June 22, 2020

Re: "Emergency Temporary Standard, Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19"

To Whom it May Concern:

The AFL-CIO is a federation of 55 national and international unions and we represent more than 12.5 million working people in their workplaces, many in the Commonwealth of Virginia. Our 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. Without enforceable workplace safety standards, all workers will continue to be at serious risk of exposure to SARS-CoV-2, the virus responsible for the COVID-19 pandemic.

The AFL-CIO commends Virginia for being the first state to expeditiously propose a comprehensive standard to protect all workers from COVID-19. We urge the Safety and Health Codes Board to swiftly approve a meaningful emergency temporary standard, and not a regulation, so that the Commonwealth's Department of Labor and Industry and Board can continue to work towards a permanent standard to protect Virginia workers from occupational exposure to infectious diseases. As the governor directed in his recent order, as Virginia reopens, it is critical the state become more vigilant in improving workplace health and safety.

We support DOLI's approach to issue a programmatic standard. The very structure of a programmatic standard makes it extremely flexible and adaptable to different workplaces and to changing conditions. Other OSHA standards that are structured in a programmatic way, such as hazard communication, bloodborne pathogens, respiratory protection, process safety management, and others require employers to include key elements of the standard into their prevention plan, and at the same time apply to a variety of settings and conditions (https://www.osha.gov/shpguidelines/docs/Crosswalk_to_Existing_OSHA_Standards_7-9-18.pdf). This is a strong approach to preventing workplace exposures, and several improvements listed below will make this a stronger workplace standard.

COVID-19 poses a grave danger to Virginia workers and an enforceable standard is needed to protect them and prevent the spread of the virus.

Current federal and state approaches to minimizing occupational risk to SARS-CoV-2 are not working in Virginia. Workplaces have been central to the major outbreaks that have spread throughout communities and have strapped state resources in response. In Virginia and across the country, thousands of workers have become unnecessarily ill and many have died due to workplace SARS-CoV-2 exposures. In the early months of the outbreak, workplaces were unprepared to control infectious disease exposures and especially unprepared for a virus as contagious as this; essential workers paid the price. Now that others return to work at a rapid pace, many more are at significant risk of exposure and no standards are in place to protect those returning and those who have been working the entire pandemic. Improving working conditions so that workers are safe from the virus at work is necessary to keep communities safe.

In Virginia, many of the outbreaks are related to the workplace. The Virginia Department of Health reports 3,262 health care workers have been infected and many other outbreaks have occured at corrections, long term care, poultry processing, and other workplace facilities. (https://www.vdh.virginia.gov/coronavirus/) As the city of Harrisonburg resolution already in the record shows, there have been hundreds of cases of infections among poultry workers. According to the Centers for Medicare and Medicaid Services, just last week there were 183 newly confirmed COVID-19 infections and 181 newly suspected infections among nursing home staff. There have been a total of 956 confirmed and 1,520 suspected nursing home staff infections and 11 deaths among nursing home workers in Virginia. (https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp)

Existing tools have failed to prevent occupational exposures to the novel coronavirus. DOLI recognized that adequate mitigations strategies for COVID-19 are not already covered by VOSH standards and regulations and that guidelines cannot be enforceable. It is critical that Virginia move now to adopt the ETS to protect workers before the next wave hits and before more workers are exposed and infected.

We urge the board to make several amendments to strengthen the standard in order to adequately protect workers from and prevent the spread of COVID-19.

I. Employers must not be able to use compliance with any Centers for Disease Control and Prevention (CDC) guidelines as an adequate substitute for compliance with the Virginia standard. This provision must be completely removed.

Every Virginia employer must have an enforceable COVID-19 workplace safety plan if they are to remain open or reopen during the pandemic. Although the proposed provision (*See* §10 G) uses the phrase "CDC requirements," all CDC guidelines are strictly voluntary and not enforceable. Guidance must not supersede specific, enforceable government standards created with stakeholder feedback. An enforceable standard can require employers to do a risk assessment of their workplace and determine the risk of COVID-19 exposures, develop and implement a control plan according to the hierarchy of controls, train employees, and report and record cases to prevent the spread of the virus.

CDC guidelines simply provide suggestions on what employers can do, not must do. This allows each employer the discretion to implement, ignore, or selectively follow the guidelines. For example, the various CDC guidelines state that employers "should consider" implementing their suggestions "if possible." [https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html] This difference between standards and guidelines is pointed out by DOLI, as they assess "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." *See* briefing package p. 48.

CDC is not the agency that leads with occupational health and industrial hygiene expertise. Without this expertise, CDC guidelines have not incorporated longstanding and proven practices that prevent exposure to infectious diseases. CDC's guidelines have even been harmful; for example, CDC health care guidance that had been weakened and downgraded throughout this

pandemic resulted in many health care worker infections and deaths
[https://www.revealnews.org/article/31000-and-counting/]

II. The standard must be based on sound science and existing evidence.

A. The assessment and control requirements of the standard must clearly reflect airborne and asymptomatic transmission of the virus.

Scientific evidence on the transmission of the SARS-CoV-2 virus has grown since the beginning of the pandemic and it is scientifically verified and widely accepted that the virus is transmitted through both airborne and droplet sized respiratory particles. [https://doi.org/10.1016/S0140-6736(20)31183-1; https://www.cidrap.umn.edu/news-perspective/2020/03/commentary-covid-19-transmission-messages-should-hinge-science.] The DOLI recognized this mode of transmission stating, “SARS-CoV-2 is easily transmitted through the air from person-to-person through respiratory aerosols.” *See* Briefing Package, p. 3. Also, the disease can be spread by asymptomatic or -presymptomatic infected individuals. [https://doi.org/10.3201/eid2607.201595] All forms of SARS-CoV-2 transmission must be reflected throughout the proposed standard and clarified under the “types of contact” (*See* §10 D(2)(b)) so that employers account for airborne transmission when they assess risk, create infection plans and implement control measures.

Airborne transmission requires a greater level of respiratory protection (i.e., disposable N95 respirators and reusable elastomeric and powered air purifying respirators (PAPRs)) than droplet transmission alone (i.e., surgical masks, non-medical masks, face shields). Asymptomatic transmission requires additional control measures such as mandatory physical distancing, removal from work with infection or potential infection, 14 day quarantine periods without retaliation or loss of income, and reporting of cases to proper health authorities. Social distancing is integral to the reduction of the spread of the virus as airborne sized particles can travel farther distances than droplets and asymptomatic carriers can spread the disease without their knowledge.

There are some areas of the proposed standard where the important differences between transmission routes and the various levels of protection are clearly presented. We strongly support DOLI for these provisions; however, several need clarity or correction. These include:

- Face shields definition: Face shields are not respirators and do not protect from airborne particles; they only protect against droplets. *See* §30.
- PPE requirements: Surgical masks and respirators, while properly defined, are presented as equal forms of protection for high risk health care workers. Workers exposed to confirmed or suspected patients or workers in close contact with the general public or their co-workers require respirators (i.e., level of N95 or greater). *See* §50 C(5).
- PPE requirements (medium risk): The provisions must specify that respirators may be necessary if the airborne hazards are not mitigated by engineering and administrative controls. *See* §60 C(4). Additionally, the §60 C provisions must cross reference OSHA’s respiratory protection standard as outlined in the very high/high risk exposure category. *See* §50 C(4).

B. Serological testing requirements and recommendations must be removed from the standard as it is not reliable and does not provide meaningful information to keep workers safe from SARS-CoV-2.

Antibody (serological) testing is not reliable to determine thresholds for returning to work, and cannot be used to weaken safety protections that employers are required to provide under the law. The proposed standard conflicts with CDC guidelines that state these results should not be used for individual determinations due to the tests' lack of sensitivity and specificity. DOLI also recognized this when issuing this proposal. *See* Briefing Package, p. 37. This is backed by recent U.S. Equal Employment Opportunity Commission guidance concluding that federal disability law does not allow employers to require antibody testing for employees to return to work. Further, a recent study concluded that a person may only retain SARS-CoV-2 antibodies for two or three months, and that levels of SARS-CoV-2 antibodies can vary widely and depend on individuals' symptoms, where persons without symptoms had a weaker antibody response than those with symptoms. It is important to remember that the majority of individuals who test positive for COVID-19 are asymptomatic or presymptomatic. [https://www.nejm.org/doi/full/10.1056/NEJMe2009758.] Making any assumptions about workers' ability to be physically in a worksite and about their susceptibility to the virus based on antibody testing would be completely misleading and will place their coworkers at risk. Prohibitions on serological testing, however, should be expanded and moved to the discrimination section; please see below.

III. The proposal must more accurately reflect occupational exposures to COVID-19.

A. Risk must be categorized based on current exposure and infection rates in workplaces and the risk must be mitigated.

We agree that some jobs pose more risk of exposure to SARS-CoV-2 than others and that high risk job tasks require the implementation of more protective control measures. However, the "exposure risk levels" in the proposed standard are misguided, somewhat arbitrary and not based on true measures of risk to this virus. For example, the current risk model lumps meatpacking workers—where major outbreaks have occurred—into the same medium category as a chiropractor. A standard structure based on arbitrary risk categories can be dangerous because it can lock groups of workers into risk levels that require fewer protections than they need, even where major outbreaks are occurring. These outbreaks already have changed with time during different stages of the outbreak: early on health care workers were at the forefront of major exposures and as the pandemic progressed, meatpacking, correctional facilities, transportation and agriculture have faced waves of serious exposures. As the Commonwealth continues to reopen, outbreaks could begin to occur in workplaces formerly considered medium or low risk.

We urge the board to restructure the way the proposed standard assesses occupational risk and recognizes airborne transmission of exposure to the virus. The standard should require employers to assess the current risk of exposure depending on their worksite and current conditions and develop a plan to mitigate that risk. Risk to SARS-CoV-2 should take into account many factors, including:

- Focusing only on confirmed and suspected cases does not take into account widespread asymptomatic transmission of the virus;
- Everyone working with COVID-19 patients must continue to be labeled as very high risk, but focusing on confirmed and suspected cases only in health care misses workers in other settings who are at high risk due to other exposure and control factors;

- Due to airborne transmission of the virus, risk is increased by indoor environments (but outdoor workers are still at risk);
- Due to airborne transmission of the virus, risk is increased by the number of people in a space and their proximity to coworkers and to the public;
- Risk is increased by workers' inability to physically distance or isolate;
- Risk is increased by lack of respirators, and any gaps in training or fit-testing requirements where respirators are available;
- Any category designated as "low risk" should be narrowed and reserved for those who are truly low risk (i.e., those who can work in isolation).

To fully understand occupational risks, the definition of occupational exposure needs to be amended to accurately reflect workplace exposures, (i.e., all exposures that take place during the course of employment).

B. Section 40 of the standard must be amended to ensure that all employers create an infectious disease preparedness and response plan, mitigate the risk using the hierarchy of controls, and train their employees on the hazard, risks, plan and controls—not just those workplaces that fall in the higher risk categories in the proposed standard.

The methods of compliance in the infection plan must incorporate the hierarchy of controls and where respiratory protection and PPE are a control measure, they must be used in combination with other controls up the hierarchy (such as engineering and work practice controls) and they must be accompanied by effective training and fit testing. There are some areas of the proposed standard that clearly support the hierarchy of controls, but there are few specific places where the standard could be clearer, including:

- Engineering controls definition: The workplace must be redesigned to allow for social distancing. *See* §30.
- Physical distancing and PPE requirements: The provision should not allow the use of PPE until all engineering and administrative controls have been exhausted. *See* §40 F.
- Engineering controls in health care: airborne infection isolation rooms must be used for known or suspected COVID-19 patients and for performing aerosol-generating procedures. *See* §50 A(3)-(4).
- Ventilation: Air-controlled systems should be installed and maintained for all indoor work environments at risk. *See* §50 A(1) & §60 A(1).

Training should be required to ensure that all workers receive training on the symptoms associated with COVID-19, modes of transmission, control methods and their limitations, the medical surveillance program, and other information necessary for preventing worker exposure and COVID-19 spread. Training provides all at-risk (even low risk) employees with the most current information on the disease and knowledge to understand how their employer is assessing and mitigating risks. This is particularly important with novel infectious diseases and a disease that spreads as rapidly as COVID-19. The training must be provided during working hours and the training materials be given in appropriate content and vocabulary to the education, literacy and language of the workers receiving the training. Training should be systematically updated as new research and guidance on effective prevention strategies become available.

IV. The standard must include strong requirements for reporting and recordkeeping.

Positive cases among workers pose a potential exposure risk to other workers in the workplace whether or not the cases are work-related. In order to facilitate prompt follow-up and contact tracing for positive cases, the employer reporting requirements under Section 40 A(7) must be expanded to include prompt reporting of individual COVID-19 cases to the Virginia Department of Health within 24 hours of discovery of the case. In order to identify and investigate potential workplace outbreaks, the standard must require employer reporting to the DOLI of all outbreaks of two or more employees present at the place of employment within a 14 day period of testing positive for COVID-19 during that 14 day time period, whether the cases are determined to be work-related or not. .

V. Workers must be protected from all forms of discrimination and retaliation.

The proposed standard includes strong discrimination and retaliation provisions that apply to all workers. These provisions are essential to ensuring that workers are protected and have the confidence to speak out against unsafe work and use PPE that is available during this crisis. However, this provision must be strengthened to ensure that those who are exposed or test positive must be protected and using serological test results must be prohibited from being used to make decisions about returning employees to work. Workers shall not be discriminated against for contracting or previously contracting COVID-19.

Sincerely,

Rebecca L. Reindel

Safety and Health Director, AFL-CIO