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April 22, 2022

Mr. Douglas Parker
Assistant Secretary of Labor for OSHA
Occupational Safety and Health Administration
U.S. Department of Labor - OSHA
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Comments on Occupational Exposure to COVID-19 in Healthcare Settings; Occupational Safety and Health Administration; Docket No. OSHA-2020-0004

Dear Assistant Secretary Parker,

I am pleased to submit the following comments on the Occupational Safety and Health Administration's ("OSHA")'s permanent COVID-19 standard for healthcare, "Occupational Exposure to COVID-19; Emergency Temporary Standard" ("ETS"), Docket No. OSHA-2020-0004, published in the Federal Register of June 21, 2021, on behalf of the Association of Dental Support Organizations ("ADSO").

The ADSO is comprised of 78 members supporting over 11,000 dentists at more than 6,400 office locations, with millions of employees across thousands of workplaces in every state in the Nation. A common thread among our members is that they are responsible employers who care deeply about their employees' health and safety.

The Occupational Safety and Health Act ("OSH Act") section 6(b) requires that the agency make a finding of "significant risk" of workplace exposure. While there is certainly significant risk to employees in areas of healthcare facilities where COVID-19 positive patients are being treated, that risk simply does not exist inside dental office practices. This is at least in part because, as explained below, there is no reason to believe that those who are suspected or confirmed to have COVID-19 would come to dental offices. Additionally, dental employees are well protected by long-standing, industry-specific CDC infection control guidance and have high vaccination rates. As a result, there have been virtually zero instances of workplace COVID-19 transmission in dental offices, and no known outbreaks. Accordingly, because application of a permanent COVID-19 standard to dental offices will not "substantially reduce or eliminate significant risk of material impairment of health" as required by Section 6(b) of the OSH Act, we believe OSHA should expressly exclude the dental industry from the permanent standard.

If, however, OSHA is unwilling to exclude dental practices from the permanent standard, it is critical to ADSO members that in the standard OSHA preserve the exemption under which dental offices and operations were exempt from OSHA's Emergency Temporary Standard for COVID-19 ("Healthcare ETS" or "ETS") – 29 C.F.R. Section 1910.502(a)(2)(iii), providing an exemption for "[n]on-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" ("screening exemption").

Introduction and Background

At the outset of the pandemic, the United States saw 80 percent of its dental practices initially shuttered. Those that remained opened, did so to provide urgent and emergent dental care. However, by March of 2020, even though we knew little about the disease – the Cybersecurity and Infrastructure Security Agency ("CISA") identified dentists as part of the critical infrastructure workforce – dentists recognized the need to be supportive of our hospital systems by continuing to treat patients to reduce the number of dental patients entering the already fatigued emergency room departments nationwide. Despite the initial unknowns, dentists provided dental services willingly to meet the best interests of their patients, ensure appropriate and efficient use of PPE during times of shortage, and protect our medical systems.

Indeed, while we have not seen a pandemic of this magnitude in our lifetime, the dental industry has been prepared to deal with such a crisis for decades. Dental Support Organization ("DSO")-supported practices follow long-standing, industry-specific CDC infection control guidance that has protected our employees and patients and kept the provision of oral health care safe during outbreaks of respiratory disease such as the SARS and H1N1 outbreak. *See* CDC "Guidelines for Infection Control in Dental Healthcare Settings" (December 19, 2003) ("CDC dental IC guidance"). Importantly, this guidance was not written in a reactionary way to deal with COVID-19, but rather, was meant to withstand the test of time – and it has. Although ***this*** version is from 2003, the infection control practices therein have been implemented throughout our industry for almost half a century (the 2003 version simply reflects the most up-to-date version). Since the initial outbreak of the COVID-19 pandemic in early 2020, we have applied our guidance and maintained infection control practices to protect our dentists, dental hygienists and other staff who have worked in our offices to provide vital oral healthcare to their patients throughout virtually the entire pandemic, ***regardless*** of the ETS.

The limited (if any) utility of the ETS in keeping our industry safe can be broken down into three time periods. First, before the Healthcare ETS was issued, when the first reported cases of COVID-19 in the U.S. occurred during the middle of January 2020, through June 2021, our industry was able to keep employees and patients safe by immediately initiating any additional applicable parts of the CDC dental IC guidance. Next, when the ETS was issued in June 2021, through December 2021, the dental industry maintained its screening and barring practices to qualify under the screening exemption (and, as such, the ETS had little to no impact on our industry). And, when OSHA announced the withdrawal of the Healthcare ETS in December 2021, and since that time, the dental industry has been able to continue to keep employees and patients safe by continuing to adhere to its CDC dental IC guidance, including through the surge of 2022 as a result of the Omicron variant.

The Healthcare ETS was only in place for six out of the 27 months our country has been dealing with COVID-19. Nonetheless, DSOs have kept employees and patients safe throughout this 27-month time period. Indeed, there have been virtually zero instances of workplace COVID-19 transmission in dental offices, and no known outbreaks. As set forth below, the ASDO is confident that we can continue to keep employees and patients safe regardless of any new SARS-CoV-2 variants or any other respiratory diseases that our supported practice may encounter, and regardless of any COVID-19 specific permanent standard.

Nonetheless, we understand that OSHA has reopened the comment period in part to solicit comments on the removal of scope exemptions, including the screening exemption. *See* 87 FR 16426, 16427 (March 23, 2022). Under its "Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID–19 patients are screened out; home healthcare)" section, OSHA states:

> A final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of significant risk from exposure to COVID–19, rather than the finding of grave danger OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible. In view of this different risk finding, OSHA is considering whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk. OSHA seeks comment on this approach.

See id. To the extent OSHA does not provide a limited carve out for our industry, we believe removal of this exemption, at least as it applies to this industry, is unnecessary and unwise. Application of a standard that is similar to the ETS would be onerous – in fact impossible in many instances – for most dental offices, and based on the last 2+ years of safe operation without ***any*** outbreaks and virtually ***no*** workplace transmissions, would be completely unnecessary.

As a fundamental backdrop to these comments, we wish OSHA to recognize and focus on the critical distinction between the universe of patients serviced by healthcare personnel working in dental offices from those serviced by healthcare personnel working in hospitals. While the healthcare personnel in dental offices may be professionally equivalent to their hospital counterparts, there is a ***fundamental difference between the clientele treated***. Hospitals are designed to accept COVID-19 patients; dental offices are not. People with suspected or confirmed COVID-19 have good reason to go to the hospital for COVID-19 related treatment and care, but should not to go to the dentist's office. Additionally, regardless of the ETS, dental employers have had systems in place for over two years now to prevent COVID-19 persons from coming in if they have or are suspected of being infectious with the coronavirus. Thus, the healthcare personnel at dental offices are providing care to a universe of patients who already have been identified as not having COVID-19.

Beyond this, even if COVID-19 were to unknowingly enter the workplace via an asymptomatic patient or employee, the services provided at dental offices are fundamentally different than

those provided at hospitals: dental personnel simply do not treat COVID-19; healthcare workers in hospitals do, and the PPE required by approximately half the states and universally implemented based on CDC dental IC guidance, has been sufficient to prevent transmission.

I. OSHA Should Grant a Limited Exception for the Dental Industry Because There is No Significant Risk of COVID-19 Transmission

The ADSO respectfully asks OSHA to grant a limited exception to the permanent standard for the dental industry because there is no significant risk of COVID-19 transmission in our industry. As set forth above, the legal standard for Section 6(b) rulemaking is different from that for emergency rulemaking conducted under Section 6(c) of the OSH Act. As OSHA explains, "[a] final standard will be adopted under Section 6(b) of the OSH Act, which requires a finding of ***significant risk*** from exposure to COVID–19, rather than the finding of ***grave danger*** OSHA made in issuing the Healthcare ETS under Section 6(c) of the OSH Act. Section 6(b) requires that the standard substantially reduce or eliminate significant risk of material impairment of health to the extent feasible." *See* 87 FR at 16427 (emphasis added).

Here, there is serious question as to whether OSHA would have legal authority under Section 6(b)'s "significant risk of material impairment" standard to impose the healthcare COVID-19 standard on dental offices in light of the fact that dental offices do not draw persons suspected to have or with COVID-19 into their offices, and because of the long-standing, industry-specific infection control procedures recommended by CDC and universally practiced in all U.S. dental offices. *See* CDC "Guidelines for Infection Control in Dental Healthcare Settings" (December 19, 2003).

First, as mentioned above, dental employers do not draw suspected or confirmed COVID-19 patients into their offices. Unlike hospitals or urgent care centers, there is no reason for someone who believes they have or actually does have COVID-19 to go to the dentist. In this regard, there is no reason to believe dental offices are any different from, say, office settings.

Additionally, and also as mentioned above, the dental industry adheres to long-standing, industry-specific infection control procedures recommended by CDC. These CDC guidelines are robust and comprehensive – and should look familiar to current COVID-19 mitigation strategies. They cover topics such as education and training; immunization programs; exposure prevention and postexposure management; medical conditions, work-related illness, and work restrictions; exposure prevention methods; hand hygiene; personal protective equipment ("PPE"), including masks, protective eyewear, face shields, protective clothing, and gloves; sterilization and disinfection of patient-care items; environmental infection control; etc. *See id.* And importantly, they center around employee – or, as the guidelines call them, dental health-care personnel ("DHCP") – safety. *See id.* Indeed, per a May 12, 2021 research article (published before the Healthcare ETS took effect), "the risk for transmission of SARS-CoV-2 and other respiratory pathogens from aerosolized saliva in dental operatories is moderately low and ***current infection control practices are adequately robust to protect personnel and patients alike***." *See* Journal of Dental Research "Sources of SARS-CoV-2 and Other Microorganisms in Dental Aerosols" (May 12, 2021) (emphasis added).

While the ADSO understands that it may be concerning to OSHA that these are just "guidelines," in reality, these practices are legally mandated in over half the states in the country (and universally implemented even where not legally mandated). For example, in Massachusetts, "[a]ll persons licensed by the Board and all practices providing dental services are required to operate in compliance with the current Recommended Infection Control in Dental Health-Care Settings - 2003, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta." *See* 234 CMR 5.05. Additionally, New Mexico law states, "Each person who is licensed pursuant to the provisions of chapter 631 of NRS ["Dentistry, Dental Hygiene, and Dental Therapy"] shall comply with: [t]he provisions of the *Guidelines for Infection Control in Dental Health-Care Settings-2003* adopted by the Centers for Disease Control and Prevention which is hereby adopted by reference." *See* NAC 631.178.

It bears mentioning that there is also a very high vaccination rate within the dental industry. For example, the California Dental Association and California Department of Public Health surveyed practicing dentists in the state from May 26 to June 8, 2021 and found that 94% had been vaccinated against COVID-19. *See* CDA "94% of Surveyed California Dentists Vaccinated Against COVID-19" (July 8, 2021). Additionally, per the Oregon Health Authority, 100% of dentists have completed at least one dose of the vaccine, the only category of licensee type to achieve this result. *See* Oregon Health Authority "Oregon Health Care Workforce COVID-19 Vaccine Uptake" (updated March 31, 2022). And, per a national study, full COVID-19 vaccination rates in U.S. dental hygienists rose sharply from February 5, 2021 to March 5, 2021, and reached 75.4% by August 30, 2021. *See* Journal of Dental Hygiene "COVID-19 Vaccine Intention and Hesitancy of Dental Hygienists in the United States" (January 10, 2022). Therefore, dental industry employees are well protected from the risk of severe disease.

Based on these factors, even without screening, dental offices do not present "significant risk" of COVID-19 hazards.[1] Accordingly, OSHA should grant a limited exception to the permanent standard for the dental industry.

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[1] While the landmark decision by the Supreme Court in *Industrial Union Department, AFL-CIO v. American Petroleum Institute*, 448 U.S. 607 (1980), commonly known as the "Benzene" decision, relates to carcinogenicity risks, it may be useful to apply the principles set forth in this decision to the current situation. In the Benzene decision, the Court observed that "the requirement that a 'significant' risk be identified is not a mathematical straitjacket" and that the Secretary's obligation was to "make a ***rational judgment*** about the ***relative significance*** of the risks associated with exposure to a particular carcinogen." *See* 448 U.S. at 655, 656-57 (emphasis added). The Court offered the following illustration:

> "If, for example, the odds are ***one in a billion*** that a person will die from cancer by taking a drink of chlorinated water, the risk clearly could not be considered significant. On the other hand, if the odds are ***one in a thousand*** that regular inhalation of gasoline vapors that are two percent benzene will be fatal, a reasonable person might well consider the risk significant and take appropriate steps to decrease or eliminate it. Although the Agency has no duty to calculate the exact probability of harm, it does have an obligation to find that a significant risk is present before it can characterize a place of employment as 'unsafe.'"

See id. at 655 (emphasis added). As of April 16, 2022, the case rate in the United States is 11 per 100,000, or .011%. *See* The New York Times "Coronavirus in the U.S.: Latest Map and Case Count" (April 16, 2022). While clearly this is more than one in a billion, it is significantly less than one in a thousand, or .1%. And, what's more, 11 per 100,000 is a rate that would never be experienced in dental offices for the reasons outlined herein, including specifically the fact that dental offices do no draw COVID-19 in and are protected by long-standing CDC dental IC guidance. Given these factors, the risk of COVID-19 exposure to employees in dental offices is likely much closer to one in a billion than one in a thousand. Indeed, unlike hospital or urgent care settings, which draw those with COVID-19 in (i.e., persons suspected or confirmed to have COVID-19 should typically either

II. To the Extent OSHA Does Not Provide an Exception for the Dental Industry, OSHA Should Preserve the Screening Exemption

A. Screening is an Effective Tool to Keep Infectious Patients Out of Dental Offices.

OSHA's screening exemption is an extremely effective tool in excluding suspected and confirmed COVID-19 persons from dental offices. Screening, as well as the long-standing CDC-derived, industry-specific infection control procedures universally implemented in U.S. dental offices, have very effectively protected our dentists, hygienists, dental assistants and administrative staff from any significant risk of COVID-19 transmission in our offices. To the extent OSHA does not exclude the dental industry, there is no reason to remove the screening exemption and now layer onto the dental industry additional, differing regulatory requirements, in particular requirements that are designed for a far different setting than a dental office – a setting where severely ill COVID-19 patients remain for days, weeks, or months, needing constant care by the heroic healthcare providers working in hospital settings. It bears emphasis and repeating that those settings – and the risk exposure potential for those employees – is far-removed from a dental office setting.

Additionally, the ADSO would like to note that, despite the fact that screening cannot always identify asymptomatic or pre-symptomatic cases, from a risk perspective, screening does keep out those who are likely to be the most infectious. OSHA states in the preamble to its Healthcare ETS, "persons with symptoms early in their SARS-CoV-2 infection are among the most infectious. Therefore, symptom-based screening will identify some of the highest-risk individuals for SARS-CoV-2 transmission and thereby reduce the risk to workers." *See* 86 FR at 32430 (internal citations omitted). Indeed, for purposes of quarantine, current CDC guidelines do not even require individuals who are up to date with their COVID-19 vaccines and have had close contact with someone who has COVID-19 to quarantine, unless they experience symptoms. *See* CDC, "Quarantine and Isolation" (updated March 30, 2022). Accordingly, the fact that screening targets those who are most likely to transmit the virus means that barring those individuals if they fail a screening – which is the criteria set forth under the screening exemption – is an effective method to keep employees in dental offices safe.

B. Precedent Exists for Screening Exemptions for the Dental Industry.

There exists clear precedent for allowing a screening exemption for the dental industry in the context of generic respirable infectious diseases. California's Division of Occupational Safety and Health ("Cal/OSHA") included a full exemption for the dental industry in its Aerosol Transmissible Diseases ("ATD") standard well before the COVID-19 pandemic. This exemption allows all "outpatient dental clinics and offices" to avoid implementation of the ATD standard as long as they meet the following conditions:

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stay home or go to the hospital or urgent care), dental offices that screen and bar actually ***turn away*** suspected and confirmed cases. Accordingly, based on the Benzene decision, there is likely good question as to whether OSHA would be able to meet the legal threshold of "significant risk" with respect to these offices.

1. Dental procedures are not performed on patients identified to them as ATD cases or suspected ATD cases.
2. The Injury and Illness Prevention Program includes a written procedure for screening patients for ATDs that is consistent with current guidelines issued by the Centers for Disease Control and Prevention (CDC) for infection control in dental settings, and this procedure is followed before performing any dental procedure on a patient to determine whether the patient may present an ATD exposure risk.
3. Employees have been trained in the screening procedure in accordance with Section 3203 [Cal/OSHA's Injury and Illness Prevention Program standard].
4. Aerosol generating dental procedures are not performed on a patient identified through the screening procedure as presenting a possible ATD exposure risk unless a licensed physician determines that the patient does not currently have an ATD.

See 8 CCR 5199(a)(2)(A). This carve-out embodies the screening exemption of the Healthcare ETS, tailored to dental offices. The ADSO believes it is meaningful that Cal/OSHA – one of, if not the, most protective OSH Plan States in the Nation – decided to include this carve out in its ATD standard, in particular because this was done before the pandemic, through less rushed, regular, more thoughtful rulemaking than occupational safety and health agencies have had an opportunity to do since the pandemic. Rather than catching up with the science, Cal/OSHA's ATD standard is based on fundamental, basic principles of infection control (which are applied universally at U.S. dental offices). And, that screening exemption has "stood the test of time" and the challenges of the pandemic. While Cal/OSHA could have reopened the ATD standard to additional emergency rulemaking during the pandemic, it has not done so, and in fact, developed its general industry COVID-19 ETS ***around*** the ATD standard. OSHA should follow the lead of Cal/OSHA and either maintain the generic screening exemption currently in the ETS as it develops its permanent standard, or include a specific industry exemption for dentistry.

C. <u>There is No Scientific Basis for Removal of the Screening Exemption.</u>

We understand that OSHA may be considering elimination of the screening exemption based on concern that screening does not detect asymptomatic or pre-symptomatic individuals who are unaware of any recent close contacts. However, when OSHA issued its Healthcare ETS in June 2021, it was already well aware of this potential risk. For example, in the preamble to the Healthcare ETS, OSHA states, "Regular health screening for possible indications of COVID-19 is a first step in detecting employees who might be COVID-19-positive so those employees can seek medical care or testing, or inform the employer if they have certain symptoms. While pre-symptomatic and asymptomatic infections and the non-specificity of COVID-19 symptoms make it difficult to quantify the accuracy of symptom screening in predicting COVID-19, health screening is a strategy supported by the CDC and the American College of Occupational and Environmental Medicine (ACOEM)." *See* 86 FR 32376, 32452 (June 21, 2021).

OSHA goes on to state, "[t]he CDC recommends that employers conduct screening at the worksite, or train employees to be aware of and recognize the signs and symptoms of COVID-19 and to follow CDC recommendations to self-screen for symptoms before coming to work. Screening for employee symptoms, particularly when combined with their recent activities (e.g., the likelihood they have had a recent exposure to COVID-19), can help determine if the

employee is suspected to have COVID-19 or should be tested." *See* 86 FR at 32452 (internal citations omitted).

Additional language from the preamble goes on to show that OSHA recognized the potential shortcomings associated with screening, but decided to support it not only as an overall mitigation strategy, but also as a mechanism for dental offices to be exempt from the standard, as long as these employers did not allow those who failed screening to enter their offices:

- "Limited contact with potentially infectious persons is a cornerstone of COVID-19 pandemic management. For example, screening and triage of everyone entering a healthcare setting is an essential means of identifying those individuals who have symptoms that could indicate infection with the SARS-CoV-2 virus. Persons with such symptoms can then be triaged appropriately to minimize exposure risk to employees." *See* 86 FR at 32430 (internal citations omitted).

- "Paragraph (a)(2)(iii) provides that the ETS does not apply to 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. This exception is intended to exclude from the standard certain healthcare providers that do not treat, and instead exclude from their facilities, people with suspected or confirmed COVID-19, either because such treatment is not related to the nature of their practice or because the provider chooses not to engage in such treatment as a matter of policy. The exception will apply so long as the employer meets the exception's conditions: the employer must screen each non-employee prior to entry, make a determination based on that screen whether the non-employee has suspected or confirmed COVID-19, and bar entry to that non-employee if it is determined that the non-employee has suspected or confirmed COVID-19." See 86 FR at 32564.

- "As defined in paragraph (b), screen means asking questions to determine whether a person is COVID-19 positive or has symptoms of COVID-19. Although it is not a perfect tool, screening is an important aspect of a multi-layered approach to minimizing workplace exposures to COVID-19." See 86 FR at 32571.

There is no new, additional scientific evidence that was not available to OSHA at the time it promulgated the ETS to suggest that the screening exemption should be eliminated. While certainly the Omicron variant was shown to be more transmissible than previous variants, and Ba2 and now Ba2.1 subvariants, all more transmissible than the previous, there does not appear to be any evidence to suggest that it caused more asymptomatic or pre-symptomatic cases. Indeed, in describing the Omicron variant, as it was on the rise in December 2021, the CDC stated, "Preliminary information from South Africa indicates that there are no unusual symptoms associated with Omicron variant infection, ***and as with other variants, some patients are asymptomatic***." *See* CDC "Science Brief: Omicron (B.1.1.529) Variant" (updated December 2, 2021) (emphasis added). The use of CDC's "as with other variants" in describing asymptomatic Omicron cases goes to suggest that there is nothing particular or unique about Omicron in terms of the number of asymptomatic cases. Thus, the effectiveness of screening

now is essentially the same as it was back in June 2021, when OSHA promulgated its Healthcare ETS. Therefore, there is no scientific basis for eliminating the screening exemption.

III. It Would be Technologically and/or Economically Infeasible to Apply the Permanent COVID-19 Requirements to Dental Offices

ADSO members express concern that it would be technologically and/or economically infeasible and certainly unnecessarily time-consuming and operationally challenging to apply certain requirements of the Healthcare ETS, which acts as the proposed permanent standard, to their offices.

For example, employers reported concerns about having to comply with the Healthcare ETS physical distancing requirements. The proposed standard states, "The employer must ensure that each employee is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (e.g., hands-on medical care)." *See* 29 C.F.R. Section 1910.502(h)(1). In many dental offices where the medical staff work, it is impossible to maintain physical distances. Although the physical distancing provision expressly incorporates an element of feasibility into the requirement, OSHA provided guidance that "[t]he burden is on the employer to demonstrate that it is infeasible to comply with the required physical distancing for a specific activity or workspace. If the employer can demonstrate that the space cannot be expanded, and that multiple employees must be in that space at the same time (i.e., that there are no other feasible alternatives that would permit 6 feet of physical distancing), the employer satisfies its burden under the physical distancing requirements. However, in such cases, employers must ensure that employees maintain as much physical distance as possible." *See* OSHA Healthcare ETS FAQs #28. Employers are concerned about having to demonstrate infeasibility, particularly because compliance officers might issue citations without a thorough review of infeasibility, leading employers to then have to expend, if they can, significant resources towards defending (meritless) citations.

Employers also express concern about the proposed standard's masking requirements. Per the proposal, "[e]mployers must provide, and ensure that employees wear, facemasks that meet the definition in paragraph (b) of [the ETS]; and [t]he employer must ensure a facemask is worn by each employee over the nose and mouth when indoors and when occupying a vehicle with other people for work purposes. The employer must provide a sufficient number of facemasks to each employee to comply with this paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (*e.g.*, patient care reasons)." *See* 29 C.F.R. Section 1910.502(f)(1)(i)-(ii). Although dental staff performing dental services wear not only surgical masks but face shields, gloves and gowns pursuant to CDC guidelines, as OSHA is well-aware, masking has become a hot-bed political issue. Requiring employees to wear masks is difficult when they are not providing patient care. In this increasingly tight labor market, ADSO members express serious concern that requiring masking full-shift, regardless of activities, would result in an additional employment challenge – we most certainly would lose experienced staff who have shared with us that they will leave their profession rather than be required to wear face masks all shift long.

Furthermore, ADSO members expressed concerns about the ventilation and physical barrier requirements of the proposed permanent standard for similar reasons as those set forth above for physical distancing. For example, ADSO members typically do not own the facilities where their businesses are located, and thus, cannot follow the requirements in the ETS's ventilation provision. Although ADSO members recognize that the ETS includes language that the ventilation requirements only apply to "[e]mployers who own or control buildings or structures with an existing heating, ventilation, and air conditioning (HVAC) system(s)[,]" they are concerned that this might not be so obvious to compliance officers, even if explained. Additionally, similar to the physical distancing requirement, while ADSO members recognize that the physical barrier requirements of the ETS incorporate an element of feasibility – the provisions states that "[a]t each fixed work location outside of direct patient care areas (e.g., entryway/lobby, check-in desks, triage, hospital pharmacy windows, bill payment) where each employee is not separated from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible" – members again express concern about the potential for misguided citations. *See* 29 C.F.R. Section 1910.502(i).

All these concerns when our 2+ year history with this virus shows that transmission is essentially not occurring in our offices.

IV. Comments on the Contents of the Standard.

For the reasons outlined above, ADSO believes the dental industry should not be covered by OSHA's permanent COVID-19 standard. Below we provide comment and suggestions on the terms and content of the standard itself in the event the industry is covered.

A. OSHA Should Ensure the Standard Provides Flexibility to Comply with Evolving CDC Guidance.

The ADSO recognizes that OSHA is considering whether it is appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period, as well as providing a ''safe harbor'' enforcement policy for employers who are in compliance with CDC guidance applicable during the period at issue. *See* 87 FR at 16427. The ADSO strongly supports OSHA in these approaches.

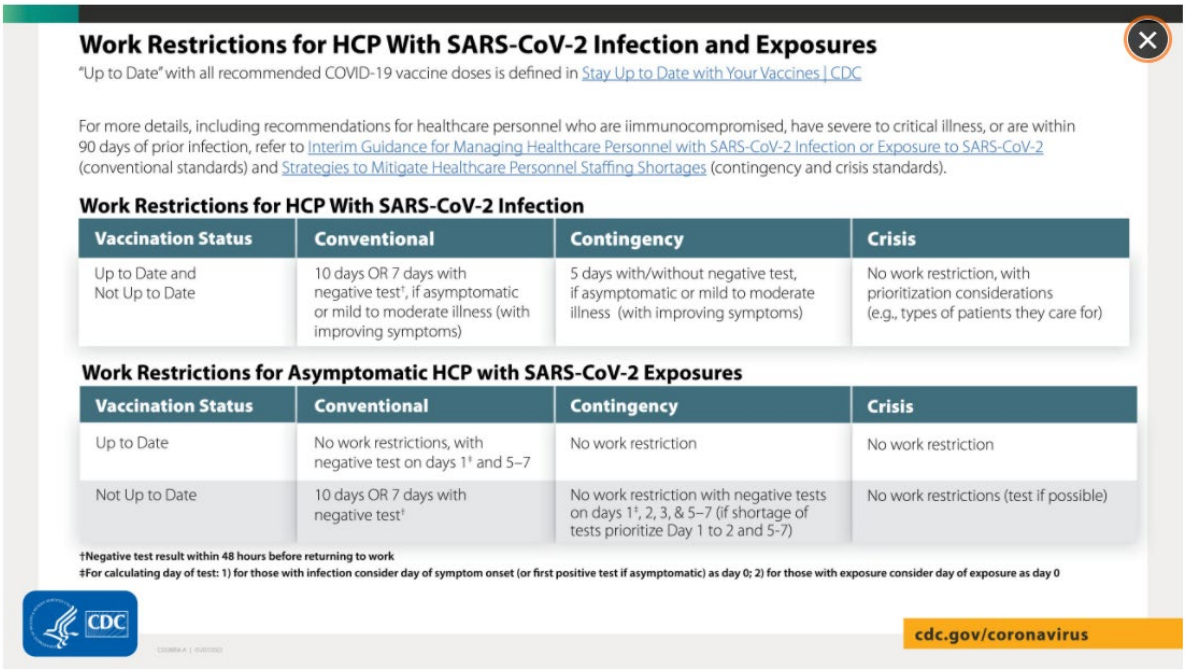
It is imperative that the standard provides flexibility to comply with evolving CDC guidance. CDC has consistently and regularly updated its COVID-19 prevention guidelines based on emerging science and data as it continues to study and gain an understanding of SARS-CoV-2. Over the past 2+ years, the CDC has updated workplace-related guidelines multiple times each month, often in ways that directly contradict prior guidance. That is understandable, of course, in the context of any novel virus like SARS-CoV-2. For example, in October 2020, CDC updated its guidance regarding the airborne nature of SARS-CoV-2; prior to that, COVID-19 was understood to be principally transmitted by droplets and/or surface contamination. CDC revised its "return-to-work" criteria at least twice over the summer of 2020 – once addressing

the recommended number of days of home isolation, and later, within days of Virginia OSHA ("VOSH") issuing its state ETS, eliminating the test-based criteria, which had just been memorialized in the VOSH ETS. Most visibly perhaps, over the course of the pandemic, the CDC rejected the need for face coverings, then recommended their use when distancing could not be maintained, then recommended them for most indoor work, then updated its guidance to consider "double masking," then allowed for fully vaccinated individuals to drop their masks, then recommended that all individuals, including those who are fully vaccinated, wear masks again, and now, recommends masking for the general population based on recently rejiggered county Community Levels.

The lesson from this constantly changing landscape, a lesson VOSH learned the hard way, is that any effective standard must provide flexibility to allow employers to revise their programs consistent with updated CDC guidance without running afoul of the standard. While OSHA has considerable expertise in controlling workplace hazards, the coronavirus hazard is not uniquely a workplace hazard – it does not originate in or emanate from the workplace or work practices; it is not a by-product of an operation or task performed at a workplace. Rather, it is a community hazard coincidentally, inadvertently and unknowingly carried into the workplace by employees and the public. The pandemic is, first and foremost, a public health concern, rather than a workplace hazard, and as such, the principal policymaker for defeating it should remain the CDC, the preeminent U.S. authority on public health and infectious disease. This is not to say that OSHA does not have jurisdiction to establish a standard requiring mitigation protocols; however, that standard should not require employers to ignore the guidelines set by the CDC in order to comply with OSHA's standard. Moreover, it can be virtually impossible to establish workplace mandates that our healthcare workers must follow in our healthcare settings when the CDC is not recommending those same requirements be followed when our employees walk out the door.

There are a number of inconsistencies between CDC's guidelines and the ETS. Although the CDC notes in its "Strategies for Optimizing the Supply of Facemasks" guidelines that the supply and availability of facemasks have increased significantly over the last several months, and therefore, healthcare facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices, the CDC at least provides an option for use of cloth face coverings in combination with face shields when no facemasks are available. *See* CDC "Strategies for Optimizing the Supply of Facemasks" (updated November 23, 2020). The ETS, however, does not provide this option. While we certainly hope that we do not see shortages like those that were experienced over the Spring, Summer, and even Fall of 2020, we do think it is unwise to ignore this possibility, particularly in light of the new, highly transmissible variants that are emerging.

Additionally, there are discrepancies between CDC guidelines and ETS requirements regarding isolation and quarantine rules. The CDC provides the following chart as current guidance for isolation and quarantine for healthcare personnel:



Work Restrictions for HCP With SARS-CoV-2 Infection and Exposures

"Up to Date" with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines | CDC

For more details, including recommendations for healthcare personnel who are iimmunocompromised, have severe to critical illness, or are within 90 days of prior infection, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 (conventional standards) and Strategies to Mitigate Healthcare Personnel Staffing Shortages (contingency and crisis standards).

Work Restrictions for HCP With SARS-CoV-2 Infection

Vaccination Status	Conventional	Contingency	Crisis
Up to Date and Not Up to Date	10 days OR 7 days with negative test†, if asymptomatic or mild to moderate illness (with improving symptoms)	5 days with/without negative test, if asymptomatic or mild to moderate illness (with improving symptoms)	No work restriction, with prioritization considerations (e.g., types of patients they care for)

Work Restrictions for Asymptomatic HCP with SARS-CoV-2 Exposures

Vaccination Status	Conventional	Contingency	Crisis
Up to Date	No work restrictions, with negative test on days 1‡ and 5–7	No work restriction	No work restriction
Not Up to Date	10 days OR 7 days with negative test†	No work restriction with negative tests on days 1‡, 2, 3, & 5–7 (if shortage of tests prioritize Day 1 to 2 and 5-7)	No work restrictions (test if possible)

†Negative test result within 48 hours before returning to work
‡For calculating day of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0

CDC

cdc.gov/coronavirus

See CDC "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2" (January 21, 2022).

The ETS, on the other hand, provides:

- If the employer knows an employee meets the criteria listed in paragraph (l)(2)(i) of this section [i.e., the employee is COVID-19 positive (i.e., confirmed positive test for, or has been diagnosed by a licensed healthcare provider with, COVID-19)], then the employer must immediately remove that employee and keep the employee removed until they meet the return to work criteria in paragraph (l)(6) of this section [providing that employers 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 or CDC's "Isolation Guidance" (incorporated by reference, § 1910.509); and CDC's "Return to Work Healthcare Guidance" (incorporated by reference, § 1910.509)]. *See* 29 C.F.R. Section 1910.502(l)(4)(i).

- If the employer knows an employee meets the criteria listed in paragraphs (l)(2)(ii) through (iv) of this section [i.e., the employee: has 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], then the employer must immediately remove that employee and either:

    - Keep the employee removed until they meet the return to work criteria in paragraph (l)(6) of this section [providing that employers 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 or CDC's "Isolation Guidance" (incorporated by reference, § 1910.509); and CDC's "Return to Work Healthcare Guidance" (incorporated by reference, § 1910.509)]; or

- Keep the employee removed and provide a COVID-19 polymerase chain reaction (PCR) test at no cost to the employee.

    - If the test results are negative, the employee may return to work immediately.
    - If the test results are positive, the employer must comply with paragraph (l)(4)(i) of this section [see first black round bullet above].
    - If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with paragraph (l)(4)(ii)(A) of this section [see first while round bullet above], but the employer is not obligated to provide medical removal protection benefits in accordance with paragraph (l)(5)(iii) of this section. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons.

See 29 C.F.R. Section 1910.502(l)(4)(ii).

- If the employer is required to notify the employee of close contact in the workplace to a person who is COVID-19 positive in accordance with paragraph (l)(3)(i)(A) of this section [requiring employers, when notified that a person who has been in the workplace(s) is COVID-19 positive, to, within 24 hours notify each employee who was not wearing a respirator and any other required PPE and has been in close contact with that person in the workplace], then the employer must immediately remove that employee and either:

    - Keep the employee removed for 14 days; or

    - Keep the employee removed and provide a COVID-19 test at least five days after the exposure at no cost to the employee.

        - If the test results are negative, the employee may return to work after seven days following exposure.
        - If the test results are positive, the employer must comply with paragraph (l)(4)(i) of this section [requiring employers to immediately remove the employee and follow applicable return-to-work criteria].
        - If the employee refuses to take the test, the employer must continue to keep the employee removed from the workplace consistent with paragraph (l)(4)(iii)(A)(1) of this section [requiring the employer to keep the employee removed for 14 days], but the employer is not

> obligated to provide medical removal protection benefits in accordance with paragraph (l)(5)(iii) of this section. Absent undue hardship, employers must make reasonable accommodations for employees who cannot take the test for religious or disability-related medical reasons, consistent with applicable non-discrimination laws.

See 29 C.F.R. Section 1910.502(l)(4)(iii).

Although OSHA incorporates by reference CDC guidelines in its Healthcare ETS return-to-work provisions, those guidelines are outdated. For example, CDC's "Isolation Guidance," to which OSHA refers, is from February 28, 2021. And, the CDC "Return to Work Healthcare Guidance" that is incorporated by reference is from April 27, 2021. These have both changed significantly since December 2021. OSHA's 14-day quarantine requirement is outdated as well.

Presumably, OSHA does not dispute the expertise of CDC in making specific recommendations applicable specifically to the healthcare industry; yet OSHA seems to either second-guess or ignore those recommendations and set the agency's own standard. Consistent guidance between federal agencies is critical and it is imperative that OSHA's requirements align fully with applicable CDC guidance. Because OSHA's ETS is a static regulation whereas CDC's guidance is ever-changing based on the evolving study of this virus, a mechanism must be built into the standard to address this situation.

To that end, we endorse the adoption of an approach similar to that included in VOSH's COVID-19 standard (rescinded on March 23, 2022). As referenced above, it was only days after VOSH issued its ETS that the CDC upended its "return-to-work" guidance, leaving a major element of VOSH's ETS out of step with the current scientific consensus only days after the ETS was issued. Other elements of the VOSH rule similarly fell behind current CDC guidance over the next few months. Thankfully, VOSH had the foresight to build in flexibility for employers, employees, and VOSH to keep up with the evolving science and data related to the virus. Specifically, they incorporated a provision that essentially allowed employers to be deemed in compliance with the ETS if they complied with updated CDC guidelines, even where they conflict with a specific term in the ETS. *See* 16VAC25-220-10(E) (rescinded). We urge OSHA to add a similar provision to the federal standard. This will address the existing inconsistencies but, as or more important, will allow the regulated community to continue to be guided by the CDC without risk of non-compliance with OSHA's standard.

Cal/OSHA and the California Occupational Safety and Health Standards Board did not follow the same approach as VOSH, and experienced the same types of issues, but without an efficient mechanism to address them because no such flexibility provision was included in California's ETS. For example, only a few days after Cal/OSHA's ETS went into effect, the CDC relaxed its quarantine guidelines, prompting the California Department of Public Health ("CDPH") to update its COVID-19 Quarantine Guidance, and Governor Newsom to issue an Executive Order ("EO") regarding the same. *See* CDC, "CDC Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing" (updated December 2, 2020) (archived); *see also* CDPH, "COVID-19 Quarantine Guidance" (December 14, 2020); and California EO N-84-20 (December 14, 2020). Despite the EO

suspending some of the then-outdated and conflicting Cal/OSHA ETS requirements, this caused significant confusion and uncertainty among the regulated community because the ETS was no longer aligned with the revised position of the executive branch.

To keep up with evolving science and avoid confusion, we urge OSHA to adopt an approach like VOSH did, with regulatory text that allows employers to follow current CDC guidance. Here is specific language we recommend: "*To the extent an employer complies with an applicable recommendation contained in CDC guidelines, whether written in mandatory or non-mandatory terms, to mitigate COVID-19 related hazards addressed by this standard, even if the CDC guidelines conflict with the terms of this standard, the employer's actions shall be considered in compliance with the related terms of this standard.*" Alternatively, we recommend that the standard explicitly state that compliance with the standard is fulfilled to the extent that an employer meets the requirements included in the standard or the most stringent of federal CDC recommendations or state/local jurisdiction requirements. Failure to do this will make OSHA's requirements continually lagging, making it nearly impossible for any health care network to consistently follow.

B. <u>The Standard Should be More Performance-Oriented as OSHA is Considering.</u>

We understand that OSHA is considering restating various provisions as broader requirements without the level of detail included in the Healthcare ETS. *See* 87 FR at 16427. The ADSO strongly supports OSHA in this regard, including, but not limited, with respect to the provisions OSHA specifically lists as examples of requirements that may be more prescriptive in the Healthcare ETS – criteria for medical removal and return to work, cleaning, ventilation, barriers, aerosol-generating procedures. *See id.*

The ADSO urges OSHA to establish a standard that is more performance-oriented rather than command-and-control. There simply is simply no "one-size-fits-all" approach to tackling the hazards of COVID-19. While employers have similar goals, their approaches, by necessity, are very different. Revising the standard to make it more performance oriented makes sense at least in part because of the diverse set of healthcare settings OSHA intends to regulate, but also because of the complexity associated with assessing and mitigating COVID-19 hazards. There are myriad factors relevant to determining whether COVID-19 presents a significant risk. For example, community level of transmission, vaccination status of the workforce, and whether there are any workers at higher risk of severe infection, to name a few. Based on the factors that OSHA has determined are impactful and relevant to this hazard, even within the same company – and at times even within the same facility – there can be still substantial variability with respect to the severity of the hazard.

Additionally, there are countless effective approaches to address the COVID-19 hazard, as demonstrated by the programmatic style of the ETS. While there are some common threads in the approaches employers utilize to mitigate the COVID-19 hazard, there are many more differences. For example, while physical distancing may be feasible in large hospital settings, it tends to be infeasible in smaller dental office settings. Quite simply, there is no way for OSHA to effectively regulate COVID-19 hazards through a prescriptive standard. Accordingly, ADSO members urge OSHA to revise the ETS to make it more performance oriented and flexible.

OSHA should look to the performance-oriented Process Safety Management ("PSM") Standard as a model. For PSM, this approach was met with substantial support from the regulated community in large part because it allows employers to consider and address the specific needs of their particularized workplaces in establishing workplace requirements. In the preamble to the final rule, OSHA provides:

> Participants in the rulemaking also supported OSHA's development of a performance-oriented standard. The Chemical Manufacturers Association remarked: [']Initially CMA would like to commend OSHA on its efforts to craft a comprehensive performance-based standard addressing process safety management of highly hazardous chemicals. As CMA has commented in past rulemakings, ***performance language capitalizes on industry's ingenuity and capability to effectively reduce hazards as they may be uniquely applied to a particular safety concern.***['] Ashland Petroleum Company stated: [']Ashland * * * is generally supportive of the efforts of the Secretary and of the Occupational Safety and Health Administration with respect to this proposed regulation. While our internal commentors had divided between a desire for specificity and the obvious value of the non-detailed performance approach, ultimately we believe ***the "performance standard" approach is the best way to regulate a wide variety of situations for which a common end is desired***.['] The American Society of Safety Engineers noted: [']The Society commends ***OSHA's use of a performance standard rather than a specification rule, believing this is the better means to help ensure each affected facility address its individual situation***.[']

See 56 FR 6356, 6360 (February 24, 1991) (exhibit references omitted) (emphasis added). Likewise, for similar reasons, the standard would be most effective through a more performance-oriented approach.

In fact, even more than with process safety management, COVID-19 hazards are deeply dependent on the individual worker. Two employees working in ***identical environments***, may experience vastly different risk of COVID-19 based on factors such as vaccination status, age, and preexisting conditions. This is at least one reason regulating COVID-19 hazards is so challenging. To be effective and successful, any such standard must allow employers the ability to consider and address the particulars of their individual workplaces and workforce.

C. <u>To the Extent the Permanent Standard Applies, it Should Include a Sunset Provision</u>

To the extent that the permanent standard applies to dental offices – again, which it should not – it should include an express sunset provision. The ADSO understands that OSHA is seeking comment on whether the permanent standard should apply "not only to COVID-19, but also to subsequent related strains of the virus that are transmitted through aerosols and pose similar risks and health effects." *See* 87 FR 16428. The ADSO urges OSHA to not take such an approach. This is in part because the ETS was designed to address the unique characteristics of transmission of the SARS-CoV-2 virus and required mitigation strategies and prevention techniques tailored to prevent transmission of this particular coronavirus. Accordingly, the permanent standard should include a sunset provision triggering automatic expiration based

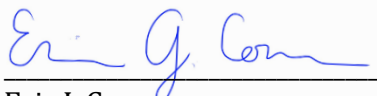
on some designated official status, such as issuance of OSHA's infectious diseases standard, the President declaring an end to the National Emergency Status, the Department of Health and Human Services Secretary decision to not renew the Public Health Emergency, or the World Health Organization removing the global pandemic designation from the public health crisis description, whichever comes first. The standard should serve its purpose, and then expire.

Indeed, OSHA commenced a rulemaking to develop a more generic infectious disease standard applicable to the healthcare industry over a decade ago, but never completed that rulemaking. It would be inappropriate to short-circuit further rulemaking efforts on an infectious disease standard by keeping the permanent standard based on a COVID-19 Healthcare ETS "on the books" in its place. If OSHA wishes to promulgate a broader infectious disease standard to address a broad range of infectious diseases, it should pick up the rulemaking process set aside in 2017, and actively continue that process rather than converting the ETS and this permanent rule into such a standard. Public participation in the emergency rulemaking process was by definition virtually non-existent, and also is severely limited in this abbreviated permanent standard rulemaking. A Section 6(b) rulemaking for infectious diseases will provide stakeholders a much better opportunity for input into the development of the standard and likely would result in a better standard than simply expanding the COVID-19 standard to cover all next versions of the coronavirus. This is not to say that the lessons learned from the mitigation strategies employed during this pandemic should not inform the agency in another, broader rulemaking to develop an infectious disease standard. However, the ETS should not automatically transform into that. It should expire upon victory over the SARS-CoV-2 pandemic.

CONCLUSION

On behalf of our members, we respectfully request that OSHA give meaningful consideration to these comments and recommendations in considering the development of any permanent COVID-19 healthcare standard.

Sincerely,



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