Report on Public Hearing held April 20th, 2023
by the Philadelphia Board of Health Regarding an Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19
(Revised Safety Measures and Delegation of Authority).

Submitted by: _____ Date: 5/4/2023

Department of Public Health
Cheryl A. Bettigole, MD, MPH
Health Commissioner

Approved by: Lewis Rosman /s/ Date: 5/5/2023

Law Department
Lewis Rosman
Chief Deputy City Solicitor
Legislation & Legal Counsel Unit

CITY OF PHILADELPHIA
DEPARTMENT OF PUBLIC HEALH
Board of Health

Report Concerning Public Comments on an Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Revised Safety Measures and Delegation of Authority).

I. Procedural Background

The Board of Health (the "Board") approved an Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Revised Safety Measures and Delegation of Authority) (the "Amendment")[1] on March 9, 2023 at a public meeting by unanimous vote of the seven members present.[2] Written public comment was accepted prior to the vote and considered by the Board.

The Law Department approved the Regulation on March 10, 2023. The Department of Public Health ("PDPH") submitted the Regulation to the Department of Records for publication on March 10, 2023. The Department of Records acknowledged receipt of the Amendment on March 10, 2023, which was advertised to the public on March 15, 2023.

On April 4, 2023, PDPH received a written comment regarding the Amendment, which the Department treated as a request for a public hearing. On April 17, 2023, PDPH published notice of a public hearing to be held in the Philadelphia Daily News, the Legal Intelligencer, and on the official City website. The public hearing occurred on April 20, 2023, at 6:30 PM via Zoom.

II. Legal Authority

The Board is established under the Philadelphia Home Rule Charter (the "City Charter") and is the primary authority for disease prevention and control in the City. The Disease Prevention and Control Law of 1955, 1956, April 23, P.L. (1955) 1510, 35 P.S. § 521.1, et seq., (the "DCPA") at § 3, 35 P.S. § 521.3. Pursuant to the City Charter, the Board is authorized to "[m]ake reasonable regulations, not contrary to any statute or ordinance, for the preservation and promotion of the health of the people of the City." City Charter at § 5-301. The Board has two independent sources of legal authority for promulgating regulations to prevent the spread of SARS-CoV-2 ("COVID-19").

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[1] See Exhibit A, "*Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Revised Safety Measures and Delegation of Authority)*," as approved by Philadelphia Board of Health on March 9, 2023. Available at https://regulations.phila-records.com/.

[2] Dr. Cheryl Bettigole, Dr. Usama Bilal, Dr. Tyra Bryant-Stephens, Dr. Ana Diez-Roux, Dr. Marla Gold, Dr. Jennifer Ibrahim, Dr. A. Scott McNeal.

Under Chapter 6-200 of The Philadelphia Code, the Board is authorized to establish lists of communicable, reportable and quarantinable diseases, and to implement various reporting and control measures to prevent the spread of such disease. Philadelphia Code §§ 6-201 through 6-206, and § 6-210.

Pennsylvania law independently authorizes the Board to implement "regulations relating to disease prevention and control, which are not less strict than the provisions of [the DCPA] or the rules and regulations issued thereunder by" the Pennsylvania Board of Health. 35 P.S. § 521.16.

The Board promulgated the Amendment using the procedures set forth in Section 8-407 of the City Charter.

III. April 20, 2023 Public Comment Hearing

Six representatives of the Board[3] and one member of the City's Law Department[4] appeared at the April 20, 2023 hearing. Approximately 5 members of the public attended. The following individuals provided comment: Yaron Fishman and Marianne Banbor.[5]

The following is a summary of the public verbal comments:

Yaron Fishman

- I am a long COVID patient having been diagnosed 2.5 years ago. I was re-infected with COVID in July 2022 and I am terrified of getting COVID again.
- My question to decision makers is how many more people are going to die or become chronically ill with long COVID if the mask mandate is revoked? I understand that direct contact healthcare workers will still be masked, but there are many people who will avoid going to hospitals or doctors' offices if other patients aren't required to mask. This could result in more deaths.
- The question is whether your decision to allow patients to enter facilities without masks will protect people and save lives? How many people will die and become chronically ill because of the proposed change? I respectfully ask you to consider these outcomes.
- If the mask mandates are removed, I don't know if I will be comfortable going for my surgery. At the very least take a step back and wait until you see what happens at other hospitals that have gotten rid of the mandates.

[3] Dr. Cheryl Bettigole; Dr. Marla J. Gold, MD; Dr. Jennifer Ibrahim; Dr. Amid I. Ismail; Dr. Ana Diez Roux; Dr. Usama Bilal

[4] Lewis Rosman, Chief Deputy City Solicitor, Legislation & Legal Counsel Unit

[5] A full recording of comments provided are available on the Philadelphia Department of Public Health YouTube page, available at https://youtu.be/5tNJgk50T1E ("Philadelphia Board of Health - Public Comment Meeting - April 20, 2023"

Marianne Banbor

- I had emailed a response but would also like to echo Yaron Fishman's plea to not narrow the mask mandates. Even though I understand that healthcare workers will still be masked, those of us that must go to hospitals cannot choose not to go. This is not a concert or restaurant; we must be there.
- Healthcare workers are not the only problem when we are waiting for hours in emergency and surgical waiting rooms with other people. It is comforting and could be lifesaving when other people are masked in these areas.

IV. Written Comments

In addition to verbal comments provided at the Board's April 20, 2023 hearing, the Board received written comments on the Amendment submitted by email to Benjamin Hartung, Public Policy Advisor for the Division of Chronic Disease and Injury Prevention, Department of Public Health.[6] The following individuals and entities submitted comment:[7] Carl Sirio, MD, on behalf of Temple University Health System; Thane Blinman, M.D., MBA; Lori Braunstien; Sonia Belasco; Marianne Banbor; Debra Zellner, Ph.D.; Scott Parker; Dena Heilik; Jonathan Baron,; Judith Baron; Dr. Dorothy M. French; Xiu Yu; Rev. Crystal Baylor. The following is a summary of the written testimony submitted by the individuals listed above.

A. Comments Requesting End to Masking Requirement

Dr. Carl Sirio, MD, on behalf of Temple University Health System

- Urges the Board of Health to provide equal treatment of healthcare workers, patients, and visitors of health care facilities in terms of masking requirements.
- The CDC no longer recommends universal source control in healthcare settings as a result of significant vaccination, infection induced immunity and available treatments. Masking protocols for healthcare workers, patients and visitors would be more appropriate in high risk patient populations where droplet dispersion would be a significant concern.
- The proposed regulation requires healthcare workers to wear masks to protect patients and their family members against COVID-19, while exposing the healthcare worker to the very same hazard. This inequitable treatment of participants in Philadelphia's healthcare delivery system has no basis in public health policy. There is no evidence to support the Board of Health's proposed recommendation that removes masking in healthcare settings, but makes an exception for healthcare workers.
- We respectfully request that the Board of Health eliminate the requirement that all individuals wear a facemask.

[6] See Exhibit B for reproductions of all written comments received.
[7] Affiliations are as provided.

Thane Blinman, MD, MBA

- Mandated masking is unsupported theoretically, empirically, and ethically. The CDC dropped their recommendation for masking in hospitals October 2022. Most health systems across the United States and Europe have abandoned their mandates. On April 10, 2023, the US Government officially ended the "Covid Emergency." Mask mandates should be ended now.
- Masks reduce droplets, but studies before covid demonstrate that paper and cloth masks offer no protection against viruses. While masks reduce droplets, viruses like covid spread mostly through aerosols. Paper surgical masks offer virtually no protection against aerosol spread, the main way that covid is disseminated.
- The Cochrane Collaboration report published in January 2023 concluded that wearing masks in the community probably makes little or no difference to the outcome of influenza-like illness (ILI)/COVID-19 like illness compared to not wearing masks.
- Statistically, in the long run, it is impossible to outrun, outlast or outwit the virus with masks. The short-term use of N95s and other PPE in acute care circumstances is not useless, but the mandated long-term universal masking is futile, regardless of mask type.
- The burdens of requiring masking are substantial and are higher than the benefits of masking.
- Drop the mask mandate and leave the choice of masking up to individuals.

B. Comments Requesting Continuation of Masking Requirements

- Multiple comments expressed concerns about potential exposure of immunocompromised persons and their families to COVID-19 via other patients in the common areas of healthcare facilities if patients will no longer be required to mask.[8]
- Multiple commentors expressed being uncomfortable or fearful of waiting rooms where patients are unmasked. This discomfort would dissuade them from seeking medical care.[9]
- One commentor expressed support for keeping the mask mandate in medical facilities and for re-instating the mask mandate for travel on public transportation and for attending educational institutions.[10]

V. Response to Verbal and Written Comments

The Board heard verbal comments from 2 individuals and received 13 written comments on the Amendment. Two comments requested complete removal of masking requirements for all

[8] Lori Braunstein, Sonia Belasco, Marianne Banbor, Debra Zellner, Ph.D., Scott Parker, Dena Heilik, Xiu Yu, Rev. Crystal Baylor
[9] Lori Braunstein, Sonia Belasco, Marianne Banbor, Debra Zellner, Ph.D., Scott Parker, Jonathan Baron, Judith Baron
[10] Dr. Dorothy M. French

healthcare participants. The remaining comments requested a continuation of the requirement that persons at healthcare facilities wear masks.

A. <u>Board of Health's Response to Verbal and Written Comments Regarding Masking Requirements:</u>

The COVID-19 hospitalization and infection rate continue to remain low.[11] *Indeed, the numbers of hospitalizations and deaths have continued to decline since the March 9, 2023 Amendment was approved. Most cities across the country that at one point required masking in healthcare facilities during the pandemic have ended those mandates due to the continued decline in severe outcomes from COVID-19 infection.*

The Board recognizes that mandating that healthcare workers wear masks has become more challenging for healthcare facilities to enforce as COVID-19 metrics continue to improve. Given the progressively lower risk posed by COVID-19, such a mandate no longer conforms to the Board's goal of instituting the least restrictive measures necessary.

The Board has therefore decided that it is time to lift mask mandates entirely and to further revise the amendment to the regulation to additionally remove the masking requirement for healthcare providers. This does not in any way limit the authority for, or appropriateness of, institutional or business mask mandates. The Board's Amendment to the regulation means that decisions will be made by healthcare institution leadership rather than by a Board mandate.

PDPH advises that all operators of healthcare facilities should develop and implement masking plans and guidance for staff and visitors based on changes to COVID-19 risk in the community and on the individual risk for their patient population or unit (e.g., the risk level is different in an oncology unit or nursing home than it is in an outpatient pediatric office).

The Board recognizes that COVID-19 remains a risk for Philadelphians, especially those who are immunocompromised or who have other medical conditions that cause additional medical vulnerabilities. The Board encourages all patients to continue to seek their recommended medical care from Philadelphia medical facilities and to request masking accommodations from their providers if it will reduce their fear of COVID-19 transmission. The Amendment to the Board of Health's regulations do not prevent any person from wearing a mask in any healthcare facility or other institution.

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[11] *See* "COVID-19 Testing Data, City of Philadelphia COVID-19 Overview, available at https://www.phila.gov/programs/coronavirus-disease-2019-covid-19/testing/testing-data/; "COVID Data Tracker," Centers for Disease Control and Prevention, available at https://covid.cdc.gov/covid-data-tracker/.

VI. Final Action

A copy of the final Regulation, as amended, is attached hereto, as Exhibit C.

EXHIBIT A

CITY OF PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH	BOARD OF HEALTH: 3/9/2023 LAW DEPARTMENT: 3/10/2023 RECORDS DEPARTMENT:

AMENDMENT TO THE FOURTH CONSOLIDATED AND RESTATED SUPPLEMENTAL REGULATION GOVERNING THE CONTROL AND PREVENTION OF COVID-19 (REVISED SAFETY MEASURES AND DELEGATION OF AUTHORITY)

WHEREAS, the Pennsylvania Disease Control and Prevention Act of 1955, 1956, April 23, P.L. 1510, 35 P.S. § 52.1 et seq., (the "DCPA") and Chapter 6-200 of The Philadelphia Code authorize the Board of Health ("the Board") to establish lists of reportable diseases and conditions, and further provide that the Board and the Department of Public Health are responsible for implementing appropriate disease control and prevention measures in order to limit the spread of disease in an epidemic emergency; and

WHEREAS, Sections 6-201 through 6-206 and 6-210 of The Philadelphia Code likewise vest the Board, and in times of emergency the Department of Public Health, with the authority to forbid the congregation of persons when necessary to prevent the further spread of a communicable and quarantinable disease to take such other measures as are necessary to prevent the spread of such disease; and

WHEREAS, the SARS-CoV-2 ("COVID-19") can cause severe disease and death, particularly in older adult and other vulnerable populations; and

WHEREAS, to date there have been more than 26,000 COVID-19 hospitalizations and 5,400 COVID-19 deaths in Philadelphia since the beginning of the pandemic and

WHEREAS, on March 12, 2020, the Board by emergency regulation added COVID-19 to the City's list of reportable and quarantinable diseases and subsequently has adopted a series of regulations, both adding and relaxing various restrictions and requirements, that were designed to prevent the spread of COVID-19 in Philadelphia; and

WHEREAS, on October 19, 2022 (effective November 19, 2022)**,** the Board promulgated the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Consolidated Safety Measures for Full Reopening and Delegation of Authority) (the "Fourth Consolidated Regulation"), which included as Exhibit "A" the "Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)"; and

WHEREAS, hospitalizations and deaths have remained either level or declined slightly since October 2022; and

WHEREAS, we have not seen the types of spikes in COVID-related hospitalization rates and deaths in the winter of 2022-23 that we saw in the previous two winters; and

WHEREAS, the Board has determined that it is appropriate to make further changes to City requirements, to eliminate certain masking requirements that are no longer necessary;

NOW, **THEREFORE**, pursuant to its authority under Philadelphia and Pennsylvania law, the Board of Health hereby adopts the following amendment to Exhibit "A" to the Fourth Consolidated Regulation, entitled the "Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)," as follows (Deletions in ~~Strikethrough~~; Additions in **Bold**):

CITY OF PHILADELPHIA BOARD OF HEALTH

Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)

Section 1. Generally Applicable Requirements for Masks.

* * *

(A) Face Coverings Required.

(1) No business, organization, or other establishment shall allow ~~an individual entrance into~~ **a healthcare worker to provide direct patient care at** any indoor location at a healthcare ~~or congregate care facility,~~ **institution,** further identified below, that is controlled by such business, organization, or other establishment unless such ~~individual~~ **healthcare worker** is wearing a face mask or other face covering recommended by the Department of Health**,** regardless of vaccination status of the individual, unless otherwise expressly provided **herein**. ~~Individuals are required to wear face~~ **Face** coverings **must be worn** properly, which means in a manner that fully covers the mouth and nose, consistent with applicable ~~guidance, at all times when they are at the following locations:~~ **Department guidance. Provided, however, that when a healthcare worker returns to work at a healthcare institution following a high-risk exposure or testing positive for COVID, such healthcare worker shall mask consistent with Center for Disease Control guidance in all areas of the facility, including those restricted to only employees, except as otherwise provided herein.**

(a) Healthcare Institutions, ~~as~~ **has the meaning** as defined in the Emergency Regulation Governing the Control and Prevention of COVID-19 Mandating Vaccines for Healthcare Workers and In Higher Education, Healthcare, and Related Settings, as it has been or shall be further amended, ("Healthcare Vaccine Mandate"), including temporary indoor community healthcare events such as vaccine clinics and blood ~~drives, except when in~~

~~an area restricted to only employees.~~ **drives.** ~~Provided, however, that when an employee returns to work following a high-risk exposure or testing positive for COVID such employee shall mask consistent with Center for Disease Control guidance in all areas, including those restricted to only employees.~~

~~(b) Congregate facilities such as prisons, shelters, and adult day programs.~~

~~(2)~~ **(b)** "Indoor" means a location enclosed by three or more walls or other non-permeable barriers and an overhead covering, such as a roof or a tent top. Tents with one side open are considered indoor spaces. In contrast, a space that is fully open on two or more sides is considered an outdoor space.

* * *

EXHIBIT B

Written Comments Received in Response to Proposed Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Revised Safety Measures and Delegation of Authority)

1. Comments of Carl Sirio, MD, on behalf of Temple University Health System.[1]

2. Thank you for soliciting comments on mask mandates, and for the thoughtful efforts by the PDPH.

   Please find comments on this topic in the attachment.[2]

   Thane Blinman, MD, MBA

3. To whom it may concern,

   I am begging you to continue mask mandates in healthcare settings. My 91 year old father has pulmonary fibrosis and is on high levels of oxygen around the clock. He is very fragile due to his age and disease. He recently had a fall and had to go the Jefferson Hospital ER and was subsequently admitted. The ER was filled with people who seemed very sick and showing symptoms of respiratory disease. The staff interacts with folks who are very sick on a regular basis and could easily pass disease from patient to patient. COVID or another respiratory illness would likely kill him. People who seek healthcare in all settings have a high probability of being sick. It makes no sense to me to drop mask mandates in these settings. Vulnerable people and their caregivers (actually everyone) deserve to have basic infection control measures in place when they seek medical attention. This feels like a human rights and justice issue to me. PLEASE fight for the most vulnerable among us and keep these mask mandates in place.

   Thank you,

   Lori Braunstein
   Philadelphia, PA 19130

4. I am emailing in regards to the proposed amendment regarding the regulations governing the prevention of Covid-19. It is my understanding that this amendment would remove the masking requirement for hospitals. As someone who is immunocompromised and has chronic health issues potentially affected by covid - including re-infection - I ask that the Council reconsider. Hospitals are designed to be safe spaces for the sick. Removing this precaution would mean making that space unsafe for everyone and could lead to higher rates of covid transmission, especially considering how contagious the current variants are.

[1] *See* Attachment 1
[2] *See* Attachment 2 ("The mathematical futility of masking").

Thank you for considering my comment.

Sincerely,
Sonia Belasco

5. I hope the Philadelphia Board of Health will keep the mask mandate in our hospitals. Masking is an inconvenience, but could be a life-saver for those of us who are elderly and immunocompromised.

   Masking hospital staff who interact with patients is not enough. We can sit for hours in rooms with other patients waiting to be seen by staff. For example, an elderly friend waited more than five hours last Thursday in HUP's ER. Her PCP had told her to go to the ER. It was not a whim.

   I also waited hours for my spouse in Pennsylvania Hospital's surgical waiting room. It was a comfort that all of us stuck there waiting had to be masked. Nobody minded or complained. One woman coughed her lungs out nonstop but through her mask at least. There were pregnant women waiting for elderly parents undergoing procedures, too.

   Nobody wants to go to hospitals. It's not like a restaurant or a concert. It's not fun. It's rarely quick. We're there because we have to be. COVID-19 is not over. Please keep hospitals safe spaces for the most vulnerable.

   Thank you for listening,
   Marianne Banbor

6. I urge you to keep the masking mandate in place. As a senior being treated for cancer, I would be terrified to visit a doctor's office if nobody other than myself was masked. I am fully vaccinated, but as I have seen with many friends, that is not enough. The elderly and sick people, like myself, see doctors more often than younger, well people. Please consider people like me when making your decision. Wearing a mask is not too much to ask so that high-risk individuals are safe getting medical help.

   I would feel uncomfortable waiting in a full waiting room to see a doctor (sometimes for a good 30 min.) among unmasked people of unknown vaccination or contagion status. That change would certainly dissuade me from getting medical care.

   Sincerely,

   Debra Zellner, Ph.D.

7. I hope that Philadelphia will continue to require that people wear masks in health-care facilities. I am an asthmatic octogenarian and so have elevated risk of serious problems if I contract Covid-19. I haven't resumed eating in indoor restaurants or going to theaters or

concerts, an accommodation I make voluntarily. Lots of people at less risk than me have resumed those activities and I'm all for it. But I can't stop going to see the various physicians who treat me and the medical labs they send me to. Those are trips I have to take. Being in a crowded waiting room for an extended period with a lot of unmasked people who want to see the doctor would elevate both my risk level and my discomfort (even though I'll be masked).

Philadelphia has a lot of senior citizens and immunocompromised people and they need to access health care. Requiring masking in health-care settings is an easy way to make that a low-risk and low-anxiety activity.

Thank you for your attention.

Scott Parker

Philadelphia 19103

8. I would like to keep the requirement that all people in hospitals need to be masked, not just the healthcare workers. A high percentage of elderly or immunocompromised folks are in hospitals for long stretches of time and they need to be protected, especially in waiting areas and if they're around sick people.

   Dena Heilik

9. I understand that you are considering a change in the rules concerning mask wearing.

   I do not think that the COVID-19 pandemic is over. I still won't go to a concert or an indoor restaurant. We do not know enough yet about long covid. It seems pretty likely to me that even a mild case of the disease can cause lasting damage that does not show up as reportable symptoms but does increase vulnerability to common causes of death.

   Thus from my perspective (age 78 and in generally good health), the last thing I want to do right now is sit in a busy waiting room with a bunch of other patients and staff not wearing masks.

   Jonathan Baron, Professor of Psychology, University of Pennsylvania

10. I am a 76 year old resident of Center City and urge you to keep the mask mandate for Philadelphia health-care facilities. Without the mandate I would dread waiting rooms and interactions with doctors and staff who are unmasked. Covid, unfortunately, is still with us and we should not risk unnecessary exposure in order to access health care in the city.

    Judith Baron

11. I write in strong support of keeping the mask mandate for hospitals and all medical facilities in Philadelphia. In addition, I would also support re-instating the mask mandate for travel on public transportation and for attending public schools, colleges and other educational institutions . SARS-COVID-2 is a level -3 biohazard. People who handle such dangerous viral agents must comply with strict protocols to eliminate the risk of spreading contagion. A Covid infection is not the same as getting the 'flu or a bad cold. What are we doing, exposing an entire population to an unknown virus that may cause sequelae that could cause very serious health problems?

    Wearing an N- 95 type respirator mask has been shown to be a safe and effective way to reduce the transmission of airborne viruses such as SARS-COVID-2. Mask wearing, and vaccination, and improved ventilation are the three most feasible modes of mitigation that we, the public, can adopt to fight the spread of this dreadful disease which continues to maim and kill Philadelphians of all ages.

    Recognizing and acknowledging danger and taking steps to avoid disaster are the charge and solemn duty of those in charge. Abdicating this responsibility is the very definition of "Failure of Command", in nautical terms. I urge you to resist the herd and stand fast for masks in all Philadelphia hospitals and public medical facilities. It is the right thing to do.

    Thank you,
    Dr. Dorothy M. French.

12. Since I will not be available to participate in the virtual meeting, I would appreciate it if hospitals would continue to require the use of masks to protect the elderly and immunocompromised.

    Thank you.

    Xiu Yu

13. PLEASE choose to keep our older adults and immunocompromised people safe by NOT lifting hospital mask mandates!

    As it's truly a matter of life and death for the elderly and sick…let us who are less vulnerable do everything we possibly can to protect them!

    Philippians 2:3-4 "…but in humility regard others as better than yourselves. 4 Let each of you look not to your own interests but to the interests of others.

Hospitals That Ditch Masks Risk Exposure | Bill of Health (harvard.edu)

Rev. Crystal Baylor

ATTACHMENT 1

TEMPLE HEALTH
TEMPLE UNIVERSITY HOSPITAL

Administration

Tel (215) 707-2000 3401 North Broad Street
Fax: (215) 707-7351 Philadelphia, PA 19140

April 4, 2023

Cheryl Bettigole, MD, MPH
Chair, Board of Health
Philadelphia Department of Public Health
1101 Market Street, 13th Floor
Philadelphia, PA 19107

Submitted via email to Cheryl.Bettigole@phil.gov and Benjamin.Hartung@phila.gov

Re: Amendment to the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19

Dear Dr. Bettigole,

On behalf of Temple University Health System our healthcare workers, patients and communities we serve, thank you for the opportunity to comment on the proposed amendment referenced above. Specifically, we strongly urge the Board of Health, in eliminating masking requirements that it determined to be no longer necessary, to provide equal treatment of healthcare workers, patients and visitors of health care facilities.

The CDC no longer recommends universal source control in healthcare settings as a result of significant vaccination, infection induced immunity and available treatments. Masking protocols for healthcare workers, patients and visitors would be more appropriate in high risk patient populations where respiratory droplet dispersion would be a significant concern for serious illness.

Furthermore, if implemented as proposed by the Board of Health, this amendment would remove the requirement that individuals entering a healthcare institution wear a face mask, while leaving in place the requirement that healthcare workers wear masks within that same healthcare facility.

As noted in the amendment, Philadelphia's Board of Health and the Department of Public Health are responsible for implementing appropriate disease control and prevention measures to limit the spread of disease in an epidemic emergency. Noting that there have been reduced spikes in COVID-related hospitalization rates and deaths, the Board of Health proposes to eliminate masking requirements for patients and other visitors to the hospital. In contrast, however, the Board of Health suggests that there is a high risk of COVID-19 transmission by requiring healthcare workers to wear masks.

Under this scenario, the healthcare worker wears a mask to protect patients and their family members against the threat of COVID-19, while exposing the healthcare worker to the very same hazard. This inequitable treatment of participants in Philadelphia's healthcare delivery system suggests a disrespect of healthcare workers and has no basis in public health policy.

Again, the CDC no longer recommends universal masking in healthcare settings, unless the facilities are in areas of high COVID-19 transmission. There is no evidence to support the Board of Health's proposed recommendation that removes the masking requirement in healthcare settings, but makes an exception for healthcare workers.

For the above reasons, we respectfully request that the Board of Health eliminate the requirement that all individuals, not a subset of healthcare workers, wear a facemask.

Sincerely,

Carl Sirio, MD
Chief Medical Officer
Temple University Health System

ATTACHMENT 2

The Futility of Mandated Universal Masking

Mandated masking is unsupported theoretically, empirically, and ethically.

Hospital surgical masks are widely touted as effective, even essential for "combating" covid. Authorities repeat this assertion routinely, claiming that routine universal masking will "keep you safe". Many believe this, and forcefully repeat that "masks work." Meanwhile, those who question the utility of mask mandates generally find themselves targeted for abuse, ridicule, and even professional sanction. Now, the value of masks has been seen as so obvious, that masks have been *mandated* as a common-sense requirement[1].

The CDC dropped their recommendation for masking in hospitals October 2022. Meanwhile, the prevalence of covid is so low that our hospital no longer reports covid cases in its enterprise report.[2] Most health systems across the United States and Europe have abandoned their mandates. On 10April2023, the US Government officially ended the "Covid Emergency." Nevertheless, the Philadelphia Department of Public Health maintains the mandate for hospitals and other medical settings, but without showing evidence that this mandate carries any benefit. What *does* the evidence show?

Here we explore whether masks, and in particular mask mandates, convey utility.[3] We show that multiple lines of evidence (observation, randomized trials, mathematical models, economic analysis) concordantly indicate that the utility of mandated routine masking is so small as to be undetectable. The *disutility* of mask mandates, in contrast, outpaces any utility of this intervention. It follows that **mask mandates should be ended now and abandoned as a future public health intervention.**

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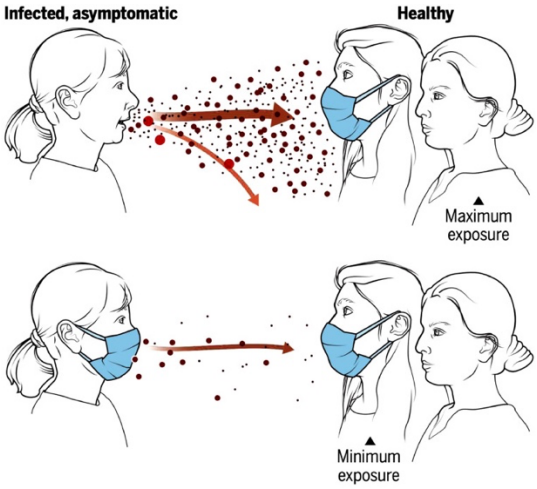
[1] It has never made sense that individuals might have to be compelled by force to take action "obviously" of benefit to themselves. While not the topic here, the "totalitarian impulse" finds a ready home in modern notions of "safety", which some have called "safetyism."

[2] For a while RSV and Flu-A were reported, with this unspoken implication that masks are needed to reduce spread of these viruses. But even these have abated, and have been dropped from the distributed report. The justification of universal masking started with "flattening the curve" and has mutated into a series of goal-post adjustments, all as post-hoc rationalizations for keeping the universal mask mandate.

[3] None of the following discussion pertains to the use of personal protective equipment (PPE) when caring for an actively infected patient. The use of N95 masks, gloves, and eye protection when in close proximity to an isolated, infected patient appears to reduce transmission to the clinician, at least over the short term.

Scientific Evidence Shows No or Weak Protection

In general, beliefs about the efficacy of masks depend on cartoon models of viral spread like this:

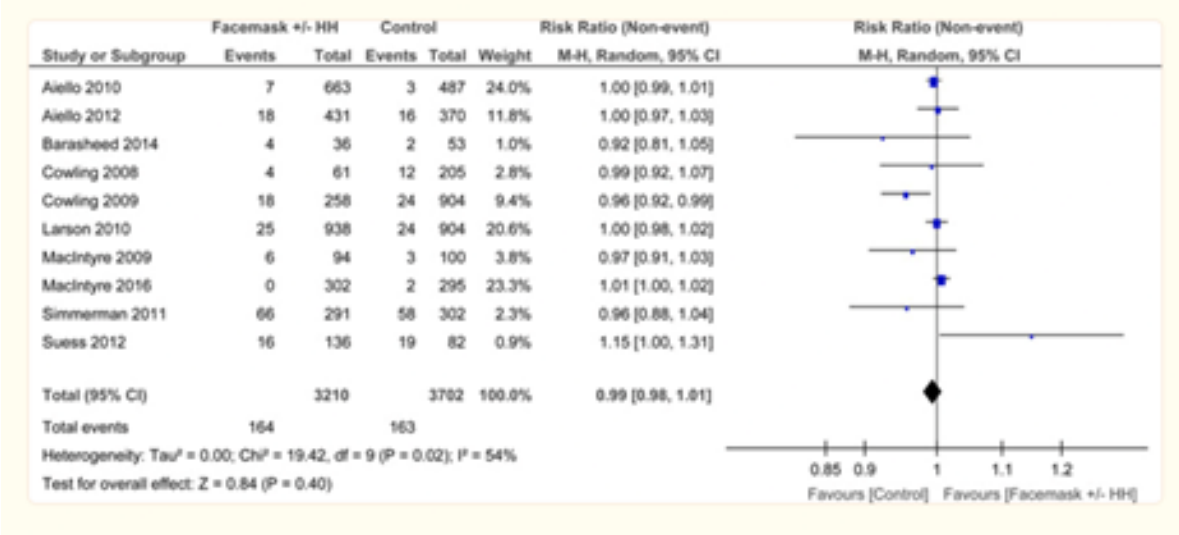


This image presents an appealing, but misleading, model: this cartoon over-weights the role of droplets (rather than aerosols or surfaces), and implies a linear dose response between exposure and contraction, rather than, say, a threshold effect (e.g. where the threshold inoculum is still well below the "minimum exposure" portrayed here). Most evidence and advocacy about masks' advantages with covid hinge on models of droplet spread or on short-term exposure data. Undeniably, masks reduce droplets. But the evidence shows that droplets are beside the point: studies before covid demonstrate that paper and cloth masks offer *no* protection against viruses. While masks reduce droplets, viruses like covid spread mostly through aerosols[4]. **Paper surgical masks offer virtually no protection against *aerosol* spread, the main way that covid is disseminated**.

If viruses spread by aerosols, and if masks are powerless against aerosol spread, then the data should show no protective effect. The data shows exactly this non-effect: A 2021 meta-analysis[5] demonstrates plainly that paper surgical masks offer no protective effect against respiratory viruses (like influenza). If anything, masks have a slight *disadvantage*:

[4] DOI: 10.1126/science.abd9149

[5] J Evid Based Med. 2021 May; 14(2): 97–111. Published online 2021 Feb 9. doi: 10.1111/jebm.12424



This analysis is concordant with other analyses such as this study showing no statistically detectable protection from masks (from Baier et al[6]):

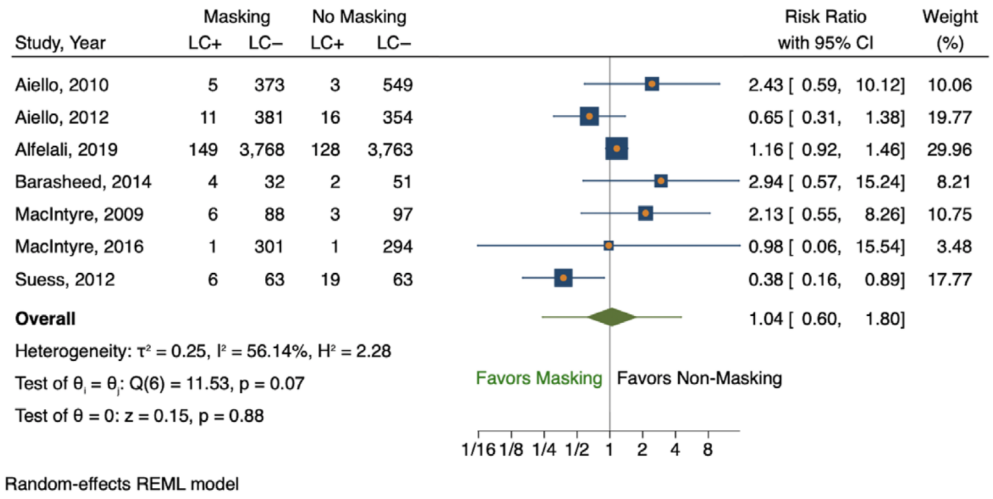


Figure 3. Forest plot of estimations of the association between face mask use and laboratory-confirmed respiratory infection. LC+ = laboratory-confirmed respiratory infection; LC− = no laboratory-confirmed respiratory infection.

This evidence strongly suggested masks were virtually useless, but left some doubt. Then, in January 2023, the Cochrane Collaboration published the most comprehensive review to date[7], surveying the extant literature, with particular attention to quality of data (e.g. randomized studies).

[6] DOI: 10.1017/dmp.2021.369

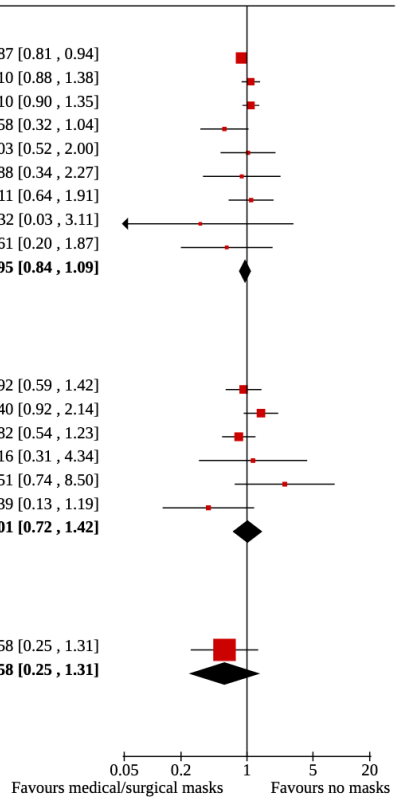
[7] https://www.readcube.com/articles/10.1002/14651858.CD006207.pub6

The conclusion: "Wearing masks in the community probably makes little or no difference to the outcome of influenza-like illness (ILI)/COVID-19 like illness compared to not wearing masks."

The data looks similar to previous analyses:

Analysis 1.1. Comparison 1: Randomised trials: medical/surgical masks versus no masks, Outcome 1: Viral illness

Study or Subgroup	log[RR]	SE	Medical/surgical masks Total	No masks Total	Weight	Risk Ratio IV, Random, 95% CI
1.1.1 Influenza/COVID-like illness						
Abaluck 2022 (1)	-0.135	0.036	111525	155268	41.4%	0.87 [0.81 , 0.94]
Aiello 2012	0.095	0.115	392	370	19.8%	1.10 [0.88 , 1.38]
Alfelali 2020	0.095	0.105	3864	3823	21.9%	1.10 [0.90 , 1.35]
Barasheed 2014	-0.55	0.3	75	89	4.6%	0.58 [0.32 , 1.04]
Canini 2010	0.025	0.342	148	158	3.6%	1.03 [0.52 , 2.00]
Cowling 2008	-0.128	0.483	61	205	1.9%	0.88 [0.34 , 2.27]
MacIntyre 2009	0.1	0.28	186	100	5.2%	1.11 [0.64 , 1.91]
MacIntyre 2016	-1.139	1.16	302	295	0.3%	0.32 [0.03 , 3.11]
Suess 2012	-0.494	0.571	26	30	1.4%	0.61 [0.20 , 1.87]
Subtotal (95% CI)			**116579**	**160338**	**100.0%**	**0.95 [0.84 , 1.09]**
Heterogeneity: Tau² = 0.01; Chi² = 11.44, df = 8 (P = 0.18); I² = 30%						
Test for overall effect: Z = 0.71 (P = 0.48)						
1.1.2 Laboratory-confirmed influenza or SARS-cov-2						
Aiello 2012	-0.083	0.223	392	370	25.9%	0.92 [0.59 , 1.42]
Alfelali 2020	0.34	0.215	3864	3823	26.7%	1.40 [0.92 , 2.14]
Bundgaard 2021 (2)	-0.2	0.208	2392	2470	27.4%	0.82 [0.54 , 1.23]
Cowling 2008	0.148	0.674	61	205	5.8%	1.16 [0.31 , 4.34]
MacIntyre 2009	0.92	0.6225	186	100	6.6%	2.51 [0.74 , 8.50]
Suess 2012	-0.942	0.57	26	30	7.7%	0.39 [0.13 , 1.19]
Subtotal (95% CI)			**6921**	**6998**	**100.0%**	**1.01 [0.72 , 1.42]**
Heterogeneity: Tau² = 0.07; Chi² = 8.52, df = 5 (P = 0.13); I² = 41%						
Test for overall effect: Z = 0.07 (P = 0.95)						
1.1.3 Laboratory-confirmed other respiratory viruses						
Bundgaard 2021	-0.55	0.42	2392	2470	100.0%	0.58 [0.25 , 1.31]
Subtotal (95% CI)			**2392**	**2470**	**100.0%**	**0.58 [0.25 , 1.31]**
Heterogeneity: Not applicable						
Test for overall effect: Z = 1.31 (P = 0.19)						



Footnotes
(1) Covid-like-illness
(2) SARS-cov-2

The data are clear and concordant: universal routine masking offers no detectable protection against viral transmission.

Probability Modeling Excludes Long Term Benefit

Still, many hold a firm intuitive belief that "masks just have to do *something*." For the sake of argument, let's stipulate that masks *can* cut one's risk of contracting covid or other viruses from someone who is infected to some degree: No one suggests seriously

that masks offer an *impenetrable* defense, but rather that wearing a mask offers *some probabilistic reduction* in the risk of contracting covid given some exposure. Is "some protection" enough to make universal mandated masking "the right thing"?

No. Even allowing this, masks *cannot* save anyone from Covid, *in the long run*. To understand why, we need a little math. Let's lay out some plausible assumptions.

First, assume a classic "susceptible-infected-recovered" (SIR) world. In such a world, some individuals are Susceptible to covid (nearly everyone started as susceptible it seems, aside from an unknown fraction of people who had persistent t-cell immunity from past coronavirus infections that conveyed protection). Or they have already had covid and Recovered (or have died) and are immune. (Ignore the tiny number of people who seem to have had covid twice—if someone has developed insufficient immunity after infection, we can group them with the Susceptible.). Finally, some individuals will be Infected, and can spread the virus to the Susceptible.

Assume further that the Infected mix freely among the Susceptible (and Recovered), and that each *exposure* of a Susceptible by an Infected produces some probability that the Susceptible will contract covid.

We want to bias this *gedankenexperiment* to favor masks[8], so let's assume that the probability of contracting covid with each exposure is relatively high. That is, assume $P(C \mid n=1) = P_{c,1}$ (read that as "the probability of contracting covid given one exposure") is 2%.[9] Put in a more positive way, assume that you can be 98% certain a Susceptible will *not* contract covid given a single encounter with an Infected. Call this the probability of staying safe P_s, which is simply $1 - P_c$.

This sounds pretty safe! But we *also* know that covid has spread rapidly and unrelentingly through the population. How can *both* be true? The answer lies in serial probability.

Consider a simple coin flipping game. If you flip a Heads, you get to stay in the game and flip again. If you flip Tails, you are out. What is the probability you can stay in the game for 2 flips? If the coin is fair (that is a ½ probability of flipping Heads or Tails), the chance is ½ * ½ = ¼ . What is the probability you can stay in the game for 3 flips? ½ * ½ * ½ =

[8] The aim is to stipulate the *strongest* case for masks. If even that case fails, all arguments for masks fail.
[9] This probability can be higher or lower without changing the argument. But a much higher value like 20% is not consistent with historical spread or surveillance data, and a much lower value like 0.2% would obviate any value of mitigation attempts.

1/8. What is the probability you can stay in the game for $\boldsymbol{n}$ flips? It is ½ multiplied by itself $\boldsymbol{n}$ times or:

$$\prod_{n}\left(\frac{1}{2}\right) = \left(\frac{1}{2}\right)^{n}$$

Contracting covid is like this coin flipping game, but with very different probabilities. Every time a Susceptible encounters an Infected, that represents one flip of the coin. If the Susceptible flips a Heads, she is safe, and carries on in the game. If she flips a Tails, she contracts covid and she is out (of the Susceptible pool). Each encounter between a Susceptible and an Infected can thus be viewed as a single flip of a *loaded* coin. In this case, assume the coin is loaded such that it comes up Heads (safe) 98% of the time, and Tails (contracting covid) only 2% of the time. With such a loaded coin, what is the probability that one can flip it three times (have three encounters) and get all Heads (never get covid)? It is:

$$P_{s,3} = P_s * P_s * P_s = (P_s)^3 = 0.98^3 = 94\%$$

What about the probability one can be "safe" (get all Heads) with 10 flips (exposures)?

$$P_{s,10} = (P_s)^{10} = 0.98^{10} = 81\%$$

It follows that the probability of being "safe" (no Tails, all Heads) with $\boldsymbol{n}$ coin flips is

$$P_{s,n} = (P_s)^n = 0.98^n$$

Assume encounters are rare, averaging just 2 a day[10]. What is the probability one can stay "safe" (flip all Heads) for a whole year (365 days * 2 exposures/day = 730 exposures)?

$$P_{s,730} = (P_s)^{730} = 0.98^{730} = 0.000039\%$$

In other words, the probability one will flip a Tails eventually (contract covid, given susceptibility) is 1-0.00000039 = 0.99999961 or 99.999961%, *a virtual certainty*.

[10] Following the argument here also reveals the futility of lockdowns. Lockdowns and other measures that reduce the number of encounters among Infected and Susceptible individuals per day. This will indeed "slow the spread", at least a little, in the early phase of a pandemic. But in the long run, encounters continue and a Susceptible only needs to flip a Tails once.

But maybe we can load the coin further by introducing a factor that cuts the risk, P_c a little more. Let's introduce masks. Moreover, let's give masks more protective ability than they warrant: assume that they cut the risk of contracting covid per exposure *in half* [11]. This would be the same as overloading our loaded coin, so that it now comes up Tails only 1% of the time instead of 2%. What is the probability of a masked but Susceptible individual never flipping Tails, with an average of 2 encounters with Infected individuals each day for one year?

$$P_{s,730} = (P_s)^{730} = 0.99^{730} = 0.065\%$$

This is 1654 times safer than the case without masks! Mask advocates are vindicated!

But look again. The chance of flipping a Tails over the long term (contracting covid) is 1-0.00065 or 99.935%. Again, a *virtual certainty*: Masks do *not* "work," even with the generous assumptions stipulated here. Given enough encounters, *every* Susceptible will contract covid. In other words, **over the long run it is impossible to outrun, outlast, or outwit the virus with masks**.[12]

What about N95 masks? The "95" in "N95" means these masks filter out 95 percent of 0.3-micron particles in *laboratory testing*. Real world performance is far less[13]:

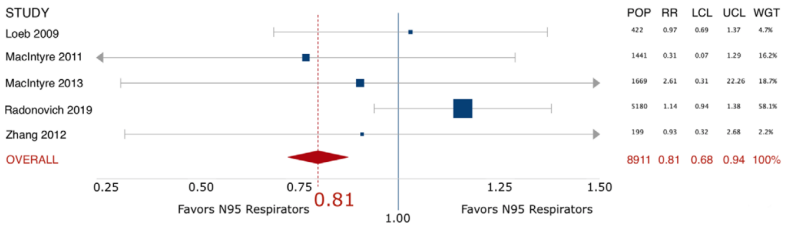


FIGURE 2 Results of N95 respirator effectiveness versus surgical masks against influenza-like illness. Abbreviations: LCL, lower confidence limit; POP, population; RR, risk ratio; UCL, upper confidence limit; WGT, weight

[11] It is widely admitted now that protection from *cloth* masks is zero. Hospital surgical masks are claimed to be better: the most touted study suggests the protective effect seems to be very modest at best, perhaps a 9.5% reduced probability of contracting covid over several weeks (DOI: 10.1126/science.abi9069) although this study appears to be hopelessly flawed. It is more likely that the viral protection conveyed by hospital surgical masks is also zero, concordant with the meta-analysis shown above.
[12] Without, perhaps, some clever biotechnology.
[13] DOI: 10.1002/emp2.12582

Indeed, **a recent randomized trial in *Annals of Internal Medicine* demonstrates that N95s offer *no advantage* (but are associated with many *adverse events*)**[14]**.**

Nevertheless, people have been led to *believe* that there must be some protection. So let's assume an N95 mask that is always perfectly fitted, undamaged, and never removed, and therefore approaches benchtop performance. This would make our weighted coin *even more* strongly weighted, with tails coming up just 0.1% of the time (98% + 95%*(1-98%)=99.9% Heads)

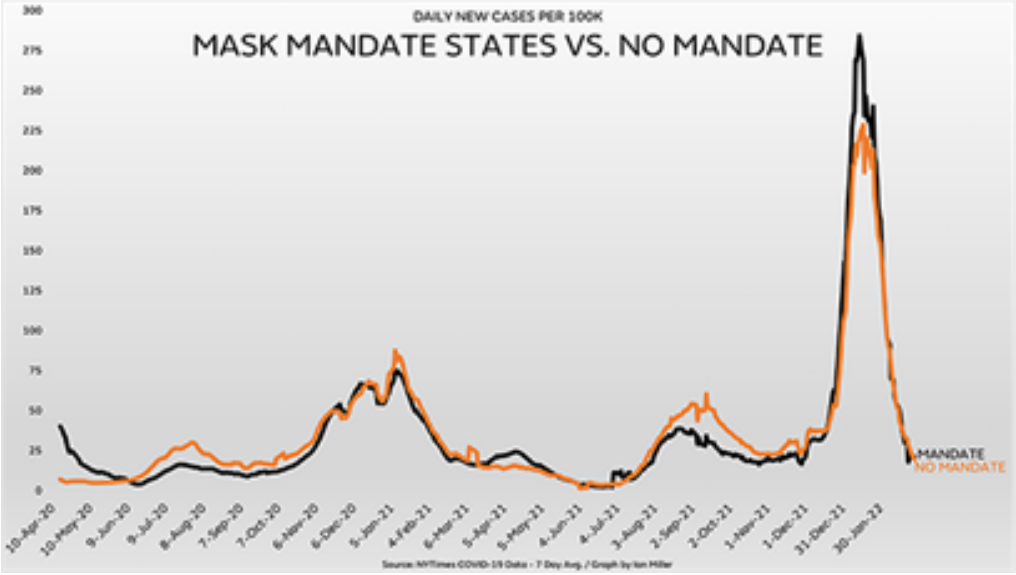
The pandemic has lasted over 2 years. What is the probability of this N95-weighted coin will never come up tails after 2 years with an average of 2 flips (exposures) per day?

$$P_{s,1460} = (P_s)^{1460} = 0.999^{1460} = 23.2\%$$

If the goal is to *slow* the spread in the exponential pandemic phase, N95 masks might help. In cases where there is high risk of exposure to a Susceptible host (e.g. caring for a hospitalized patient), an N95 can help. *But wearing them all the time cannot work forever*: even with *impossibly perfect* N95 use for two years the probability of contracting covid with daily incidental exposures would still be over 75%! This comports with the data in *Annals of Internal Medicine* showing that N95s offer no extra protection in the long-term. Again, this does not mean that short-term use of N95s and other PPE in *acute care* circumstances is useless (the opposite is in fact assumed here), only that **mandated long-term universal masking is futile, *regardless of mask type*.**

If this math was correct, then we would expect that mask mandates would have no effect, and that there would be no difference in spread between areas that had strict mandates and those that had none. Indeed, that is exactly what has been shown[15]:

[14] https://doi.org/10.7326/M22-1966
[15] https://www.city-journal.org/the-failed-covid-policy-of-mask-mandates



The original argument for masks was to "slow the spread" to conserve hospital resources and give time to come up with countermeasures (like Paxlovid). Now, those countermeasures have been deployed, and the virus is *endemic*: it *has already* spread, it is everywhere, and no hospital is overwhelmed. "Slowing the spread" is like unscrambling an egg: no longer an achievable objective. Meanwhile, it is a virtual tautology that all Susceptible individuals will, given enough exposures, become Infected. **The most important intervention then has been, and *always* should have been, using medical science to increase the probability that the Infected will move rapidly into the ranks of the Recovered, rather than the Dead[16].**

Masking Mandates Predicated on Logical Fallacies

Many still hold a strong intuitive belief in masking, an intuition so strong that they still demand universal mask mandates. But the arguments for mandates virtually always rely on *post-hoc* rationalizations that stumble into well-known **logical fallacies, e.g.**:

- **Argument from anecdote**, and the **attribution fallacy** : "I hardly got sick wearing a mask".
- **Argument from edge cases**: "Well…I have an elderly grandmother" or "My cousin's daughter has an immune deficiency"
- **Appeals to authority**: "The CDC recommends it"

[16] The big scientific breakthroughs of the pandemic were not mRNA vaccines, but protease inhibitors and the shift away from mechanical ventilation. All of these innovations saved many lives.

- **Appeal to emotion**: "I feel better wearing it."
- **Appeals to altruism**: "The mask is to protect others, not you."
- **Fallacy of Fluid Standards**: "But there are other viruses surging now!"
- **Mistaking intentions for results**: "But masks are *intended* to keep people safe!"
- **Free-lunch fallacy**: "It's not that big a deal to just wear a mask"
- **Appeal to cowardice**: "It's just not politically correct right now; I know it's wrong, but I am afraid to speak up and lose my status."

None of these are sensible arguments. And none provide a defensible ethical rationale for imposing the costs and burdens of mask mandates on anyone.

Masks Impose Large Burdens

Of all the fallacies listed above, perhaps the most pervasive and pernicious is the Free-Lunch Fallacy. This is the belief that one can gain safety benefits while incurring or imposing trivial costs. Because of this cognitive error, the burdens of masks have been downplayed or ignored. But the burdens are heavy, and include:

- Perpetuation of sense of crisis: never-ending emergencies create psychological stress, and add mightily to **burnout** in an already over-burdened clinical team.
- Added "friction" to everyday clinical work
- Discomfort (masks are untenable over 12 hour shifts)
- Restriction of breathing
- Skin problems: pressure injuries, irritation, acne, etc.
- Impediments to communication
- Reduction in language skill acquisition in children
- Needlessly increased trash burden, carbon load, energy cost of production
- Holding of bacteria and fungi against the mouth and nose[17]

And there is one more: **Moral Hazard.** Because of pro-mask propaganda (such as the baseless but endlessly repeated assertion that "Masks save lives!"), people have acquired an intuition that suggests masks are highly effective—so effective in fact that they can come to work sick and not expose anyone if they "mask up". After all, exhortations to use masks to "keep everyone safe" still appear on posters and screens around campus. Perversely however, it is now common to see colleagues (and parents and patients!) in the office, coughing and sneezing, but wearing a mask as if that would hold back the shedding virus. **Ironically, mask propaganda has produced behavior that, more likely than not, *increases* general exposures to viruses in the hospital.**

[17] https://www.nature.com/articles/s41598-022-15409-x

Conclusion

We have seen that all the foundational premises underlying mask mandates are false:

- The empirical data shows that paper surgical masks offer virtually no protection
- The mechanism of viral spread reveals that paper masks do not offer a plausible mechanism of protection
- The math shows that masking is futile, even with generous assumptions
- Arguments in favor of masks rely on rationalizations of intuitions that blunder into logical fallacy
- Costs and burdens of masks are demonstrably high, much higher than any possible benefit

In other words, the randomized trials, epidemiological surveillance, mathematical model, and biological mechanisms are concordant that universal mask mandates are not a useful or even plausible tool for control of viral spread: Masks are all burden, and no benefit. The evidence does not support universal mandated masking as an epidemiological strategy, and ethics reveals that universal mandated masking decreases utility making everyone worse off, on average. **Like cupping, blood-letting, phrenology, or theories of humors, mask mandates should be condemned and abandoned forever as harmful nonsense**.

Maybe the mathematics and the published evidence remain unconvincing. Despite the evidence, some may feel that they would accept the costs of masking based on their own values. In that case, the unconvinced are free to mask up as much as they themselves wish! However, there can be no moral case for these individuals' feelings to justify forced impositions on others. From a policy point of view, the rational and moral move is to drop mandated masking and **leave the choice of masking up to individuals**.

EXHIBIT C

CITY OF PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH	BOARD OF HEALTH: LAW DEPARTMENT: RECORDS DEPARTMENT:

REVISED AMENDMENT TO THE FOURTH CONSOLIDATED AND RESTATED SUPPLEMENTAL REGULATION GOVERNING THE CONTROL AND PREVENTION OF COVID-19 (REVISED SAFETY MEASURES AND DELEGATION OF AUTHORITY)

WHEREAS, the Pennsylvania Disease Control and Prevention Act of 1955, 1956, April 23, P.L. 1510, 35 P.S. § 52.1 et seq., (the "DCPA") and Chapter 6-200 of The Philadelphia Code authorize the Board of Health ("the Board") to establish lists of reportable diseases and conditions, and further provide that the Board and the Department of Public Health are responsible for implementing appropriate disease control and prevention measures in order to limit the spread of disease in an epidemic emergency; and

WHEREAS, Sections 6-201 through 6-206 and 6-210 of The Philadelphia Code likewise vest the Board, and in times of emergency the Department of Public Health, with the authority to forbid the congregation of persons when necessary to prevent the further spread of a communicable and quarantinable disease to take such other measures as are necessary to prevent the spread of such disease; and

WHEREAS, the SARS-CoV-2 ("COVID-19") can cause severe disease and death, particularly in older adult and other vulnerable populations; and

WHEREAS, to date there have been more than 26,000 COVID-19 hospitalizations and 5,400 COVID-19 deaths in Philadelphia since the beginning of the pandemic and

WHEREAS, on March 12, 2020, the Board by emergency regulation added COVID-19 to the City's list of reportable and quarantinable diseases and subsequently has adopted a series of regulations, both adding and relaxing various restrictions and requirements, that were designed to prevent the spread of COVID-19 in Philadelphia; and

WHEREAS, on October 19, 2022 (effective November 19, 2022)**,** the Board promulgated the Fourth Consolidated and Restated Supplemental Regulation Governing the Control and Prevention of COVID-19 (Consolidated Safety Measures for Full Reopening and Delegation of Authority) (the "Fourth Consolidated Regulation"), which included as Exhibit "A" the "Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)"; and

WHEREAS, hospitalizations and deaths have remained either level or declined slightly since October 2022; and

WHEREAS, we have not seen the types of spikes in COVID-related hospitalization rates and deaths in the winter of 2022-23 that we saw in the previous two winters; and

WHEREAS, the Board has determined that it is appropriate to make further changes to City requirements, to eliminate certain masking requirements that are no longer necessary;

NOW, **THEREFORE**, pursuant to its authority under Philadelphia and Pennsylvania law, the Board of Health hereby adopts the following amendment to Exhibit "A" to the Fourth Consolidated Regulation, entitled the "Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)," as follows (Deletions in ~~Strikethrough~~; Additions in **Bold**):

CITY OF PHILADELPHIA BOARD OF HEALTH

Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19)

Section 1. Generally Applicable Requirements for Masks.

All businesses, organizations, or other establishments that are operating within the City of Philadelphia must allow all individuals, including customers, and employees or other workers to wear masks coverings their nose and mouth, as clarified by any guidance issued by the Department, if they choose to do so. Nothing shall be interpreted to prohibit any establishment from implementing masking requirements for such establishment if they choose to do so, nor do these Second Revised Consolidated and Restated Safety Measures for a Continued Full Reopening to Prevent the Spread of SARS-CoV-2 (COVID-19) (the "Consolidated Safety Measures") relax any face covering requirements mandated by the Commonwealth of Pennsylvania.

~~(A) Face Coverings Required.~~

~~(1) No business, organization, or other establishment shall allow an individual entrance into any indoor location at a healthcare or congregate care facility, as further identified below, that is controlled by such business, organization, or other establishment unless such individual is wearing a face mask or other face covering recommended by the Department of Health regardless of vaccination status of the individual, unless otherwise expressly provided. Individuals are required to wear face coverings properly, which means in a manner that fully covers the mouth and nose, consistent with applicable guidance, at all times when they are at the following locations:~~

~~(a) Healthcare Institutions, as defined in the Emergency Regulation Governing the Control and Prevention of COVID-19 Mandating Vaccines for Healthcare Workers and In Higher Education, Healthcare, and Related Settings, as it has been or shall be further amended, ("Healthcare Vaccine Mandate"), including temporary indoor community healthcare events such as vaccine clinics and blood drives, except when in an area restricted~~

~~to only employees. Provided, however, that when an employee returns to work following a high-risk exposure or testing positive for COVID such employee shall mask consistent with Center for Disease Control guidance in all areas, including those restricted to only employees.~~

~~(b) Congregate facilities such as prisons, shelters, and adult day programs.~~

~~(2) "Indoor" means a location enclosed by three or more walls or other nonpermeable barriers and an overhead covering, such as a roof or a tent top. Tents with one side open are considered indoor spaces. In contrast, a space that is fully open on two or more sides is considered an outdoor space.~~

~~(B) Exceptions.~~

~~(1) Section 1(A)(1) is not applicable with respect to the following individuals:~~

~~(a) Any child younger than 2 years of age.~~

~~(b) Any individual who has a physical disability that prevents easily wearing or removing a face covering.~~

~~(c) Any individual who is deaf and uses facial and mouth movements as part of communication.~~

~~(d) Any individual who has been advised by a medical provisional that wearing a face covering may pose a risk to that individual for health-related reasons.~~

~~(e) Any individual who has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove the face covering without assistance.~~

~~(2) Other exceptions.~~

~~(a) Face coverings are not required to be worn when eating or drinking, provided that eating and drinking may only take place when seated, or when standing at a table with four or fewer people.~~

~~(b) Face coverings are not required when an individual is alone in an office or a similar location that is completely separated from other individuals by floor to ceiling physical barriers.~~

Section 2. Worker Isolation and Masking Recommendations for Businesses and Workers.

All businesses, organizations, and other establishments that are operating within the City of Philadelphia must comply with the following, as clarified by any guidance issued by the Department:

(A) Worker Isolation: Businesses and organizations shall permit any worker who is diagnosed with or tests positive for COVID-19 to remain absent from any in-person workplace during isolation in accordance with guidance from the Philadelphia Department of Public Health or a health care provider. The worker shall isolate in accordance with such guidance.

(B) Masking Recommendations for Close Contacts: Businesses, organizations, and other establishments should encourage any worker who is a close contact (within six feet for at least 15 minutes) with a person with COVID-19 from the period 48 hours before symptom onset (or 48 hours prior to test date if asymptomatic) of a person who is diagnosed with or tests positive for COVID-19 to consistently mask when around others in accordance with guidance from the Philadelphia Department of Public Health, which currently recommends the use of a high quality mask, as defined in applicable guidance, for ten (10) days following the date of the last exposure.

Section 3. Additional Responsibility for Masking and Worker Isolation Requirements.

(A) The owner or operator of any business, organization, or other establishment shall also be liable and subject to fines and penalties under this Order for non-compliance by employees, customers, members, visitors and any other occupants of the business with the following, subject to fines and all other remedies under this Order:

~~(1) With respect to applicable masking requirements under Section 1 of these Consolidated Safety Measures, as clarified by any applicable guidance documents; and~~

~~(2)~~ **(1)** With respect to worker isolation requirements under Section 2(A), excluding the actual isolation requirements which are the responsibility of individual workers, and any other applicable guidance.

Section 4. Interpretation and Implementation.

(A) Except to the extent of a direct conflict, these shall be interpreted as consistent with Applicable orders and requirements of the Commonwealth of Pennsylvania. In the event of a direct conflict, the most restrictive order or requirement controls. The City shall continue reviewing inquiries and submissions regarding the applicability of the City's orders and regulations to businesses and activities.

(B) The owners, operators, and individuals in possession of any business, organization, or other establishment subject to these Consolidated Safety Measures must allow inspection of ongoing operations as further clarified in any guidance issued by the Department of Health, as a condition of operation.