WSDA
WASHINGTON STATE
DENTAL ASSOCIATION

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June 3, 2020

Anne F. Soiza
Assistant Director, Washington State Department of Labor and Industries
Division of Occupational Safety and Health
P.O. Box 44600
Olympia, WA 98504

Re: Requested Revisions to DOSH Directive 1.70 General Coronavirus Prevention Under Stay Home – Stay Healthy Order May 15, 2020 and Questions about DOSH's June 1, 2020 "Which Mask for Which Task?" Document

*Sent via email only*

Dear Assistant Director Soiza:

On behalf of the Washington State Dental Association (WSDA) and our 4,400 member dentists, we wanted to thank you and members of your staff for discussing our concerns with DOSH Directive 1.70, which was last updated on May 15, 2020 (the directive). We appreciate that you scheduled a conference call on May 21, 2020 to discuss concerns we first raised with you on May 17, 2020. We also appreciate you directing Division of Occupational Safety and Health (DOSH) technical staff to speak with WSDA and American Dental Association (ADA) staff about these concerns prior to the call.

As we expressed on the May 21, 2020 call, WSDA is concerned that portions of the directive are detrimentally affecting the health of our state's residents, as implementation of the directive is delaying necessary dental care. More specifically, portions of the directive related to dental care do not reflect the realities of the state's current personal protective equipment (PPE) supply chains and are inconsistent with current Centers for Disease Control and Prevention (CDC) guidelines, current COVID-19 related proclamations issued by Governor Jay Inslee, other national dental-specific guidelines, and educational materials generated by DOSH after May 15, 2020. WSDA again respectfully requests that the directive be revised to reflect current supply chain realities and the most current proclamations and guidelines as soon as possible.

Section IV.D.2.b. of the directive states:

> *Workers within 3 feet of a patient or equipment during an aerosol generating procedure must wear a fit-tested N95 filtering facepiece respirator or more protective respirator. (Particulate filters with any N, R, or P and 95, 99, or 100 rating are protective against the COVID-19 virus.)*

As written, this section of the directive restricts dentists from providing necessary and timely dental care in at least two ways. First, the directive restricts dentists' exercise of the clinical judgement needed to assess the level and trend of COVID-19 infections in their local area, the patient's treatment needs and underlying health conditions, and other factors in order to provide needed health care (with PPE deemed appropriate by the provider and consistent with the Department of Health's PPE preservation guidelines) as clearly articulated in Proclamation 20-24.1 issued by the Governor on May 18, 2020. Second, the directive creates a threshold to provide dental care that

currently is impossible to meet due to COVID-19-related disruptions to the supply of N95 respirators, FDA-approved KN95 respirators, and materials required to perform fit tests on N95 and KN95 respirators.

During our May 15 conference call, DOSH indicated that the directive was developed based upon COVID-19 guidance from the Occupational Safety and Health Administration (OSHA). Based upon our review of dental specific guidance issued by OSHA available to the public, WSDA believes DOSH must update the directive to remain consistent with COVID-19 developments.

The OSHA guidance clearly indicates that dental offices (employers) should be given flexibility to assess the evolving hazards associated with the COVID-19 outbreak and take appropriate action to prevent exposure. The guidance specifically states that:

> *Employers should remain alert of changing outbreak conditions, including as they relate to community spread of the virus and testing availability, and implement infection prevention measures accordingly. As states or regions satisfy the gating criteria to progress through the phases of the guidelines for Opening up America Again, employers will likely be able to adapt this guidance to better suit evolving risk levels and necessary control measures in their workplaces.*

(Emphasis added.)

OSHA's dental specific guidance clearly indicates that the CDC will be the federal government source with the most updated COVID-19 dental related information. On May 19, the CDC updated its Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response. This CDC guidance provides more flexibility with regards to mask/respirator use during aerosol generating procedures than the directive published by DOSH on May 15. The updated CDC guidance states:

> *During aerosol-generating procedures conducted on patients assumed to be non-contagious, consider the use of an N95 respirator or a respirator that offers a higher level of protection such as other disposable filtering facepiece respirators, PAPRs, or elastomeric respirators, if available…If a respirator is not available for an aerosol-generating procedure, use both a surgical mask and a full-face shield. Ensure that the mask is cleared by the US Food and Drug Administration (FDA) as a surgical mask. Use the highest level of surgical mask available. If a surgical mask and a full-face shield are not available, do not perform any aerosol-generating procedures.*

(Emphasis is from the CDC.)

Taken together, OSHA's statement that its dental-specific guidance can be updated based upon evolving risk levels and updated CDC guidance for dental settings provides DOSH with a clear pathway to update its directive without further written guidance from OSHA.

Evolving COVID-19 Proclamations from Governor Inslee also indicate that a one-size-fits-all approach for the entire state and the entire health care system is no longer tenable. This is clearly articulated in Proclamation 20-24.1, Reducing Restrictions on, and Safe Expansion of, Non-Urgent Medical and Dental Procedures.

The concluding clause of Proclamation 20-24.1 articulates that:

> *[G]iven the geographic diversity of Washington, the variability in COVID-19 disease burden within the state, and health care system capabilities and capacity, no uniform approach to expanding access to care is possible nor would any such approach be effective or wise. It is essential that health care system participants act with good judgment within the context of their patients' needs, their environment, and their capabilities and capacity.*

WSDA implores DOSH to update the directive to include PPE flexibility articulated in the updated CDC guidelines for dental settings and Proclamation 20-24.1.

Another area of significant concern with the directive is its inconsistency with the realities of the current dental supply chain. As we have previously stated, FDA approved N95 respirators are incredibly difficult, if not impossible, to purchase in the open market. FDA approved KN95 respirators are more obtainable and WSDA continues to work with the Washington State Military Department Emergency Management Division to distribute one model of FDA approved KN95 respirators to all actively practicing dentists in the state. Unfortunately, not all dentists and dental team members are able to pass a fit test with this one model of mask.

Dental offices and dental organizations are working tirelessly to obtain PPE of all types. WSDA now routinely surveys dentists to gauge PPE supplies and continues to explore legitimate sources of FDA-approved PPE. Fortunately, supplies of surgical masks and face shields are more readily available than N95 and KN95 respirators.

Prior to the COVID-19 pandemic, no dental offices routinely used N95 respirators to provide patient care. As a result, the state's dental care delivery system does not have established fit-testing infrastructure to rely upon. Dental offices continue to communicate difficulties in finding test-fitting resources available in their communities. One reason for these difficulties is that the material needed to conduct fit tests is in short supply.

WSDA strongly opposes any directive for dental offices that establishes an unobtainable threshold that results in delayed patient care, especially when suitable alternatives exists. DOSH's directive sets a standard that cannot be met by many dental practices across the state that result in undue burdens on Washingtonians during an incredibly difficult and stressful time. We urge DOSH to work closely with the dental community establish an updated directive that is achievable and appropriately protects patients and all members of the dental team.

Unfortunately, a document dated June 1, 2020 entitled "Which Mask for Which Task?" has created further confusion within the dental community regarding DOSH's guidance. In this document, DOSH suggests that dentists and dental hygienists fall into a "High Risk Category". The respirator featured for use by workers in this category is a NIOSH approved elastomeric half- or full-face piece respirators with cartridges, a type of respirator that is not widely available at this time. This class of respirator is not used in dental practices nor, to our knowledge, in most medical settings. Though not featured, N95s are also recommended for this risk category with the caveat to use "when supplies allow". What is not clarified is what workers in this category should use when supplies of N95 are not available (which is currently the case across the state).

The June 1, 2020 document also creates further confusion around the use of KN95 respirators approved by the FDA. In the "Medium Risk" category, one option that workers are encouraged to use is a "KN95 approved in other countries". Foreign made respirators are also listed as appropriate for "High Risk" workers if those respirators are "approved by NIOSH (or an equivalent approval body from outside the United States)". While these descriptions of foreign made respirators sound similar, they are distinct. This new document does not indicate for which category or categories FDA-approved KN95 respirators are appropriate, which compounds the confusion.

An additional source of confusion in the June 1 document is the category to which surgical masks are assigned. Workers in the "Extremely High Risk" category are offered several choices including "FDA-approved N95s or surgical masks" (emphasis added). Since surgical masks are listed as appropriate masks for workers in the "Extremely High Risk" category, can workers assigned to the "High Risk" category also use surgical masks? Furthermore, does this guidance from June 1 somehow supersede or replace the directive from May 15, 2020? Does the June 1 document indicate that surgical masks can or should be used when N95 respirators are not available?

At best, the June 1 document provides poorly communicated PPE guidance updates and, at worst, represents DOSH educating workers to use a standard that appears to be inconsistent with the May 15 enforcement policy that may be used to discipline employers. Clarity on how the May 15 and June 1 documents relate to one another is absolutely necessary.

WSDA also has several questions about the enforceability of the directive, especially if the directive is inconsistent with one or more the Governor's emergency proclamations. RCW 43.06.220(2)(g) states that Governor's emergency proclamation powers include:

> *"Such other statutory and regulatory obligations or limitations prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency if strict compliance with the provision of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency . . ."*

This statute clarifies that the proclamation power of the Governor is superior to agency rules.

Furthermore, in *J.E. Dunn Nw., Inc. v. Washington State Dept of Labor & Indus.*, 139 Wn. App. 35, 156 P.3d 250 (2007), as amended on reconsideration in part (July 18, 2007), the court examined the weight of a WISHA Regional Directive ("WRD"). The court considered the difference between "rules" and "policy statements." Rules carry the force of law while policy statements do not. Despite being entitled a "directive" (which falls within the definition of a "rule"), the Court concluded that the WRD was effectively issuing a policy statement because it had not gone through the rulemaking procedure set forth in the Administrative Procedures Act. Because the WRD had not gone through the rulemaking process, the WRD was not a "rule" and did not have the force of law.

WSDA does not have any indication that the directive has gone through the rulemaking process. As such, WSDA believes that the directive, pursuant to *J.E. Dunn*, does not have the force of law. If DOSH has undertaken a rulemaking process for the directive or can explain how this directive can be enforced without undertaking the rulemaking process, please provide us with a clarifying explanation.

In closing, WSDA appreciates the hard work that DOSH has undertaken during the COVID-19 pandemic. On our May 21 conference call, WSDA was asked to appreciate the vast array of moving regulatory pieces that DOSH must address. We do appreciate the sheer amount of work and the degree of difficulty that this work requires.

In turn, we respectfully request that DOSH provide the dental community with flexible guidance, consistent with CDC's guidelines for dental settings, that reflects the realities of the dental supply chain as soon as possible. We also ask that DOSH only enforce directives consistent with these requests.

The dental and health care needs of Washingtonians cannot be paused; dental issues left untreated become more costly and can result in less desirable patient outcomes. We look forward to working with DOSH to quickly resolve these issues.

Respectfully,

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