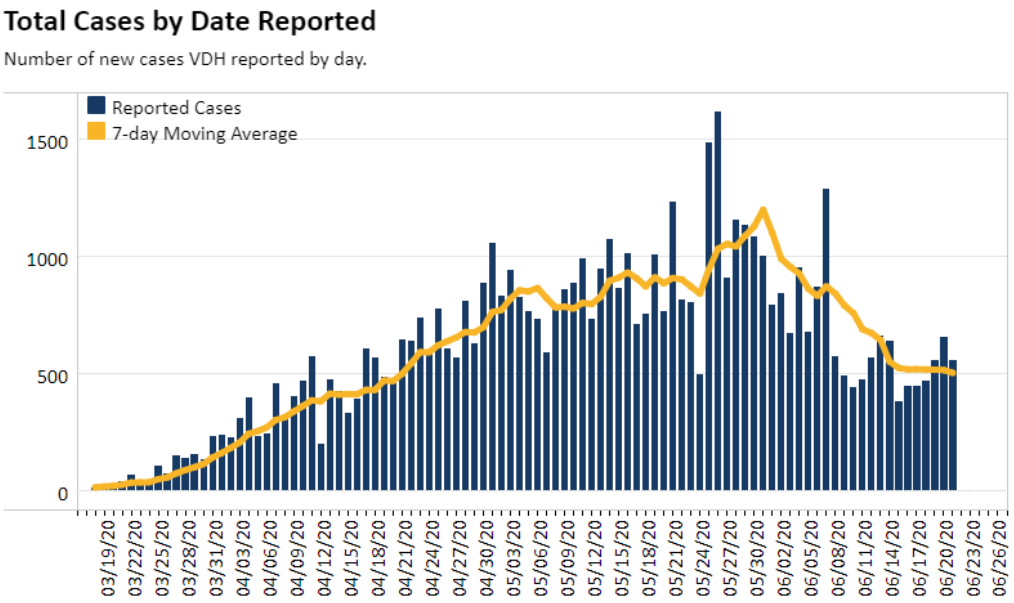
[111] https://townhall.virginia.gov/L/GetFile.cfm?File=meeting\92\32669\Agenda_DOLI_32669_v6.pdf

National COVID-19 Cases as of August 17, 2021[112]

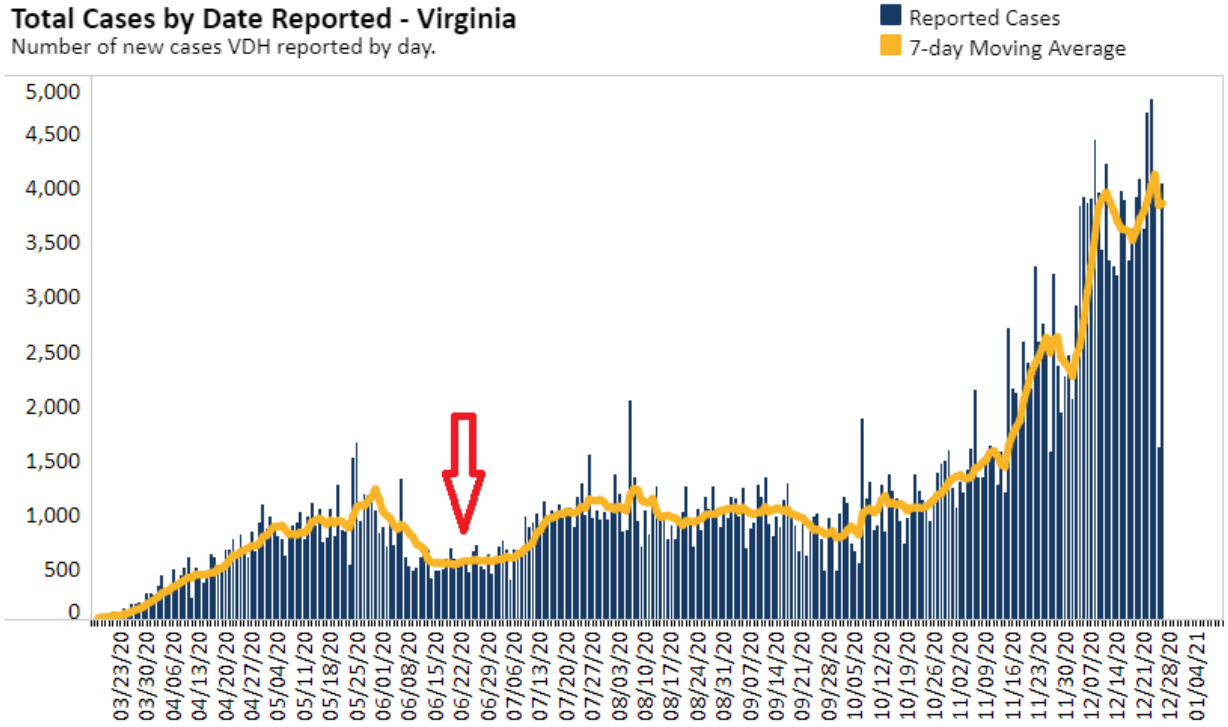


[112] https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases

Virginia Cases as of June 21, 2020.[113]

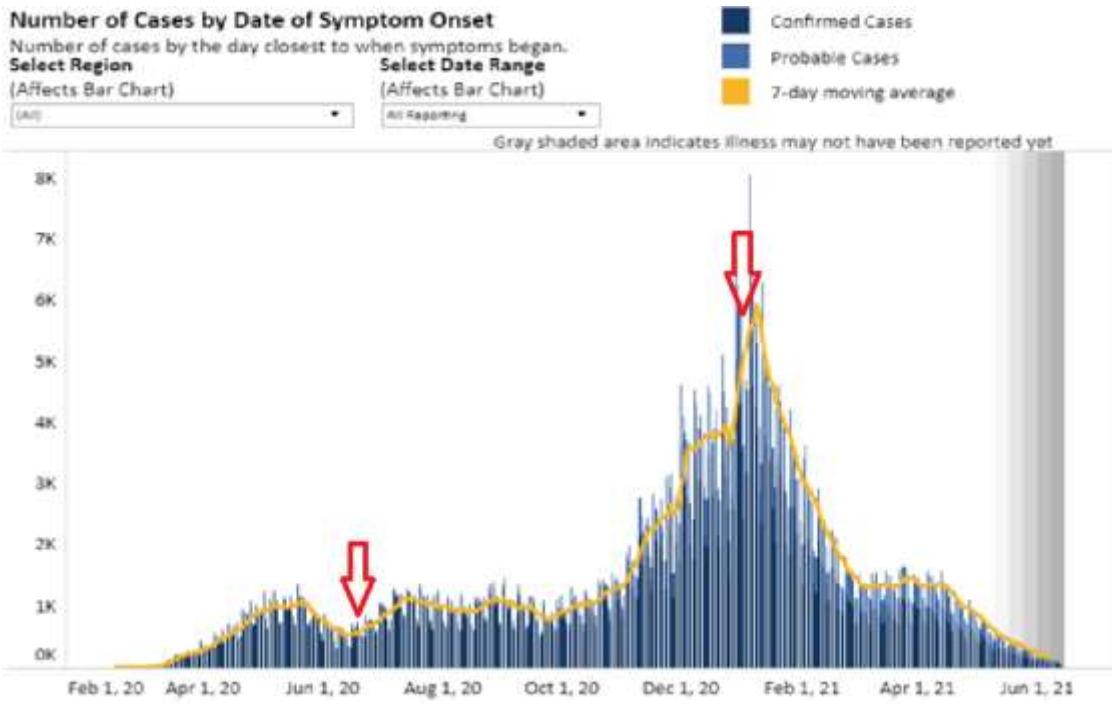


Virginia Cases as of December 26, 2020.[114]

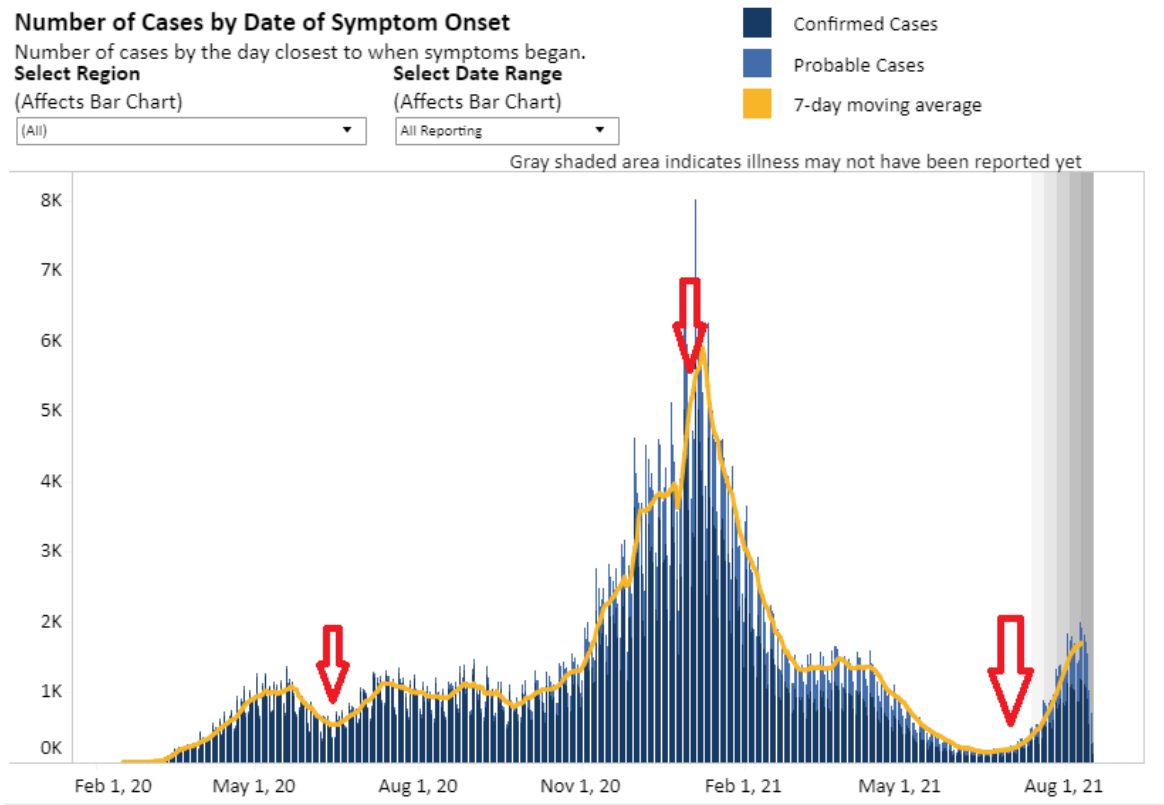


[113] https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf
[114] *Id.*

Virginia Cases as of June 14, 2021.[115]



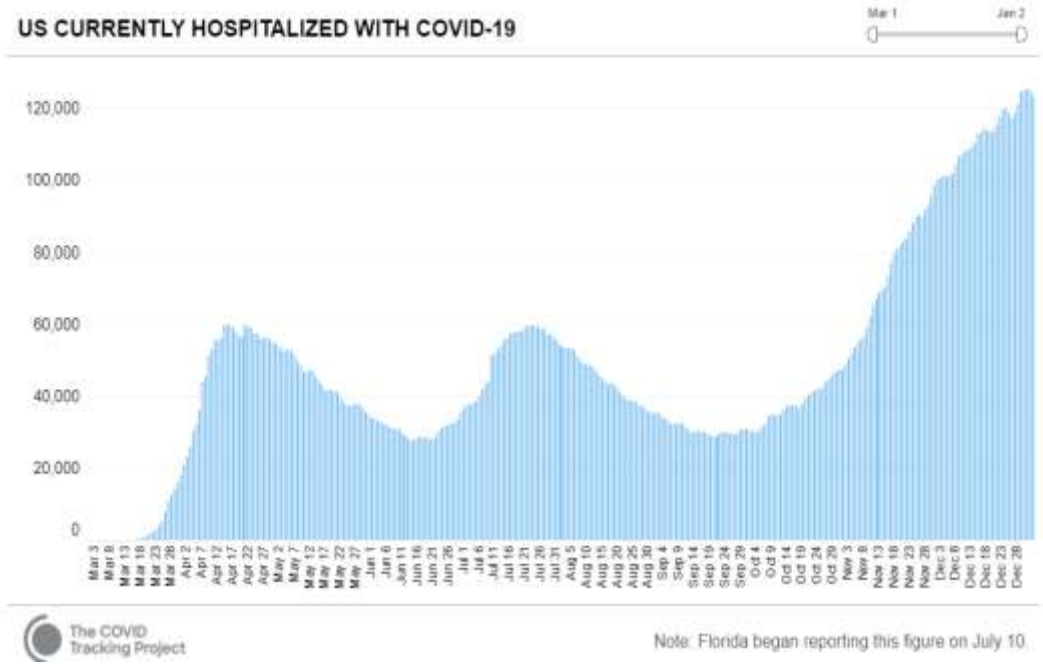
Virginia Cases as of August 17, 2021.[116]



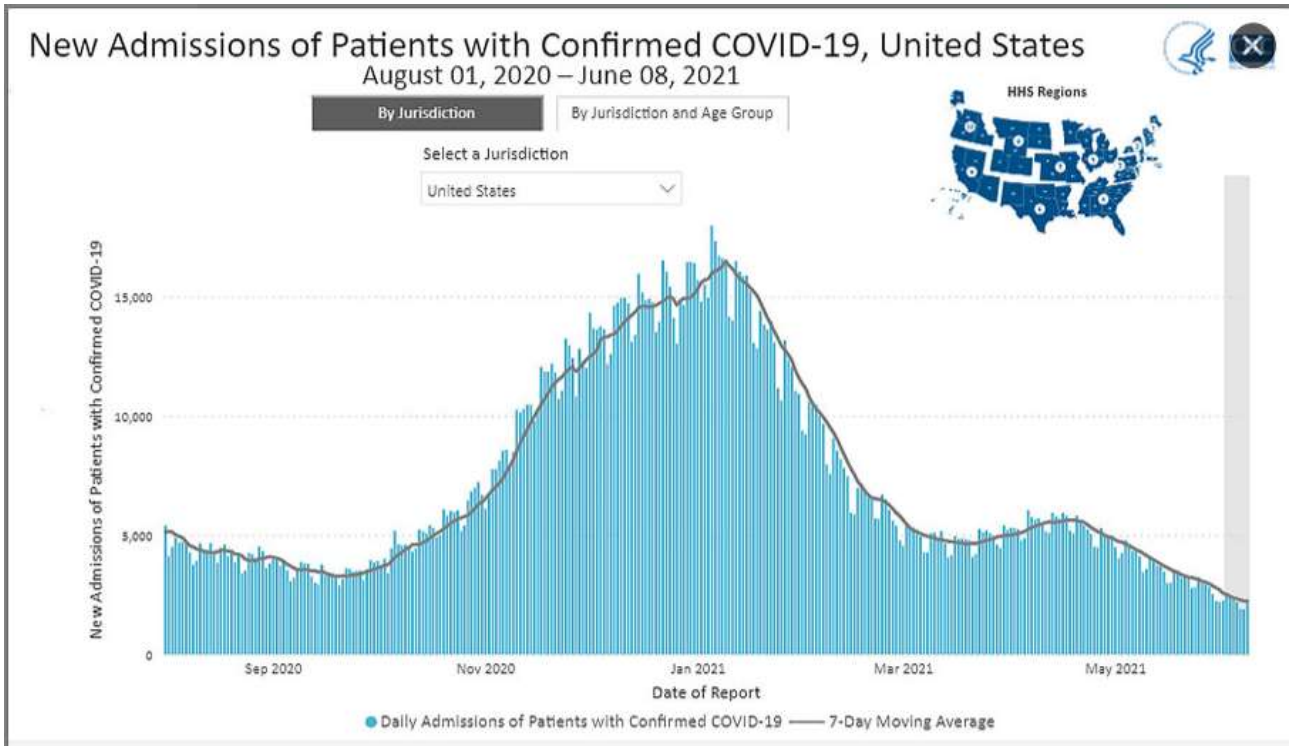
[115] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[116] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/

Current hospitalizations remain the most reliable statistic. Hospitalizations are a much better reflection of reality than the other metrics through the holiday reporting bumpiness.[117]

U. S. Hospitalizations through January 2, 2021.

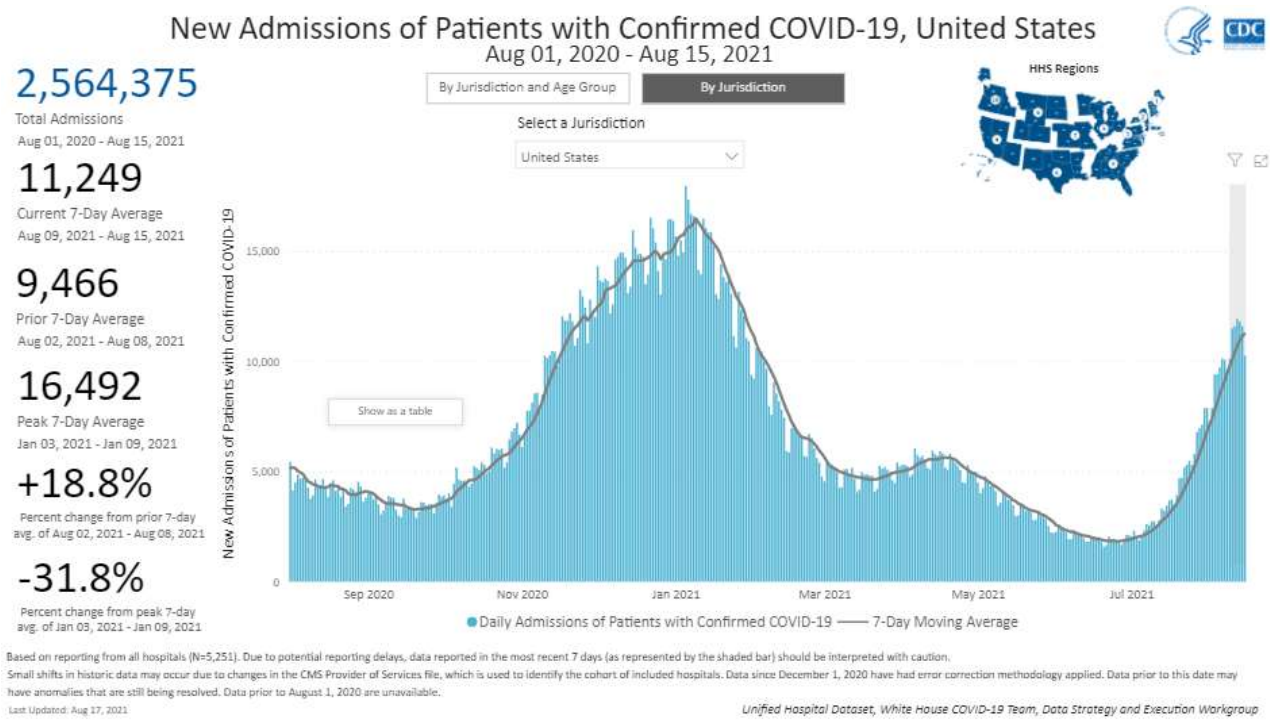


U. S. Hospitalizations August 1, 2020 through June 8, 2021.[118]



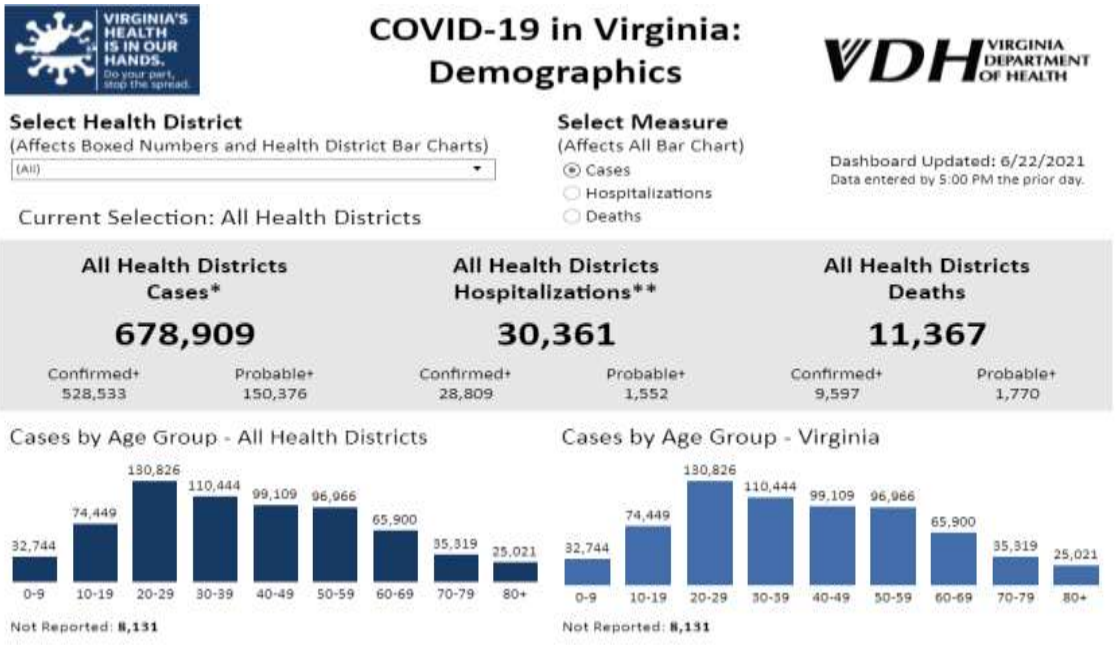
[117] https://covidtracking.com/data/charts/us-currently-hospitalized
[118] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

U. S. Hospitalizations from August 1, 2020 through August 15, 2021.[119]



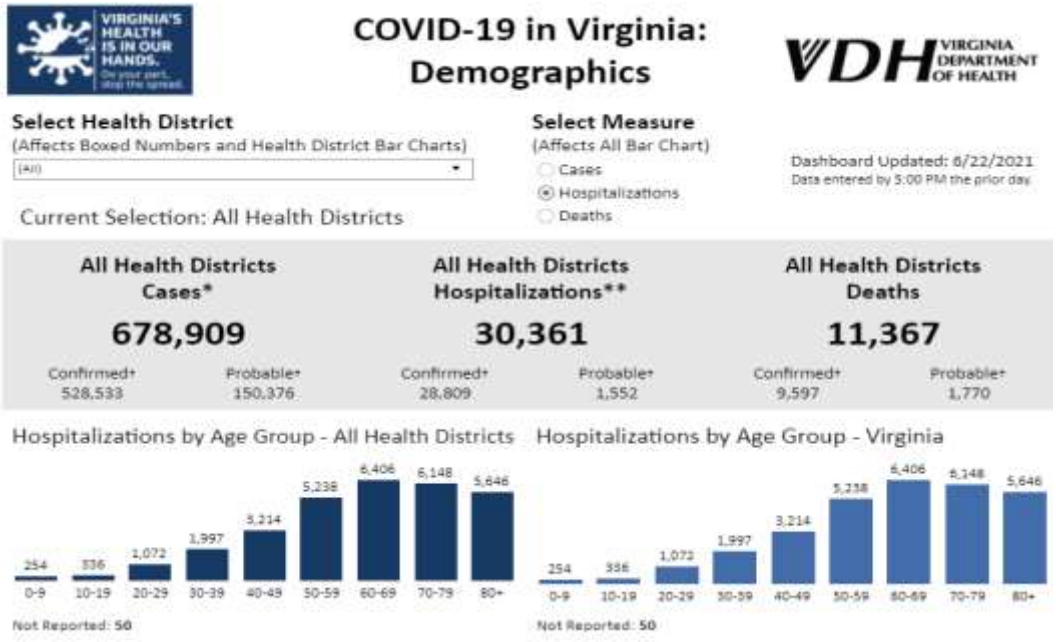
COVID-19 in Virginia Demographics[120]

Approximately **74.1% of COVID-19 cases** occurred in the working age population of 20-69.

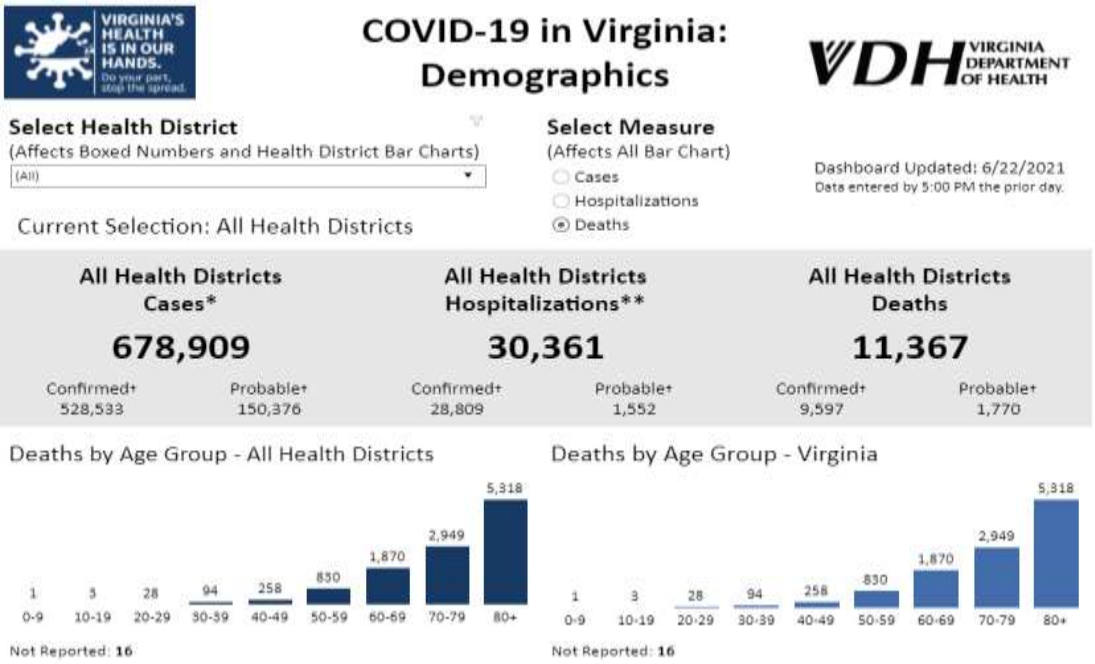


[119] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[120] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-demographics/

Approximately **59.0% of COVID-19 hospitalizations** occurred in the working age population of 20-69.

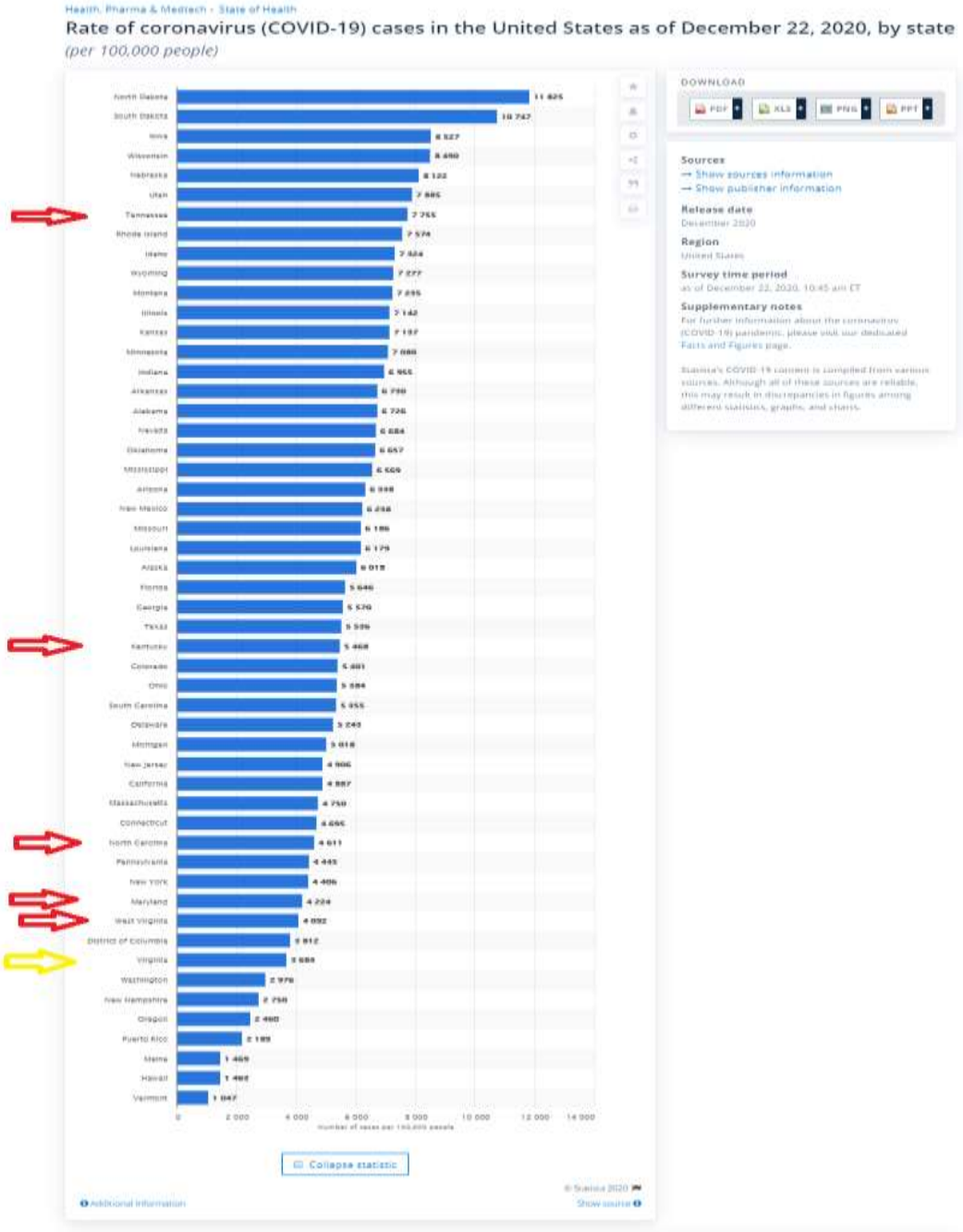


Approximately **27.1% of COVID-19 deaths** occurred in the working age population of 20-69.



COVID-19 State Rankings: Total Cases per 100K as of December 22, 2020 [121]

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



[121] 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

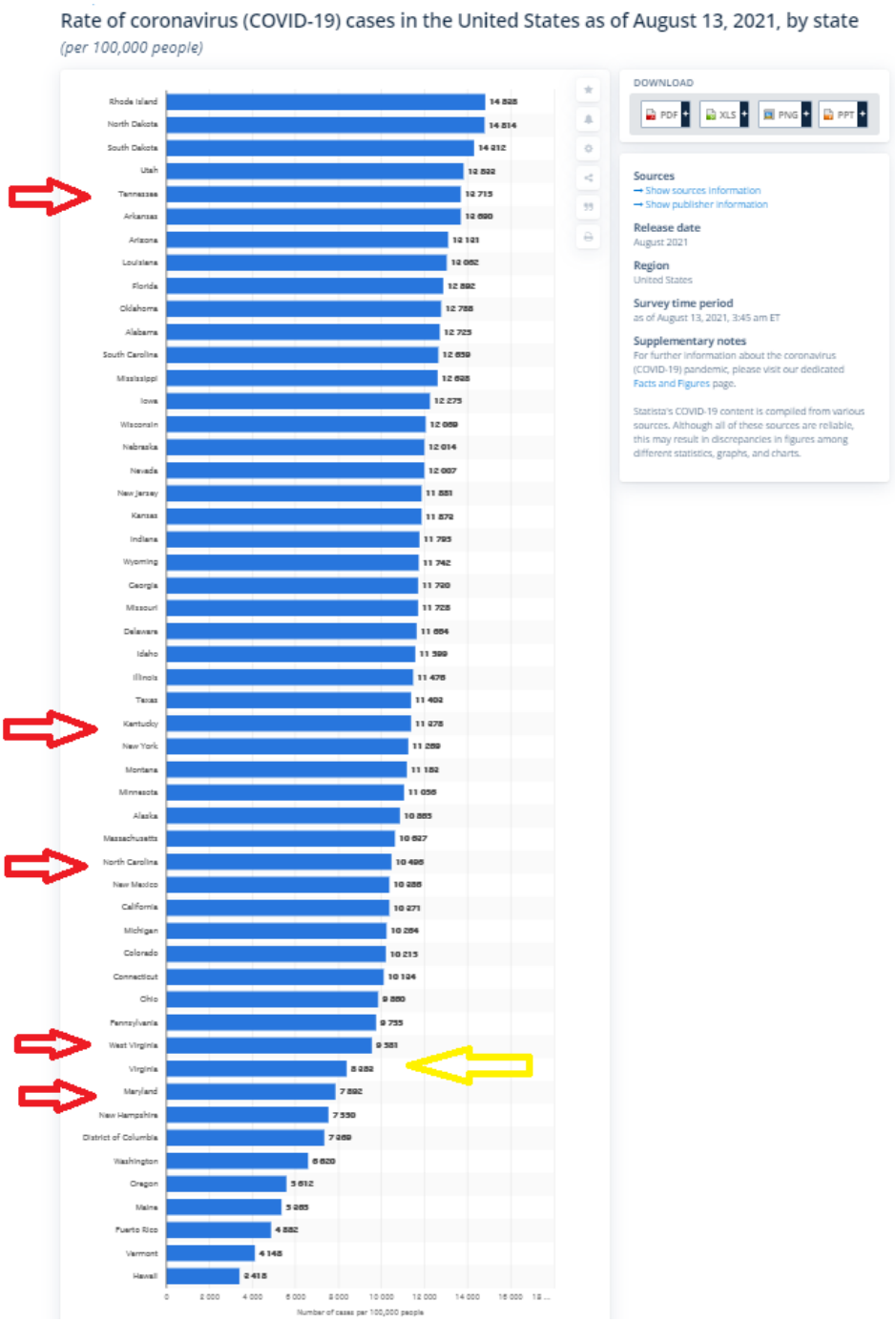
COVID-19 State Rankings: Total Cases per 100K as of June 11, 2021 [122]

5	-	Tennessee
28	-	Kentucky
38	-	North Carolina
42	-	West Virginia
43	-	Virginia
44	-	Maryland

[122] https://www.statista.com/statistics/1109004/coronavirus-covid19-cases-rate-us-americans-by-state/

COVID-19 State Rankings: Total Cases per 100K as of August 13, 2021 [123]

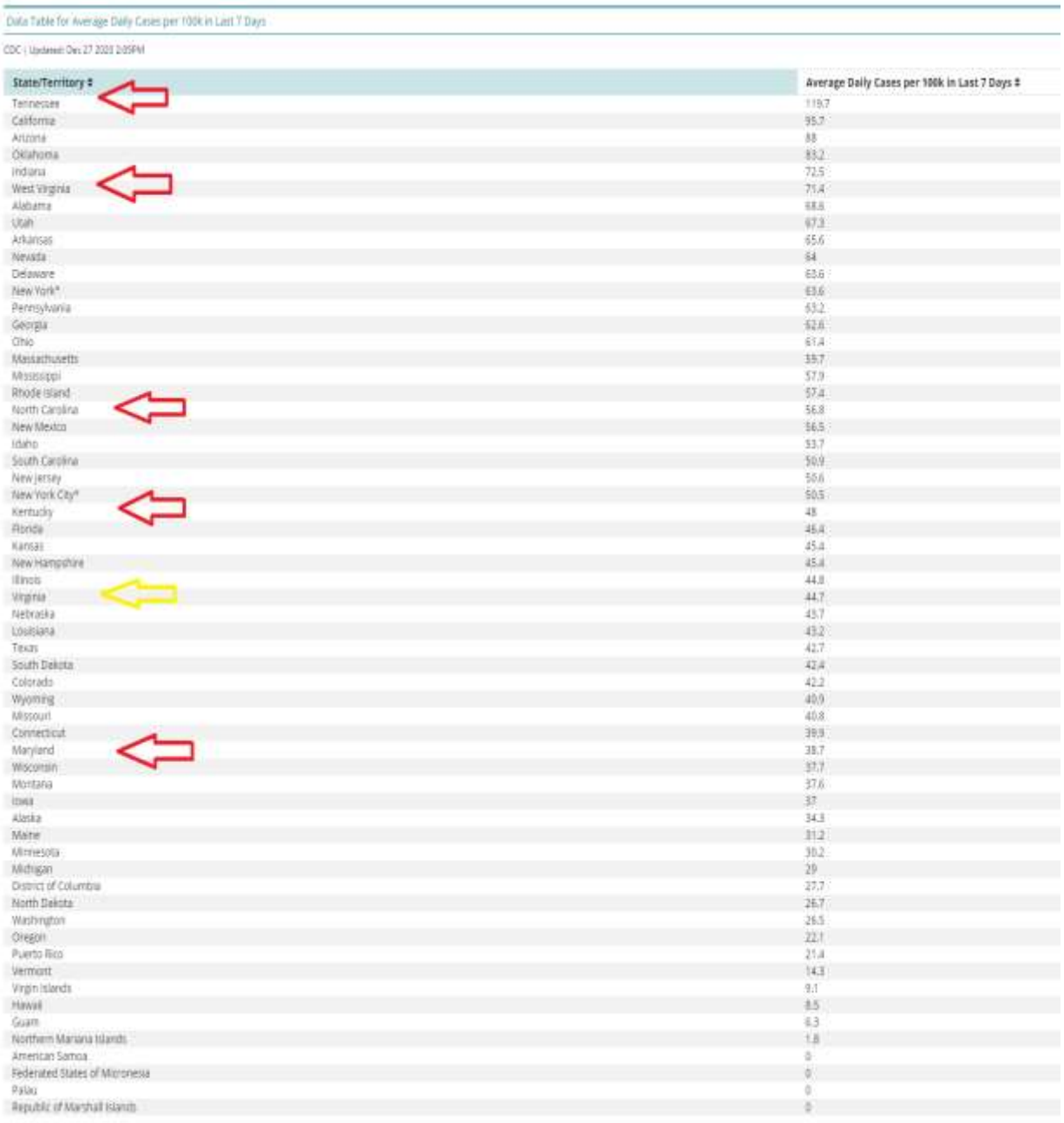
5	-	Tennessee
28	-	Kentucky
34	-	North Carolina
42	-	West Virginia
43	-	Virginia
44	-	Maryland



[123] 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. [124]

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	119.7
California	95.7
Arizona	88
Oklahoma	83.2
Indiana	72.5
West Virginia	71.4
Alabama	68.6
Utah	67.3
Arkansas	65.6
Nevada	64
Delaware	63.6
New York*	63.6
Pennsylvania	63.2
Georgia	62.6
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

[124] 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

COVID-19 State Rankings: Average Daily Cases per 100K in Last 7 Days as of June 14, 2021. [125]

11	-	Kentucky
21	-	West Virginia
39	-	Tennessee
42	-	North Carolina
47	-	Virginia
49	-	Maryland

Data Table for Cumulative Cases per 100k in Last 7 Days

CDC | Data as of June 14, 2021 1:13 PM ET. Posted: June 14, 2021 2:13 PM ET

Download Data

State/Territory ⇕	7-Day Case Rate per 100,000 ⇕
Virgin Islands	89.8
Colorado	73.2
Wyoming	67.7
Missouri	64.2
Utah	59.8
Washington	51.8
Arkansas	50.7
Florida	50.6
Nevada	43.2
Oregon	42.1
Kentucky	40.7
Arizona	40.3
Montana	39.6
Indiana	33.9
Idaho	32.1
Alabama	31.1
Louisiana	29.7
North Dakota	29.5
Texas	29
Mississippi	28.9
West Virginia	28.1
Kansas	26.6
Hawaii	25.6
Maine	25.4
Oklahoma	25.1
South Carolina	24.9
Georgia	24.1
Delaware	23.8
Pennsylvania	22
New Mexico	20.5
Ohio	20.5
Alaska	19.6
American Samoa	N/A
Guam	20.5
New York City*	20.2
Minnesota	19
New Jersey	18.7
Illinois	18.6
Tennessee	18.3
Michigan	18.2
Iowa	17.4
North Carolina	16.5
New York*	15.7
Rhode Island	14
Wisconsin	12.5
Massachusetts	11.5
Virginia	11.5
Puerto Rico	11.1
Maryland	11
New Hampshire	11
Nebraska	10.6
South Dakota	10.1
California	9.7
Vermont	9.3
Connecticut	9.2
District of Columbia	8.8
Federated States of Micronesia	N/A
Northern Mariana Islands	0
Palau	0
Republic of Marshall Islands	0

[125] https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

COVID-19 State Rankings: Average Daily Cases per 100K in Last 7 Days as of August 16, 2021. [126]

10 - Kentucky
11 - Tennessee
29 - North Carolina
42 - Virginia
43 - West Virginia
47 - Maryland

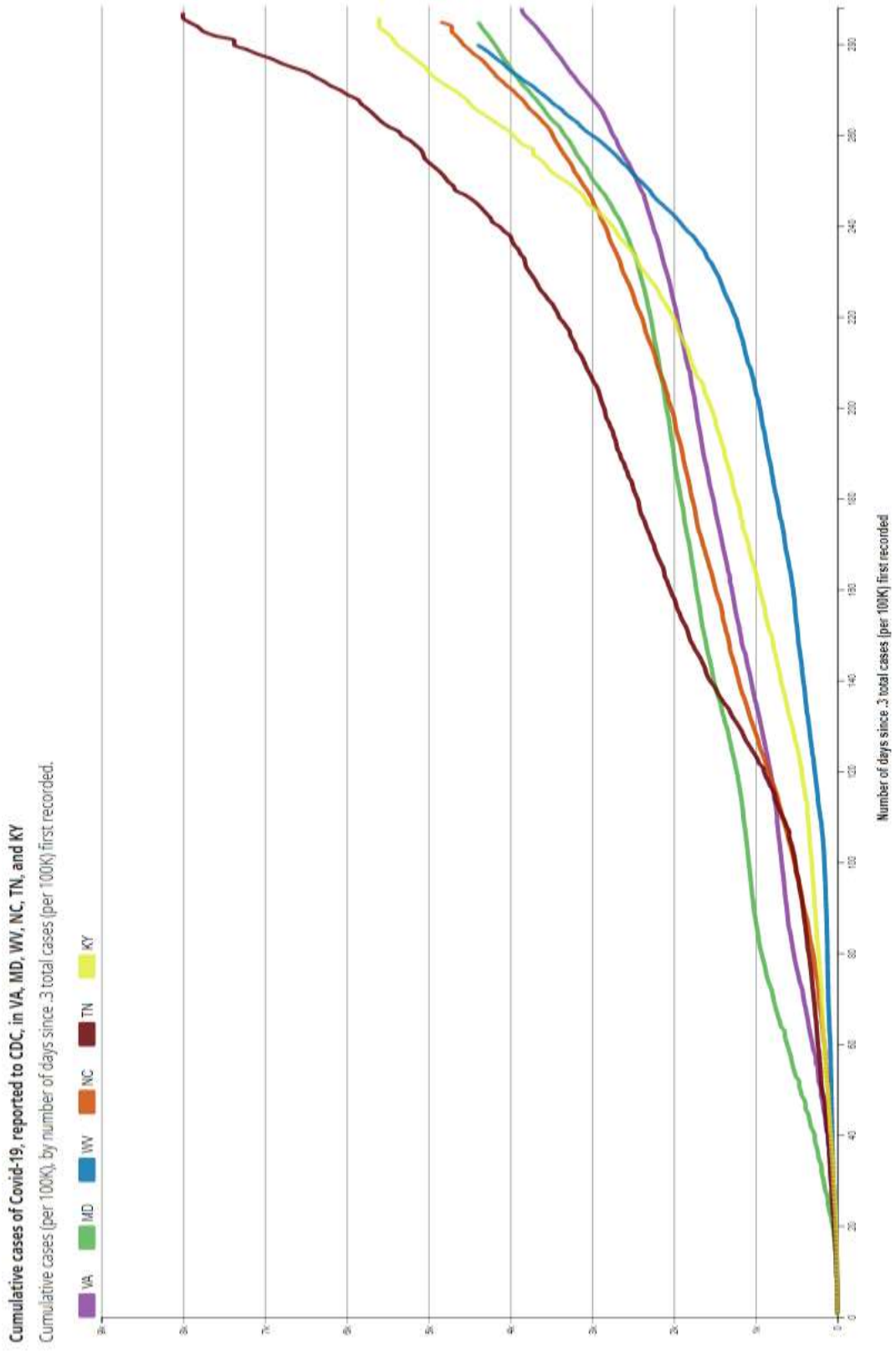
Data Table for Cumulative Cases per 100k in Last 7 Days

CDC | Data as of: August 16, 2021 1:36 PM ET. Posted: August 16, 2021 4:59 PM ET

State/Territory	7-Day Case Rate per 100,000
Florida	704.5
Louisiana	642
Mississippi	540.5
Arkansas	514.6
Alabama	356
Texas	337.2
Hawaii	324.6
Missouri	317.3
Georgia	306
Kentucky	306
Tennessee	291.8
South Carolina	289.7
Virgin Islands	285.6
Arizona	266.6
Wyoming	248.3
Oklahoma	231.3
Kansas	227.3
Oregon	223.5
Alaska	213.1
Puerto Rico	197
Idaho	186.7
Washington	186.4
New Mexico	186.3
Nevada	180.1
Indiana	179.9
Guam	176.8
Delaware	176
New York City*	171.2
North Carolina	164.4
Montana	161.3
New York (Level of Community Transmission)*	151.8
Ohio	149.1
Utah	142.3
New York*	137.1
California	136.6
Wisconsin	136.1
Rhode Island	132.9
Iowa	132.7
New Jersey	131.9
North Dakota	130.4
Illinois	127
Virginia	124.1
West Virginia	119.7
Minnesota	112.1
District of Columbia	109
Pennsylvania	108.1
Maryland	99
Massachusetts	91.8
Connecticut	81.5
Maine	77.1
Colorado	76.9
South Dakota	74.8
Michigan	70.5
New Hampshire	68.9
Vermont	66.5
Nebraska	39.6
Northern Mariana Islands	0
Palau	0
Republic of Marshall Islands	0
American Samoa	N/A
Federated States of Micronesia	N/A

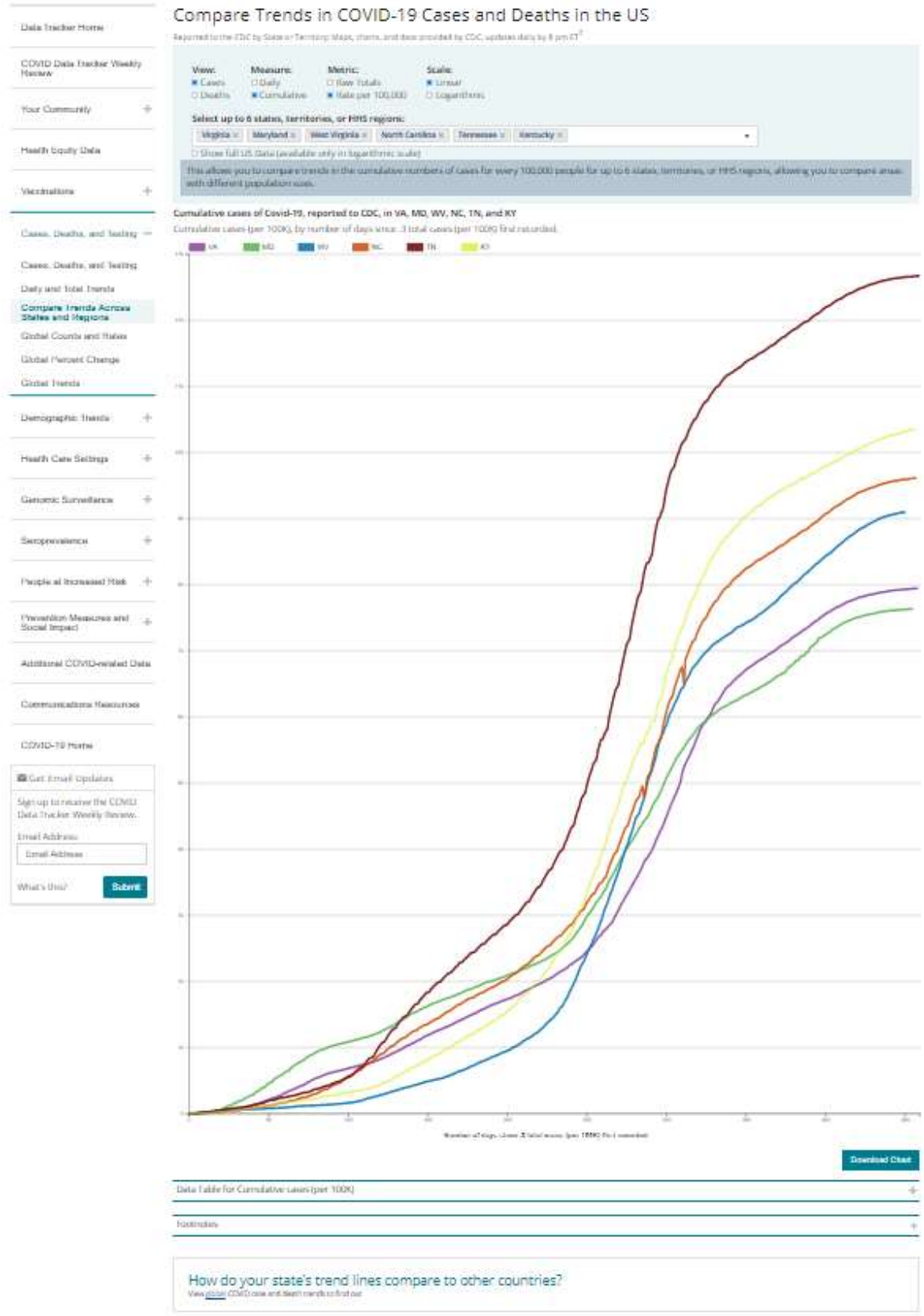
[126] https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

Comparison of trends (Totals per 100,000) in COVID-19 cases by state December 26, 2020:[127]



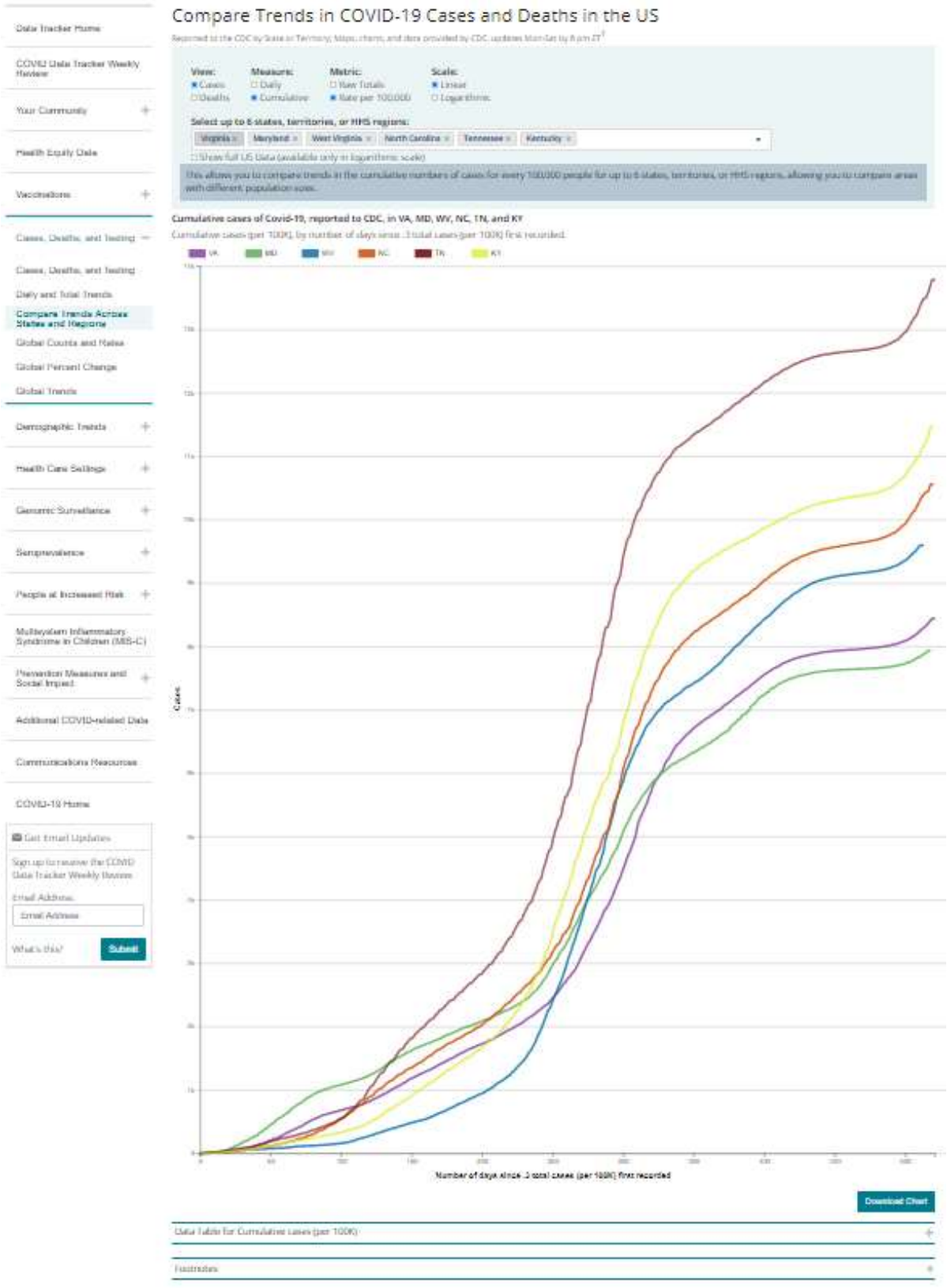
[127] https://www.doli.virginia.gov/wp-content/uploads/2021/01/BP-Final-Standard-for-SARS-CoV-2-that-Causes-COVID-19-DRAFT-1.4.2021.pdf

Comparison of trends (Totals per 100,000) in COVID-19 cases by state June 14, 2021:[128]



[128] 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

Comparison of trends (Totals per 100,000) in COVID-19 cases by state August 15, 2021:[129]



[129] https://covid.cdc.gov/covid-data-tracker/#compare-trends_cases-cum-rate-lin

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

1. General Information on Pandemics.[130]

"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

[130] 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

"The principal mode by which people are infected with SARS-CoV-2 (the virus that causes COVID-19) is through exposure to respiratory fluids carrying infectious virus. Exposure occurs in three principal ways:

(1) inhalation of very fine respiratory droplets and aerosol particles,

(2) deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye by direct splashes and sprays, and

(3) touching mucous membranes with hands that have been soiled either directly by virus-containing respiratory fluids or indirectly by touching surfaces with virus on them.

People release respiratory fluids during exhalation (e.g., quiet breathing, speaking, singing, exercise, coughing, sneezing) in the form of droplets across a spectrum of sizes.1-9 These droplets carry virus and transmit infection.

- The largest droplets settle out of the air rapidly, within seconds to minutes.
- The smallest very fine droplets, and aerosol particles formed when these fine droplets rapidly dry, are small enough that they can remain suspended in the air for minutes to hours.

Infectious exposures to respiratory fluids carrying SARS-CoV-2 occur in three principal ways (not mutually exclusive):

1. Inhalation of air carrying very small fine droplets and aerosol particles that contain infectious virus. Risk of transmission is greatest within three to six feet of an infectious source where the concentration of these very fine droplets and particles is greatest.

2. Deposition of virus carried in exhaled droplets and particles onto exposed mucous membranes (i.e., "splashes and sprays", such as being coughed on). Risk of transmission is likewise greatest close to an infectious source where the concentration of these exhaled droplets and particles is greatest.

3. Touching mucous membranes with hands soiled by exhaled respiratory fluids containing virus or from touching inanimate surfaces contaminated with virus." [131]

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.[132]

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.[133] The current best estimate of the CDC based on data through August 1, 2020 is an R_0 value of 2.5.[134]

[131] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fscience%2Fscience-briefs%2Fscientific-brief-sars-cov-2.html
[132] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[133] https://wwwnc.cdc.gov/eid/article/26/6/20-0495_article
[134] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

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.[135]

"The incubation period for COVID-19 is thought to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset. One study reported that 97.5% of people with COVID-19 who have symptoms will do so within 11.5 days of SARS-CoV-2 infection."[136]

"**Available data indicate that persons with mild to moderate COVID-19 remain infectious no longer than 10 days after symptom onset.** Most adults with more severe to critical illness or severe immunocompromise likely remain infectious no longer than 20 days after symptom onset; however, there have been several reports of people shedding replication-competent virus beyond 20 days due to severe immunocompromise. Recovered adults can continue to shed detectable but non-infectious SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in concentration ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. The circumstances that result in persistently detectable SARS-CoV-2 RNA have yet to be determined. Studies have not found evidence that clinically recovered adults with persistence of viral RNA have transmitted SARS-CoV-2 to others. **These findings strengthen the justification for relying on a symptom-based rather than test-based strategy for ending isolation of most patients, so that adults who are no longer infectious are not kept unnecessarily isolated and excluded from work or other responsibilities.**"[137] (Emphasis added).

The CDC's current best estimate of the percentage of persons with positive COVID-19 infections that are asymptomatic is 30%.[138]

The CDC's current best estimate of the percentage of COVID-19 disease transmission occurring prior to symptom onset is 50%.[139]

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."[140]

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[135] https://newatlas.com/health-wellbeing/covid19-case-studies-coronavirus-superspreader-clusters-cdc-report/
[136] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[137] https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html
[138] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html
[139] *Id.*
[140] https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_

"Viral shedding[141]…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 study[142] 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 subside; one study[143] 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.[144]

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.

[141] https://achi.net/newsroom/defining-covid-19-terms-viral-shedding/
[142] https://www.nature.com/articles/s41591-020-0869-5
[143] 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
[144] https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/

One study[145] 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."[146] (Emphasis added).

3. Cross Border Transmission.

According to the Director-General of the World Health Organization, "This [SARS-CoV-2] virus does not respect borders."[147] 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.[148]

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.[149] For instance, during calendar year 2019, contractors from the following states were inspected by VOSH:

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

WSLS.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.

[145] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30196-1/fulltext
[146] https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/
[147] https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---27-february-2020
[148] https://www.aarp.org/politics-society/government-elections/info-2020/coronavirus-state-restrictions.html
[149] https://www.kayak.com/travel-restrictions/united-states/

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.

All work was halted at the Cave Spring High School construction site on Monday, per recommendation from the health department."[150] (Emphasis added).

CNBC.com, June 14, 2021, "Boris Johnson extends current lockdown rules in England due to concerns over delta Covid variant"

> "LONDON — Prime Minister Boris Johnson on Monday announced a delay of four weeks to the next phase of England's lockdown reopening, amid a surge in the delta variant of Covid-19 first discovered in India.
>
> Rules on the use of face masks, limiting the number of people who can meet indoors and out, and shutting nightclubs and similar venues were due to be lifted June 21, but that has now been pushed back to July 19. At the moment, gatherings are limited to six people indoors and 30 outdoors.
> ….
> New figures from Public Health England indicate that 42,323 cases of the delta variant of the coronavirus have now been confirmed across the U.K., an increase of 240% from last week, while the country's transmission rate is at its highest since January.
>
> More than 70 million vaccine doses have been administered across the U.K., with around 80% of the country having now received at least one dose. **But a Public Health England paper in late May showed that the Pfizer and AstraZeneca vaccines were only 33% effective against the delta variant after a single shot.**
>
> New data on Monday showed much better effectiveness against the delta variant after two doses. Public Health England said the Pfizer-BioNTech vaccine is 96% effective against hospitalization after two doses and the Oxford-AstraZeneca shot is 92% effective."[151] (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

[150] https://www.wsls.com/news/local/2020/05/06/25-covid-19-cases-connected-to-cave-spring-high-school-construction-work/
[151] https://www.cnbc.com/2021/06/14/uks-boris-johnson-to-extend-covid-19-restrictions-in-england-reports.html

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%.[152] Another study calculated a global IFR of 1.04%.[153]

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%.[154] Nearly the entire cruise ships 3,711 passengers and crew were tested.

A study[155] 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."

As of March 19, 2021, the CDC's best estimate of the infection fatality rate for COVID-19 is 2.5.[156]

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[152] 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).

[153] https://www.medrxiv.org/content/10.1101/2020.05.11.20098780v1

[154] https://www.medrxiv.org/content/10.1101/2020.03.05.20031773v2

[155] *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

[156] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

The generally accepted approximate IFR-S of seasonal influenza is 0.1%.[157]

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."[158]

"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."[159] (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%.[160]

The mortality rate or death rate of the seasonal influenza in 2018 was approximately 0.1%.[161]

"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)."[162]

COVID-19

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157 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00455?utm_campaign=covid19fasttrack&utm_medium=press&utm_content=basu&utm_source=mediaadvisory&

158 https://www.cdc.gov/flu/about/season/flu-season.htm

159 https://www.cdc.gov/flu/about/burden/2018-2019.html

160 https://www.cdc.gov/flu/vaccines-work/2018-2019.html

161 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

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

"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."[163] (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."[164]

"[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 scenarios[165] 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."[166] (Emphasis added).

As of August 11, 2021, in the U. S. there were 36,268,057 total cases (current 7-day average of 114,190 cases), 2,507,105 hospitalizations (current 7-day average of 10,072), and 617,096 total deaths (current 7-day moving average of 407 deaths).[167]

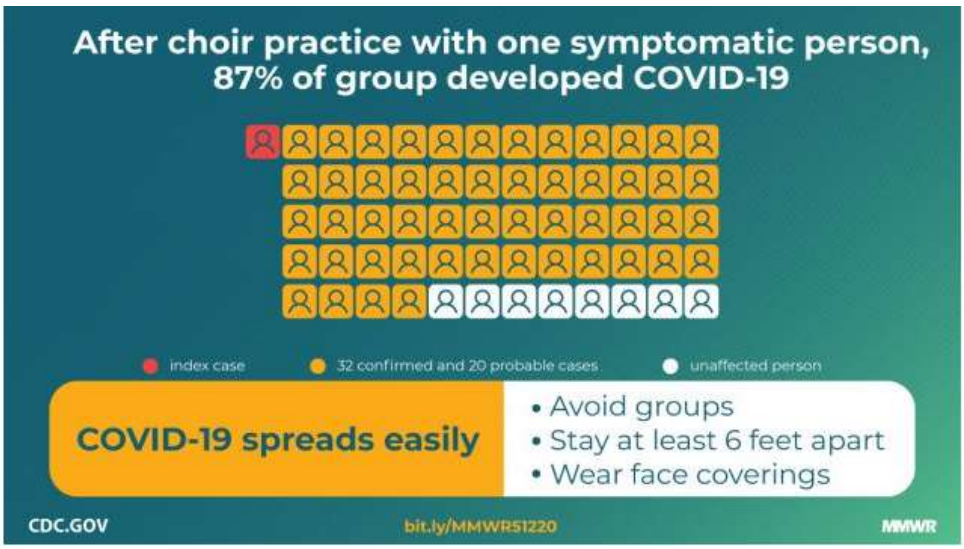
"During the week ending April 21, 2020, 15,455 coronavirus-related deaths [occurred], which made the coronavirus' peak death rate 10 to 40 times higher than the one-week peak of the flu."[168] (Emphasis added).

6. Superspreader Cases.

"Superspreader Event": High SARS-CoV-2 Attack Rate Following Exposure at

[163] https://www.cdc.gov/media/releases/2020/p0121-novel-coronavirus-travel-case.html
[164] https://www.cidrap.umn.edu/news-perspective/2020/04/coroner-first-us-covid-19-death-occurred-early-february
[165] 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
[166] https://www.npr.org/sections/health-shots/2020/05/22/860981956/scientists-say-new-lower-cdc-estimates-for-severity-of-covid-19-are-optimistic
[167] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[168] https://www.thedenverchannel.com/news/coronavirus/study-covid-19-10-to-40-times-deadlier-than-seasonal-flu

a Choir Practice — Skagit County, Washington, March, 2020[169]



"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%)[170]; 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.[171]

….

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

[169] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm

[170] "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.*

[171] *Id.*

speech than do their peers, might have contributed to this and previously reported COVID-19 superspreading events (2–5). These data demonstrate the high 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."[172]

High COVID-19 Attack Rate Among Attendees at Events at a Church — Arkansas, March 2020[173]

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

[172] *Id.*

[173] 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.

travel and had no known contact with a traveler or anyone with confirmed COVID-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 2020[174]

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 cases[175] 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

[174] *Id.*

[175] 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.*

apparently able to transmit infection to 10 other persons, despite having no household 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 2[176]

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 R0, 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.

[August 8, 2020] Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios.[177]

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

[176] https://wwwnc.cdc.gov/eid/article/26/6/20-0495_article
[177] 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

Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
					70+ years: 0.054
Percent of infections that are asymptomatic[§]	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:

[August 8, 2020] From Table 2: CDC Parameter Values Common to the Five COVID-19 Pandemic Planning Scenarios.[178]

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)

[178] 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

Parameter Values Related to Healthcare Usage	
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

[March 19, 2021] Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios.[179]

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 March 19, 2021.

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 (Estimated number of deaths per 1,000,000 infections)†	0–17 years old: 6 18–49 years old: 150 50–64 years old: 1,800 65+ years old: 26,000		0–17 years old: 80 18–49 years old: 1,700 50–64 years old: 20,000 65+ years old: 270,000		0–17 years old: 20 18–49 years old: 500 50–64 years old: 6,000 65+ years old: 90,000
Percent of infections that are asymptomatic§	15%	70%	15%	70%	30%
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%

[179] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

[February 14, 2021] Table 2. Parameter Values Common to the Five COVID-19 Pandemic Planning Scenarios.[180] 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 between December 31, 2020, and February 14, 2021, including COVID-19 Case Surveillance Data (public use version of 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 December 31, 2020); and data from Human and Health Services Protect (*HHS Protect*) (through February 14, 2021).

Parameter values Table 2

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	
Median number of days from symptom onset to SARS-CoV-2 test among SARS-CoV-2 positive patients (interquartile range)^	Overall: 2 (0, 4) days
Median number of days from symptom onset to hospitalization (interquartile range)**	0–17 years old: 2 (0, 7) days 18–49 years old: 6 (2, 10) days 50–64 years old: 6 (2, 10) days ≥65 years old: 4 (1, 9) days
Median number of days of hospitalization among those not admitted to ICU (interquartile range) ††	0–17 years old: 2 (1, 4) days 18–49 years old: 3 (2, 6) days 50–64 years old: 4 (2, 7) days ≥65 years old: 5 (3, 9) days

[180] https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Median number of days of hospitalization among those admitted to the ICU (interquartile range)††,§§	0–17 years old: 5 (2, 10.5) days 18–49 years old: 10 (6, 20) days 50–64 years old: 14 (8, 25) days ≥65 years old: 13 (7, 22) days
Percent admitted to the ICU among those hospitalized††	0–17 years old: 27.5% 18–49 years old: 18.9% 50–64 years old: 27.1% ≥65 years old: 26.9%
Percent on mechanical ventilation among those hospitalized. Includes both non-ICU and ICU admissions††	0–17 years old: 5.8% 18–49 years old: 9.0% 50–64 years old: 15.1% ≥65 years old: 15.6%
Percent that die among those hospitalized. Includes both non-ICU and ICU admissions††	0–17 years old: 0.7% 18–49 years old: 2.1% 50–64 years old: 7.9% ≥65 years old: 18.8%
Median number of days of mechanical ventilation (interquartile range)**	Overall: 5 (2, 11) days
Median number of days from symptom onset to death (interquartile range)**	0–17 years old: 10 (4, 31) days 18–49 years old: 17 (10, 30) days 50–64 years old: 19 (11, 30) days ≥65 years old: 16 (9, 25) days
Median number of days from death to reporting (interquartile range)^^	0–17 years old: 8 (3, 33) days 18–49 years old: 26 (5, 63) days 50–64 years old: 28 (5, 64) days ≥65 years old: 23 (4, 59) 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…."[181]

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."[182]

Nypost.com, Dr. Fauci says COVID-19 herd immunity may take 90%[183] 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."
>
> 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?

[181] https://www.cdc.gov/vaccines/terms/glossary.html#commimmunity
[182] https://coronavirus.jhu.edu/from-our-experts/early-herd-immunity-against-covid-19-a-dangerous-misconception
[183] https://nypost.com/2020/12/24/fauci-covid-herd-immunity-requires-90-to-be-infected-or-vaccinated/

‘The jury is definitely still out’:[184]

> 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.
>
> 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

[184] https://www.yahoo.com/now/covid-19-vaccines-us-herd-110023026.html

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."[185]

As of May 29, 2021, the CDC has calculated the "Estimated Disease Burden of COVID-19."[186]

Table 1: Preliminary estimated COVID-19 cumulative incidence, by age group — United States, February 2020-May 2021[†]

	Infections		Symptomatic Illness		Hospitalizations		Deaths	
Age group	**Estimate**	**95% UI***	**Estimate**	**95% UI***	**Estimate**	**95% UI***	**Estimate**	**95% UI***
0-17 years	26,838,244	21,966,492 – 33,109,862	22,895,857	19,681,278 – 27,181,718	209,264	169,035 – 256,472	332	310-449
18-49 years	60,461,355	50,372,115 – 73,172,038	51,581,445	45,181,664 – 59,344,624	1,533,679	1,313,618 – 1,796,098	34,171	31,355 – 37,360
50-64 years	20,375,641	17,043,764 – 24,561,779	17,377,602	15,329,878 – 19,854,568	1,604,612	1,411,704 – 1,831,326	116,284	112,590 – 120,005
65+ years	12,298,890	9,934,247 – 15,460,317	10,005,696	8,872,135 – 11,338,584	2,808,089	2,474,510 – 3,218,931	615,824	607,666 – 623,771
All ages	120,259,370	103,321,791 – 140,873,869	101,886,269	90,959,297 – 115,248,191	6,156,065	5,502,505 – 6,954,083	766,611	754,944 – 778,170

* Adjusted estimates and rates are presented in two parts: an uncertainty interval [UI] and a point estimate. The uncertainty interval provides a range in which the true number or rate of COVID-19 infections, symptomatic illnesses, or hospitalization would be expected to fall if the same study was repeated many times, and it gives an idea of the precision of the point estimate. A 95% uncertainty interval means that if the study were repeated 100 times, then 95 out of 100 times the uncertainty interval would contain the true point estimate. Conversely, in only 5 times out of a 100 would the uncertainty interval not contain the true point estimate.

[185] 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
[186] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html

9. COVID-19 Virus Mutations.

Depending on the level of contagiousness of COVID-19 expressed in the R_0[187] 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).[188]

"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 (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 Laboratory[189] 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

[187] "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

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

[189] https://www.biorxiv.org/content/10.1101/2020.04.29.069054v1

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."[190]

Forbes.com, December 29, 2020. First U.S. Case Of New Covid Mutation[191] 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 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

[190] https://www.healthline.com/health-news/what-to-know-about-mutation-and-covid-19#The-new-coronavirus-is-mutating,-but-very-slowly
[191] https://www.forbes.com/sites/joewalsh/2021/12/29/first-us-case-of-new-covid-mutation-discovered-in-colorado/?sh=5560175e1d79

virus' spread even more difficult, adding to an already-dire surge in cases throughout the United States." (Emphasis added).

CNN.com, June 14, 2021, "A new coronavirus variant is on the rise. Here's why experts are concerned"[192]

"The Delta variant[193] is on its way to becoming the dominant strain of coronavirus in the US, raising concerns that outbreaks could hit unvaccinated people this fall.

And a new study shows the Delta variant is associated with almost double the risk of hospitalization compared to the Alpha variant.

The Alpha (B.1.1.7) variant, which is "stickier" and more contagious[194] than the original strain of novel coronavirus, became the dominant strain in the US[195] this spring.

But health experts worry the Alpha variant could be trumped by the Delta variant, which appears to be even more transmissible and may cause more severe illness [196]for those not vaccinated.

As of June 14, 2021, about 10% of Covid-19 cases in the US can be attributed to the Delta variant. But that proportion is doubling every two weeks, Scott Gottlieb, a former commissioner of the US Food and Drug Administration, said in a CBS interview Sunday. He said the Delta variant will probably take over as the dominant strain of coronavirus in the US.

As of June 22, 2021, the Delta variant now makes up about 20% of all new COVID-19 cases in the U.S.[197]

"I think in parts of the country where you have less vaccination -- particularly in parts of the South, where you have some cities where vaccination rates are low -- there's a risk that you could see outbreaks with this new variant," Gottlieb said.

While 52.4% of Americans have received at least one dose of vaccine, only 43.4% have been fully vaccinated, according to data Sunday from the US Centers for Disease Control and Prevention.

The Delta variant could pose a serious risk for states lagging in Covid-19 vaccinations, but the good news is Americans can stave off the danger by getting vaccinated.

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[192] https://www.cnn.com/2021/06/14/health/us-coronavirus-monday/index.html
[193] https://www.cnn.com/2021/06/10/health/delta-variant-india-explained-coronavirus-intl-cmd/index.html
[194] https://www.cnn.com/2021/04/12/health/b117-covid-variant-young-patients/index.html
[195] https://www.cnn.com/videos/health/2021/04/07/walensky-covid-19-uk-variant-sot-cohen-nr-vpx.cnn
[196] https://www.cnn.com/2021/06/10/health/delta-variant-india-explained-coronavirus-intl-cmd/index.html
[197] https://www.cnbc.com/2021/06/22/fauci-declares-delta-variant-greatest-threat-to-the-nations-efforts-to-eliminate-covid.html

Studies suggest those who are fully vaccinated have protection against the Delta variant.
"We have the tools to control this and defeat it," Gottlieb said. "We just need to use those tools."

New research shows the Delta variant may lead to more hospitalizations. The Delta variant -- or the B1.617.2 strain first detected in India -- has been linked to about double the risk of hospitalization compared to the Alpha variant first found in the UK, according to the preliminary findings of a Scottish study published Monday in The Lancet.

The Alpha variant used to be the dominant strain in the UK. But last week, Health Secretary Matt Hancock said the Delta variant had taken over -- making up 91% of new cases in the UK."

CNBC.com, June 8, 2021, "Fauci says U.S. must vaccinate more people before Delta becomes dominant Covid variant in America"[198]

"In the U.S., the Delta variant accounts for more than 6% of cases scientists have been able to sequence, he said. The actual number is likely higher, as the U.S. is running the genetic sequence on a fraction of cases.

"In the U.K., the Delta variant is rapidly emerging as the dominant variant ... It is replacing the B.1.1.7," Fauci said. "We cannot let that happen in the United States."
….
First detected in October, the Delta variant has spread to at least 62 countries, the World Health Organization said last week.

"We continue to observe significantly increased transmissibility and a growing number of countries reporting outbreaks associated with this variant," the WHO said of the Delta strain last week, noting that further study was a high priority.

The Delta strain has a stranglehold on India, causing a spike in infections and deaths that has clogged hospital systems. The Indian government announced Monday that the country will soon begin providing Covid-19 vaccines for free to all adults in the country.

Fauci also said that the Delta variant is more contagious and may be associated with a higher risk of hospitalization than the original "wild type" Covid-19 strain.

Studies also show that two doses of the Pfizer or AstraZeneca shots are effective against the Delta strain, according to the National Institutes of Health.

[198] https://www.cnbc.com/2021/06/08/fauci-says-us-must-vaccinate-more-people-before-delta-becomes-dominant-covid-variant-in-america.html

> Two doses of the Pfizer vaccine were shown to be 88% effective against the Delta variant, while two doses of the AstraZeneca shot were shown to be 60% effective against the strain, according to NIH data.
>
> Fauci stressed the importance of getting two doses after NIH studies showed that, three weeks after being given, **just one dose of either vaccine provided only 33% efficacy against the Delta variant."** (Emphasis added).

WRIC.com, Richmond, Virginia, June 23, 2021, "State's vaccine coordinator: Delta variant is spreading, gives look into what school may look like in the fall"[199]

> "Virginia hit the benchmark for vaccinations earlier this week, but the state's vaccine coordinator, Dr. Danny Avula, says there is still more work to be done.
>
> On Monday, Governor Ralph Northam reported 70% of adults in Virginia have received at least one dose of the vaccine, but there are segments of the Commonwealth still reporting a 30% or 40% vaccination rate. It comes as the delta variant is already starting to spread.
>
> 'At the end of May the Delta variant was about 2% of our new infections and as of last week it was 10% and I think it's going to be much more than that,' Avula told our sister station, WAVY.
>
> The good news is that those fully vaccinated don't need to worry. Luckily, he said the vaccine appears to be working against that variant and others that have emerged so far. 'So far, I think we've been lucky,' Avula said. 'These variants like the U-K variant, the alpha the delta, that have really emerged in different countries – our vaccines have been incredibly effective against them.'
>
> So, what about the rest of the population who hasn't gotten the shot?
> 'What that means is that kids who are not vaccinated will likely at some point be vectors – the will spread this new variant widely,' Avula stated.
> The concern then becomes spreading the virus to unvaccinated adults.
>
> 'So, for segments in our community like in Southern or Southwest Virginia where the adult vaccination rate is about 40% that means that kids will contribute to the spread of disease – if we're not careful," he said.'"

Current CDC National Statistics on COVID-19.

As of August 11, 2021:[200]

SARS-CoV-2 Variants

[199] https://www.wric.com/health/coronavirus/states-vaccine-coordinator-delta-variant-is-spreading-gives-look-into-what-school-may-look-like-in-the-fall/
[200] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

Multiple variants of the virus that causes COVID-19 are circulating globally, including within the United States. Currently, four variants are classified as a variant of concern (VOC). Nowcast estimates* of COVID-19 cases caused by these VOCs for the week ending August 7 are summarized here.

Nationally, the combined proportion of cases attributed to Delta (B.1.617.2, AY.1, AY.2, AY.3) is estimated to increase to 97.4%; Alpha (B.1.1.7) proportion is estimated to decrease to 0.9%; Gamma (P.1) proportion is estimated to decrease to 0.5%; and Beta (B.1.351) is estimated to be less than 0.1%.

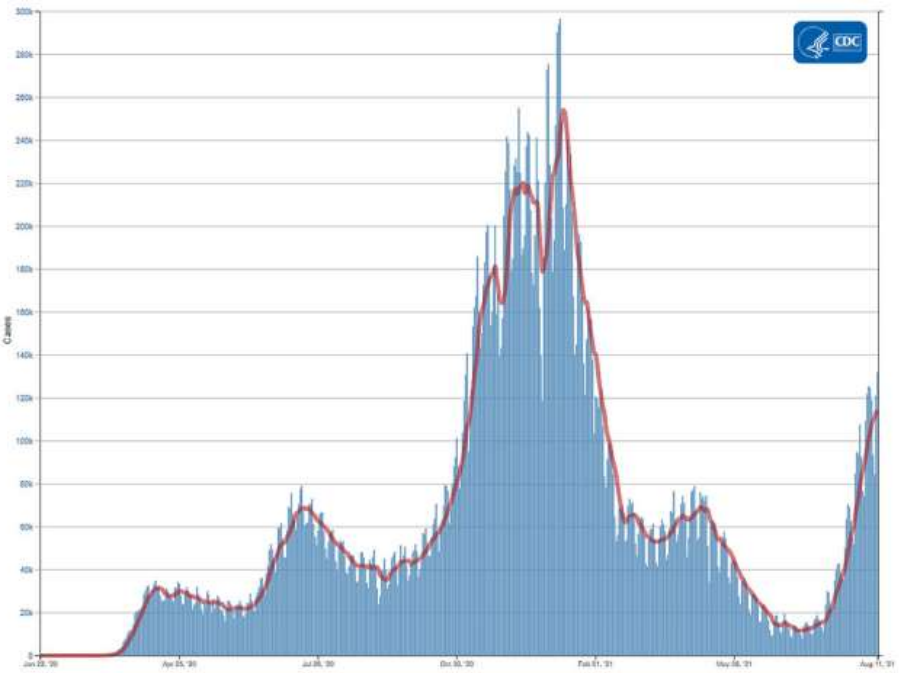
Nowcast estimates that Delta (B.1.617.2, AY.1, AY.2, and AY.3) will continue to be the predominant variant circulating in all 10 HHS regions. Alpha (B.1.1.7) is estimated to be 1.6% or less in all HHS regions. Gamma (P.1) is estimated to be 1.2% or less in all HHS regions; and Beta (B.1.351) is estimated to be less than 0.1% in all HHS regions.

Reported Cases

The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). **The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685).** The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is **882.8% higher than the lowest value observed on June 19, 2021 (11,619)**. A total of 36,268,057 COVID-19 cases have been reported as of August 11.

Daily Trends in COVID-19 Cases in the United States Reported to CDC

7-Day moving average



10. COVID-19 Vaccine Development and Deployment.

How COVID-19 Vaccines Work[201]

"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 immunity."

Authorized Vaccines

Currently, three vaccines are authorized and recommended to prevent COVID-19:[202]

- Pfizer-BioNTech COVID-19 vaccine[203] [2 shots given 21 days apart]

  "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. In clinical trials, the Pfizer-BioNTech vaccine was also highly effective at preventing laboratory-confirmed COVID-19 illness in adolescents aged 12–15 years, and the immune response in people aged 12–15 years was at least as strong as the immune response in people aged 16–25 years."

- Moderna's COVID-19 vaccine[204] [2 shots given 28 days apart]

- "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. The vaccine was also highly effective in clinical trials at preventing COVID-19 among people of diverse age, sex, race, and ethnicity categories and among

[201] 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
[202] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html
[203] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Pfizer-BioNTech.html
[204] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/Moderna.html

people with underlying medical conditions."

- Johnson & Johnson's/Jansesen[205] [1 shot]

  "The J&J/Janssen COVID-19 Vaccine was 66.3% effective in clinical trials (efficacy) at preventing laboratory-confirmed COVID-19 illness in people who had no evidence of prior infection. People had the most protection 2 weeks after getting vaccinated. The vaccine had high efficacy at preventing hospitalization and death in people who did get sick. No one who got COVID-19 at least 4 weeks after receiving the J&J/Janssen COVID-19 Vaccine had to be hospitalized. Early evidence suggests that the J&J/Janssen COVID-19 Vaccine might provide protection against asymptomatic infection, which is when a person is infected by the virus that causes COVID-19 but does not get sick."

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

COVID-19 vaccines are available for everyone at no cost. Vaccines were paid for with taxpayer dollars and will be given to all people living in the United States, regardless of insurance or immigration status.[206]

Previously infected people, natural immunity and access to a COVID-19 vaccine

"Getting COVID-19 may offer some natural protection, known as immunity. Current evidence suggests that reinfection with the virus that causes COVID-19 is uncommon in the 90 days after initial infection. However, experts don't know for sure how long this protection lasts, and the risk of severe illness and death from COVID-19 far outweighs any benefits of natural immunity."[207]

You should be vaccinated regardless of whether you already had COVID-19. That's because experts do not yet know how long you are protected from getting sick again after recovering from COVID-19. Studies have shown that in people who have recovered from COVID-19, vaccination provides a strong boost in protection. Learn more about why getting vaccinated is a safer way to build protection than getting infected.

A recent study[208] published in the CDC's Morbidity and Mortality Weekly Report on August 13, 2021 found that:

> "Although laboratory evidence suggests that antibody responses following COVID-19 vaccination provide better neutralization of some circulating variants than does natural infection,[209] few real-world epidemiologic studies

[205] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/janssen.html
[206] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/no-cost.html
[207] https://www.cdc.gov/vaccines/covid-19/hcp/answering-questions.html
[208] https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm
[209] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-

exist to support the benefit of vaccination for previously infected persons. This report details the findings of a case-control evaluation of the association between vaccination and SARS-CoV-2 reinfection in Kentucky during May–June 2021…."

….

"Among Kentucky residents infected with SARS-CoV-2 in 2020, vaccination status of those reinfected during May–June 2021 was compared with that of residents who were not reinfected. In this case-control study, being unvaccinated was associated with 2.34 times the odds of reinfection compared with being fully vaccinated."

If you were treated for COVID-19 with monoclonal antibodies or convalescent plasma, you should wait 90 days before getting a COVID-19 vaccine. Talk to your doctor if you are unsure what treatments you received or if you have more questions about getting a COVID-19 vaccine.

If you or your child have a history of multisystem inflammatory syndrome in adults or children (MIS-A or MIS-C), consider delaying vaccination until you or your child have recovered from being sick and for 90 days after the date of diagnosis of MIS-A or MIS-C. Learn more about the clinical considerations people with a history of multisystem MIS-C or MIS-A."[210]

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

On May 16, 2021, the CDC issued updated guidance on fully vaccinated persons.[211]

Fully vaccinated people can resume activities without wearing a mask or physically distancing, except where required by federal, state, local, tribal, or territorial laws, rules, and regulations, including local business and workplace guidance.

In general, people are considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine

If you don't meet these requirements, regardless of your age, you are NOT fully vaccinated. Keep taking all precautions[212] until you are fully vaccinated.

"On July 27, 2021, CDC released updated guidance on the need for urgently increasing COVID-19 vaccination coverage and a recommendation for everyone in areas of substantial or high transmission to wear a mask in public indoor places, even if they are fully vaccinated. CDC issued this new guidance due to several concerning

product%2Fclinical-considerations.html#CoV-19-vaccination and https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

[210] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

[211] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html

[212] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

developments and newly emerging data signals. First is a reversal in the downward trajectory of cases. In the days leading up to our guidance update, CDC saw a rapid and alarming rise in the COVID case and hospitalization rates around the country.

- In late June, our 7-day moving average of reported cases was around 12,000. On July 27, the 7-day moving average of cases reached over 60,000. This case rate looked more like the rate of cases we had seen before the vaccine was widely available.

  [As of August 11, 2021, "the current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619)."[213]]

  Second, new data began to emerge that the Delta variant was more infectious and was leading to increased transmissibility when compared to other variants, even in vaccinated individuals. This includes recently published data from CDC and our public health partners, unpublished surveillance data that will be publicly available in the coming weeks, information included in CDC's updated Science Brief on COVID-19 Vaccines and Vaccination, and ongoing outbreak investigations linked to the Delta variant.

Delta is currently the predominant strain of the virus in the United States."

Vaccine rollout and timeline

ABC News, December 30, 2020.

> "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.

[213] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

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."

U.S. Population

There are over 332,000,000 people living in the United States.[214]

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' survey[215] 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 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."[216]

VCU.edu, December 14, 2020. Study[217] 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.

[214] https://www.census.gov/popclock/
[215] 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

[216] *Id.*
[217] https://news.vcu.edu/article/Study_finds_more_than_half_of_respondents_are_unlikely_to_get

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.

"[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:[218] 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. 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."

While fully vaccinated rates are improving, they have not reached a range that could be considered able to achieve population or herd immunity. Here are fully vaccinated rates for some surrounding states as of August 17, 2021[219]:

8. Maryland	51.95%
14. District of Columbia	49.09%
16. Virginia	48.36%
30. Kentucky	40.82%
37. North Carolina	37.85%
41. West Virginia	35.68%
46. Tennessee	33.58%

NOTE: As of June 22, 2021, 70.0% of Virginia's adult population has been fully vaccinated (approximately 15.9% of Virginia's population is 65 years and over.[220]

[218] https://www.npr.org/sections/coronavirus-live-updates/2020/12/15/946761737/poll-americans-are-growing-less-reluctant-to-take-covid-19-vaccine
[219] https://www.beckershospitalreview.com/public-health/states-ranked-by-percentage-of-population-vaccinated-march-15.html
[220] https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/

While fully vaccinated rates are improving, they have not reached a range that could be considered able to achieve population or herd immunity. Here are fully vaccinated rates for some surrounding states as of August 17, 2021[221]:

6. Maryland	60.04%
13. District of Columbia	56.27%
14. Virginia	55.79%
29. Kentucky	46.82%
38. North Carolina	44.82%
43. Tennessee	40.19%
45. West Virginia	39.31%

NOTE: As of August 17, 2021, 74.4% of Virginia's adult population has been fully vaccinated (approximately 15.9% of Virginia's population is 65 years and over.[222]

Unvaccinated and Not Fully Vaccinated People

APNews.com, June 24, 2021, "Nearly all COVID deaths in US are now among unvaccinated."[223]

> " Nearly all COVID-19 deaths in the U.S. now are in people who weren't vaccinated, a staggering demonstration of how effective the shots have been and an indication that deaths per day — now down to under 300 — could be practically zero if everyone eligible got the vaccine.
>
> An Associated Press analysis of available government data from May shows that "breakthrough" infections in fully vaccinated people accounted for fewer than 1,200 of more than 853,000 COVID-19 hospitalizations. That's about 0.1%.
>
> And only about 150 of the more than 18,000 COVID-19 deaths in May were in fully vaccinated people. That translates to about 0.8%, or five deaths per day on average.
>
> The AP analyzed figures provided by the Centers for Disease Control and Prevention. The CDC itself has not estimated what percentage of hospitalizations and deaths are in fully vaccinated people, citing limitations in the data.
>
> Among them: Only about 45 states report breakthrough infections, and some are more aggressive than others in looking for such cases. So the data probably understates such infections, CDC officials said.

[221] https://www.beckershospitalreview.com/public-health/states-ranked-by-percentage-of-population-vaccinated-march-15.html
[222] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-vaccine-summary/
[223] https://apnews.com/article/coronavirus-pandemic-health-941fcf43d9731c76c16e7354f5d5e187

> Still, the overall trend that emerges from the data echoes what many health care authorities are seeing around the country and what top experts are saying.
>
> Earlier this month, Andy Slavitt, a former adviser to the Biden administration on COVID-19, suggested that 98% to 99% of the Americans dying of the coronavirus are unvaccinated.
>
> And CDC Director Dr. Rochelle Walensky said on Tuesday that the vaccine is so effective that "nearly every death, especially among adults, due to COVID-19, is, at this point, entirely preventable." She called such deaths 'particularly tragic.'"

CNN.com, June 22, 2021, "A coronavirus outbreak hit a Florida government building. Two people are dead but a vaccinated employee wasn't infected."[224]

> "Two people are dead and four of their coworkers were hospitalized after a Covid-19 outbreak swept through a government building in Manatee County, Florida.
>
> The outbreak began in the IT department, according to Manatee County Administrator Scott Hopes, who is also an epidemiologist. Another person who worked on the same floor but in a different department also tested positive for coronavirus last week.
>
> Of the six people infected, five were hospitalized. One employee who was in the hospital died and another employee who was not hospitalized also died, Hopes told CNN's Erin Burnett.
>
> The only exposed employee in the IT office who was vaccinated did not get infected, Hopes said. "The clinical presentation gives me concern that we're dealing with a very infectious variant that is quite deadly," Hopes told Burnett.
>
> The government building was closed on Friday as a precaution. It reopened Monday but officials didn't implement a mask requirement, instead keeping them optional."

USAToday.com, June 16, 2021, "People hospitalized with COVID-19 now have one overwhelming thing in common. They're not vaccinated."[225]

> "In Minnesota, the HealthPartners system has seen a "precipitous decline" in COVID-19 hospitalizations, says Dr. Mark Sannes, an infectious disease physician and senior medical director for the system, which operates nine hospitals and more than 55 clinics. But now, nearly every admitted patient he does see is unvaccinated.
>
> "Less than 1% of our hospitalized COVID patients are vaccinated," he said.

[224] https://www.cnn.com/2021/06/22/us/florida-manatee-county-coronavirus-outbreak/index.html
[225] https://www.usatoday.com/story/news/health/2021/06/16/majority-covid-19-hospital-patients-us-now-unvaccinated-younger/7684857002/

In Ohio, at University Hospitals Cleveland Medical Center, only 2% of the COVID-19 patients admitted in the last month were vaccinated, said Dr. Robert Salata, the hospital's physician-in-chief.

And at Sanford Health, which runs 44 medical centers and more than 200 clinics across the Dakotas, Minnesota and Iowa, less than 5% of the 1,456 patients admitted with COVID-19 so far this year were fully vaccinated, said spokesperson Angela Dejene.

Falling rates of COVID-19 across the United States mask a harsh reality – the overwhelming majority of those getting sick and being hospitalized today are unvaccinated, while vaccinated patients are becoming rare.

Hospitals in states with the lowest vaccination rates tend to have more COVID-19 patients in intensive care units, according to hospital data collected in the past week by the Department of Health and Human Services and vaccination rates published by the Centers for Disease Control and Prevention."

USAToday.com, June 3, 2021, "First in line, still no shot: Surprising number of hospital workers refuse vaccines"[226]

" USA TODAY surveyed some of the largest hospital networks and public hospitals in the country. At the nine networks that responded, fully vaccinated rates ranged from 53% to 72%. Rates among 15 of the nation's largest public hospitals ranged from 51% to 91%.

The survey encompassed 276 hospitals, or about 4.5% of the nation's hospitals. Most fell below President Joe Biden's goal of 70% by July 4. Staff included ranged from workers with medical training, such as doctors and nurses, to those in support roles, such as cafeteria workers.

The fact that so many hospital workers remain unvaccinated is troubling news for public health officials who are counting on the vaccines to stop the spread of the virus. Experts worry that the rest of the population will follow suit.

"I think it'll be a bit of a struggle to get to that 70-to-75% vaccination rate," said Stacey Gabriel, the chief executive officer of the 80-bed Hocking Valley Community Hospital in Logan, Ohio, where only 50% of her workers are vaccinated."

How Long Does Vaccine Immunity Last

USAToday.com, August 19, 2021, "Vaccine effectiveness declines over time, studies say"

[226] https://www.usatoday.com/in-depth/news/investigations/2021/06/03/covid-19-vaccines-refused-surprising-number-hospital-workers/7432058002/

> Protection provided by COVID-19 vaccines declines over time, but protection against the most severe effects of the disease — including hospitalization and death — remains strong, according to three studies published Wednesday by the Centers for Disease Control and Prevention.

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, "New COVID-19 Cases and Hospitalizations Among Adults, by Vaccination Status — New York, May 3–July 25, 2021"[227]

> In this study, current COVID-19 vaccines were highly effective against hospitalization ([vaccine effectiveness] VE >90%) for fully vaccinated New York residents, even during a period during which prevalence of the Delta variant increased from <2% to >80% in the U.S. region that includes New York, societal public health restrictions eased,§§ and adult full-vaccine coverage in New York neared 65%. However, during the assessed period, rates of new cases increased among both unvaccinated and fully vaccinated adults, with lower relative rates among fully vaccinated persons. Moreover, VE against new infection declined from 91.7% to 79.8%. To reduce new COVID-19 cases and hospitalizations, these findings support the implementation of a layered approach centered on vaccination, as well as other prevention strategies.

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, " Effectiveness of Pfizer-BioNTech and Moderna Vaccines in Preventing SARS-CoV-2 Infection Among Nursing Home Residents Before and During Widespread Circulation of the SARS-CoV-2 B.1.617.2 (Delta) Variant — National Healthcare Safety Network, March 1–August 1, 2021"[228]

> Analysis of nursing home COVID-19 data from NHSN indicated a significant decline in effectiveness of full mRNA COVID-19 vaccination against laboratory-confirmed SARS-CoV-2 infection, from 74.7% during the pre-Delta period (March 1–May 9, 2021) to 53.1% during the period when the Delta variant predominated in the United States. This study could not differentiate the independent impact of the Delta variant from other factors, such as potential waning of vaccine-induced immunity. Further research on the possible impact of both factors on VE among nursing home residents is warranted. Because nursing home residents might remain at some risk for SARS-CoV-2 infection despite vaccination, multipronged COVID-19 prevention strategies, including infection control,§§ testing, and vaccination of nursing home staff members, residents, and visitors are critical.

Medrxiv.org, August 8, 2021, "Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence"[229]

> Although clinical trials and real-world studies have affirmed the effectiveness and safety of the FDA-authorized COVID-19 vaccines, reports of

[227] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e1.htm?s_cid=mm7034e1_w
[228] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e3.htm?s_cid=mm7034e3_w
[229] https://www.medrxiv.org/content/10.1101/2021.08.06.21261707v1

breakthrough infections and persistent emergence of new variants highlight the need to vigilantly monitor the effectiveness of these vaccines. Here we compare the effectiveness of two full-length Spike protein-encoding mRNA vaccines from Moderna (mRNA-1273) and Pfizer/BioNTech (BNT162b2) in the Mayo Clinic Health System over time from January to July 2021, during which either the Alpha or Delta variant was highly prevalent. We defined cohorts of vaccinated and unvaccinated individuals from Minnesota (n = 25,589 each) matched on age, sex, race, history of prior SARS-CoV-2 PCR testing, and date of full vaccination.

Both vaccines were highly effective during this study period against SARS-CoV-2 infection (mRNA-1273: 86%, 95%CI: 81-90.6%; BNT162b2: 76%, 95%CI: 69-81%) and COVID-19 associated hospitalization (mRNA-1273: 91.6%, 95% CI: 81-97%; BNT162b2: 85%, 95% CI: 73-93%).

However, in July, the effectiveness against infection was considerably lower for mRNA-1273 (76%, 95% CI: 58-87%) with an even more pronounced reduction in effectiveness for BNT162b2 (42%, 95% CI: 13-62%).

Morbidity and Mortality Weekly Report (MMWR), August 18, 2021, Sustained Effectiveness of Pfizer-BioNTech and Moderna Vaccines Against COVID-19 Associated Hospitalizations Among Adults — United States, March–July 2021[230]

In a multistate network that enrolled adults hospitalized during March–July 2021, effectiveness of 2 doses of mRNA vaccine against COVID-19–associated hospitalization was sustained over a follow-up period of 24 weeks (approximately 6 months). These findings of sustained VE [vaccine effectiveness] were consistent among subgroups at highest risk for severe outcomes from COVID-19, including older adults, adults with three or more chronic medical conditions, and those with immunocompromising conditions. Overall VE in adults with immunocompromising conditions was lower than that in those without immunocompromising conditions but was sustained over time in both populations.

These data provide evidence for sustained high protection from severe COVID-19 requiring hospitalization for up to 24 weeks among fully vaccinated adults, which is consistent with data demonstrating mRNA COVID-19 vaccines have the capacity to induce durable immunity, particularly in limiting the severity of disease. Alpha variants were the predominant viruses sequenced, although Delta variants became dominant starting in mid-June, consistent with national surveillance data. Because of limited sequenced virus, Delta-specific VE was not assessed. VE was similar during June–July when circulation of Delta increased in the United States compared with VE during March–May

[230] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e2.htm

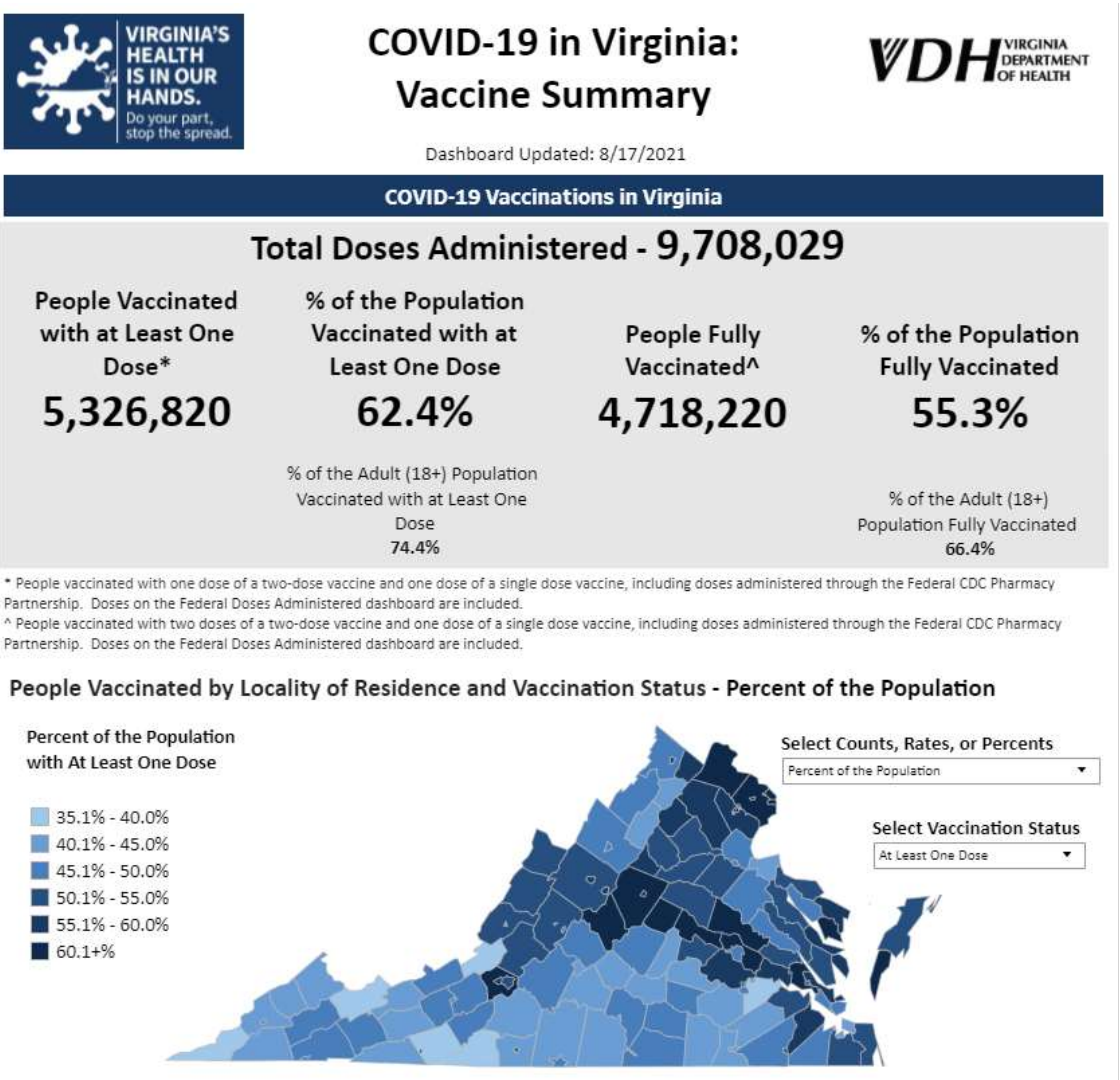
when Alpha variants predominated, although further surveillance is needed.

Virginia Vaccination Data

As of August 17, 2021, 55.3% of the population in Virginia is fully vaccinated.[231]

74.4% of the adult population has been fully vaccinated (approximately 15.9% of Virginia's population is 65 years and over[232]).

62.4% of the population in Virginia is vaccinated with at least one dose.



Community and Workplace Transmission

Although U. S. and Virginia vaccination rates and case rates are very promising and

[231] https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/
[232] https://www.vdh.virginia.gov/coronavirus/covid-19-vaccine-summary/
https://www.census.gov/quickfacts/VA

heading in the right directions, most scientific sources indicate that COVID-19 exposures in the workplace will not be going away anytime soon:

An uneven vaccine rollout could eventually make coronavirus outbreaks look a bit like measles outbreaks,...A single person carrying the measles virus can infect 12 or more people, but the spread of the virus is mostly contained through high vaccination rates. There are, however, still outbreaks in communities where immunization rates are low….Occasionally, those outbreaks spill out into the wider community….it's unlikely we'll ever eradicate the coronavirus — not any time soon, anyway. There's only one virus scientists have wiped out with a vaccine: smallpox. The World Health Organization began that effort in 1959, declaring the disease eradicated by 1980.[233]

CDC modeling of "Projected Incident Cases by Epidemiological Week and by Scenario for Round 5" shows a wide variance of future incident cases depending on the prevalence of vaccinations and the use of NPI (NonPharmaceutical Interventions such as face coverings and physical distancing)).[234]

"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 may be obtained from the VDH website and is assessed using, at a minimum, two metrics: new COVID-19 cases per 100,000 persons in the last 7 days and percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days. For each of these metrics, CDC classifies transmission values as low, moderate, substantial, or high. If the values for each of these two metrics differ (e.g., one indicates moderate and the other low), then the higher of the two should be used for decision-making.[235]

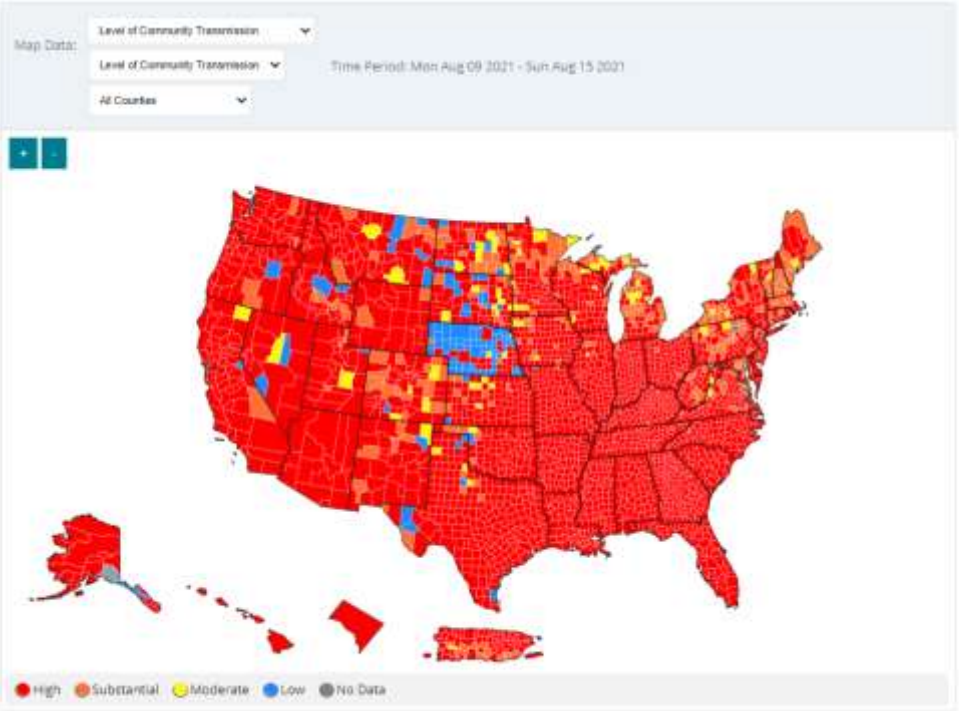
CDC core indicators of and thresholds for community transmission levels of SARS-CoV-2:

Indicator Level	**Low**	**Moderate**	**Substantial**	**High**
New COVID-19 cases per 100,000 persons in the last 7 days	0–9.99	10.00–49.99	50.00–99.99	≥100.00

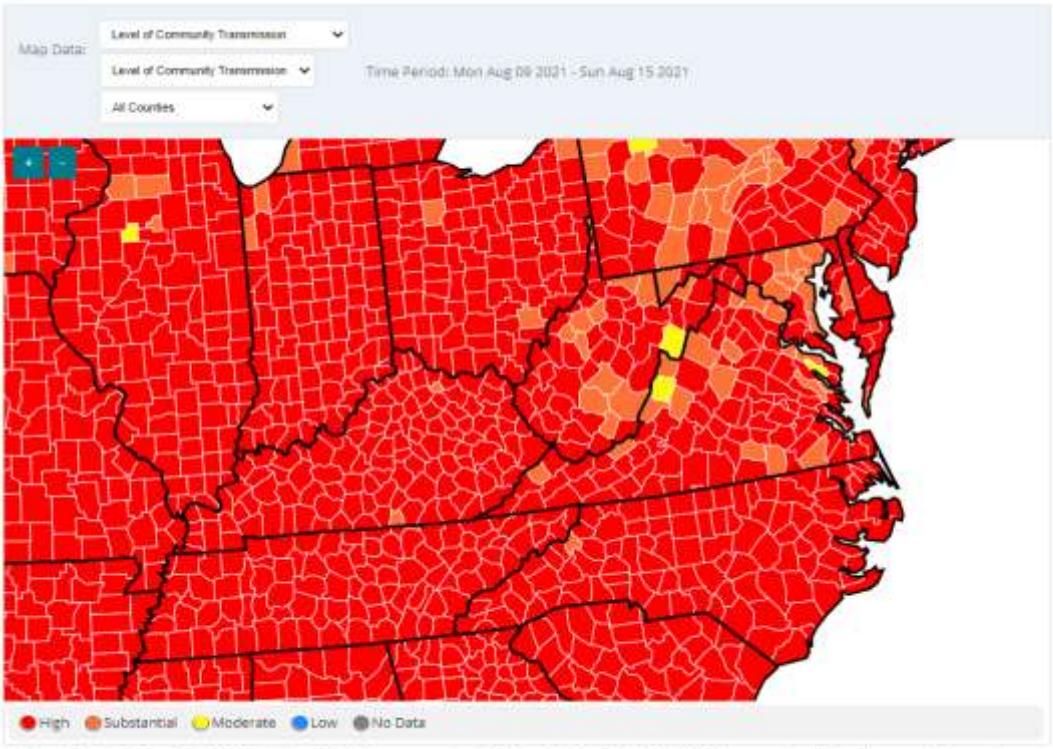
[233] https://www.sandiegouniontribune.com/news/health/story/2021-05-22/the-pandemic-will-end-but-the-coronavirus-is-probably-here-to-stay-heres-why
[234] https://covid19scenariomodelinghub.org/viz.html
[235] https://www.doli.virginia.gov/wp-content/uploads/2021/08/Revisions-to-Proposed-Amendments-to-the-FPS-for-COVID-19-16VAC25-220-Adopted-06.29.2021.pdf and https://www.cdc.gov/mmwr/volumes/70/wr/mm7030e2.htm#T1_down

Percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days	<5.00	5.00–7.99	8.00–9.99	≥10.00

As of August 15, 2021, the overwhelming majority of US and Virginia counties and cities have high or substantial levels of community transmission.[236]



[236] https://covid.cdc.gov/covid-data-tracker/#county-view



Current 7-days is Mon Aug 09 2021 - Sun Aug 15 2021 for case rate and Fri Aug 06 2021 - Thu Aug 12 2021 for percent positivity. The percent change in counties at each level of transmission is the absolute change compared to the previous 7-day period.

National Trends

As of June 11, 2021, in the U. S. there were 33,246,578 total cases (current 7-day average of 13,997 cases), 2,243,371 hospitalizations (current 7-day average of 2,239), and 596,059 total deaths (current 7-day moving average of 347 deaths).[237]

As of August 11, 2021, in the U. S. there were 36,268,057 total cases (current 7-day average of 114,190 cases), 2,507,105 hospitalizations (current 7-day average of 10,072), and 617,096 total deaths (current 7-day moving average of 407 deaths).[238]

Since June 11, 2021, the 7 day average of cases in the US has increased approximately 815%.

Since June 11, 2021, the 7 day average of hospitalizations in the US has approximately increased 450%. (NOTE: Hospitalization rates typically lag behind illness indicators[239]).

Since June 11, 2021, the 7 day average of deaths in the US has increased approximately 17%.

Virginia Trends

[237] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[238] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[239] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-17-2020.pdf

As of June 14, 2021, cases in Virginia totaled 677,812[240] (7-day average 140 cases), 30,182 hospitalizations (7-day average of 10 hospitalizations),[241] with 11,318 deaths (7-day average of 3 deaths).[242]

As of August 10, 2021, cases in Virginia totaled 725,971[243] (7-day average 1,700 cases), 32,399 hospitalizations (7-day average of 37 hospitalizations),[244] with 11,625 deaths (7-day average of 5 deaths).[245]

Since June 14, 2021, the 7 day average of cases in Virginia has increased approximately 1,114%.

Since June 14, 2021, the 7 day average of hospitalizations in Virginia has increased approximately 270%. (NOTE: Hospitalization rates typically lag behind illness indicators[246]).

Since June 14, 2021, the 7 day average of death in Virginia has increased approximately 67%.

Fortunately, employee deaths, hospitalizations and outbreaks in Virginia are down substantially from the height of the pandemic. However, there is a concerning trend in the number of outbreaks of 3 or more cases occurring since the beginning of July, 2021.

Weekly VOSH COVID-19 Response report for June 11, 2021:

[240] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
[241] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[242] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[243] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
[244] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[245] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[246] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-17-2020.pdf

SUMMARY | VOSH COVID-19 RESPONSE									
Dates	4/23/21	4/30/21	5/7/21	5/14/21	5/21/21	5/28/21	6/4/21	6/11/21	Total
Phone Calls									
Total Phone Calls	94	69	64	110	113	92	78	70	12948
UPAs Complaints | OIS Statewide	19	8	12	7	4	1	4	1	1943 *
# Inspections *Complaints, Referrals, Hospitalizations & Fatalities*	6	1	3	3	0	2	0	0	208 **
Inspections w/ Violations	*57*	*57*	*57*	*58*	*61*	*63*	*66*	*70*	*70*
Inspections Closed	*99*	*104*	*105*	*109*	*117*	*118*	*119*	*125*	*125*
# of Violations Issued - Final Order Cases (Willful, Serious, OTS)	*148*	*198*	*198*	*202*	*207*	*211*	*221*	*232*	*232*
#EEs Exposed	*7065*	*12316*	*12316*	*12364*	*12519*	*12584*	*12690*	*12806*	*12806*
# Hospitalizations	1	2	0	0	0	0	0	0	78 ***
Fatalities/Workplace deaths	0	1	2	0	0	1	0	0	44
# of Emails forwarded to Regional/Field Offices from MF *COVID-19 positive Cases Reports (ETS) | Complaints* *(does not include reports submitted by phone in the Regional Offices).*	3	3	2	2	0	2	0	0	669
# REDCAP Notifications *(Launched 09/28/20)*	283	267	201	126	88	93	45	48	25832
# REDCAP Notifications (3 or more cases reported)	80	50	30	33	14	14	9	5	6714

** **Time Range:** 01/01/2020 to 06/11/2021 (UPA numbers may change as Regions update the system.*

***Inspections opened (Total: 208 - Draft + Final)*

% of COVID-19 inspections closed - 60% (125)
% of COVID-19 inspections with violations - 34% (70)

****There are Employers submitting multiple notifications. Some of the hospitalizations reported to VOSH later resulted in fatalities.*

Fatalities - *Calendar Year*	2020	2021	% [2021]
Total	57	24	33
COVID-19	31	13	*54%*
Fall	8	6	*25%*
Struck-By	12	4	*17%*
Caught-in	5	1	*4%*
Electrocution	1		*0%*

NOTE: The "REDCAP Notifications" row has statistics for employer reported outbreaks to VDH of 1 or more positive COVID-19 employee cases within a 14 day period of employees who were at the facility within the previous 14 days.

The "REDCAP Notifications (3 or more cases reported) row has statistics for employer reported outbreaks to DOLI of 3 or more positive COVID-19 employee cases within a 14 day period of employees who were at the facility within the previous 14 days. (During the week of 6/4/2021, the 5 reports of 3 or more cases to DOLI are included in the total of 48 REDCAP notifications overall).

Weekly VOSH COVID-19 Response report for August 13, 2021:

SUMMARY | VOSH COVID-19 RESPONSE								
Dates	7/9/21	7/16/21	7/23/21	7/30/21	8/6/21	8/13/21	Total	
Phone Calls								
Total Phone Calls	41	35	46	48	55	59	13383	
UPAs Complaints | OIS Statewide	0	3	2	7	3	14	2057	*
# Inspections Complaints, Referrals, Hospitalizations & Fatalities	1	0	0	0	0	0	212	**
Inspections w/ Violations	*75*	*79*	*80*	*88*	*89*	*90*	*90*	
Inspections Closed	*143*	*145*	*147*	*151*	*152*	*179*	*179*	
# of Violations Issued - Final Order Cases (Willful, Serious, OTS)	*250*	*258*	*269*	*291*	*292*	*295*	*295*	
#EEs Exposed	*13038*	*13234*	*13481*	*13868*	*13900*	*14701*	*14701*	
Current Penalty ($)			*$ 573,303*	*$ 647,351*	*$ 651,201*	*$ 735,175*	*$ 735,175*	
# Hospitalizations	0	0	0	1	0	0	84	***
Fatalities/Workplace deaths	0	0	0	0	0	0	44	
# of Emails forwarded to Regional/Field Offices from MF COVID-19 positive Cases Reports (ETS) | Complaints (does not include reports submitted by phone in the Regional Offices).	0	2	0	0	1	0	676	
# REDCAP Notifications *(Launched 09/28/20)*	39	55	114	170	246	415	26975	
# REDCAP Notifications (3 or more cases reported)	8	6	29	49	67	126	7009	

** **Time Range:** 01/01/2020 to 08/13/2021 (UPA numbers may change as Regions update the system.*

***Inspections opened (Total: 212 - Draft + Final)*

% of COVID-19 Inspections closed - 84% (179)
% of COVID-19 Inspections with violations - 42% (90)

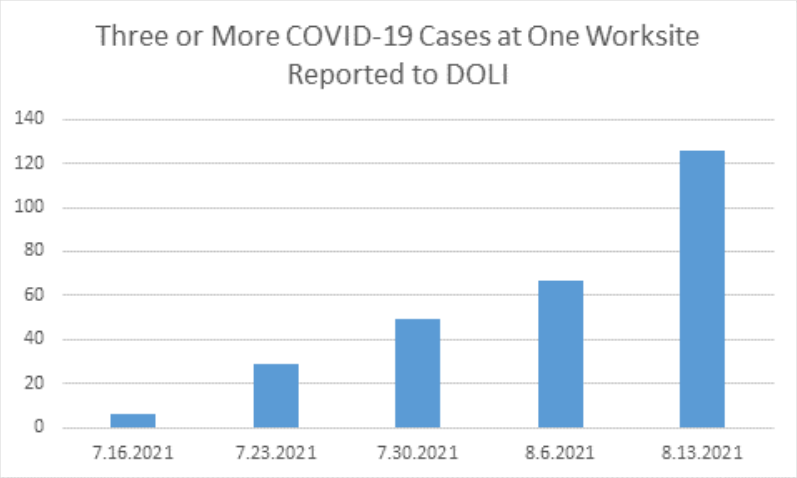
****There are Employers submitting multiple notifications. Some of the hospitalizations reported to VOSH later resulted in fatalities.*

Fatalities - *Calendar Year*	2020	2021	% [2021]
Total	57	26	31
COVID-19	31	13	*50%*
Fall	8	6	*23%*
Struck-By	12	5	*19%*
Caught-in	5	1	*4%*
Asphyxiation	0	1	*4%*
Electrocution	1		*0%*

<u>Increase in Outbreak Reports to DOLI</u>

The Standard requires employers to report to DOLI outbreaks of three or more employees at one worksite being infected with COVID-19 within a 14 day period. For all of June and the first two weeks in July, those report numbers had been averaging 5 per week (the lowest averages since early in the pandemic).

For the third week in July the number increased to 29 and in succeeding weeks it has now reached 126 reports during the week ending August 13, 2021 – a level not seen since February 26, 2021.



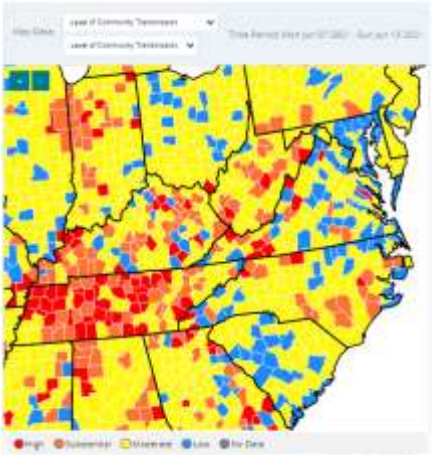
While 126 reports in one week is nowhere near the 597 reports received on January 8, 2021 at or near the height of the pandemic, this workplace trend is definitely concerning and will be a focus of the Department's efforts to mitigate the spread of the virus in the workplace.

One Virginia state agency recently reported an outbreak of 21 COVID-19 cases at a call center which resulted in four hospitalizations and one employee in critical condition. Initial indications are that the outbreak may have resulted from a reluctance of employees to be vaccinated.

In addition, some states have trouble spots as well – and as noted below, there remain some in Virginia.[247] Virginia community transmission rates can be found on a county-by-county basis at: https://covid.cdc.gov/covid-data-tracker/#county-view

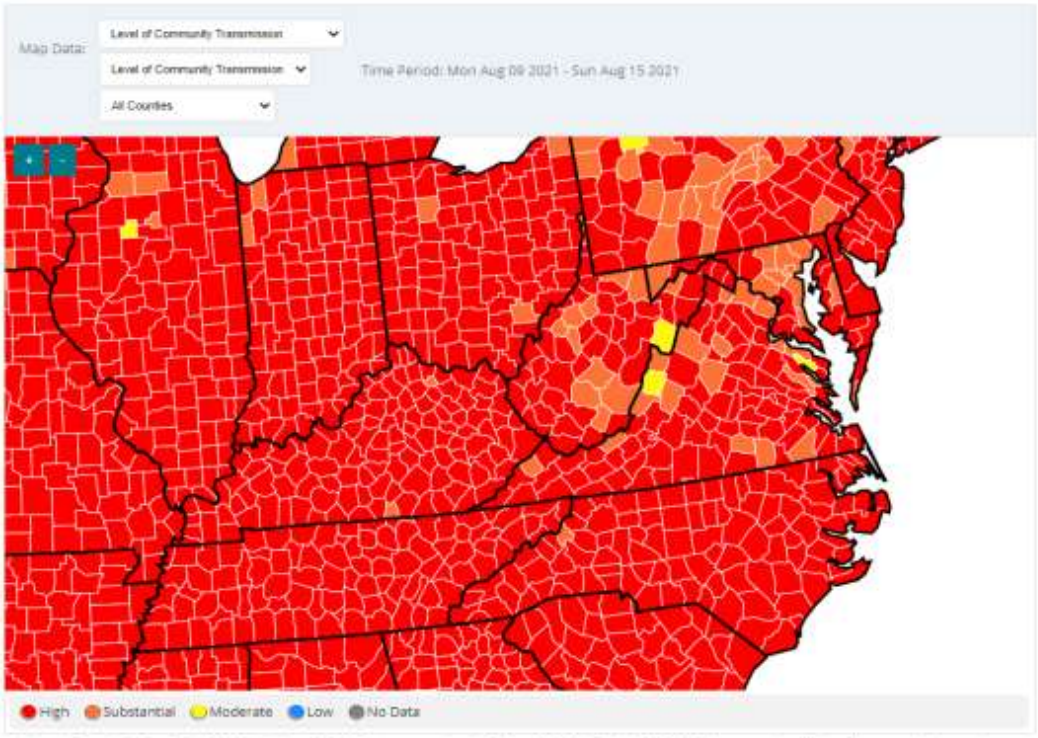
You can see the following from the screenshot below (June 13, 2021):

- about 25-30% of Virginia counties have a low community transmission rate
- about 8% of Virginia counties have a high transmission rate,
- about 7% of Virginia counties having a substantial transmission rate
- the remaining 55-60% of Virginia counties have a moderate transmission rate



[247] https://covid.cdc.gov/covid-data-tracker/#county-view

As of August 15, 2021, the overwhelming majority of Virginia counties and cities have high or substantial levels of community transmission.[248]



The jury is still out as to whether the United States will reach herd immunity levels (generally considered to be in the 70-85% range). Even if the country does reach herd/population immunity, it is possible to lose the immunity in the future, or go in and out of herd/population immunity depending on the season. Herd/population immunity is not immediately possible because "No one younger than 12 can get a Covid-19 vaccine in the US right now. The Pfizer/BioNTech vaccine is authorized for those age 12 and older, and the Moderna and Johnson & Johnson vaccines are authorized for adults 18 and older."[249]

In addition, surveys continue to indicate that a certain percentage of the population will refuse to get vaccinated ("about 20% of people surveyed said they definitely would not get vaccinated or would only get vaccinated if their job or school required it, according to the Kaiser Family Foundation COVID-19 Vaccine Monitor.").[250]

Also, it is not currently known how long immunity from a natural infection lasts in a person, or how long it will last for fully vaccinated or partially vaccinated people. The virus has shown a propensity for mutations, some of which appear to be more infectious and therefore more easily spread. Increased travel in state, around the country and from other countries could make the U.S. fall out of herd/population immunity even after it is reached.

E. Virginia VWCC and VOSH Statistics.

[248] https://covid.cdc.gov/covid-data-tracker/#county-view
[249] https://www.cnn.com/2021/03/30/health/herd-immunity-covid-shifts/index.html
[250] https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-march-2021/

1. Virginia Workers Compensation Statistics as of May 31, 2020.[251]

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"[252] of employees as independent contractors that has been found to be prevalent in certain industries[253] 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:

NAICS[254]	Industry
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)

[251] 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.

[252] https://www.doli.virginia.gov/vosh-programs/misclassification-in-the-workplace/

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

[254] North American Industrial Classification System, https://www.census.gov/eos/www/naics/

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.

3. Virginia Workers Compensation Statistics as of June 15, 2021.

Since February, 2020, the Virginia Workers' Compensation Commission received 15,770 COVID-19 related claims as of June 15, 2021.

VWCC Reports Thirty-three (33) Employee Deaths as of June 15, 2021

NOTE: The June 15, 2021 report from the VWCC contains data on 23 employee deaths not currently included in VOSH COVID-19 Employee Death Statistics. VOSH is actively investigating this data issue to determine if these employee deaths fall within VOSH jurisdiction. If so, VOSH will open inspections for each case. If confirmed, 23 additional deaths would result in a 52% increase in employee deaths attributed to COVID-19 since February 1, 2020.

Date of Injury	Date Death	Year Of Birth	Industry Code	Industry Code Description
4/26/2021	5/15/2021 12:00:00 AM	1986	561320	Temporary Help Services
3/4/2021	3/31/2021 12:00:00 AM	1959	926120	Regulation and Administration of Transportation Programs
12/31/2020	2/17/2021 12:00:00 AM	1974	551112	Offices of Other Holding Companies
1/19/2021	2/2/2021 12:00:00 AM	1966		
12/21/2020	1/15/2021 12:00:00 AM	1961	562111	Solid Waste Collection
1/15/2021	1/15/2021 12:00:00 AM	1961	562111	Solid Waste Collection

12/15/2020	1/10/2021 12:00:00 AM	1948	541611	Administrative Management and General Management Consulting Services
12/17/2020	1/9/2021 12:00:00 AM	1967	926120	Regulation and Administration of Transportation Programs
1/7/2021	1/8/2021 12:00:00 AM	1954		
12/1/2020	1/1/2021 12:00:00 AM	1960	524126	Direct Property and Casualty Insurance Carriers
11/29/2020	11/29/2020 12:00:00 AM	1960	922190	Other Justice, Public Order, and Safety Activities
9/25/2020	11/3/2020 12:00:00 AM	1951	311613	Rendering and Meat Byproduct Processing
10/5/2020	10/22/2020 12:00:00 AM	1970	339999	All Other Miscellaneous Manufacturing
9/24/2020	10/4/2020 12:00:00 AM	1950	722310	Food Service Contractors
9/10/2020	9/11/2020 12:00:00 AM	1957	325212	Synthetic Rubber Manufacturing
8/31/2020	9/9/2020 12:00:00 AM	1953	921190	Other General Government Support
7/16/2020	8/16/2020 12:00:00 AM	1945	922190	Other Justice, Public Order, and Safety Activities
8/7/2020	8/13/2020 12:00:00 AM	1945	325613	Surface Active Agent Manufacturing
7/2/2020	7/27/2020 12:00:00 AM	1961		
5/12/2020	7/19/2020 12:00:00 AM	1959	621111	Offices of Physicians (except Mental Health Specialists)
5/28/2020	7/14/2020 12:00:00 AM	1969	622210	Psychiatric and Substance Abuse Hospitals
6/2/2020	6/8/2020 12:00:00 AM	1963	722310	Food Service Contractors
4/1/2020	5/24/2020 12:00:00 AM	1961	445110	Supermarkets and Other Grocery (except Convenience) Stores
5/22/2020	5/22/2020 12:00:00 AM	1975	561110	Office Administrative Services
5/3/2020	5/19/2020 12:00:00 AM	1958	621610	Home Health Care Services
3/31/2020	5/11/2020 12:00:00 AM	1966	453998	All Other Miscellaneous Store Retailers (except Tobacco Stores)
4/24/2020	5/5/2020 12:00:00 AM	1963		
4/13/2020	4/20/2020 12:00:00 AM	1979	237990	Other Heavy and Civil Engineering Construction
4/19/2020	4/19/2020 12:00:00 AM		484121	General Freight Trucking, Long-Distance, Truckload
4/8/2020	4/12/2020 12:00:00 AM	1946	623311	Continuing Care Retirement Communities
3/20/2020	4/9/2020 12:00:00 AM	1969	721110	Hotels (except Casino Hotels) and Motels
3/28/2020	4/7/2020 12:00:00 AM	1951		
3/23/2020	4/3/2020 12:00:00 AM	1963	721110	Hotels (except Casino Hotels) and Motels

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

Pursuant to Va. Code §40.1-51.1.D,[255] employers must report employee deaths and hospitalizations to DOLI.

NOTE: The VOSH Program has investigated an average of 37 annual work-related[256] employee deaths over the last five calendar years. The 31 COVID-19 death notifications in 2020 would represent 84% of the deaths investigated by VOSH in an average year.

The 13 COVID-19 death notifications in 2021 would represent 35% of the deaths investigated by VOSH in an average year.

Fatalities through August 13, 2021:

Fatalities - *Calendar Year*	2020	2021	% [2021]
Total	57	26	31
COVID-19	31	13	*50%*
Fall	8	6	*23%*
Struck-By	12	5	*19%*
Caught-in	5	1	*4%*
Asphyxiation	0	1	*4%*
Electrocution	1		*0%*

NOTE: The June 15, 2021 report from the VWCC contains data on 23 employee deaths not currently included in VOSH COVID-19 Employee Death Statistics. VOSH is actively investigating this data issue to determine if these employee deaths fall within VOSH jurisdiction. If so, VOSH will open inspections for each case. If confirmed, 23 additional deaths would result in a 52% increase in employee deaths attributed to COVID-19 since February 1, 2020.

[255] https://law.lis.virginia.gov/vacode/40.1-51.1/

[256] 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	4/23/21	4/30/21	5/7/21	5/14/21	5/21/21	5/28/21	6/4/21	6/11/21	Total
Phone Calls									
Total Phone Calls	94	69	64	110	113	92	78	70	12948
UPAs Complaints | OIS Statewide	19	8	12	7	4	1	4	1	1943 *
# Inspections *Complaints, Referrals, Hospitalizations & Fatalities*	6	1	3	3	0	2	0	0	208 **
Inspections w/ Violations	57	57	57	58	61	63	66	70	70
Inspections Closed	99	104	105	109	117	118	119	125	125
# of Violations Issued - Final Order Cases (Willful, Serious, OTS)	148	198	198	202	207	211	221	232	232
#EEs Exposed	7065	12316	12316	12364	12519	12584	12690	12806	12806
# Hospitalizations	1	2	0	0	0	0	0	0	78 ***
Fatalities/Workplace deaths	0	1	2	0	0	1	0	0	44
# of Emails forwarded to Regional/Field Offices from MF *COVID-19 positive Cases Reports (ETS) | Complaints (does not include reports submitted by phone in the Regional Offices).*	3	3	2	2	0	2	0	0	669
# REDCAP Notifications *(Launched 09/28/20)*	283	267	201	126	88	93	45	48	25832
# REDCAP Notifications (3 or more cases reported)	80	50	30	33	14	14	9	5	6714

** **Time Range:** 01/01/2020 to 06/11/2021 \|UPA numbers may change as Regions update the system.*

***Inspections opened (Total: 208 - Draft + Final)*

% of COVID-19 Inspections closed - 60% (125)
% of COVID-19 Inspections with violations - 34% (70)

****There are Employers submitting multiple notifications. Some of the hospitalizations reported to VOSH later resulted in fatalities.*

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 June 16, 2021.

Inspections for All COVID-19 Inspections through June 16, 2021:

Inspections in Progress	39
Inspections Closed with No Violations	79
Inspections with Violations	68
Total Inspections	186

Violation Types

Serious	147	(64.2%)
Other-than-serious	79	(34.5%)
Willful	3	(1.3%)
Repeat	0	(0%)

Total Violations 229

Total Penalties Issued: $551,140.00

g. Inspection Statistics by NAICS.[257]

Virginia Department of Labor and Industry (DOLI)
Virginia Occupational Safety and Health (VOSH)
COVID-19 Inspections Conducted From January 1, 2020 to June 16, 2021

Site NAICS	NAICS Description	Insp With Viols Issued	No Citations Issued	Insp in Progress	Insp Closed	Employee Death	Ownership Type	Entry Date
	NAICS Sector 11: Agriculture, Forestry, Fishing and Hunting							
115114	Postharvest Crop Activities (except Cotton Ginning)	1				1	Private Sector	09/01/2020
111998	All Other Miscellaneous Crop Farming	1			1		Private Sector	09/18/2020
114111	Finfish Fishing		1		1		Private Sector	10/30/2020
111421	Nursery and Tree Production	1			1		Private Sector	09/18/2020
115114	Postharvest Crop Activities (except Cotton Ginning)			1			Private Sector	04/08/2021
112512	Shellfish Farming			1		1	Private Sector	04/22/2021
	NAICS Sector 21-23: Mining, Quarrying, and Oil and Gas Extraction; Utilities; Construction							
221310	Water Supply and Irrigation Systems		1		1	1	Private Sector	06/02/2020
236118	Residential Remodelers		1		1		Private Sector	11/12/2020
238990	All Other Specialty Trade Contractors			1			Private Sector	02/24/2021
238310	Drywall and Insulation Contractors			1			Private Sector	03/09/2021
238320	Painting and Wall Covering Contractors		1		1		Private Sector	05/12/2021
	NAICS Sector 31-33: Manufacturing							
311615	Poultry Processing		1		1	1	Private Sector	04/28/2020

[257] North America Industrial Classification System.

311612	Meat Processed from Carcasses		1		1		Private Sector	05/20/2020
311812	Commercial Bakeries		1		1		Private Sector	06/24/2020
327390	Other Concrete Product Manufacturing		1		1	1	Private Sector	07/15/2020
314110	Carpet and Rug Mills		1		1		Private Sector	08/07/2020
311821	Cookie and Cracker Manufacturing		1		1		Private Sector	09/01/2020
311612	Meat Processed from Carcasses	1			1		Private Sector	09/22/2020
333991	Power-Driven Handtool Manufacturing	1			1		Private Sector	09/30/2020
333414	Heating Equipment (except Warm Air Furnaces) Manufacturing	1			1		Private Sector	10/07/2020
336211	Motor Vehicle Body Manufacturing	1			1		Private Sector	10/20/2020
321212	Softwood Veneer and Plywood Manufacturing		1		1	1	Private Sector	10/23/2020
326291	Rubber Product Manufacturing for Mechanical Use	1			1		Private Sector	10/29/2020
311613	Rendering and Meat Byproduct Processing	1			1		Private Sector	10/30/2020
321999	All Other Miscellaneous Wood Product Manufacturing	1			1		Private Sector	11/24/2020
332994	Small Arms, Ordnance, and Ordnance Accessories Manufacturing	1			1		Private Sector	12/15/2020
337110	Wood Kitchen Cabinet and Countertop Manufacturing	1					Private Sector	12/22/2020
327991	Cut Stone and Stone Product Manufacturing	1					Private Sector	01/12/2021
337110	Wood Kitchen Cabinet and Countertop Manufacturing		1		1		Private Sector	01/13/2021
326191	Plastics Plumbing Fixture Manufacturing		1		1		Private Sector	02/08/2021
326211	Tire Manufacturing (except Retreading)			1		1	Private Sector	02/08/2021
326199	All Other Plastics Product Manufacturing			1			Private Sector	03/17/2021
324121	Asphalt Paving Mixture and Block Manufacturing		1		1		Private Sector	04/05/2021
	NAICS Sector 42: Wholesale Trade							
424410	General Line Grocery Merchant Wholesalers	1			1		Private Sector	07/31/2020
423310	Lumber, Plywood, Millwork, and Wood Panel Merchant Wholesalers	1				1	Private Sector	09/04/2020
423910	Sporting and Recreational Goods and Supplies Merchant Wholesalers		1		1		Private Sector	11/16/2020
423910	Sporting and Recreational Goods and Supplies Merchant Wholesalers		1		1		Private Sector	01/19/2021
423210	Furniture Merchant Wholesalers		1		1		Private Sector	02/12/2021

423320	Brick, Stone, and Related Construction Material Merchant Wholesalers	1					Private Sector	03/18/2021
	NAICS Sector 44-45: Retail Trade							
441120	Used Car Dealers		1		1	1	Private Sector	06/18/2020
442110	Furniture Stores	1			1	1	Private Sector	08/11/2020
441222	Boat Dealers	1					Private Sector	08/28/2020
444110	Home Centers		1		1		Private Sector	10/19/2020
453910	Pet and Pet Supplies Stores	1			1		Private Sector	11/02/2020
441310	Automotive Parts and Accessories Stores	1			1		Private Sector	11/18/2020
441228	Motorcycle, ATV, and All Other Motor Vehicle Dealers		1		1		Private Sector	11/23/2020
444110	Home Centers		1		1		Private Sector	12/15/2020
453998	All Other Miscellaneous Store Retailers (except Tobacco Stores)	1					Private Sector	12/14/2020
444130	Hardware Stores		1		1		Private Sector	12/23/2020
451120	Hobby, Toy, and Game Stores		1		1		Private Sector	01/05/2021
441310	Automotive Parts and Accessories Stores		1		1		Private Sector	11/06/2020
451110	Sporting Goods Stores		1		1		Private Sector	01/08/2021
445110	Supermarkets and Other Grocery (except Convenience) Stores	1					Private Sector	01/13/2021
441310	Automotive Parts and Accessories Stores		1		1		Private Sector	01/21/2021
452110	Department Stores		1		1		Private Sector	01/21/2021
442110	Furniture Stores		1		1		Private Sector	04/20/2021
445210	Meat Markets			1			Private Sector	04/20/2021
445210	Meat Markets			1			Private Sector	04/20/2021
441110	New Car Dealers			1			Private Sector	01/26/2021
444130	Hardware Stores		1		1		Private Sector	01/29/2021
453910	Pet and Pet Supplies Stores	1			1		Private Sector	02/01/2021
444110	Home Centers		1		1		Private Sector	02/03/2021
441110	New Car Dealers		1		1		Private Sector	02/05/2021
453310	Used Merchandise Stores			1			Private Sector	02/25/2021
441120	Used Car Dealers	1					Private Sector	03/02/2021
441110	New Car Dealers			1			Private Sector	03/08/2021
445110	Supermarkets and Other Grocery (except Convenience) Stores			1			Private Sector	03/08/2021

453998	All Other Miscellaneous Store Retailers (except Tobacco Stores)		1		1		Private Sector	03/10/2021
441310	Automotive Parts and Accessories Stores		1		1		Private Sector	04/15/2021
446191	Food (Health) Supplement Stores			1			Private Sector	04/29/2021
	NAICS Sector 48-49: Transportation and Warehousing							
488119	Other Airport Operations		1		1	1	Private Sector	04/29/2020
485113	Bus and Other Motor Vehicle Transit Systems		1		1		Private Sector	06/08/2020
485310	Taxi Service	1			1		Private Sector	06/29/2020
492110	Couriers and Express Delivery Services		1		1		Private Sector	10/30/2020
492110	Couriers and Express Delivery Services	1					Private Sector	10/30/2020
493110	General Warehousing and Storage		1		1		Private Sector	12/09/2020
485999	All Other Transit and Ground Passenger Transportation	1			1		Private Sector	01/08/2021
485113	Bus and Other Motor Vehicle Transit Systems			1			Private Sector	01/12/2021
485113	Bus and Other Motor Vehicle Transit Systems			1			Private Sector	04/12/2021
	NAICS Sector 51: Information							
519120	Libraries and Archives		1		1		Local Government	09/14/2020
	NAICS Sector 52: Finance and Insurance							
522310	Mortgage and Nonmortgage Loan Brokers		1		1		Private Sector	12/30/2020
522310	Mortgage and Nonmortgage Loan Brokers	1					Private Sector	01/08/2021
524114	All Other Professional, Scientific, and Technical Services		1		1		Private Sector	02/04/2021
	NAICS Sector 53: Real Estate and Rental and Leasing							
531110	Lessors of Residential Buildings and Dwellings		1		1	1	Private Sector	05/26/2020
531110	Lessors of Residential Buildings and Dwellings			1		1	Private Sector	03/03/2021
	NAICS Sector 54: Professional, Scientific, and Technical Services							
541519	Other Computer Related Services		1		1		Private Sector	04/29/2020
541350	Building Inspection Services		1		1		Local Government	07/10/2020

	NAICS Sector 56: Administrative and Support and Waste Management and Remediation Services							
561422	Telemarketing Bureaus and Other Contact Centers	1				1	Private Sector	05/13/2020
561720	Janitorial Services		1		1		Private Sector	07/16/2020
561110	Office Administrative Services	1			1		Private Sector	08/12/2020
561720	Janitorial Services	1			1		Private Sector	06/26/2020
561612	Security Guards and Patrol Services		1		1	1	Private Sector	09/10/2020
561720	Janitorial Services	1				1	Private Sector	09/28/2020
562910	Remediation Services		1		1		Private Sector	10/02/2020
561612	Security Guards and Patrol Services	1					Private Sector	10/30/2020
561720	Janitorial Services		1		1		Private Sector	11/09/2020
561320	Temporary Help Services			1		1	Private Sector	05/26/2021
561790	Other Services to Buildings and Dwellings			1			Private Sector	04/13/2021
561720	Janitorial Services			1			Private Sector	02/10/2021
562212	Solid Waste Landfill			1			Private Sector	05/10/2021
	NAICS Sector 61: Educational Services							
611110	Elementary and Secondary Schools		1		1	1	Local Government	10/28/2020
	NAICS Sector 62: Health Care and Social Assistance							
623311	Continuing Care Retirement Communities	1			1	1	Private Sector	04/27/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1	Private Sector	04/30/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1		Private Sector	05/06/2020
622110	Nursing Care Facilities (Skilled Nursing Facilities)	1			1		Private Sector	05/08/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1	Private Sector	05/05/2020
621610	Home Health Care Services		1		1		Private Sector	05/13/2020
621491	HMO Medical Centers	1			1		Private Sector	05/20/2020
621610	Home Health Care Services	1			1	1	Private Sector	05/20/2020
622110	General Medical and Surgical Hospitals	1			1		Private Sector	05/29/2020

623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1		Private Sector	06/08/2020
621498	All Other Outpatient Care Centers	1			1		Private Sector	06/16/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1	Private Sector	06/23/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1		Private Sector	07/02/2020
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	1					Private Sector	07/02/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1					Private Sector	07/02/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1			1		Private Sector	07/06/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)		1		1	1	Private Sector	07/27/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1					Private Sector	08/04/2020
623312	Assisted Living Facilities for the Elderly	1			1		Private Sector	08/07/2020
622110	General Medical and Surgical Hospitals		1		1		Private Sector	08/12/2020
622310	General Medical and Surgical Hospitals		1		1		Private Sector	08/13/2020
622110	General Medical and Surgical Hospitals		1		1		Private Sector	08/11/2020
623312	Assisted Living Facilities for the Elderly		1		1	1	Private Sector	09/04/2020
622210	Psychiatric and Substance Abuse Hospitals		1		1	1	State Government	09/06/2020
621210	Offices of Dentists	1			1		Private Sector	09/25/2020
621330	Offices of Mental Health Practitioners (except Physicians)		1		1		Private Sector	10/15/2020
621310	Offices of Chiropractors	1			1		Private Sector	10/28/2020
622110	General Medical and Surgical Hospitals		1		1		Private Sector	10/30/2020
623312	Assisted Living Facilities for the Elderly	1			1		Private Sector	11/19/2020
621420	Outpatient Mental Health and Substance Abuse Centers		1		1		Private Sector	11/19/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1	Private Sector	11/24/2020
623110	Offices of Chiropractors		1		1	1	Private Sector	12/07/2020
621310	Offices of Chiropractors	1					Private Sector	12/10/2020
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1			1		Private Sector	12/11/2020
621420	Outpatient Mental Health and Substance Abuse Centers			1		1	Private Sector	01/11/2021
623110	Nursing Care Facilities (Skilled Nursing Facilities)	1				1	Private Sector	01/13/2021
622110	General Medical and Surgical Hospitals		1		1		Private Sector	01/14/2021

621112	Offices of Physicians, Mental Health Specialists			1		1	Private Sector	01/29/2021
624190	Other Individual and Family Services			1			Private Sector	02/05/2021
622210	Psychiatric and Substance Abuse Hospitals			1		1	Private Sector	02/16/2021
621910	Ambulance Services	1					Private Sector	02/19/2021
622210	Psychiatric and Substance Abuse Hospitals			1			State Government	02/25/2021
623110	Nursing Care Facilities (Skilled Nursing Facilities)			1			Private Sector	03/02/2021
623311	Continuing Care Retirement Communities			1		1	Private Sector	03/03/2021
623311	Continuing Care Retirement Communities			1		1	Private Sector	03/03/2021
623210	Residential Intellectual and Developmental Disability Facilities		1		1		Private Sector	04/13/2021
623220	Residential Mental Health and Substance Abuse Facilities			1		1	State Government	05/26/2021
	NAICS 71: Arts, Entertainment, and Recreation							
713940	Fitness and Recreational Sports Centers			1			Private Sector	02/24/2021
	NAICS 72: Accommodation and Food Services							
721110	Hotels (except Casino Hotels) and Motels	1			1	1	Private Sector	06/01/2020
722310	Food Service Contractors		1		1		Private Sector	07/06/2020
722511	Full-Service Restaurants	1					Private Sector	08/20/2020
722511	Office Administrative Services	1					Private Sector	08/20/2020
722515	Snack and Nonalcoholic Beverage Bars		1		1		Private Sector	09/22/2020
722511	Full-Service Restaurants	1					Private Sector	10/08/2020
722513	Limited-Service Restaurants		1		1		Private Sector	10/27/2020
722513	Limited-Service Restaurants		1		1		Private Sector	01/14/2021
722511	Full-Service Restaurants			1			Private Sector	01/26/2021
722513	Limited-Service Restaurants		1		1		Private Sector	02/03/2021
722511	Full-Service Restaurants			1			Private Sector	02/03/2021
713210	Casinos (except Casino Hotels)		1		1		Private Sector	02/04/2021
721110	Hotels (except Casino Hotels) and Motels		1		1		Private Sector	03/02/2021
721110	Hotels (except Casino Hotels) and Motels		1		1		Private Sector	03/08/2021
721110	Hotels (except Casino Hotels) and Motels			1			Private Sector	03/08/2021

722513	Limited-Service Restaurants	1			1		Private Sector	01/26/2021
722511	Full-Service Restaurants			1			Private Sector	05/03/2021
	NAICS 81: Other Services (except Public Administration)							
811192	Car Washes	1			1		Private Sector	07/17/2020
812112	Beauty Salons	1					Private Sector	10/28/2020
812199	Other Personal Care Services	1					Private Sector	12/03/2020
811111	General Automotive Repair		1		1		Private Sector	01/06/2021
811121	Automotive Body, Paint, and Interior Repair and Maintenance			1			Private Sector	01/20/2021
811219	Other Electronic and Precision Equipment Repair and Maintenance	1					Private Sector	01/20/2021
812112	Automotive Exhaust System Repair		1		1		Private Sector	01/22/2021
813110	Religious Organizations			1		1	Private Sector	03/09/2021
812910	Pet Care (except Veterinary) Services			1			Private Sector	04/14/2021
811198	All Other Automotive Repair and Maintenance	1					Private Sector	05/03/2021
	NAICS Sector 92: Public Administration							
922120	Police Protection	1			1		Local Government	06/30/2020
921190	Other General Government Support		1		1	1	Local Government	08/25/2020
923120	Administration of Public Health Programs		1		1		Private Sector	08/25/2020
923120	Administration of Public Health Programs		1		1		Local Government	08/25/2020
922120	Administration of Public Health Programs		1		1	1	Local Government	08/27/2020
922140	Correctional Institutions	1			1	1	State Government	09/09/2020
922140	Correctional Institutions	1			1	1	Local Government	09/30/2020
922160	Fire Protection	1			1		Local Government	11/19/2020
922120	Police Protection			1		1	Local Government	01/19/2021
922140	Correctional Institutions	1				1	State Government	02/17/2021
Total Inspections: 186		**68**	**79**	**39**	**117**	**43**		
		36.6%	**42.5%**	**21.0%**				

V. Economic and Workplace Impacts.

A. Economic Impact Analysis.

1. An economic impact analysis (EIA) meeting the requirements of Va. Code §2.2-4007.04[258] was issued on January 11, 2021. The EIA was prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.[259] **See Attachment I.**

   A DOLI Addendum to the EIA was issued on January 11, 2021. **See Attachment J.**

2. An economic impact analysis (EIA)[260] on the Proposed Amendments based on the requirements of Va. Code §2.2-4007.04[261] is being prepared by Chmura Economics & Analytics, a nationally recognized economic consulting firm.[262]

   [The EIA will be provided to the Board along with the Department's response in separate documents]

B. Impact on Employers.

Employers will have to familiarize themselves with the amendments to the VOSH Standard in effect since January 27, 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 Proposed Amendments to the VOSH Standard and attached text of proposed amendments to the VOSH 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 proposed amendments to the VOSH Standard.

A substantial majority of the proposed substantive amendments concern issues that have already been addressed by Frequently Asked Questions (FAQs)[263] published by the Department at www.doli.virginia.gov and updated information provided by the CDC.

The regulatory burden for employers is substantially reduced for those employees that are fully vaccinated in non-healthcare settings.

On June 29, 2021, the Board adopted federal OSHA's COVID-19 ETS for Virginia with an effective date of August 2, 2021.[264] The COVID-19 ETS will expire within six months or when repealed by the Board, whichever occurs first. During the

[258] https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/
[259] http://www.chmuraecon.com/
[260] https://www.doli.virginia.gov/wp-content/uploads/2021/01/VDOLI-COVID-Regulation-Economic-Impact-Analysis-EIA-20210111.pdf
[261] https://law.lis.virginia.gov/vacode/title2.2/chapter40/section2.2-4007.04/
[262] http://www.chmuraecon.com/
[263] https://www.doli.virginia.gov/final-covid-19-standard-frequently-asked-questions/
[264] https://www.doli.virginia.gov/emergency-temporary-standard-interim-final-rule/

pendency of the COVID-19 ETS, application of the VOSH Standard to healthcare services and healthcare support services is suspended and will reapply after the COVID-19 ETS is no longer in effect.

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 are[265]:

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

[265] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html

- 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 mellitus[266]

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."[267]

[266] 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
[267] https://www.seniorliving.org/research/senior-employment-outlook-covid/

NOTE: In 2008, the labor force participation rate for employees 65 and older in Virginia was 16%.[268] 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%.[269]

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.[270]

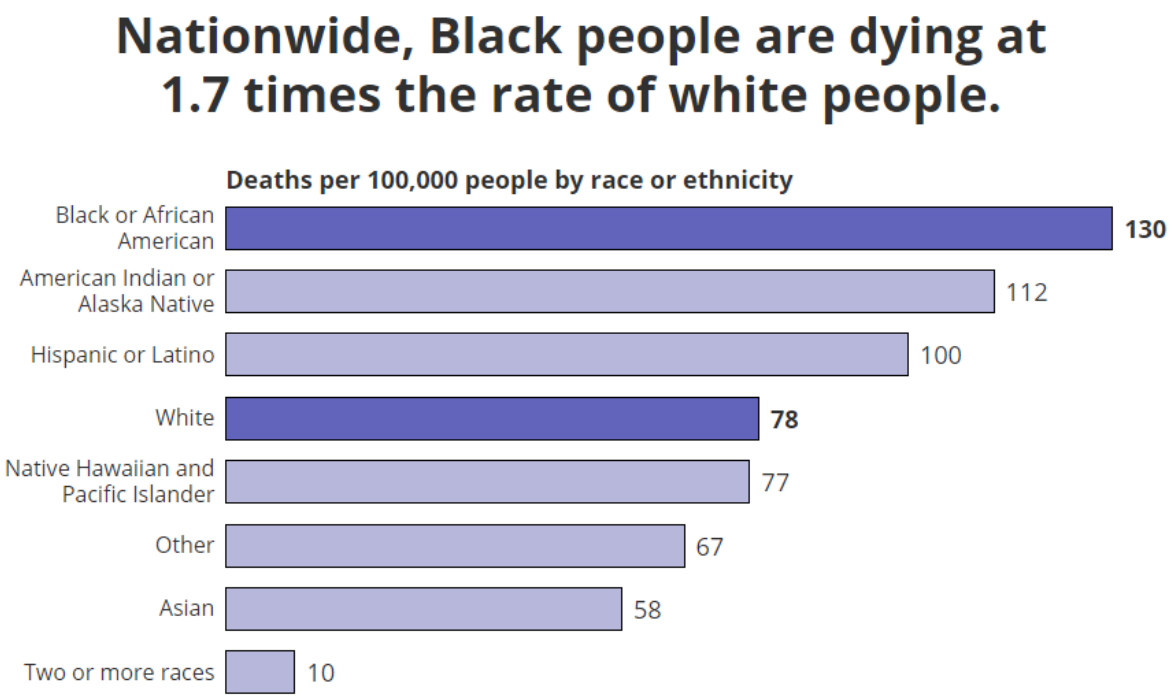
A labor force participation rate for those 65 and older in Virginia of 17.9% would equate to 235,289 elderly employees.

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.[271]

[268] http://sfc.virginia.gov/pdf/health/2008%20Session/August%2020%20mtg/HHR%20-%20Perrone%20-%20UVA%20-%208.20.08%20(B&W).pdf
[269] https://www.aging.senate.gov/imo/media/doc/Aging%20Workforce%20Report%20FINAL.pdf, p. 12.
[270] https://www.census.gov/quickfacts/fact/table/VA#
[271] https://covidtracking.com/race



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.[272]

Almost 40% of the population of Virginia are from a racial minority.[273]

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?[274] 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"[275]:

[272] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html
[273] https://www.census.gov/quickfacts/VA
[274] https://www.bls.gov/opub/mlr/2020/article/covid-19-shutdowns.htm
[275] *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
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
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

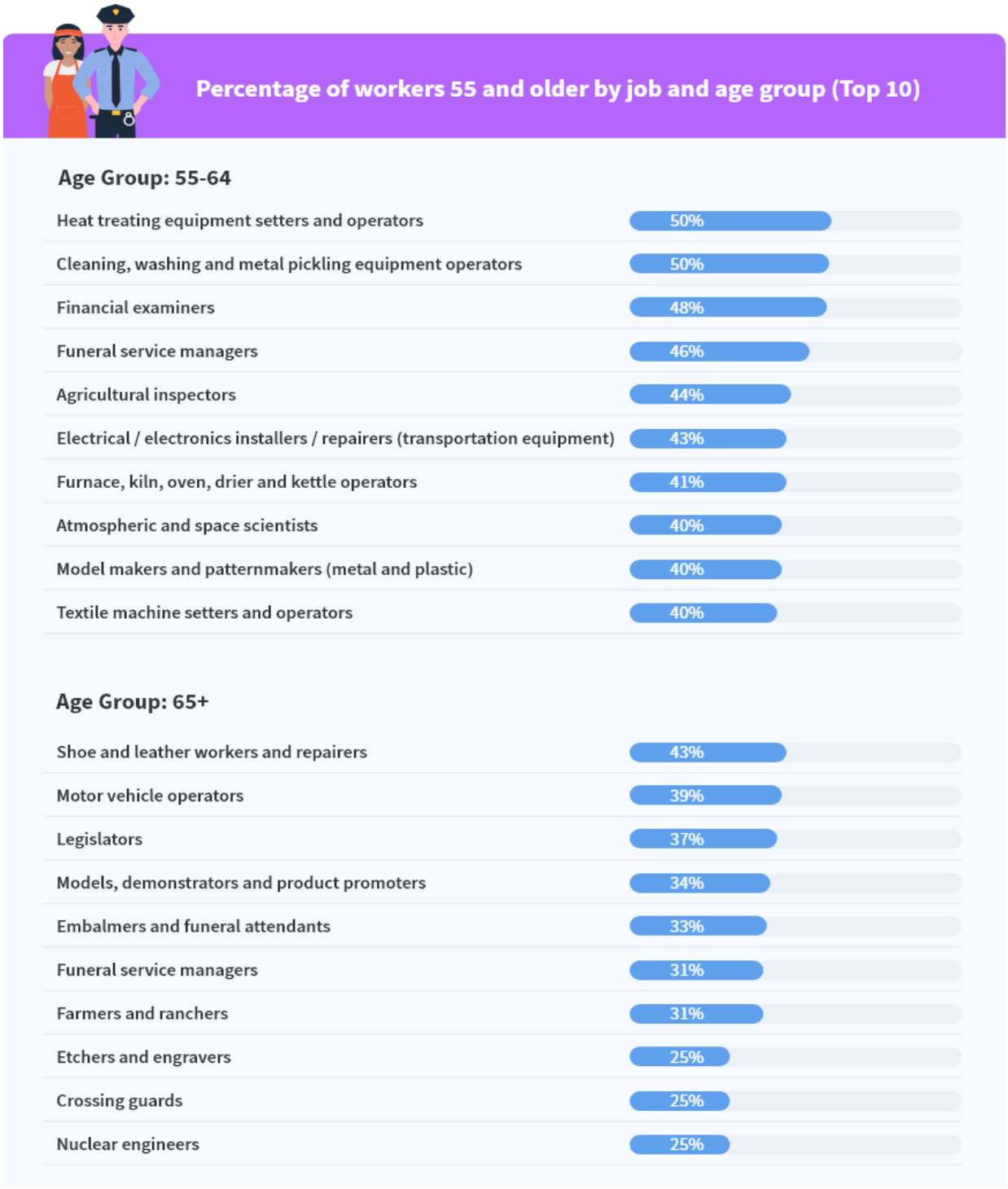
Note: Firms are identified by Employer Identification Number.

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/.

"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."[276]

[276] 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)."[277]



[277] *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"[278] 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
Diabetes[1]					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
Hypercholesterolemia[3]										
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 cholesterol[5]										
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
Hypertension[6]										
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 hypertension[7]										
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 obesity[8]										
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
Obesity[9]										
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 caries[10]										
Total, age-adjusted[4]	27.7	24.4	21.3	29.8	24.4	21.7	---	25.5	31.5	26.1
Total, crude	28.2	25.0	21.7	30.2	24.5	21.8	---	25.5	31.3	25.9
Obesity[11]					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 caries[10]										
5–19 years	24.3	23.6	21.2	25.6	16.2	16.9	14.6	17.5	19.6	14.3

[278] https://www.cdc.gov/nchs/data/hus/2018/021.pdf

3. Virginia Statistics.

Virginia's Adult Reported Diabetes Rate in 2020 was 10.9%.[279]

Virginia's Hypertension Rate in 2015 was 33.2%[280]

Virginia's Adult Reported High Cholesterol Rate[281] in 2020 was 32.7%.[282]

Virginia's Adult Reported Obesity Rate[283] in 2019 was 31.9%.[284]

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 amendments to the VOSH Standard. A VOSH Compliance Directive on Inspection and Enforcement Procedures would be developed by staff. Updates to training and outreach products would be developed by VOSH Cooperative Programs staff and made available to the regulated community, employees, and the general public at:

https://www.doli.virginia.gov/covid-19-outreach-education-and-training/

Contact Person:

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[279] https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA
[280] https://www.vdh.virginia.gov/content/uploads/sites/65/2018/05/VA-Heart-Disease-FactSheetFINAL.pdf
[281] Percentage of adults who reported having their cholesterol checked and were told by a health professional that it was high.
[282] https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA
[283] Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight (pre-2011 BRFSS methodology).
[284] https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/VA

RECOMMENDED ACTION

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

The Department also recommends that the Board state in any motion it may make to amend this standard 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.

ATTACHMENT A: INDUSTRY SPECIFIC INFORMATION ASSOCIATED WITH ADOPTION OF THE EMERGENCY TEMPORARY STANDARD AND ORIGINAL VOSH STANDARD

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.[285]" 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.

[285] https://www.osha.gov/Publications/OSHA3990.pdf

- 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.[286]
      (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."[287]

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."[288]

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

[286] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html
[287] https://www.newsobserver.com/news/business/article242944156.html
[288] https://www.nbc12.com/2020/05/05/covid-cases-keep-climbing-virginia-poultry-plants-some-members-congress-seek-better-protections/

physical distancing and hygiene and crowded living and transportation conditions.
….
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."[289]

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

[289] https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e3.htm

this industry include exposures to biological aerosols containing allergens, microorganisms, and toxins; bacteria and parasites; excessive noise levels; low temperatures; poor workplace organization; poor ergonomics; and contact with machinery and equipment."[290]

[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.[291]

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

[290] https://www.cdc.gov/niosh/programs/cmshs/seafood_processing.html
[291] *Id.*

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 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.'"[292]

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."[293]

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

[292] https://www.seafoodsource.com/news/supply-trade/covid-19-outbreak-sickens-100-workers-in-louisiana-crawfish-industry
[293] 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

aged 60 to 69),' Clatsop County Public Health said."[294]

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.

[294] https://katu.com/news/local/11-employees-at-astoria-borstein-seafood-processing-facility-test-positive-for-covid-19-closure

> ‘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.”[295]

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.”[296]

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

[295] 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
[296] https://www.oregonlive.com/business/2020/05/vancouver-frozen-fruit-processor-reports-10-coronavirus-cases.html

cases."[297]

"We can confirm the Maruchan Virginia report about employees testing positive for COVID-19 at their Chesterfield facility," Chesterfield Health District Director Dr. Alexander Samuel said in a statement to Fox5."[298]

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."[299]

4. Healthcare, Nursing Home Care,[300] and Long Term Care.[301]

The healthcare, nursing home care and long term care work environment contains various hazards and job tasks which present the full spectrum or 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."[302]

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."[303]

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."[304]

Lower – "Performing administrative duties in non-public areas of healthcare facilities,

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[297] https://www.ktvu.com/news/coronavirus-outbreak-at-maruchan-ramen-noodle-factory-sickens-at-least-7-workers-in-virginia

[298] https://www.fox5dc.com/news/health-officials-cant-provide-updates-on-covid-19-outbreak-at-virginia-maruchan-ramen-factory

[299] https://www.oregonlive.com/business/2020/05/oregon-cites-national-frozen-foods-site-of-coronavirus-outbreak-for-unsafe-practices.html

[300] 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."

[301] *Id.*

[302] https://www.osha.gov/SLTC/covid-19/healthcare-workers.html

[303] *Id.*

[304] *Id.*

away from other staff members."[305]

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: 318"[306]

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

[305] *Id.*
[306] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

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 climbing, you can be prepared for that.'"[307] (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.[308]

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%).[309]

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.

[307] https://www.usatoday.com/story/news/nation/2020/04/13/ohio-health-care-workers-test-positive-covid-19-alarming-rate/2981253001/
[308] https://www.wric.com/health/coronavirus/canterbury-rehabilitation-healthcare-center-reports-50th-covid-19-death/
[309] https://www.vdh.virginia.gov/content/uploads/sites/96/2020/05/Canterbury-04-16-2020-COVID-Focus-POC.pdf

….
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 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."[310]

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."[311]

Dentist Offices COVID-19 Reports and Statistics

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

[310] https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm?s_cid=mm6912e1_w
[311] https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

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 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."[312]

Bridgemi.com, April 10, 2020, Michigan, "Ascension doctor becomes 7th Michigan health care worker to die of coronavirus"[313]

> "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"[314]

> "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)"[315]

> "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

[312] https://www.dental-tribune.com/news/dentists-in-indonesia-are-dying-from-covid-19/
[313] https://www.bridgemi.com/michigan-health-watch/ascension-doctor-becomes-7th-michigan-health-care-worker-die-coronavirus
[314] https://www.docseducation.com/blog/pandemic-and-dentist
[315] https://www.medrxiv.org/content/10.1101/2020.04.05.20054494v1.full.pdf

(9/192) and Indonesia (7/192)." (Emphasis added).

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."[316]

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."[317]

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)."[318]

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]."[319]

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

[316] https://www.osha.gov/Publications/OSHA3990.pdf at page 19.
[317] *Id.*
[318] *Id.* at page 20.
[319] *Id.* at page 20.

underscores the essential work still being done by so-called "last responders" in the community's morgues and mortuaries.

'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.'"[320]

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)."[321] (Emphasis added).

7. Veterinary Services.

[320] https://tucson.com/news/local/illnesses-at-tucson-funeral-home-highlight-risks-to-last-responders-during-pandemic/article_e0ea6dbc-721b-5b46-a30b-609fcdd9ae5a.html

[321] 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 veterinary work environment contains various hazards and job tasks which present "medium" (close contact), and "lower" risk exposures:

"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.[322]

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:"

[322] https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html

"Wildlife, avian veterinarian honored. Dr. Peter Sakas (Illinois '83), a staff 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.'"[323]

"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."[324]

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

[323] https://www.avma.org/javma-news/2020-07-01/remembering-veterinarians-who-have-died-during-pandemic
[324] *Id.*

through droplets, close contact and surfaces.

….

'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.'[325]

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.

[325] https://www.northcarolinahealthnews.org/2020/03/13/for-migrant-workers-in-nc-coronavirus-may-be-hard-to-avoid/

….
Unlike grain crops that rely on machinery, America's fruits and vegetables are 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.'"[326] (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

[326] https://www.bloomberg.com/news/articles/2020-05-29/every-single-worker-has-covid-at-one-u-s-farm-on-eve-of-harvest

wouldn't be surprised, in fact, if it hasn't spread to the whole group," he told NJ Spotlight.

Several thousand migrant farmworkers — many from Mexico, Hati, 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."[327]

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.[328]

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

[327] https://www.wbgo.org/post/coronavirus-update-cases-spike-among-farmworkers-nj-curbs-wave-parades#stream/0
[328] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e1.htm

industry.

The Virginia Department of Corrections website[329] 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

[329] 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."[330]

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*

[330] 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"[331]

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

[331] https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html

coronavirus, according to a May 2 news release.[332] 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.

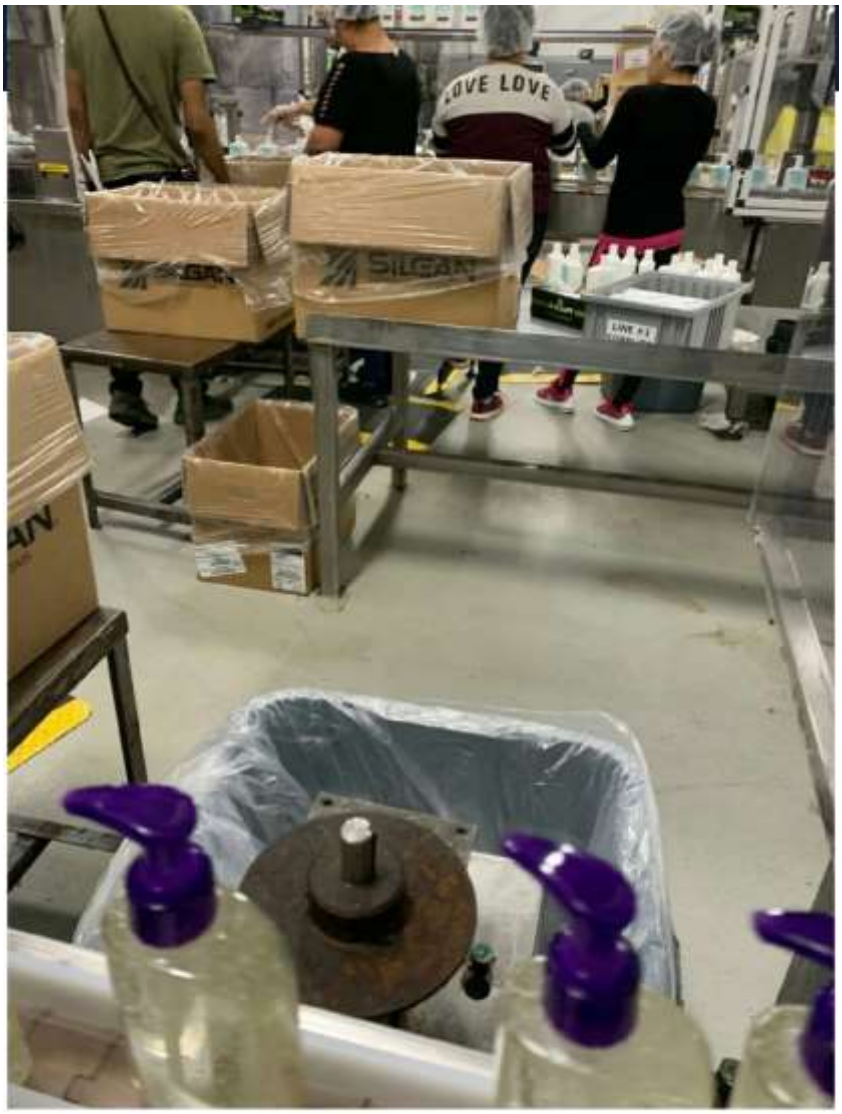
….

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."[333] (Emphasis added).

[332] 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."

[333] 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."[334] (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."[335]

[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."[336] (Emphasis added).

Construction COVID-19 Reports and Statistics

[334] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/construction-workers.html
[335] https://www.cpwr.com/sites/default/files/NABTU_CPWR_Standards_COVID-19.pdf
[336] https://www.agc.org/sites/default/files/Files/Safety%20%26%20Health/NABTU%20Covid%204.30.20.pdf

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."[337]

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 case" on the site was discovered earlier this month. In one email, General

[337] https://www.charlotteobserver.com/news/business/biz-columns-blogs/development/article242928141.html

> 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."[338]

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."[339]

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."[340]

WSLS.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.

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[338] https://www.newschannel5.com/news/newschannel-5-investigates/mass-testing-at-construction-site-reveals-74-workers-with-covid-19
[339] https://www.wataugademocrat.com/covid19/16-app-state-construction-workers-test-positive-for-covid-19/article_303494af-b54d-57f6-8b59-1d75b50b5843.html
[340] 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."[341]
(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 positive for COVID-19 so far, as DCist reported last week."[342]

[341] https://www.wsls.com/news/local/2020/05/06/25-covid-19-cases-connected-to-cave-spring-high-school-construction-work/
[342] https://dcist.com/story/20/04/30/more-covid-19-cases-reported-at-d-c-construction-sites/

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."[343]

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."[344] (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."[345] (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."[346] (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."[347] (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."[348]

"As an aircraft maintenance worker, you could be exposed to COVID-19 in situations

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[343] https://www.baltimoresun.com/coronavirus/cng-ag-hdg-school-covid-death-20200410-tuzdevg2s5ghjhdqngy6bdkw3u-story.html
[344] https://www.wjbf.com/csra-news/plant-vogtle-asking-employees-to-voluntarily-stay-home-amid-covid-19-outbreak/
[345] https://www.cdc.gov/coronavirus/2019-ncov/community/airport-customer-factsheet.html
[346] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-baggage-cargo-handlers.html
[347] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-custodial-staff.html
[348] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-passenger-assistance-workers.html

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."[349] (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."[350] (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."[351] (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."[352] (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.[353]

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 Champions for excellent customer service. He was also a union representative with the APFA.

[349] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/aircraft-maintenance-workers.html
[350] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airline-catering-kitchen-workers.html
[351] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airline-catering-truck-drivers.html
[352] https://www.cdc.gov/coronavirus/2019-ncov/community/airport-retail-factsheet.html
[353] https://www.travelandleisure.com/airlines-airports/american-united-airlines-confirm-employee-deaths-coronavirus

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."[354]

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."[355]

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."[356]
>
> UPDATE: January 4, 2020[357]

[354] https://www.nbcboston.com/news/national-international/tsa-says-500-of-its-employees-have-tested-positive-for-covid-19/2115915/
[355] https://www.usatoday.com/story/news/nation/2020/05/02/coronavirus-least-8-fatal-cases-fedex-workers-complaints-mount/3071150001/
[356] https://www.tsa.gov/coronavirus
[357] https://www.tsa.gov/coronavirus

"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."[358] (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.[359] (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."[360] (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."[361] (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."[362] (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 COVID-19."[363] (Emphasis added).

[358] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/long-haul-trucking.html
[359] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/bus-transit-operator.html
[360] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rail-transit-operator.html
[361] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-maintenance-worker.html
[362] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-station-workers.html
[363] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/mail-parcel-drivers.html

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."[364] (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." [365] (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…."[366] (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 during the pandemic — and one of seven bus operators, so far, to die from coronavirus.

[364] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rideshare-drivers-for-hire.html
[365] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/food-grocery-drivers.html
[366] https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us.html

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."[367] (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."[368] (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.

Water Transportation COVID-19 Reports and Statistics

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

[367] https://www.thecity.nyc/health/2020/4/7/21216831/bus-drivers-hardest-hit-by-deaths-as-covid-19-devastates-mta
[368] https://www.theguardian.com/world/2020/apr/20/us-bus-drivers-lack-life-saving-basic-protections-transit-worker-deaths-coronavirus

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 evacua**ted** 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."[369]

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:"[370]

[369] https://abcnews.go.com/Business/cruise-employees-sue-celebrity-covid-19-response/story?id=70147214
[370] 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."[371]

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

[371] https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/considerations.html

conference Thursday."[372]

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.'"[373]

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."[374] (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,

[372] 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
[373] https://www.clickondetroit.com/news/local/2020/04/04/wayne-state-university-employee-studying-at-college-for-degree-in-sociology-dies-from-coronavirus/
[374] 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.[375] (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."[376]

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:

[375] 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

[376] 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 Specialist[377]

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."[378]

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:

[377] https://abc7ny.com/teacher-deaths-doe-department-of-education-schools/6173896/

[378] 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 curb-side pickup.
- More Risk: Drive-through, delivery, take-out, and curb-side 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.[379]

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.

The bar posted on Facebook that this was its launch of a summer party called

[379] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/business-employers/bars-restaurants.html

> ‘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.

USAtoday.com, May 29, 2020, “Lake of the Ozarks pool partier 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.”[380]

Ny.eater.com, May 22, 2020, “Coronovirus, 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
> ….
> Michael Halkias, 82, event space owner

[380] https://www.usatoday.com/story/news/health/2020/05/29/lake-ozarks-pool-party-missouri-resident-coronavirus/5288079002/

….
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 chef"[381]

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:

"As a grocery or food retail worker, potential sources of exposures include close

[381] https://ny.eater.com/2020/5/6/21229781/nyc-coronavirus-death-restaurant-workers-chefs

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."[382]

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."[383] (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."

> "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

[382] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/grocery-food-retail-workers.html
[383] https://www.boston.com/news/coronavirus/2020/05/27/covid-19-has-killed-100-grocery-store-workers-vitalina-williams-was-one-of-the-first

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."[384] (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
Walmart - 14000 E. Exposition Ave., Aurora, 14 confirmed staff cases and 3 deaths
Mi Pueblo Market, 9171 Washington St., Thornton, 19 confirmed staff cases

[384] 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

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 cases"[385] (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."[386] (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.
….
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

[385] https://www.9news.com/article/news/health/coronavirus/costco-walmart-among-grocery-store-covid-19-outbreaks/73-bde0be4d-e1e3-41f1-a56d-8cf2356d6dde
[386] https://www.businessinsider.com/grocery-store-worker-deaths-from-coronavirus-at-least-30-nationwide-2020-4

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.[387]

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

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

[387]Photo: Hilary Wilcox of Wixom spent Friday afternoon shopping at Franklin Park Mall in Toledo. (Photo: Max Ortiz, The Detroit News)" (Emphasis added).

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."[388]

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."[389]

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

[388] https://www.cdc.gov/coronavirus/2019-ncov/hcp/pharmacies.html
[389] https://www.propublica.org/article/pharmacy-workers-are-coming-down-with-covid-19-but-they-cant-afford-to-stop-working

"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."[390] (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." [391]
> (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

[390] https://www.cnn.com/2020/05/24/us/missouri-hairstylists-coronavirus-clients-trnd/index.html
[391] https://www.cnn.com/2020/05/23/us/missouri-hairstylist-coronavirus-trnd/index.html

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.”[392]

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.
> ….
> 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

[392] https://abc7news.com/first-case-of-coronavirus-in-california-nail-salon-covid-nails/6161231/

happens most frequently among close contacts (within 6 feet).”[393]

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.”[394]

Richmond Times Dispatch, April 16, 2020, “Dozens protest social distancing orders as Virginia's death toll passes 200”

[393] https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/mass-gatherings-ready-for-covid-19.html
[394] 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."[395]

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 <u>two staff members tested positive</u> for coronavirus in late March. It wasn't clear if more people have since tested positive at the Anaheim shelter."[396] (Emphasis added).

KHOU.com, Houston, TX, May 25, 2020, "77 positive coronavirus cases reported at Houston homeless shelter"

> "Eichenbaum said 69 residents and <u>eight staff members</u> 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 increase homeless testing."[397] (Emphasis added).

23. <u>Fitness, Gyms, and Exercise Facilities.</u>

[395] https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html
[396] https://voiceofoc.org/2020/05/coronavirus-outbreak-hits-second-orange-county-homeless-shelter/
[397] https://www.khou.com/article/news/health/coronavirus/77-positive-covid-19-cases-at-houston-homeless-shelter/285-f8ad7306-cb8d-4471-b8bb-4ce310ebd3a7

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 m^2 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."[398], [399]

24. Call Centers.

The call center work environments contain various hazards and job tasks which present "medium" (close contact) to "lower" risk exposures:

[398] https://wwwnc.cdc.gov/eid/article/26/8/20-0633_article

[399] *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 through droplets, vigorous exercise in closely confined spaces should be avoided during the current outbreak, as should public gatherings, even in small groups."

"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 categoric 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."[400] [401]

Call Center COVID-19 Reports and Statistics

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

[400] https://wwwnc.cdc.gov/eid/article/26/8/20-1274_article

[401] *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 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."

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."[402]

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."[403]

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.
>
> 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;

[402] 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

[403] 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.

Waukegan, Illinois; Hawthorne, California; Tracy, California; Bethpage, New York; Jeffersonville, Indiana; and Indianapolis, Indiana."[404] (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."[405] (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 workforce of more than 55,000 people, while the FDNY has suffered two deaths among its more than 40,000 employees."[406] (Emphasis added).

Pressherald.com, "Seven state public health and emergency workers report COVID-19 symptoms"

[404] https://www.yahoo.com/lifestyle/eighth-amazon-warehouse-worker-dies-003500221.html
[405] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
[406] https://www.thecity.nyc/health/2020/4/7/21216831/bus-drivers-hardest-hit-by-deaths-as-covid-19-devastates-mta

> "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."[407]

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
>
> 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

[407] https://www.pressherald.com/2020/05/28/maine-reports-3-more-deaths-52-additional-covid-19-cases/

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-19"[408]

[408] 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.[409]

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)[410],

1910.133 (Eye and Face Protection)[411], 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 is does not reference exposure to airborne biological hazards.

1910.134 (Respiratory Protection)[412],

1910.138 (Hand Protection)[413]

1910.141 (Sanitation)[414]

1910.142 (Temporary Labor Camps)[415]

1910.1200 (Hazard Communication)[416] (i.e., regulatory requirements for employee

[409] 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).

[410] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132

[411] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.133

[412] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

[413] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.138

[414] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.141

[415] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.142

[416] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200

use of certain cleaning chemicals)

1910.1045 (Occupational Exposure to Hazardous Chemicals in Laboratories)[417]

b. Construction Industry.

1926.21(b)(2)[418] (Safety Training and Education)

1926.59 (Hazard Communication)[419] (i.e., regulatory requirements for employee use of certain cleaning chemicals)

1926.28[420] and 1926.95[421], (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.[422]

1926.102 (Eye and Face Protection)[423]; 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 is does not reference exposure to airborne biological hazards.

1926.103 (Respiratory Protection)[424]

NOTE: The Construction Industry Standards do not have a "Hand Protection" regulation similar to 1910.138.

16VAC25-160[425] (Construction Industry Sanitation Standard – Virginia unique regulation that is the functional equivalent of 1926.51 for Construction), sanitation requirements are

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[417] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1450
[418] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.21
[419] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.59
[420] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.28
[421] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.95
[422] 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.
[423] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.102
[424] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.103
[425] https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-160-10

limited to "Toilet facilities shall be operational and maintained in a clean and sanitary condition."

c. Agriculture Industry.

1928.21(a)(1)[426] (Temporary Labor Camps, 1910.142 applies to agricultural operations)

1928.21(a)(5)[427] (Hazard Communication, 1910.1200 applies to agricultural operations) (i.e., regulatory requirements for employee use of certain cleaning chemicals)

1910.142 (Temporary Labor Camps)[428] applies to the Agriculture Industry

16VAC25-180[429] (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.

1915.88[430], Shipyard Employment (Sanitation)

1915.152[431], Shipyard Employment (Personal Protective Equipment)

[426] https://www.osha.gov/laws-regs/regulations/standardnumber/1928/1928.21
[427] https://www.osha.gov/laws-regs/regulations/standardnumber/1928/1928.21
[428] https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.142
[429] https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-180-10
[430] https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.88
[431] https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.152

1915.153[432], 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 is does not reference exposure to airborne biological hazards.

1915.154[433], Shipyard Employment (Respiratory Protection)

1915.157[434], Shipyard Employment (Hand and Body Protection)

1917.127[435], Marine Terminal Operations (Sanitation)

1917.1(a)(2)(vi)[436], Marine Terminal Operations (Hazard Communication, 1910.1200)

1917.92 and 1917.1(a)(2)(x)[437], Marine Terminal Operations (Respiratory Protection, 1910.134)

1917.91[438], Marine Terminal Operations (Eye and Face Protection)

1917.95[439], Marine Terminal Operations (PPE, Other Protective Measures

1918.95[440], Longshoring (Sanitation)

1918.90[441], Longshoring (Hazard Communication)

1918.102[442] Longshoring (Respiratory Protection)

1918.101[443] 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)

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

[432] https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.153
[433] https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.154
[434] https://www.osha.gov/laws-regs/regulations/standardnumber/1915/1915.157
[435] https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.127
[436] https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.1#1917.1(a)(2)(ix)
[437] *Id.*
[438] https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.91
[439] https://www.osha.gov/laws-regs/regulations/standardnumber/1917/1917.95
[440] https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.95
[441] https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.90
[442] https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.102
[443] https://www.osha.gov/laws-regs/regulations/standardnumber/1918/1918.101

persons accessed or worked[444]

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

Employee training on SARS-CoV-2 and COVID-19 hazards, with the exception of

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[444] 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).

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:[445]

> 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 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))[446] 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 OSH Act of 1970 would be through the adoption of occupational safety and health

[445] https://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+16VAC25-60-260
[446] https://www.osha.gov/laws-regs/oshact/section_5, 29 U.S.C. § 654(a)(1).

standards[447], 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.,*[448] 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.[449]

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.[450] 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."

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

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[447] *The Law of Occupational Safety and Health,* Nothstein, 1981, page 259.

[448] 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

[449] *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.

[450] 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)

requirements, CDC recommendations, or employer safety and health rules which use "should," "may," "it is recommended," and similar non-mandatory language.[451]

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."[452]

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)"[453] 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."[454] (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.

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[451]" 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."

[452] https://www.osha.gov/Publications/OSHA3990.pdf, at page 2.

[453] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html

[454] *Id.*

For instance, the CDC's "Interim Guidance for Restaurants and Bars"[455] 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 61[456] 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.[457]

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 wearing protective masks which are deemed necessary for the physical safety of the

[455] https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf#page=53
[456] 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
[457] https://law.lis.virginia.gov/vacode/18.2-422/

> 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.

Washington.

The State of Washington's Division of Occupational Safety and Health (DOSH) just enacted Emergency COVID-19 Safety Rules[458] on "Prohibited Business Activities and Conditions for Operations."[459]

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,[460] 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 rule[461] 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.[462] 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."

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[458] https://www.lni.wa.gov/rulemaking-activity/AO20-10/2010CR103E.pdf?utm_medium=email&utm_source=govdelivery

[459] https://www.environmentalsafetyupdate.com/states/washington/wa-dosh-issues-emergency-covid-19-safety-rule-mandating-compliance-with-emergency-proclamation-and-safe-start-reopening-guidance/

[460] https://osha.oregon.gov/OSHARules/div1/437-001-0744.pdf

[461] https://osha.oregon.gov/OSHARules/adopted/2020/ao2-2020-text-emergency-rules-ag-covid.pdf

[462] *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."[463]

California.

The California Division of Occupational Safety and Health (Cal/OSHA) Aerosol Transmissible Diseases (ATD) standard[464] 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 Standards[465] on December 1, 2020. These new temporary standards apply to most workers in California not covered by Cal/OSHA's AT D standard.

South Carolina

Safetyandhealthmagazine.com, Columbia, SC, August 5, 2021, *South Carolina OSHA plans to adopt an infectious disease standard*[466]

> "South Carolina OSHA has announced its plan to adopt a standard on infectious diseases in the workplace, including COVID-19.
>
> The standard will be "an alternative" to federal OSHA's emergency temporary standard on COVID-19 focused on health care workers, which went into effect June 21.
>
> SC OSHA operates under OSHA's State Plan program, so its standards must be "at least as effective as" federal standards, meaning they can be more stringent but not less stringent.
>
> "SC OSHA made the decision to create an alternative standard following input from South Carolina stakeholders, a review of SC OSHA's COVID-19 compliance data (i.e., health industry-related fatalities, hospitalizations, complaints and inspections), and data received from the SC Department of Health and Environmental Control and the Centers for Disease Control and Prevention," a July 20 press release states.
>
> SC OSHA says it will notify employers and others on its website and social media platforms when the standard is adopted. It also will provide compliance assistance through its Standards Office, along with consultation and training services.
>
> "This approach acknowledges the issues previously seen during the pandemic; recognizes the progress made during this time; and anticipates the growing need for stability among employers, employees and the public when dealing with similar situations," SC OSHA Deputy Director Kristina Baker said in the release. "This alternative approach will place

[463] https://www.vdh.virginia.gov/environmental-health/environmental-health-services/migrant-labor-camps/9505-2/
[464] https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx
[465] https://www.dir.ca.gov/dosh/coronavirus/ETS.html
[466] https://www.safetyandhealthmagazine.com/articles/21549-south-carolina-osha-plans-to-adopt-an-infectious-disease-standard

significant focus on employer assessment and allow flexibility as the pandemic has proven to be both fluid and unpredictable. SC OSHA continues to monitor the ongoing situation involving COVID-19 and its effects on the employers and employees of the state of South Carolina and vows to make and communicate appropriate changes to this current course of action."

ATTACHMENT D: FINDING OF "GRAVE DANGER" TO SUPPORT THE ADOPTION OF THE EMERGENCY TEMPORARY STANDARD (ETS) AND VOSH STANDARD FOR INFECTIOUS DISEASE PREVENTION OF THE SARS-COV-2 VIRUS THAT CAUSES COVID-19, 16VAC25-220, EFFECTIVE JULY 27, 2020 AND JANUARY 27, 2021, RESPECTIVELY

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 [and final VOSH 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 [and final VOSH 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,[467] 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.[468]

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%."[469]

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.

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

[467] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html
[468] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html
[469] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html

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 worked[470]
- 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 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

[470] 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).

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 Industry[471]

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)[472] (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.[473]

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

[471] With the exception of the Construction Industry regulation at 1926.21(b)(2) (Safety Training and Education)

[472] https://www.osha.gov/laws-regs/regulations/standardnumber/1926/1926.21

[473] 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.

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,[474], 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 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

[474] https://www.osha.gov/laws-regs/oshact/section_6

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 [and final VOSH standard], should it decide to do so.

- On February 7, 2020, the State Health Commissioner declared COVID-19 a communicable disease of public health threat[475] 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.[476] 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.[477]

- 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.[478]

- "Although most people with COVID-19 have mild to moderate symptoms, the [COVID-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."[479] "Younger adults are also being hospitalized in the U.S. Adults 20–44 account for 20% of hospitalizations, 12% of ICU admissions."[480] Some research indicates that SARS-CoV-2 infection can cause significant morbidity in

[475] https://www.governor.virginia.gov/media/governorvirginiagov/executive-actions/Order-of-the-Governor-and-State-Health-Commissioner-Declaration-of-Public-Health-Emergency.pdf
[476] https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/
[477] https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/coronavirus-disease-2019-covid-19-frequently-asked-questions
[478] https://www.statnews.com/2020/04/14/how-much-of-the-coronavirus-does-it-take-to-make-you-sick/
[479] https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963
[480] https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_ABX_Guide/540747/all/Coronavirus_COVID_19__SARS_CoV_2_

relatively young persons without severe underlying medical conditions.[481]

- "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,'."[482] (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.[483]

- The CDC conducted a study of "Selected health conditions and risk factors, by age: United States, selected years 1988–1994 through 2015–2016"[484] 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

NOTE: Virginia's Adult Diabetes Rate in 2019 was 10.5%.[485]

Virginia's Hypertension Rate in 2015 was 33.2%[486]

Virginia's Adult High Cholesterol Rate[487] in 2019 was 33%.[488]

[481] https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e1.htm
[482] https://www.healthline.com/health-news/what-we-know-about-the-long-term-effects-of-covid-19#COVID-19-might-affect-the-brain-stem
[483] https://www.seniorliving.org/research/senior-employment-outlook-covid/
[484] https://www.cdc.gov/nchs/data/hus/2018/021.pdf
[485] https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA
[486] https://www.vdh.virginia.gov/content/uploads/sites/65/2018/05/VA-Heart-Disease-FactSheetFINAL.pdf
[487] Percentage of adults who reported having their cholesterol checked and were told by a health professional that it was high.
[488] https://www.americashealthrankings.org/explore/annual/measure/High_Chol/state/VA

Virginia's Adult Obesity Rate[489] in 2019 was 30.3%.[490]

- 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%."[491] (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.[492]
- "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."[493]
- 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%.[494] A study by the University of Washington using data through April 20, 2020, calculated the U.S. "infection mortality rate" among symptomatic cases (IFR-

[489] Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight (pre-2011 BRFSS methodology).
[490] https://www.americashealthrankings.org/learn/reports/2019-annual-report/state-summaries-virginia
[491] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[492] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[493] *Id.*
[494] *Id.* referencing https://www.cdc.gov/flu/about/burden/2018-2019.html

S) to be 1.3%[495] [13 times the seasonal influenza rate]. Another study calculated a global IFR of 1.04%[496] [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%[497] [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%.[498] The CDC's current best estimate of the percentage of COVID-19 disease transmission occurring prior to symptom onset is 40%.[499] 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.

- The CDC has documented multiple "superspreaders" of the virus at mass gathering events involving a choir practice,[500] a church service,[501] a funeral,[502] and a birthday party[503] 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

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[495] 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).

[496] https://www.medrxiv.org/content/10.1101/2020.05.11.20098780v1
[497] https://www.medrxiv.org/content/10.1101/2020.03.05.20031773v2
[498] https://www.cnn.com/2020/05/22/health/cdc-coronavirus-estimates-symptoms-deaths/index.html
[499] *Id.*
[500] https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm
[501] https://www.cdc.gov/mmwr/volumes/69/wr/mm6920e2.htm?s_cid=mm6920e2_w
[502] https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e1.htm?s_cid=mm6915e1_w
[503] *Id.*

a wide variety of occupational settings (see section IV.A.2).

- Pursuant to Va. Code §40.1-51.1.D[504], 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."[505]

- 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.[506] Depending on the level of contagiousness of COVID-19 expressed in the R_0[507] 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)."[508]

- 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

[504] https://law.lis.virginia.gov/vacode/40.1-51.1/
[505] https://www.npr.org/sections/health-shots/2020/05/22/860981956/scientists-say-new-lower-cdc-estimates-for-severity-of-covid-19-are-optimistic
[506] https://www.webmd.com/lung/what-is-herd-immunity#1
[507] "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
[508] https://wwwnc.cdc.gov/eid/article/26/7/20-0282_article#suggestedcitation

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."[509]

- "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."[510]

- "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."[511]

- 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, scientists and infectious disease experts warn."[512]

- 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.[513]

- 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' survey[514] of 4,428 U.S. adults taken between May 13 and May 19: "Fourteen percent of respondents said they were not at all

[509] https://www.cnn.com/2020/06/04/health/us-coronavirus-thursday/index.html
[510] https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Coronavirus-Disease-2019-Basics
[511] https://www.cidrap.umn.edu/news-perspective/2020/04/coroner-first-us-covid-19-death-occurred-early-february
[512] https://www.cnbc.com/2020/05/21/coronavirus-vaccine-why-it-may-be-ready-early-next-year-and-what-could-go-wrong.html
[513] https://www.census.gov/quickfacts/fact/table/VA#
[514] 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

interested in taking a vaccine, and 10% said they were not very interested. Another 11% were unsure."

- The SARS-CoV-2 virus and COVID-19 disease continue to constitute a grave danger to unvaccinated, not fully vaccinated, and otherwise at risk employees in the same manner that it did prior to the wide scale availability of vaccines. Currently, three vaccines are authorized and recommended to prevent COVID-19 in the U.S.[515]

  There are over 332,000,000 people living in the United States.[516]

  While fully vaccinated rates are improving, they have not reached a range that could be considered able to achieve population or herd immunity. Here are fully vaccinated rates for some surrounding states as of August 17, 2021[517]:

6. Maryland	60.04%
13. District of Columbia	56.27%
14. Virginia	55.79%
29. Kentucky	46.82%
38. North Carolina	44.82%
43. Tennessee	40.19%
45. West Virginia	39.31%

  NOTE: As of August 17, 2021, 74.4% of Virginia's adult population has been fully vaccinated (approximately 15.9% of Virginia's population is 65 years and over.[518]

- On July 9, 2021, the CDC has estimated that ""Preliminary data from several states over the last few months suggest that 99.5% of deaths from COVID-19 in the United States were in unvaccinated people."[519]

  "CDC Director Rochelle Walensky said that cases, hospitalizations and deaths from the coronavirus are increasing nationwide, adding that over 97% of new hospitalizations are in patients who are unvaccinated."[520]

- On August 16, 2021, after consultation with the Virginia Department of Health (VDH), DOLI decided to recommend revisions[521] to the Board's Proposed Amendments to the VOSH Standard originally adopted on June 29, 2021, in response to the CDC's Updated Guidance for Fully Vaccinated People issued on July 27, 2021[522] (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).

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[515] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html
[516] https://www.census.gov/popclock/
[517] https://www.beckershospitalreview.com/public-health/states-ranked-by-percentage-of-population-vaccinated-march-15.html
[518] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/covid-19-vaccine-summary/
[519] https://www.businessinsider.com/us-coronavirus-deaths-nearly-all-among-unvaccinated-cdc-head-2021-7
[520] https://www.usnews.com/news/national-news/articles/2021-07-16/cdc-head-covid-19-becoming-pandemic-of-the-unvaccinated
[521] https://www.doli.virginia.gov/wp-content/uploads/2021/08/Revisions-to-Proposed-Amendments-to-the-FPS-for-COVID-19-16VAC25-220-Adopted-06.29.2021.pdf
[522] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

The CDC July 27, 2021 updated guidance was based in part on new research. Following is a summary of CDC's Morbidity and Mortality Weekly Report (MMWR) of July 30, 2021[523] titled *Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021*, which resulted in the CDC update:

> Summary of MMWR: "During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons…. Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported….[Certain data] might mean that the viral load of vaccinated and unvaccinated persons infected with SARS-CoV-2 is also similar. However, microbiological studies are required to confirm these findings."

- The jury is still out as to whether the United States will reach herd immunity levels (generally considered to be in the 70-85% range). Even if the country does reach herd/population immunity, it is possible to lose the immunity in the future, or go in and out of herd/population immunity depending on the season. Herd/population immunity is not immediately possible because "No one younger than 12 can get a Covid-19 vaccine in the US right now. The Pfizer/BioNTech vaccine is authorized for those age 12 and older, and the Moderna and Johnson & Johnson vaccines are authorized for adults 18 and older."[524]

  In addition, surveys continue to indicate that a certain percentage of the population will refuse to get vaccinated ("about 20% of people surveyed said they definitely would not get vaccinated or would only get vaccinated if their job or school required it, according to the Kaiser Family Foundation COVID-19 Vaccine Monitor.").[525]

  Also, it is not currently known how long immunity from a natural infection lasts in a person, or how long it will last for fully vaccinated or partially vaccinated people. The virus has shown a propensity for mutations, some of which appear to be more infectious and therefore more easily spread. Increased travel in state, around the country and from other countries could make the U.S. fall out of herd/population immunity even after it is reached.

  "The Delta variant is on its way to becoming the dominant strain of coronavirus in the US, raising concerns that outbreaks could hit unvaccinated people this fall.[526]

  And a new study shows the Delta variant is associated with almost double the risk of hospitalization compared to the Alpha variant.

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[523] https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm
[524] https://www.cnn.com/2021/03/30/health/herd-immunity-covid-shifts/index.html
[525] https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-march-2021/
[526] https://www.cnn.com/2021/06/14/health/us-coronavirus-monday/index.html

The Alpha (B.1.1.7) variant, which is "stickier" and more contagious than the original strain of novel coronavirus, became the dominant strain in the US this spring.

But health experts worry the Alpha variant could be trumped by the Delta variant, which appears to be even more transmissible and may cause more severe illness for those not vaccinated.

As of June 14, 2021, about 10% of Covid-19 cases in the US can be attributed to the Delta variant. But that proportion is doubling every two weeks, Scott Gottlieb, a former commissioner of the US Food and Drug Administration, said in a CBS interview Sunday. He said the Delta variant will probably take over as the dominant strain of coronavirus in the US.

As of June 22, 2021, the Delta variant now makes up about 20% of all new COVID-19 cases in the U.S.[527]

- Multiple variants of the virus that causes COVID-19 are circulating globally, including within the United States. Currently, four variants are classified as a variant of concern (VOC). Nowcast estimates* of COVID-19 cases caused by these VOCs for the week ending August 7 are summarized here. Nationally, the combined proportion of cases attributed to Delta (B.1.617.2, AY.1, AY.2, AY.3) is estimated to increase to 97.4%; Alpha (B.1.1.7) proportion is estimated to decrease to 0.9%; Gamma (P.1) proportion is estimated to decrease to 0.5%; and Beta (B.1.351) is estimated to be less than 0.1%. Nowcast estimates that Delta (B.1.617.2, AY.1, AY.2, and AY.3) will continue to be the predominant variant circulating in all 10 HHS regions. Alpha (B.1.1.7) is estimated to be 1.6% or less in all HHS regions. Gamma (P.1) is estimated to be 1.2% or less in all HHS regions; and Beta (B.1.351) is estimated to be less than 0.1% in all HHS regions.

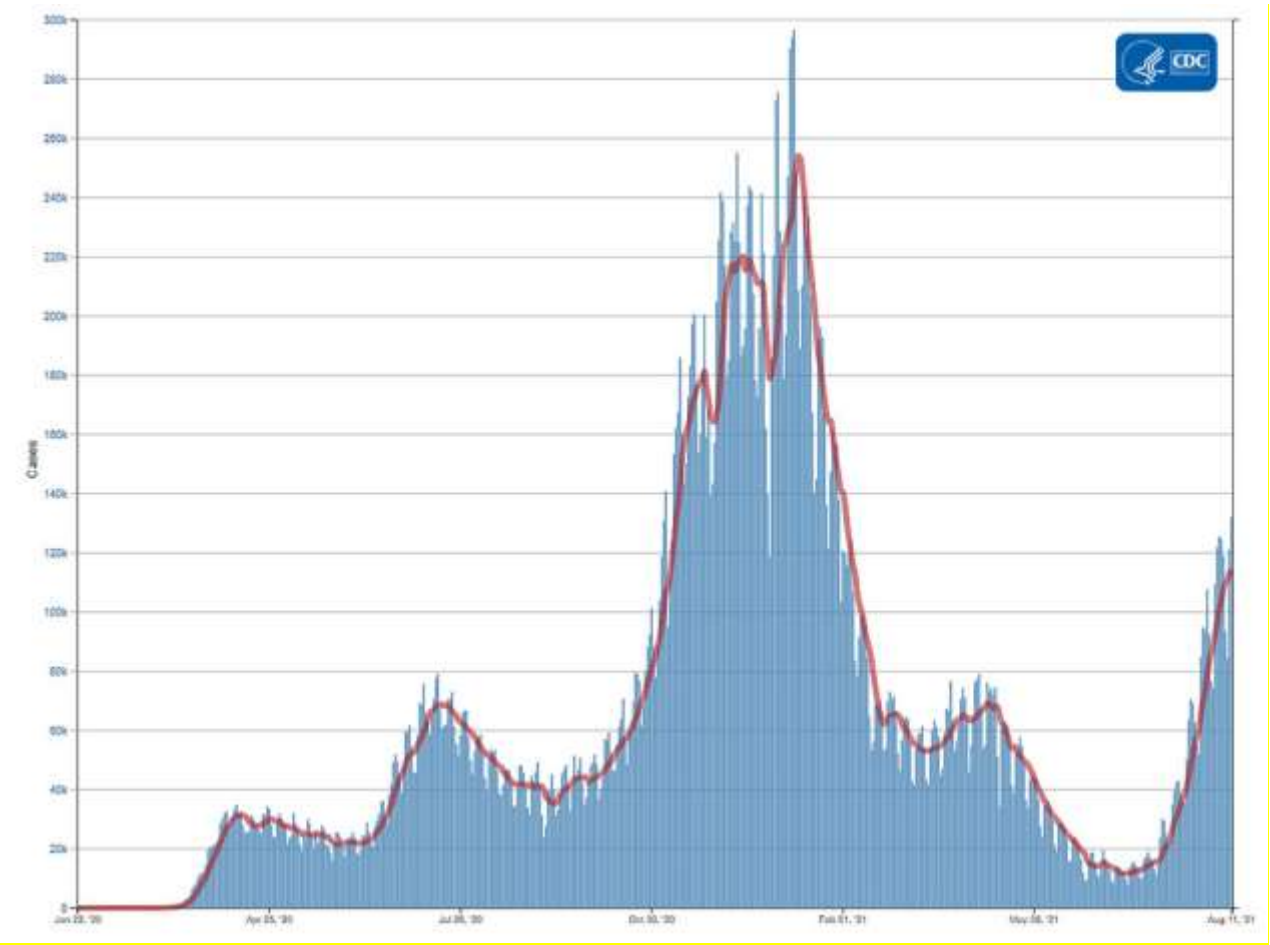
  Reported Cases

  The current 7-day moving average of daily new cases (114,190) increased 18.4% compared with the previous 7-day moving average (96,454). The current 7-day moving average is 66.3% higher compared to the peak observed on July 20, 2020 (68,685). The current 7-day moving average is 65.0% lower than the peak observed on January 10, 2021 (254,023) and is 882.8% higher than the lowest value observed on June 19, 2021 (11,619). A total of 36,268,057 COVID-19 cases have been reported as of August 11.

[527] https://www.cnbc.com/2021/06/22/fauci-declares-delta-variant-greatest-threat-to-the-nations-efforts-to-eliminate-covid.html

Daily Trends in COVID-19 Cases in the United States Reported to CDC

7-Day moving average

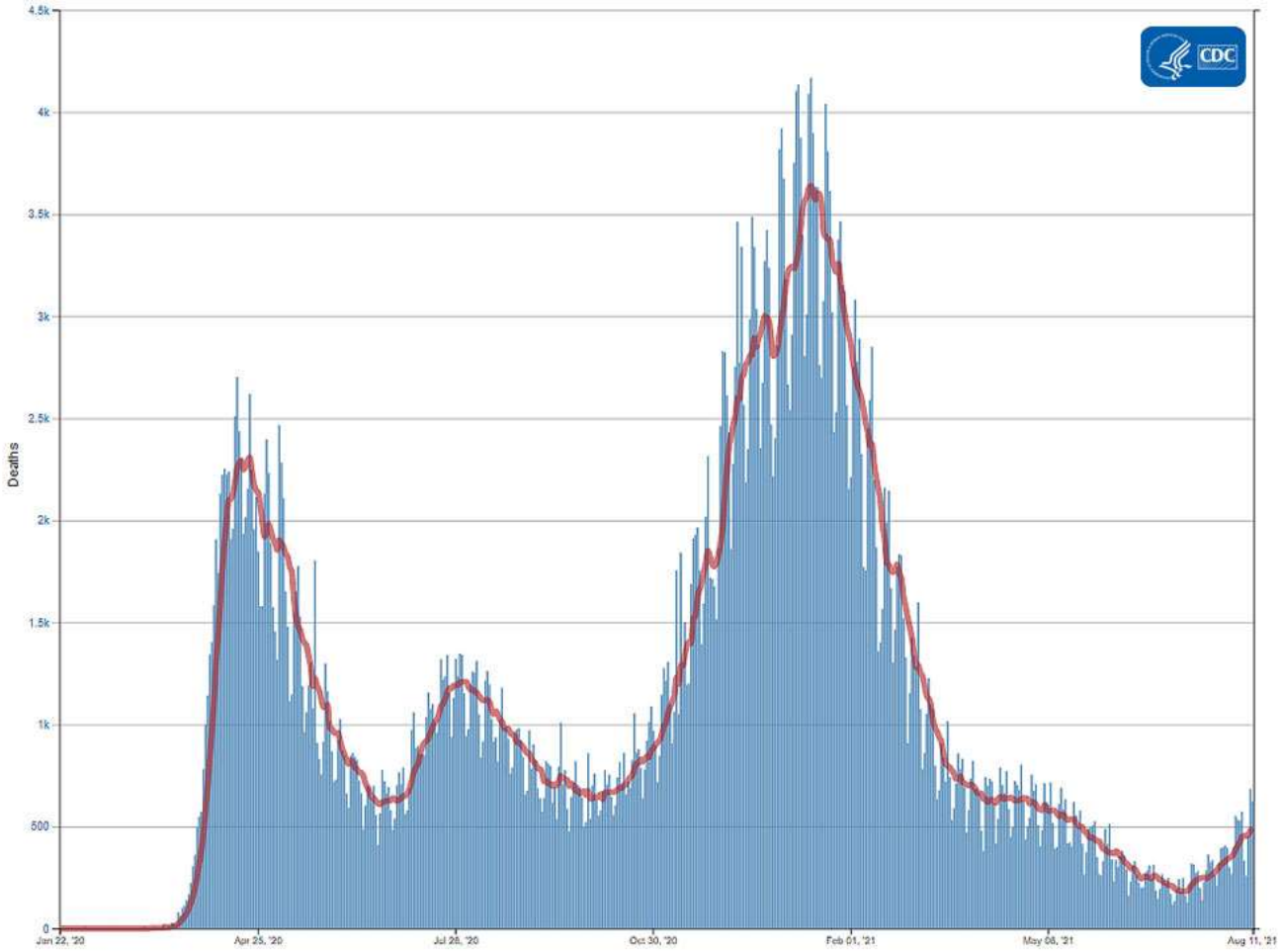


Deaths

The current 7-day moving average of new deaths (492) has increased 21.0% compared with the previous 7-day moving average (407). The current 7-day moving average is 59.3% lower compared to the peak observed on August 2, 2020 (1,210). The current 7-day moving average is 86.5% lower than the peak observed on January 13, 2021 (3,640) and is 170.4% higher than the lowest value observed on July 10, 2021 (182). As of August 11, a total of 617,096 COVID-19 deaths have been reported in the United States.

Daily Trends in Number of COVID-19 Deaths in the United States Reported to CDC

7-Day moving average

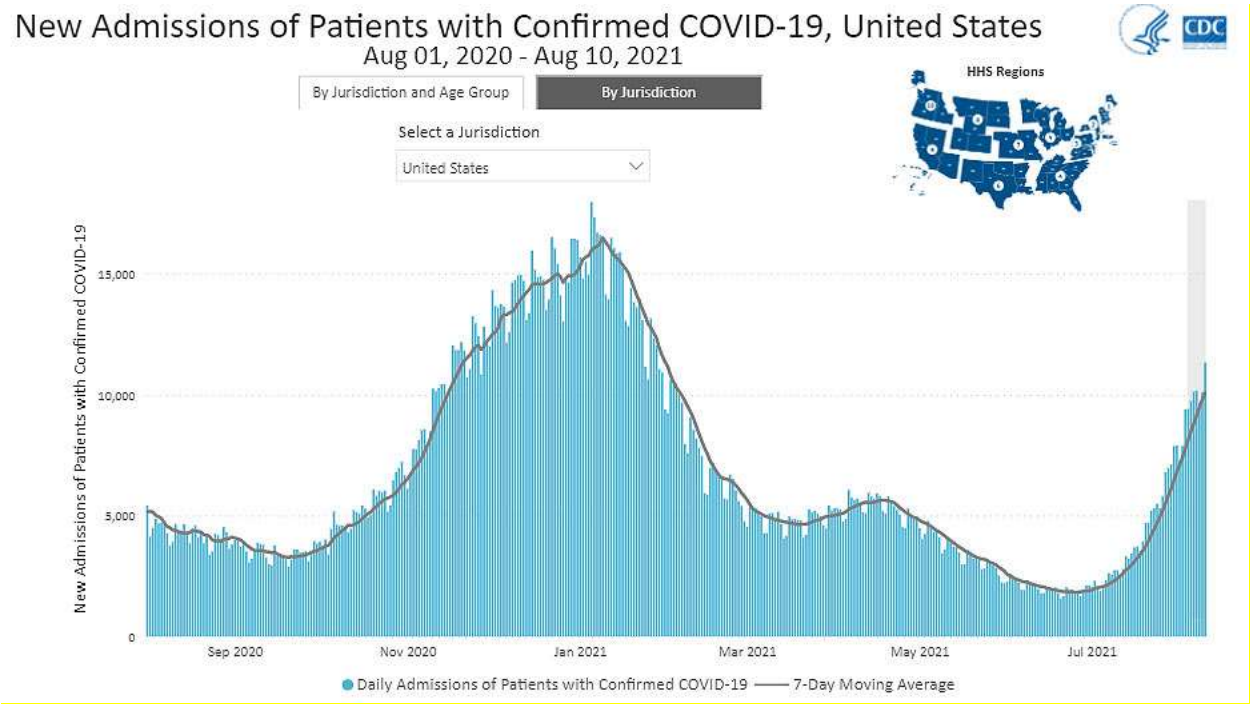


Hospitalizations

New Hospital Admissions

The current 7-day average for August 4–August 10 was 10,072. This is a 29.6% increase from the prior 7-day average (7,771) from July 28–August 3. The 7-day moving average for new admissions has consistently increased since June 25, 2021. New admissions of patients with confirmed COVID-19 are currently at their highest levels since the start of the pandemic in Florida, Louisiana, and Oregon.

Daily Trends in Number of New COVID-19 Hospital Admissions in the United States



Vaccinations

The U.S. COVID-19 Vaccination Program began December 14, 2020. As of August 12, 353.9 million vaccine doses have been administered. Overall, about 196.5 million people, or 59.2% of the total U.S. population, have received at least one dose of vaccine. About 167.4 million people, or 50.4% of the total U.S. population, have been fully vaccinated.* As of August 12, the 7-day average number of administered vaccine doses reported (by date of CDC report) to CDC per day was 699,068, a 0.03% decrease from the previous week.

CDC's COVID Data Tracker Vaccination Demographic Trends tab shows vaccination trends by age group. As of August 12, 90.6% of people ages 65 or older have received at least one dose of vaccine and 80.6% are fully vaccinated. Over two-thirds (71.5%) of people ages 18 or older have received at least one dose of vaccine and 61.3% are fully vaccinated. For people ages 12 or older, 69.2% have received at least one dose of vaccine and 59% are fully vaccinated.

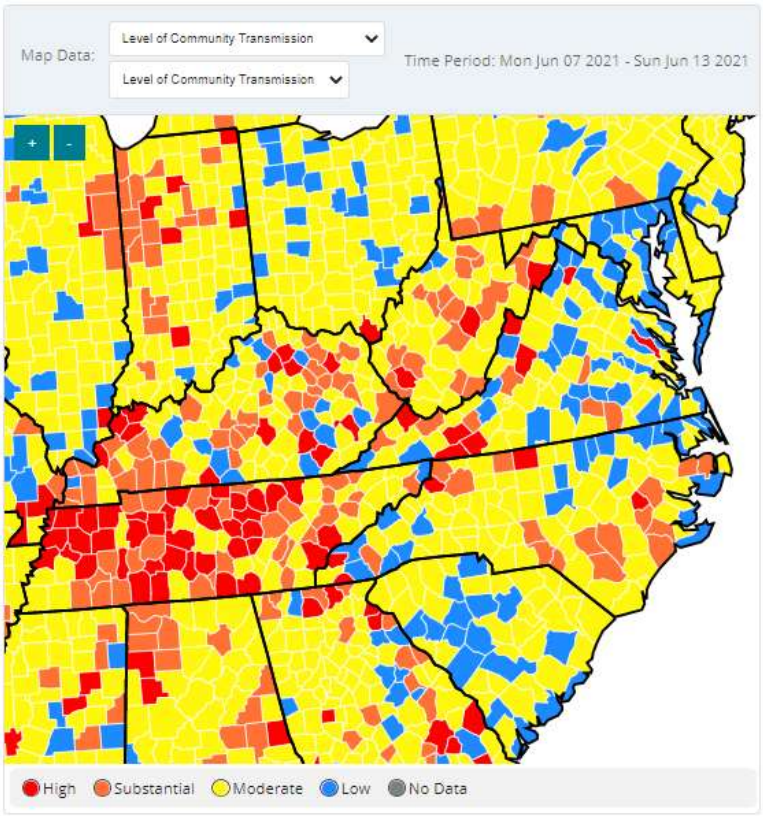
- Since February, 2020, the Virginia Workers' Compensation Commission received 15,770 COVID-19 related claims as of June 15, 2021.

- During the course of the pandemic, VOSH has inspected 53 workplace deaths. The June 15, 2021 report from the VWCC contains data on 23 employee deaths not currently included in VOSH COVID-19 Employee Death Statistics. VOSH is actively investigating this data issue to determine if these employee deaths fall within VOSH jurisdiction. If so, VOSH will open inspections for each case. If confirmed, 23 additional deaths would result in a 52% increase in employee deaths attributed to COVID-19 since February 1, 2020.

- Virginia community transmission rates[528] can be found on a county-by-county basis at: https://covid.cdc.gov/covid-data-tracker/#county-view

  You can see the following from the screenshot below (June 13, 2021):

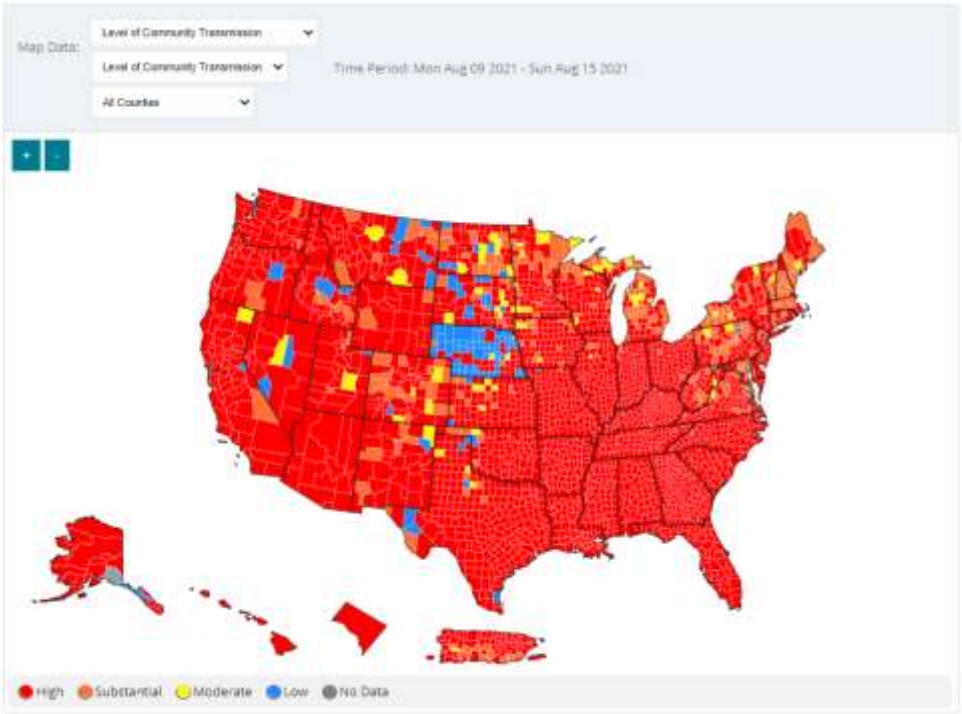
  - about 25-30% of Virginia counties have a low community transmission rate
  - about 8% of Virginia counties have a high transmission rate,
  - about 7% of Virginia counties having a substantial transmission rate
  - the remaining 55-60% of Virginia counties have a moderate transmission rate



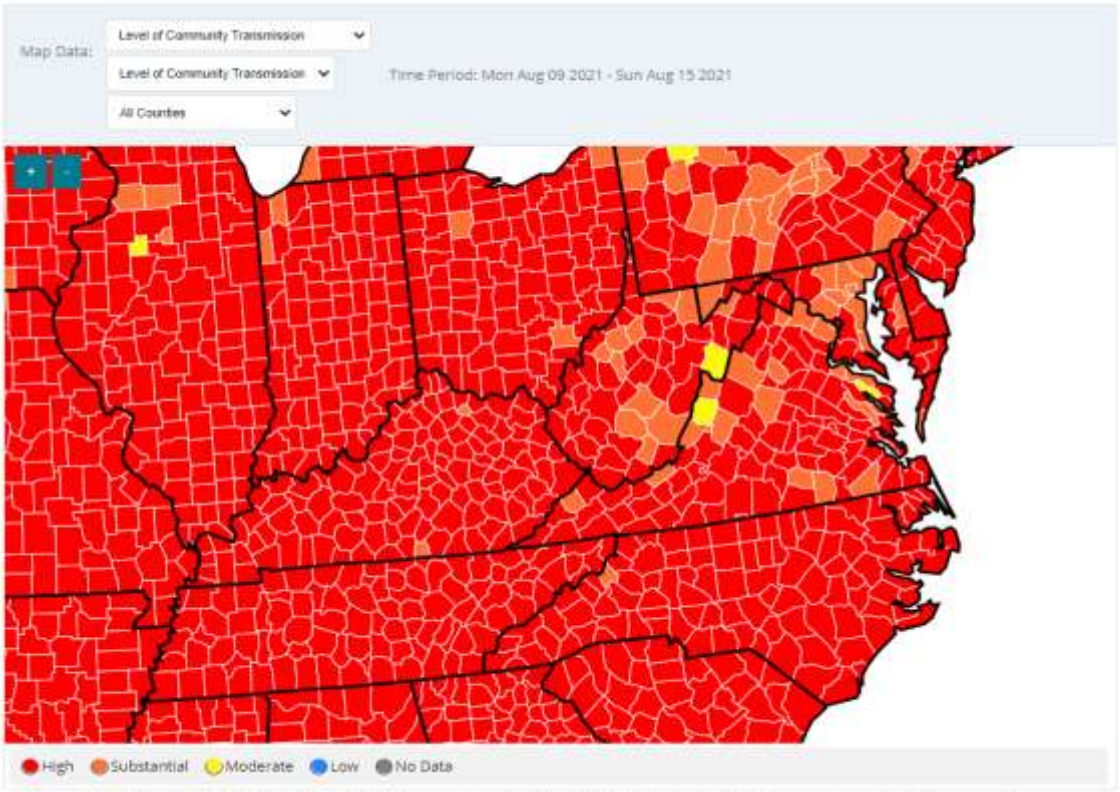
Current 7-days is Mon Jun 07 2021 - Sun Jun 13 2021 for case rate and Sun Jun 06 2021 - Sat Jun 12 2021 for percent positivity. The percent change in counties at each level of transmission is the absolute change compared to the previous 7-day period.

[528] https://covid.cdc.gov/covid-data-tracker/#county-view

As of August 15, 2021, the overwhelming majority of US and Virginia counties and cities have high or substantial levels of community transmission.[529]



Current 7-days is Mon Aug 09 2021 - Sun Aug 15 2021 for case rate and Fri Aug 06 2021 - Thu Aug 12 2021 for percent positivity. The percent change in counties at each level of transmission is the absolute change compared to the previous 7-day period.



Current 7-days is Mon Aug 09 2021 - Sun Aug 15 2021 for case rate and Fri Aug 06 2021 - Thu Aug 12 2021 for percent positivity. The percent change in counties at each level of transmission is the absolute change compared to the previous 7-day period.

[529] https://covid.cdc.gov/covid-data-tracker/#county-view

- National Trends

As of June 11, 2021, in the U. S. there were 33,246,578 total cases (current 7-day average of 13,997 cases), 2,243,371 hospitalizations (current 7-day average of 2,239), and 596,059 total deaths (current 7-day moving average of 347 deaths).[530]

As of August 11, 2021, in the U. S. there were 36,268,057 total cases (current 7-day average of 114,190 cases), 2,507,105 hospitalizations (current 7-day average of 10,072), and 617,096 total deaths (current 7-day moving average of 407 deaths).[531]

Since June 11, 2021, the 7 day average of cases in the US has increased approximately 815%.

Since June 11, 2021, the 7 day average of hospitalizations in the US has approximately increased 450%. (NOTE: Hospitalization rates typically lag behind illness indicators[532]).

Since June 11, 2021, the 7 day average of deaths in the US has increased approximately 17%.

Virginia Trends

As of June 14, 2021, cases in Virginia totaled 677,812[533] (7-day average 140 cases), 30,182 hospitalizations (7-day average of 10 hospitalizations),[534] with 11,318 deaths (7-day average of 3 deaths).[535]

As of August 10, 2021, cases in Virginia totaled 725,971[536] (7-day average 1,700 cases), 32,399 hospitalizations (7-day average of 37 hospitalizations),[537] with 11,625 deaths (7-day average of 5 deaths).[538]

Since June 14, 2021, the 7 day average of cases in Virginia has increased approximately 1,114%.

Since June 14, 2021, the 7 day average of hospitalizations in Virginia has increased approximately 270%. (NOTE: Hospitalization rates typically lag behind illness indicators[539]).

[530] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[531] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html
[532] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-17-2020.pdf
[533] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia/
[534] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
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[538] https://www.vdh.virginia.gov/coronavirus/covid-19-in-virginia-cases/
[539] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-17-2020.pdf

Since June 14, 2021, the 7 day average of death in Virginia has increased approximately 67%.

Fortunately, employee deaths, hospitalizations and outbreaks in Virginia are down substantially from the height of the pandemic. However, there is a concerning trend in the number of outbreaks of 3 or more cases occurring since the beginning of July, 2021.

- Weekly VOSH COVID-19 Response report for August 13, 2021:

SUMMARY | VOSH COVID-19 RESPONSE

Dates	7/9/21	7/16/21	7/23/21	7/30/21	8/6/21	8/13/21	Total	
Phone Calls								
Total Phone Calls	41	35	46	48	55	59	13383	
UPAs Complaints | OIS Statewide	0	3	2	7	3	14	2057	*
# Inspections *Complaints, Referrals, Hospitalizations & Fatalities*	1	0	0	0	0	0	212	**
Inspections w/ Violations	75	79	80	88	89	90	90	
Inspections Closed	143	145	147	151	152	178	179	
# of Violations Issued - Final Order Cases (Willful, Serious, OTS)	250	258	269	291	292	295	295	
#EEs Exposed	13018	13234	13481	13868	13900	14701	14701	
Current Penalty ($)			$ 573,303	$ 647,351	$ 651,201	$ 735,175	$ 735,175	
# Hospitalizations	0	0	0	1	0	0	84	***
Fatalities/Workplace deaths	0	0	0	0	0	0	44	
# of Emails forwarded to Regional/Field Offices from MF *COVID-19 positive Cases Reports (ETS) | Complaints (does not include reports submitted by phone in the Regional Offices).*	0	2	0	0	1	0	676	
# REDCAP Notifications *(Launched 09/28/20)*	39	55	114	170	246	415	26975	
# REDCAP Notifications (3 or more cases reported)	8	6	29	49	67	126	7009	

** **Time Range:** 01/01/2020 to 08/13/2021 |UPA numbers may change as Regions update the system.*

***Inspections opened (Total: 212 - Draft + Final)*

% of COVID-19 inspections closed - 84% (179)
% of COVID-19 inspections with violations - 42% (90)

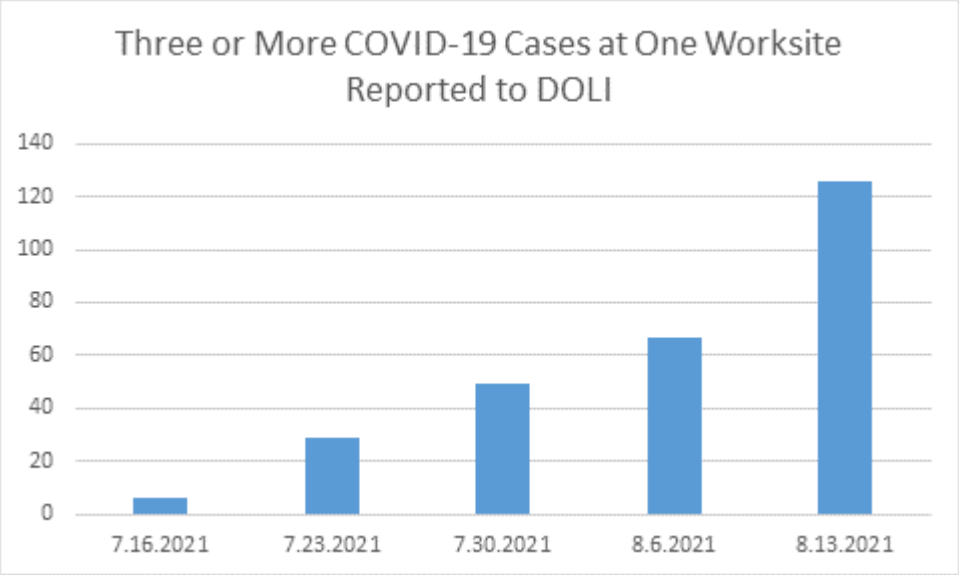
****There are Employers submitting multiple notifications. Some of the hospitalizations reported to VOSH later resulted in fatalities.*

Fatalities - *Calendar Year*	2020	2021	% [2021]
Total	57	26	31
COVID-19	31	13	*50%*
Fall	8	6	*23%*
Struck-By	12	5	*19%*
Caught-in	5	1	*4%*
Asphyxiation	0	1	*4%*
Electrocution	1		*0%*

- Increase in Outbreak Reports to DOLI

The Standard requires employers to report to DOLI outbreaks of three or more employees at one worksite being infected with COVID-19 within a 14 day period. For all of June and the first two weeks in July, those report numbers had been averaging 5 per week (the lowest averages since early in the pandemic).

For the third week in July the number increased to 29 and in succeeding weeks it has now reached 126 reports during the week ending August 13, 2021 – a level not seen since February 26, 2021.



- APNews.com, June 24, 2021, " Nearly all COVID deaths in US are now among unvaccinated."[540]

  " Nearly all COVID-19 deaths in the U.S. now are in people who weren't vaccinated, a staggering demonstration of how effective the shots have been and an indication that deaths per day — now down to under 300 — could be practically zero if everyone eligible got the vaccine.

  An Associated Press analysis of available government data from May shows that "breakthrough" infections in fully vaccinated people accounted for fewer than 1,200 of more than 853,000 COVID-19 hospitalizations. That's about 0.1%.

  And only about 150 of the more than 18,000 COVID-19 deaths in May were in fully vaccinated people. That translates to about 0.8%, or five deaths per day on average.

  The AP analyzed figures provided by the Centers for Disease Control and Prevention. The CDC itself has not estimated what percentage of hospitalizations and deaths are in fully vaccinated people, citing limitations in the data.

  Among them: Only about 45 states report breakthrough infections, and some are more aggressive than others in looking for such cases. So the data probably understates such infections, CDC officials said.

[540] https://apnews.com/article/coronavirus-pandemic-health-941fcf43d9731c76c16e7354f5d5e187

Still, the overall trend that emerges from the data echoes what many health care authorities are seeing around the country and what top experts are saying.

Earlier this month, Andy Slavitt, a former adviser to the Biden administration on COVID-19, suggested that 98% to 99% of the Americans dying of the coronavirus are unvaccinated.

And CDC Director Dr. Rochelle Walensky said on Tuesday that the vaccine is so effective that "nearly every death, especially among adults, due to COVID-19, is, at this point, entirely preventable." She called such deaths 'particularly tragic.'"

- WRIC.com, Richmond, Virginia, June 23, 2021, "State's vaccine coordinator: Delta variant is spreading, gives look into what school may look like in the fall"[541]

  "Virginia hit the benchmark for vaccinations earlier this week, but the state's vaccine coordinator, Dr. Danny Avula, says there is still more work to be done.

  On Monday, Governor Ralph Northam reported 70% of adults in Virginia have received at least one dose of the vaccine, but there are segments of the Commonwealth still reporting a 30% or 40% vaccination rate. It comes as the delta variant is already starting to spread.

  'At the end of May the Delta variant was about 2% of our new infections and as of last week it was 10% and I think it's going to be much more than that,' Avula told our sister station, WAVY.

  The good news is that those fully vaccinated don't need to worry. Luckily, he said the vaccine appears to be working against that variant and others that have emerged so far. 'So far, I think we've been lucky,' Avula said. 'These variants like the U-K variant, the alpha the delta, that have really emerged in different countries – our vaccines have been incredibly effective against them.'

  So, what about the rest of the population who hasn't gotten the shot?
  'What that means is that kids who are not vaccinated will likely at some point be vectors – the will spread this new variant widely,' Avula stated.
  The concern then becomes spreading the virus to unvaccinated adults.

  'So, for segments in our community like in Southern or Southwest Virginia where the adult vaccination rate is about 40% that means that kids will contribute to the spread of disease – if we're not careful," he said.'"

[541] https://www.wric.com/health/coronavirus/states-vaccine-coordinator-delta-variant-is-spreading-gives-look-into-what-school-may-look-like-in-the-fall/

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)"[542] 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

[542] 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**[543], 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.

[543] 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.

Priority	Category
First	Imminent Danger as defined in the VOSH Administrative Regulation Manual (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.2[544] 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)[545] 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.

[544] https://law.lis.virginia.gov/vacode/40.1-49.4/

[545] https://townhall.virginia.gov/L/GetFile.cfm?File=C:\TownHall\docroot\GuidanceDocs\181\GDoc_DOLI_5354_v6.pdf

The FOM[546] 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;

[546] *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.

ATTACHMENT G: DETERMINING CAUSE OF DEATH (CDC)

Report on "How COVID-19 Deaths Are Counted".[547]

"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.

[547] https://www.scientificamerican.com/article/how-covid-19-deaths-are-counted1/

'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 guidelines[548] 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."[549]

[548] https://www.cdc.gov/nchs/covid19/coding-and-reporting.htm
[549] *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(d)(2)	Other-than-Serious	PPE
1910.132(d)(2)	Other-than-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(c)(1)	Serious	Respiratory Protection
1910.134(c)(1)	Serious	Respiratory Protection
1910.134(c)(1)	Serious	Respiratory Protection
1910.134(c)(1)	Serious	Respiratory Protection
1910.134(c)(1)	Serious	Respiratory Protection
1910.134(c)(1)	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)(1)	Serious	Respiratory Protection
1910.134(e)(1)	Serious	Respiratory Protection
1910.134(e)(1)	Serious	Respiratory Protection
1910.134(e)(1)	Serious	Respiratory Protection
1910.134(e)(1)	Serious	Respiratory Protection
1910.134(e)(1)	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(f)(2)	Serious	Respiratory Protection
1910.134(f)(2)	Serious	Respiratory Protection
1910.134(f)(2)	Serious	Respiratory Protection
1910.134(f)(2)	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

ATTACHMENT I: January 11, 2021, Economic Impact Proposed Standard for Infectious Disease Prevention of The Sars-Cov-2 Virus That Causes Covid-19, Prepared by Chmura Economics and Analytics

PREPARED FOR

Virginia Department of Labor and Industry

January 11, 2021

ECONOMIC IMPACT

PROPOSED STANDARD FOR INFECTIOUSDISEASE PREVENTION OF THE SARS-

COV-2 VIRUS THAT CAUSES COVID-19

Contents

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 ETSwith 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 directlyor indirectly to SARS-CoV-2 virus or COVID-19 disease-related hazards.

Chmura Economics & Analytics (Chmura) was commissioned to conductthe economic impact analysis for the standard 16VAC25-220. Chmura understands there are several components to the economic impactanalysis of the proposed regulation. The analysis will include the followingelements:

- 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 forinstalling 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 toaddress 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 SectorMaritime
- 1904, Recording and Reporting Occupational Injuries and Illness in General Industry, Construction, Agriculture andPublic 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 PublicSector 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 handlingsystems 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 employmentthat 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 throughreference 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 costsassociated 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," whichis 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 exposurelevels: very high, high, medium, and lower. However, since workplace standards for businesses with jobs having very highor 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 exposureto 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 insidesix 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, medicaltransport 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, orthe 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 throughthe 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 physicaldistancing from other persons."

While the technical categorization of exposure risk is based on job tasks or job functions, Chmura uses the same categoryof 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-2Virus 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 theregulation. The latest establishment data were for the year 2019, while the latest employment data were for the four quartersending 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 werefrom 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- orhigh-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

	All Businesses		Small Businesses		Percent of Small Business	
Exposure Risk Level	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 standardsthat 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

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[3] The affected businesses presented in this report are measured by the number business establishments, not the number of firms. For example, a bankcan 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

against an employee for exercising rights under this standard is prohibited. Those four sections do not result in incrementalcosts 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

a. 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 Virginiabusinesses 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 systemto 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 tobe 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 todevelop policies and procedures related to employees. It is estimated that approximately seven to ten hours may be neededto develop such policies. The Virginia Department of Health provides guidelines for this, which could reduce the time neededto 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 GovernorNortham 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 developa 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 fora 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 forVirginia businesses.

Section L involves sanitation and disinfection standards at the workplace. Section M requires employers to provide PPE foremployees 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 ineffect due to the Executive Order 72; while some restrictions were also in place under previous executive orders, includingAmended 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

b. 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.

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

c. 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 disproportionally affected. As Table 3.1 shows, many of those are rural counties with a large number of workers in the agriculture industry.

d. Projected Impact on Employment

The proposed regulations will have minimal impact on the overall employment of the state, since the estimated incrementalmonetary 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.

e. 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 are impacted based on 2019 firm counts with a total employment of 259,719 as of the second quarter of 2020.

4. Impact of 16VAC25-220-50

a. 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 thebusinesses 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 physicaldistancing from other persons.”

- **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, mayrange 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 theSARS-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/decedent-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 notgenerate 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 aphysical 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.

- **Section C**

Section C is related to administrative and work practice control of employers categorized as having very high and high riskexposures.

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 atwo to five minutes.

Subsections C.2 and C.3 require employers to follow existing guidelines and limit or restrict access to work areas, and theydo 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." Thissection 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 oxygenlevels 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

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[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 800employees.[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 withthe regulations related to the workplace. Other provisions under Subsection C.9, including increasing social distances anddelivering services remotely, do not generate additional costs for businesses as they are optional mitigation strategies.

- **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]

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[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.

b. Businesses and Entities Affected

16VAC25-220-50 will affect very high and high-risk businesses in Virginia, estimated at 13,522 establishments in 2019, withemployment of 361,408 as of the second quarter of 2020.

c. 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, andCharlottesville 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

d. 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 notsubstantial, 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.

e. Small Businesses Impact

It is estimated that the number of small businesses impacted is 13,474, based on 2019 data. with associated employmentof 266,627 as of the second quarter of 2020.

5. Impact of 16VAC25-220-60

a. 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 physicaldistancing from other persons."

- **Section B**

Section B.1 is related to the engineering controls for businesses with medium risks. Specifically, subsection B.1 states thatair-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 applicableto 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.

- **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 costof 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,

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[31] Source: 16VAC25-60-120 [General Industry], https://law.lis.virginia.gov/admincode/title16/agency25/chapter60/section120/

[32] 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

[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.zumaoffice.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.

- **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 ofthose costs are related to administrative controls, such as conducting screenings, installing physical barriers, andsupplying face coverings for non-employees. However, businesses can mitigate these costs by adopting more flexible work-site and work-hours arrangements.[39]

b. 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.

c. 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 mediumrisk businesses. As Table 5.1 shows, examples of those localities are Covington City, Greensville County, and Madison County.

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

d. Projected Impact on Employment

The proposed standard will have limited impact onthe overall employment of the state. Since theestimated incremental costs are not substantial, it is unlikely that any of affected businesses will needto 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.

e. Small Businesses Impact

It is estimated that number of small businesses impacted was 122,243, based on 2019 establishment estimate, withassociated employment of 1.6 million, as of the second quarter of 2020.

6. Impacts of 16VAC25-220-70

a. 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 estimatedthat risk assessment and implementation of respiratory protection programs may take approximately 10 to 20 hours of stafftime to develop. To mitigate such costs to businesses, Virginia Occupational Safety and Health Administration has provideda 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]

b. 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 employmentof 2.2 million as of the second quarter of 2020.

c. 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 WilliamsburgCity.

d. 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.

e. Small Businesses Impacts

It is estimated that number of small businesses impacted was 54,402, based on 2019 establishment

Table 6.1: Top Ten Localities with Highest Percentage of Employment inAffected 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	71.5
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

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

a. Economic Impact

16VAC25-220-80 is related to providing employees with training on the hazards and characteristics of the SARS-CoV-2 andCOVID-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 thetraining 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 touse.[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.

b. 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.

c. 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/2020/08/ETS-Abbreviated-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

d. Projected Impact on Employment

The proposed regulations will have no impact on the overall employment of the state. Since the estimated incremental costsare minimal, those efforts can be accommodated by existing staff of the businesses without the need to hire additional workers.

e. 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 veryhigh, 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 asof the second quarter of 2020.

Appendix: Summary Table of Impact

Table A1: Economic Impact Summary

Standard	Description	Include in the Study	Estimated Cost
16VAC25-220-40	**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	
16VAC25-220-50	**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
16VAC25-220-60	**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
16VAC25-220-70	Develop Preparedness and response plan	Staff Hours	10-20 hours
16VAC25-220-80	Training	Staff Hours	About one hour to each employee,
	Information sheet	Staff Hours	Minimal

Source: Chmura

ATTACHMENT J: DOLI ADDENDUM to January 11, 2021, Economic Impact Proposed Standard for Infectious Disease Prevention of the Sars-Cov-2 Virus That Causes Covid-19, Prepared by Chmura Economics and Analytics

COMMONWEALTH of VIRGINIA

DEPARTMENT OF LABOR AND INDUSTRY

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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,[550] 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 holding

[550] 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 sixty day written comment period[551] and a public hearing[552] along with obtaining an Economic Impact Analysis and holding a meeting to consider a final standard.[553]

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, [554] 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 72[555]) 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.

   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

[551] The sixty day comment period was held from August 27, 2020 to September 25, 2020.
[552] The initial public hearing was held September 30, 2020.
[553] 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.
[554] 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.
[555] 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

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:

<u>General Industry</u>

- 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

<u>Construction Industry</u>

- 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)

<u>Agriculture</u>

- 16VAC25-190, Field Sanitation (including handwashing facilities) in Agriculture

<u>Public Sector Maritime</u>

- 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/

COMMONWEALTH of VIRGINIA
DEPARTMENT OF LABOR AND INDUSTRY

C. Ray Davenport
COMMISSIONER

Main Street Centre
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August 25, 2021

SUBJECT: Proposed Amendments to the VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, 16VAC25-220, as Adopted by the Virginia Safety and Health Codes Board (Board) on June 29, 2021

Recommended Revisions to the Proposed Amendments, August 19, 2021

NOTE: For proposed amendments adopted by the Board, new language is underlined and removed language is struck through.

The Department of Labor and Industry (DOLI) has consulted with the Virginia Department of Health (VDH) about whether REVISIONS should be recommended to the Board's Proposed Amendments to the FPS originally adopted on June 29, 2021, in response to the CDC's updated guidance for fully vaccinated people issued on July 27, 2021 (requirement in certain situations for fully vaccinated employees to wear face coverings in areas of substantial or high transmission).
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

DOLI and VDH are in agreement that some REVISIONS should be recommended to the Board along with the Governor's amendment to 16VAC25-220-10.E.(https://www.doli.virginia.gov/wp-content/uploads/2021/07/Summary-of-Governor-Northams-Review-of-Proposed-Amendments-to-16VAC25-220-7.1.2021.pdf).

The attached document lays out the recommended changes from DOLI and VDH and are highlighted in yellow, (please note there were a few other relatively minor changes and some non-substantive error corrections as well). The Governor's amendment is located on page 6. The other revisions can be found on pages 3-5, 8, 10-12, 14-15, 19-22, 24, 26-27, 29-40, 42-43, 45-48, 50, 55, 59-61, 67-68, 71-73.

AUGUST 25, 2021

DRAFT REVISIONS TO PROPOSED AMENDMENTS

HIGHLIGHTED IN YELLOW

REVISIONS MADE ON AUGUST 25, 2021 HIGHLIGHTED IN BLUE

Recommended Revisions to the Proposed Amendments to VOSH Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19

As Adopted by the

Virginia Safety and Health Codes Board

on June 29, 2021

DEPARTMENT OF LABOR AND INDUSTRY

VIRGINIA OCCUPATIONAL SAFETY AND HEALTH (VOSH) PROGRAM

VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY (DOLI)

Effective Date: To be Determined

16VAC25-220

Chapter 220. Standard for Infectious Disease Prevention of the SARS-Co-V-2 Virus that Causes COVID-19

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 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.

1. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502, et seq., applicable to settings where any employee provides health care services or health care support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of ~~Virginia's 16VAC25-220~~ this chapter, except for 16VAC25-220-40 B 7 d and B 7 e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

2. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502 et seq., applicable to settings where any employee provides health care services or health care support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of ~~Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-Co-V-2 Virus That Causes COVID-19~~ this chapter, including 16VAC25-220-50, shall immediately

apply to such employers and employees in its place with no further action of the board required.

3. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502 et seq., applicable to all settings where any employee provides health care services or health care support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of ~~Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19~~ this chapter, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting, conduct a regular, special, or emergency meeting to determine whether there is a continued need for ~~Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19~~ this chapter, or whether it should be maintained, modified, or revoked.

C. This ~~standard~~ chapter 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, subsection A of § 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 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~~ the appropriate workplaces.

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. 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:~~

~~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 eight 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.~~ Reserved.

E. To the extent that an employer actually complies with a recommendation contained in current 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 current CDC guidelines, 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 current CDC guidelines.

~~F. A public or private institution of higher education that has received certification from the State Council of Higher Education for Virginia that the institution's reopening 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.~~

~~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 that 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.~~

~~H.~~ F. 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.

A. Adoption process.

1. This ~~standard~~ chapter 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 subdivision A 1 of this section within 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.

~~5. The Governor reviewed the standard under subdivision A 1 of this section, and the effective date is January 27, 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.~~

~~C. Within 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 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.~~

B. The requirements for this standard shall take effect on [DATE] except where otherwise noted.

C. The requirements for 16VAC25-220-70 shall take effect on [insert date 30 days after the effective date of this standard].

D. The training requirements in 16VAC25-220-80 shall take effect on [insert date 60 days after the effective date of this standard].

16VAC25-220-30. Definitions.

The following words and terms when used in this chapter 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.

"Aerosol-generating procedure" means a medical procedure that generates aerosols that can be infectious and are of respirable size. ~~For the purposes of this section, only~~ Only the following medical procedures are considered aerosol-generating procedures: open suctioning of airways; sputum induction; cardiopulmonary resuscitation; endotracheal intubation and extubation; non-invasive ventilation (e.g., BiPAP, CPAP); bronchoscopy; manual ventilation; medical/surgical/postmortem procedures using oscillating bone saws; and dental procedures involving: ultrasonic scalers; high-speed dental handpieces; air/water syringes; air polishing; and air abrasion.

"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 six to 12 air changes per hour (ACH) (six 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~~ means a dedicated negative pressure patient-care room, with special air handling capability, which is used to isolate persons with a suspected or confirmed airborne-transmissible infectious disease. AIIRs include both permanent rooms and temporary structures (e.g., a booth, tent or other enclosure designed to operate under negative pressure).

"Ambulatory care" means healthcare services performed on an outpatient basis, without admission to a hospital or other facility. It is provided in settings such as: offices of physicians and other health care professionals; hospital outpatient departments; ambulatory surgical centers; specialty clinics or centers (e.g., dialysis, infusion, medical imaging); and urgent care clinics. Ambulatory care does not include home healthcare settings. ~~for the purposes of this section.~~

"ASTM" means American Society for Testing and Materials.

"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 recordkeeping 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 the risk of spreading infection~~ using soap and water or other cleaning agents. Cleaning alone reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces.

"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 may be obtained from the VDH website and is assessed using, at a minimum, two metrics: new COVID-19 cases per 100,000 persons in the last 7 days and percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days. For each of these metrics, CDC classifies transmission values as low, moderate, substantial, or high. If the values for each of these two metrics differ (e.g., one indicates moderate and the other low), then the higher of the two should be used for decision-making.

CDC core indicators of and thresholds for community transmission levels of SARS-CoV-2:

Indicator Level	**Low**	**Moderate**	**Substantial**	**High**
New COVID-19 cases per 100,000 persons in the last 7 days	0–9.99	10.00–49.99	50.00–99.99	≥100.00
Percentage of positive SARS-CoV-2 diagnostic nucleic acid amplification tests in the last 7 days	<5.00	5.00–7.99	8.00–9.99	≥10.00

~~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;~~

~~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.).~~

"Confirmed COVID-19" 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.

"COVID-19" means Coronavirus Disease 2019, which is primarily a respiratory disease, caused by the SARS-CoV-2 virus.

"COVID-19 positive and confirmed COVID-19" refer to a person who has a confirmed positive test for, or who has been diagnosed by a licensed healthcare provider with COVID-19.

"COVID-19 test" means a test for SARS-CoV-2 that is:

1. Cleared or approved by the U.S. Food and Drug Administration (FDA) or is authorized by an Emergency Use Authorization (EUA) from the FDA to diagnose current infection with the SARS-CoV-2 virus; and

2. Administered in accordance with the FDA clearance or approval or the FDA EUA as applicable.

"Disinfecting" means using chemicals approved for use against SARS-CoV-2 virus, for example EPA-registered disinfectants, or non-EPA-registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2 virus, 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.

"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 time of the 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 could involve a customer, patient, or other person who is not fully vaccinated not wearing a face covering or personal protective equipment or coughing or sneezing directly into the face of an employee. An example of a chronic situation could involve a job task that requires an employee who is not fully vaccinated 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~~ chapter. The cost of corrective measures to be taken will not usually be considered as a factor in determining whether a violation of this ~~standard~~ chapter 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 support a VOSH decision to decline to take enforcement action.

"Elastomeric respirator" means a tight-fitting respirator with a facepiece that is made of synthetic or rubber material that permits it to be disinfected, cleaned, and reused according to manufacturer's instructions. It is equipped with a replaceable cartridge, canister, or filter.

"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~~ chapter 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.

"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 the level of 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.

"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. Health care (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. Health care (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, 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.);~~

~~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; and~~

~~6. Correctional facilities, jails, detention centers, and juvenile detention centers.~~

~~"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; 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 health care (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; correctional facilities, jails, detentions centers, and juvenile detention centers, 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:~~

~~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.~~

"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. Nonmedical disposable masks for single use that otherwise meet the definition of "face covering" in ~~16VAC25-220~~ this chapter, with the exception that they are not washable, are permissible to use as 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.

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 federal government agency, so it is not considered a form of personal protective equipment or respiratory protection equipment under VOSH laws, rules, regulations, and standards. Notwithstanding any other provisions in this definition, face coverings approved as having met ASTM standards for face coverings effective against the SARS-CoV-2 virus shall be considered to be in compliance with this ~~standard~~ chapter.

"Facemask" means a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA Emergency Use Authorization (EUA), or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as "medical procedure masks."

"Face shield" means a device, typically made of clear plastic, that:

1. is certified to ANSI/ISEA Z87.1, or

2. covers the wearer's eyes, nose, and mouth to protect from splashes, sprays, and spatter of body fluids, wraps around the sides of the wearer's face (i.e., temple-to-temple), and extends below the wearer's chin.

~~form of personal protective equipment made of transparent, impermeable materials 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.~~

"Feasible" as used in this ~~standard~~ chapter 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).

"Fully vaccinated" means a person is considered fully vaccinated for COVID-19 ≥2 weeks after they have received the second dose in a 2-dose series, or ≥2 weeks after they have received a single-dose vaccine, provided such vaccine has been FDA-approved, or authorized by an FDA Emergency Use Authorization (EUA), or authorized for emergency use by the World Health Organization (WHO).

"Hand sanitizer" means an alcohol-based hand rub containing at least 60% alcohol, unless otherwise provided for in this ~~standard~~ chapter.

"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 known or suspected to be infected with SARS-CoV-2 virus.~~

~~"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); health care employees providing only telemedicine services; a long distance truck driver.~~

"Health care services" mean services that are provided to individuals by professional healthcare practitioners (e.g., doctors, nurses, emergency medical personnel, oral health professionals) for the purpose of promoting, maintaining, monitoring, or restoring health. Health care services are delivered through various means including: hospitalization, long-term care, ambulatory care, home health and hospice care, emergency medical response, and patient transport. ~~For the purposes of this section, healthcare~~ Health care services include autopsies.

"Health care support services" mean services that facilitate the provision of health care services. Health care support services include patient intake/admission, patient food services, equipment and facility maintenance, housekeeping services, healthcare laundry services, medical waste handling services, and medical equipment cleaning/reprocessing services.

"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.

"Otherwise at-risk" means a person whose ability to have a full immune response to vaccination may have been affected by certain conditions, such as a prior transplant, as well as prolonged use of corticosteroids or other immune-weakening medications.

"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 for actual or potential exposure to SARS-CoV-2 or COVID-19 exposure may include, but is not limited to, gloves, safety glasses, goggles, ~~shoes, earplugs or muffs, hard hats,~~ respirators, surgical ~~/medical procedure~~ masks, ~~facemask~~ facemasks, impermeable gowns or coveralls, face shields, vests, and full body suits.

"Physical distancing" also called "social distancing" means a person keeping space between himself 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 travel distance is maintained from others around the edges or sides of the wall as well.

"Powered air-purifying respirator (PAPR)" means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

"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.~~ type of personal protective equipment (PPE) that is certified by NIOSH under 42 CFR Part 84 or is authorized under an Emergency Use Authorization (EUA) by the FDA. Respirators protect against airborne hazards by removing specific air contaminants from the ambient (surrounding) air or by

supplying breathable air from a safe source. Common types of respirators include filtering facepiece respirators, elastomeric respirators, and PAPRs. Face coverings, facemasks, and face shields are not respirators

"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~~ chapter or required by other provisions in the VOSH and OSHA standards.

"SARS-CoV-2" means the novel virus that causes coronavirus disease 2019, or COVID-19. Coronaviruses are named for the crown-like spikes on their surfaces.

"Severely immunocompromised" means a seriously weakened immune system that lowers the body's ability to fight infection and may increase the risk of getting severely sick from SARS-CoV-2, from 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 less than 200, combined primary immunodeficiency disorder, and receipt of prednisone greater than 20mg per day for more than 14 days. The degree of immunocompromise is determined by the treating provider, and preventive actions are tailored to each individual and situation.

"Signs of COVID-19" are medical conditions that can be objectively observed and may include fever, cough, shortness of breath or trouble breathing ~~or shortness of breath, cough~~, vomiting, new confusion, ~~bluish lips or face,~~ inability to wake or stay awake, pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone, 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).~~

"Surgical mask" means a mask that covers the user's nose and mouth and provides a physical barrier to fluids and particulate materials. The mask meets certain fluid barrier protection standards and Class I or Class II flammability tests. Surgical masks are generally regulated by FDA as Class II devices under 21 CFR 878.4040 – Surgical apparel.

"Suspected ~~to be infected with SARS-CoV-2 virus~~ COVID-19" 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)~~ been told by a licensed healthcare provider that they are suspected to have COVID-19; or is experiencing recent loss of taste and/or smell with no other explanation; or is experiencing both fever (≥100.4°F) and new unexplained cough associated with shortness of breath; or has symptoms consistent with the clinical criteria in the CDC national case definition and no other explanation for symptoms exist.

"Symptomatic" means a person is experiencing signs or symptoms attributed to COVID-19. A person may become symptomatic two to 14 days after exposure to the SARS-CoV-2 virus.

"Symptoms of COVID-19" are medical conditions 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, congestion or runny nose, nausea, ~~congestion or runny nose,~~ or diarrhea, etc.

"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~~ chapter 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.

"Vaccine" means a biological product authorized or licensed by the FDA to prevent or provide protection against COVID-19, whether the substance is administered through a single dose or a series of doses.

"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 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.~~ Employers shall have a policy in place to ensure compliance with the requirements in this section to protect employees from workplace exposure to the SARS-CoV-2 virus that causes the COVID-19 disease. Such policy shall have a method to receive anonymous complaints of violations. An employer that enforces its policy in good faith and resolves filed complaints shall be considered in compliance with this subsection.

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 exposed to the same hazard may be grouped for classification purposes.

Employers may rely on an employee's representation of being fully vaccinated, as defined herein, without requiring proof of vaccination; however, nothing in this ~~standard~~ chapter shall be construed to preclude an employer from requiring proof that an employee is fully vaccinated.

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 illness~~.

3. Serological testing, also known as antibody testing, is a test to determine if persons have been infected with SARS-CoV-2 virus. It has not been determined that persons who test positive for the presence of antibodies by serological testing 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.~~ <u>suspected or confirmed COVID-19.</u>

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~~ <u>suspected or confirmed COVID-19</u> 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 they are experiencing signs 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."~~ <u>suspected COVID-19.</u>

5. Employers shall not permit <u>suspected or confirmed COVID-19</u> 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~~ chapter shall prohibit an employer from permitting ~~an employee known or suspected to be infected with SARS-CoV-2 virus~~ a suspected or confirmed COVID-19 employee 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. Employers shall discuss with subcontractors and companies that provide contract or temporary employees the importance and requirement 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.~~ suspected or confirmed COVID-19. Subcontractor, contract, or temporary employees ~~known or suspected to be infected with the SARS-CoV-2 virus~~ who are suspected or confirmed COVID-19 shall not report to or be allowed to remain at the work site until cleared for return to work. Subcontractors shall not allow their suspected or confirmed COVID-19 employees ~~known or suspected to be infected with the SARS-CoV-2 virus~~ to report to or be allowed to remain at work or on a job site until cleared for return to work.

7. To the extent permitted by law, including HIPAA, employers shall establish a system to receive reports of positive ~~SARS-CoV-2~~ COVID-19 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~~ suspected or confirmed COVID-19) present at the place of employment within two days prior to symptom onset (or positive test if the employee is asymptomatic) until 10 days after onset (or positive test). 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 confirmed COVID-19 person ~~known to be infected with SARS-CoV-2 virus~~ in accordance with the requirements of the Americans with Disabilities Act (ADA) and other applicable federal and Virginia laws and regulations;

b. In the same manner as subdivision 7 a of this subsection, other employers whose employees were present at the work site during the same time period;

c. In the same manner as subdivision 7 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~~ COVID-19 positive test for any employees or residents in the building. This notification will allow the owner to take the necessary steps to ~~sanitize~~ clean 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;

d. The Virginia Department of Health ~~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 work site 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~~ COVID-19 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 investigation. After the outbreak investigation is closed, subsequent identification of two or more confirmed cases of COVID-19 ~~during a declared emergency~~ shall be reported, as required by this subdivision B 7 d. 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

e. The Virginia Department of Labor and Industry within 24 hours of the discovery of ~~three~~ 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~~ COVID-19 during that 14-day time period. A reported positive ~~SARS-CoV-2 virus~~ COVID-19 test does not need to be reported more than once and will not be used for the purpose of identifying more than one grouping of ~~three~~ two or more cases, or more than one 14-day period.

8. 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. Employers shall develop and implement policies and procedures for ~~employees known or suspected to be infected with the SARS-CoV-2 virus~~ suspected or confirmed COVID-19 employees to return to work.

~~1. 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 conditions have been met:~~

~~a. The employee is fever-free (below 100.0° F) for at least 24 hours, without the use of fever-reducing medications;~~

~~b. Respiratory symptoms, such as cough and shortness of breath have improved; and~~

~~c. 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, and the employer shall 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.~~

~~2. 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.~~

1. If the employer knows an employee is COVID-19 positive, regardless of vaccination status then the employer must immediately remove that employee from the worksite and

keep the employee removed until they meet the return to work criteria in ~~16VAC25-220-40-C-3~~ subdivision C 3 of this subsection.

2. If the employer knows an employee is suspected COVID-19, regardless of vaccination status then the employer must immediately remove that employee from the worksite and either:

a. Keep the employee removed until they meet the return to work criteria in ~~16VAC25-220-40-C-3~~ subdivision C 3 of this subsection; or

b. Keep the employee removed and provide a COVID-19 polymerase chain reaction (PCR) test at no cost to the employee.

(1) If the test results are negative, the employee may return to work immediately.

(2) If the test results are positive, the employer must comply with ~~16VAC25-220-40-C-1~~ subdivision C 1 of this subsection.

(3) If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with ~~16VAC25-220-40-C-1~~ subdivision C 1 of this subsection. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons.

3. The employer must make decisions regarding an employee's return to work after a COVID-19-related workplace removal in accordance with guidance from a licensed healthcare provider, a VDH public health professional, or CDC's "Isolation Guidance" (hereby incorporated by reference); and CDC's "Return to Work Healthcare Guidance" (hereby incorporated by reference). If an employee has a known exposure to someone with

COVID-19, the employee must follow any testing or quarantine guidance provided by a VDH public health professional.

~~3~~ 4. For purposes of this section, COVID-19 testing is considered a "medical examination" under § 40.1-28 of the Code of Virginia. Employers shall not require 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 ~~this~~ subdivision C 3 of this subsection.

D. Unless otherwise provided in this ~~standard~~ chapter, employers shall establish and implement policies and procedures that ensure employees that are not fully vaccinated and otherwise at-risk 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. 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~~.~~; and

3. Provide that such requirements do not apply to fully vaccinated employees.

E. Access to common areas, breakrooms, or lunchrooms shall be closed or controlled. This subsection does not apply to fully vaccinated employees.

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:

1. At the entrance of the designated common area or room, 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 for employees who are not fully vaccinated~~.~~;

2. Employers shall limit occupancy of the designated common area or room so that occupants who are not fully vaccinated can maintain physical distancing from each other. Employers shall enforce the occupancy limit~~.~~;

3. ~~Employees shall be required to clean and disinfect the immediate area in which they were located prior to leaving, or 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).~~ When no suspected or confirmed COVID-19 persons are known to have been in a space, the employer shall clean the common area, breakroom, or lunchroom once per shift~~.~~; and

4. Handwashing 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~~ an employee is occupying a vehicle or other form of transportation with one or more employees or other persons for work purposes, employers shall use the hierarchy of hazard controls to mitigate the hazards associated with SARS-CoV-2 and COVID-19 to prevent employee exposures in the following order (This subsection does not apply to fully vaccinated employees in areas of low to moderate community transmission and except as otherwise noted):

1. Eliminate the need for employees to share work vehicles or other transportation and arrange for alternative means for additional employees to travel to work sites.

2. Provide access to fresh air ventilation (e.g., windows). Do not recirculate cabin air.

3. When physical distancing cannot be maintained, establish procedures to maximize separation between employees as well as other persons during travel (e.g., setting occupancy limits, sitting in alternate seats, etc.).

4. When ~~employees~~ an employee who is not fully vaccinated must share a work ~~vehicles~~ vehicle or other transportation with one or more employees or other persons because no other alternatives are available, such employees shall be provided with and wear respiratory protection, such as an N95 filtering face piece respirator, or a face covering at the option of the employee. When an employee who is fully vaccinated must share work vehicles or other transportation with one or more employees or other persons in areas of substantial or high community transmission because no other alternatives are available, such employees shall be provided with and wear face coverings.

5. The employer shall ensure compliance with respiratory protection and personal protective equipment standards applicable to the employer's industry (e.g., when one or

more employees is accompanying a suspected or confirmed COVID-19person in an ambulance).

~~5~~ 6. 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 or other transportation with other employees or persons.

Notwithstanding anything to the contrary in this ~~standard~~ chapter, the Secretary of ~~Commerce and Trade~~ Labor may exercise discretion in the enforcement of an employer's failure to provide PPE required by this ~~standard~~ chapter, if the employer demonstrates that the employer:

a. Is exercising due diligence to come into compliance with such requirement; and

b. Is implementing alternative methods and measures to protect employees that are satisfactory to the Secretary of ~~Commerce and Trade~~ Labor after consultation with the ~~commissioner~~ Commissioner of Labor and Industry and the Secretary of Health and Human Services.

7. For commercial motor vehicles or trucks, if the driver is the only person in the vehicle or truck, or the vehicle or truck is operated by a team who all live in the same household and are the only persons in the vehicle, an employer whose drivers complied with the above-referenced language would be considered to be in compliance with ~~16VAC25-220-40~~ subdivisions F 1 through F 5.

G. ~~Where the nature of an employee's work or the work area does not allow the employee to observe physical distancing requirements, employers shall ensure compliance with respiratory~~

~~protection and personal protective equipment standards applicable to its industry.~~ Employers shall provide and require employees that are not fully vaccinated, fully vaccinated employees in areas of substantial or high community transmission, and otherwise at-risk employees (because of a prior transplant or other medical condition), to wear face coverings or surgical masks while indoors, unless their work task requires a respirator or other PPE. Such employees shall wear a face covering or surgical mask that covers the nose and mouth to contain the wearer's respiratory droplets and help protect others and potentially themselves. This subsection does not apply to fully vaccinated employees in areas of low to moderate community transmission, and except as otherwise noted.

~~1.~~ The following are exceptions to the requirements for face coverings, facemasks or surgical masks for employees that are not fully vaccinated and fully vaccinated employees in areas of substantial or high community transmission:

~~a~~ 1. When an employee is alone in a room.

~~b~~ 2. While an employee is eating and drinking at the workplace, provided each employee who is not fully vaccinated is at least ~~6~~ six feet away from any other person, or separated from other people by a physical barrier.

~~c~~ 3. When employees are wearing respiratory protection in accordance with 1910.134 or this ~~standard~~ chapter.

~~d~~ 4. When it is important to see a person's mouth (e.g., communicating with an individual who is deaf or hard of hearing) and the conditions do not permit a facemask that is constructed of clear plastic (or includes a clear plastic window). In such situations, the

employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it.

~~e~~ 5. When employees cannot wear facemasks due to a medical necessity, medical condition, or disability as defined in the Americans with Disabilities Act (42 USC § 12101 et seq.), or due to a religious belief. Exceptions must be provided for a narrow subset of persons with a disability who cannot wear a facemask or cannot safely wear a facemask, because of the disability, as defined in the Americans with Disabilities Act (42 USC § 12101 et seq.), including a person who cannot independently remove the facemask. The remaining portion of the subset who cannot wear a facemask may be exempted on a case-by-case basis as required by the Americans with Disabilities Act and other applicable laws. In all such situations, the employer must ensure that any such employee wears a face shield for the protection of the employee, if their condition or disability permits it. Accommodations may also need to be made for religious beliefs consistent with Title VII of the Civil Rights Act of 1964 (42 USC § 2000e et seq).

~~f~~ 6. When the employer can demonstrate that the use of a facemask presents a hazard to an employee of serious injury or death (e.g., arc flash, heat stress, interfering with the safe operation of equipment). In such situations, the employer must ensure that each employee wears an alternative to protect the employee, such as a face shield, if the conditions permit it. Any employee not wearing a facemask must remain at least ~~6~~ six feet away from all other people unless the employer can demonstrate it is not feasible. The employee must resume wearing a facemask when not engaged in the activity where the facemask presents a hazard.

Note to ~~16VAC25-220-40 G 1 d, G 1 e, and G 1 f~~ subdivisions 4, 5, and 6 of this subsection: The employer may determine that the use of face shields, without facemasks, in certain settings is not appropriate due to other infection control concerns.

~~g~~ 7. Where a face shield is required to comply with this paragraph or is otherwise required by the employer, the employer must ensure that face shields are cleaned at least daily and are not damaged. When an employee provides a face shield that meets the definition of that term in 16VAC25-220-30, the employer may allow the employee to use it and is not required to reimburse the employee for that face shield.~~2.~~ Notwithstanding anything to the contrary in this standard, the Secretary of Labor may exercise discretion in the enforcement of an employer's failure to provide PPE required by this ~~standard~~ chapter, if the employer demonstrates that the employer:

a. Is exercising due diligence to come into compliance with such requirement; and

b. Is implementing alternative methods and measures to protect employees that are satisfactory to the Secretary of Labor after consultation with the Commissioner of Labor and Industry and the Secretary of Health and Human Services.

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.~~ Reserved.

I. When required by this ~~standard~~ chapter, face coverings shall be worn over the wearer's nose and mouth and extend under the chin.

J. ~~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:~~

~~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.~~

~~2. To the extent feasible, employees wearing face shields in accordance with this subsection shall observe physical distancing requirements in this standard.~~

~~3. 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.~~

~~4. Disposable face shields shall only be worn for a single use and disposed of according to manufacturer instructions.~~

~~5. Reusable face shields shall be cleaned and disinfected after each use according to manufacturer instructions.~~ Reserved.

K. ~~Requests to the Department of Labor and Industry 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 of Labor and Industry consultation with the Office of the Attorney General.~~ Reserved.

L. Sanitation and disinfecting.

1. In addition to the requirements contained in this ~~standard~~ chapter, 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.~~ Reserved.

3. In addition to the requirements contained in this ~~standard~~ chapter, employers shall comply with the VOSH hazard communication standard applicable to the employers' industry for cleaning and disinfecting materials and hand sanitizers. (e.g., 16VAC25-90-1910-1200; 16VAC25-175-1926.59).

4. Areas in the place of employment where ~~employees or other persons known or suspected to be infected with the SARS-CoV-2 virus~~ suspected or confirmed COVID-19 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.~~ as follows:

a. The provisions in subdivisions 4 b, 4 c, and 4 d of this subsection do not apply to healthcare settings or for operators of facilities such as food and agricultural production or processing workplace settings, manufacturing workplace settings, or food

preparation and food service areas where specific regulations or practices for cleaning and disinfection may apply.

b. If less than 24 hours have passed since the person who is sick or diagnosed with COVID-19 has been in the space, clean and disinfect the space.

c. If more than 24 hours have passed since the person who is sick or diagnosed with COVID-19 has been in the space, cleaning is enough. You may choose to also disinfect depending on certain conditions or everyday practices required by your facility.

d. If more than ~~3~~ three days have passed since the person who is sick or diagnosed with COVID-19 has been in the space, no additional cleaning or disinfecting beyond regular cleaning practices is needed.

5. All common spaces, including bathrooms (including port-a-johns, privies, etc.), frequently touched surfaces, and doors, shall at a minimum be cleaned ~~and disinfected~~ at least once during or at the end of the shift~~. Where~~ (where multiple shifts are employed, such spaces shall be cleaned ~~and disinfected~~ no less than once every 12 hours), except as otherwise provided below:

a. The provision in subdivision 5 b of this subsection does not apply to healthcare settings or for operators of facilities such as food and agricultural production or processing workplace settings, manufacturing workplace settings, or food preparation and food service areas where specific regulations or practices for cleaning and disinfection may apply.

b. When no suspected or confirmed COVID-19 persons are known to have been in a space, clean once a day.

6. All shared tools, equipment, workspaces, and vehicles shall be cleaned ~~and disinfected~~ prior to transfer from one employee to another. This subsection does not apply when the transfer is from one fully vaccinated employee to another fully vaccinated employee.

7. 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, or non-EPA-registered disinfectants that otherwise meet the EPA criteria for use against SARS-CoV-2.

8. 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.) are followed.

9. 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.

10. Mobile crews shall be provided with hand sanitizer where feasible for the duration of work at a work site or client or customer location 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.

11. ~~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, employers shall ensure that protective measures are put in place to prevent cross-contamination between tasks, areas, and personnel.

M. Unless otherwise provided in this ~~standard~~ chapter, 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~~ healthcare services or healthcare support services..

A. Scope and application.

1. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board and take effect, application of ~~Virginia's 16VAC-25-220~~ this chapter, except for 16VAC-25-220-40 B.7.d and e, and 16VAC25-220-90, to such covered employers and employees subject to the standard shall be suspended while the federal COVID-19 Emergency Temporary Standard remains in effect.

2. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502, et seq., applicable to settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed or invalidated by a state or federal court, the provisions of ~~Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19~~ this chapter, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required.

3. Should the federal COVID-19 Emergency Temporary Standard, 29 CFR § 1910.502, et seq., applicable to all settings where any employee provides healthcare services or healthcare support services, be adopted by the Virginia Safety and Health Codes Board but later be stayed by federal OSHA, or otherwise revoked, repealed, declared unenforceable, or permitted to expire, the provisions of ~~Virginia's 16VAC25-220, Final Permanent~~

~~Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19~~ this chapter, including 16VAC25-220-50, shall immediately apply to such employers and employees in its place with no further action of the Board required. In addition, the Virginia Safety and Health Codes Board shall within 30 days notice a regular, special, or emergency meeting/conduct a regular, special, or emergency meeting to determine whether there is a continued need for ~~Virginia's 16VAC25-220, Final Permanent Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19~~ this chapter, or whether it should be maintained, modified, or revoked.

~~A.~~ 4. 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.

5. Except as otherwise provided in this subsection, this section applies to all settings where any employee provides healthcare services or healthcare support services.

6. This section does not apply to the following:

a. the provision of first aid by an employee who is not a licensed healthcare provider;

b. the dispensing of prescriptions by pharmacists in retail settings;

c. non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;

d. well-defined hospital ambulatory care settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter those settings;

e. home healthcare settings where all employees are fully vaccinated and all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not present;

f. healthcare support services not performed in a healthcare setting (e.g., off-site laundry, off-site medical billing); or

g. telehealth services performed outside of a setting where direct patient care occurs.

Note to paragraphs 16VAC25-220-50 A 5 d and 5 e: VOSH does not intend to preclude the employers of employees who are unable to be vaccinated from the scope exemption in paragraphs 16VAC25-220-50 A 5 d and 5 e. Under various anti-discrimination laws, workers who cannot be vaccinated because of medical conditions, such as allergies to vaccine ingredients, or certain religious beliefs may ask for a reasonable accommodation from their employer. Accordingly, where an employer reasonably accommodates an employee who is unable to be vaccinated in a manner that does not expose the employee to COVID-19 hazards (e.g., telework, working in isolation), that employer may be within the scope exemption in paragraphs 16VAC25-220-50 A 5 d and 5 e.

7. Where a healthcare setting is embedded within a non-healthcare setting (e.g., medical clinic in a manufacturing facility, walk-in clinic in a retail setting), this section applies only to the embedded healthcare setting and not to the remainder of the physical location.

~~8. In well-defined areas where there is no reasonable expectation that any person with suspected or confirmed COVID-19 will be present, paragraphs (f), (h), and (i) of this section do not apply to employees who are fully vaccinated.~~

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 known or suspected persons to be infected with the SARS-CoV-2 virus~~ suspected or confirmed COVID-19 persons; and

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

(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);

(2) In ground transportation settings, 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 virus and COVID-19 disease transmission to employees, and 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;

(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;

(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;

(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

(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; and

(9) Check filters to ensure they are within service life and appropriately installed.

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

2. Reserved. ~~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 ~~known or suspected to be infected with the SARS-CoV-2 virus~~ who are suspected or confirmed COVID-19, where feasible and available, shall be placed in airborne infection isolation room (AIIRs).

4. Employers shall use AIIRs when available for performing aerosol-generating procedures on suspected or confirmed COVID-19 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~~ suspected or confirmed COVID-19 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~~ suspected or confirmed COVID-19. Diagnostic laboratories that conduct routine medical testing and environmental specimen testing for COVID-19 are not required to operate at BSL-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 virus and COVID-19 disease 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 health care facilities, employers shall follow existing guidelines and facility standards of practice for identifying and isolating infected persons and for protecting employees.

3. 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 subdivision C 3.

4. Employers shall post signs requesting patients and family members to immediately report signs or symptoms of respiratory illness on arrival at the health care facility and use disposable face coverings.

5. Employers shall offer enhanced medical monitoring of employees during COVID-19 outbreaks.

6. 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.

7. In health care settings, 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.

8. Employers shall provide face coverings to suspected COVID-19 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 (i.e., for medical evaluation and care or to return home).

9. Where feasible, employers shall:

a. Implement flexible work site (e.g., telework).

b. Implement flexible work hours (e.g., staggered shifts).

c. Increase physical distancing between employees at the work site 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). ~~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:~~

~~1. 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). 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, employers shall:~~

~~a. 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;~~

~~b. Communicate selection decisions to each affected employee; and~~

~~c. Select PPE that properly fits each affected employee.~~

~~2. 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.~~

~~4.~~ 1. Unless contraindicated by a hazard assessment and equipment selection requirements in ~~subdivision 1 of this subsection~~ 16VAC25-90-1910.132, employees ~~classified as very high or high exposure risk~~ of employers covered by this section 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 suspected or confirmed COVID-19 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.

2. In addition, hazard assessment and equipment selection requirements may determine that respirators or other PPE are necessary in other circumstances to reduce exposure. When respirators are required, 16VAC25-90-1910.134 shall apply to all employees for that purpose.

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

A. The requirements in this section for employers with ~~hazards or job tasks classified as medium exposure risk~~ higher-risk workplaceswith mixed-vaccination status employees apply in addition to requirements contained in 16VAC25-220-40, 16VAC25-70, and 16VAC25-80.

Employers shall take the additional steps in subsections B, C, and D to mitigate the spread of COVID-19 for employees who are not fully vaccinated, employees who are fully vaccinated but work in a place of employment with substantial or high community transmission, and otherwise at-risk employees in workplaces (which include, but are not limited to, manufacturing, meat and poultry processing, high-volume retail and grocery, transit, seafood processing, correctional facilities, jails, detention centers, and juvenile detention centers) where there is heightened risk due to the following types of factors:

1. Where employees who are not fully vaccinated or otherwise at-risk employees are working close to one another, for example, on production or assembly lines. Such workers may also be near one another at other times, such as when clocking in or out, during breaks, or in locker/changing rooms.

2. Where employees who are not fully vaccinated or otherwise at-risk workers often have prolonged closeness to coworkers or potential frequent contact with members of the public who may not be fully vaccinated.

3. Where employees who are not fully vaccinated or otherwise at-risk workers work in enclosed indoor spaces with inadequate ventilation where other co-workers or members of the public are present.

4. Employees who are not fully vaccinated or otherwise at-risk employees who may be exposed to the infectious virus through respiratory droplets or aerosols in the air—for example, when employees who are not fully vaccinated or otherwise at-risk employees in a manufacturing or factory setting who have the virus. 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.

5. Other distinctive factors that may increase risk among these employees who are not fully vaccinated or otherwise at-risk employees include:

a. A common practice at some workplaces of sharing employer-provided transportation such as ride-share vans or shuttle vehicles; and

b. Communal housing, or living quarters onboard vessels with other employees who are not fully vaccinated or otherwise at-risk individuals.

B. Engineering controls.

1. Employers shall ensure that air-handling systems under their control:

a. Are maintained in accordance with the manufacturer's instructions; and

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

(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);

(2) In ground transportation settings, 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 virus and COVID-19 disease transmission to employees and 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;

(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;

(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;

(6) Have staff work in "clean" ventilation zones that do not include higher-risk areas such as visitor reception or exercise facilities (if open);

(7) Ensure exhaust fans in restroom facilities are functional and operating continuously when the building is occupied;

(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; and

(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~~ install physical barriers (e.g., such as clear plastic sneeze guards, etc.)~~,~~ for employees who are not fully vaccinated or otherwise at-risk employees, where such barriers will aid in mitigating the spread of SARS-CoV-2 virus transmission.

3. In workplaces (or well-defined work areas) with processing or assembly lines where there are employees who are not fully vaccinated or otherwise at-risk employees, working on food processing or assembly lines can result in virus exposure because these workplaces have often been designed for a number of employees to stand next to or across from each other to maximize productivity. Employers shall ensure proper spacing of employee who are not fully vaccinated or otherwise at-risk employees (or if not possible, appropriate use of barriers).

C. Administrative and work practice controls. To the extent feasible, employers shall implement the following administrative and work practice controls in all higher-risk workplaces where there are employees who are not fully vaccinated or otherwise at-risk employees:

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. Provide face coverings to suspected COVID-19 non-employees ~~suspected to be infected with SARS-C0V-2~~ 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).

3. ~~Implement flexible work site (e.g., telework).~~ Stagger break times or provide temporary break areas and restrooms to avoid groups of employees who are not fully vaccinated or otherwise at-risk employees congregating during breaks. Employees who are not fully vaccinated or otherwise at-risk employees shall maintain at least 6 feet of distance from others at all times, including on breaks.

4. ~~Implement flexible work hours (e.g., staggered shifts).~~ Stagger employee's arrival and departure times to avoid congregations of employees who are not fully vaccinated or otherwise at-risk in parking areas, locker rooms, and near time clocks.

5. ~~Increase physical distancing between employees at the work site to six feet.~~ Implement flexible work hours (e.g., staggered shifts).

6. ~~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~~. Provide visual cues (e.g., floor markings, signs) as a reminder to maintain physical distancing.

7. ~~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.).~~ In retail workplaces (or well-defined work areas within retail) where there are employees who are not fully vaccinated, fully vaccinated employees in areas of substantial or high community transmission, or otherwise at-risk employees:

a. Post signage ~~requesting~~ requiring face coverings for employees who are not fully vaccinated (or unknown-status) and fully vaccinated employees in areas of substantial

or high community transmission; and requesting face coverings for customers and other visitors.

b. Require physical distancing from other people who are not known to be fully vaccinated. If distancing is not possible, implement the use of barriers between work stations used by employees who are not fully vaccinated or otherwise at-risk employees and the locations customers will stand, with pass-through openings at the bottom, if possible.

c. Move the electronic payment terminal/credit card reader farther away from any employees who are not fully vaccinated or otherwise at-risk employees in order to increase the distance between customers and such employees, if possible.

d. Shift primary stocking activities of employees who are not fully vaccinated or otherwise at-risk employees to off-peak or after hours when possible to reduce contact between employees who are not fully vaccinated or otherwise at-risk employees and customers.

8. Deliver services remotely (e.g. phone, video, internet, etc.).

9. Deliver products through curbside pick-up or delivery.

~~10. 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.~~

~~11. Employers shall provide and require employees in customer or other person facing jobs to wear face coverings.~~

D. Personal protective equipment. This subsection does not apply to fully vaccinated employees. ~~Employers~~ Otherwise, employers covered by this section and not otherwise covered by the VOSH Standards for General Industry (16VAC25-90-1910.132) shall comply with the requirements of this subsection for a SARS-CoV-2 virus and COVID-19 disease related hazard assessment and personal protective equipment selection.

1. 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). 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, employers shall:

a. Except as otherwise required in the ~~standard~~ chapter, 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;

b. Communicate selection decisions to each affected employee; and

c. Select PPE that properly fits each affected employee.

2. 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~~ SARS-Co-V-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:~~ The following employers shall develop and implement a written Infectious Disease Preparedness and Response Plan:

1. ~~Very high and high shall develop and implement a written Infectious Disease Preparedness and Response Plan~~ Employers covered by 16VAC25-220-50; and

2. ~~Medium with 11 or more employees shall develop and implement a written Infectious Disease Preparedness and Response Plan.~~ Employers covered by 16VAC25-220-60 with 11 or more employees. In counting the number of employees, the employer may exclude fully vaccinated employees.

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~~. apply to those employees:

1. Covered by 16VAC25-220-50; and

2. Covered by 16VAC25-220-60, unless such employees are fully vaccinated.

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) The general public, customers, other employees, patients, and other persons;

(2) Persons ~~known or suspected to be infected with the SARS-CoV-2 virus~~ suspected or confirmed COVID-19 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 health care employees who have had unprotected exposures to ~~persons known or suspected to be infected with SARS-CoV-2 virus~~) suspected or confirmed COVID-19 persons;

(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~~ involve potential exposure to sources of the SARS-CoV-2 virus or COVID-19 disease; and

(4) 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.

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 30 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.

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 that impact employee safety and health, such as:

a. Increased rates of employee absenteeism (an understaffed business can be at greater risk for accidents);

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; and

d. Interrupted supply chains or delayed deliveries of safety and health related products and services essential to business operations.

5. Identify 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 about the <u>infection prevention</u> procedures at 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~~ <u>suspected or confirmed COVID-19 employees</u> away from work, including procedures for employees to report when they are experiencing signs 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 contract or temporary employees to the employer, and other persons accessing

the place of employment to comply with the requirements of this ~~standard~~ chapter 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~~ chapter, as provided for in 16VAC25-220-10 E~~, F, and G~~.

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 following employers shall provide training on the hazards and characteristics of the SARS-CoV-2 virus and COVID-19 disease to employees working at the place of employment :

1. Employers covered by 16VAC25-220-50; and

2. Employers covered by 16VAC25-220-60.

Employers may provide fully vaccinated employees with written information meeting the requirements of subsection 16VAC25-220-80 F in lieu of training. Where applicable, ~~The~~ 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 of this section shall include:

1. The requirements of this standard;

2. The mandatory and non-mandatory provisions in any applicable CDC guidelines or Commonwealth of Virginia guidance documents the employer is complying with, if any, in lieu of a provision of this ~~standard~~ chapter as provided for in 16VAC25-220-10 E~~, F, and G~~;

3. The characteristics and methods of transmission of the SARS-CoV-2 virus;

4. The signs and symptoms of COVID-19 disease;

5. Risk factors for severe COVID-19 illness including underlying health conditions and advancing age;

6. Awareness of the ability of persons pre-symptomatically and asymptomatically infected with SARS-CoV-2 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;

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; and

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.

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~~ trained in accordance with this section.

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 an employer relies on training conducted by another employer, 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.

D. When 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.

E. Employers ~~with hazards or job tasks classified at lower risk~~ not covered by 16VAC25-220-50 or 16VAC25-220-60 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~~ the SARS-Co-V-2 virus, ~~and~~ the signs and 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 F of this section, which an employer may utilize to comply with this subsection.

F. The information required under subsection E of this section shall include at a minimum:

1. The requirements of this ~~standard~~ chapter;

2. The characteristics and methods of transmission of the SARS-CoV-2 virus;

3. The signs and symptoms of COVID-19 disease;

4. The ability of persons pre-symptomatically and asymptomatically infected with SARS-CoV-2 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~~ chapter in 16VAC25-220-90.

16VAC25-220-90. Discrimination against an employee for exercising rights under this ~~standard~~ chapter 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~~ chapter, 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, provided that the PPE does not create a greater hazard to the employee or create a serious hazard for other employees. In situations where face coverings are not provided by the employer, 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~~ chapter, 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.

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~~ chapter shall limit an employee from refusing to do work or enter a location because of a reasonable fear of illness or death. The requirements of 16VAC25-60-110

contain the applicable requirements concerning discharge or discipline of an employee who has refused to complete an assigned task because of a reasonable fear of illness or death.