CONSTRUCTION INDUSTRY SAFETY COALITION

April 22, 2022

The Honorable Doug Parker
Assistant Secretary
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Re: Construction Industry Safety Coalition
Occupational Exposure to COVID-19 in Healthcare Settings
Docket No. OSHA-2020-0004

Dear Mr. Parker:

The Construction Industry Safety Coalition ("CISC" or the "Coalition") respectfully submits these comments in response to the Occupational Safety and Health Administration's request for additional comment on its ("OSHA" or the "Agency") "potential provisions or approaches" to a final "Occupational Exposure to COVID-19 in Healthcare Settings" Rule, 87 Fed. Reg. 16426 (March 23, 2022). We appreciate OSHA's consideration of these comments as it determines whether to promulgate a permanent standard with an expanded scope of coverage.

The CISC is comprised of numerous trade associations representing virtually every aspect of the construction industry. Workplace safety and health is a priority for all members of the Coalition, and each is committed to helping create safer construction jobsites for workers. Furthermore, since the outset of the pandemic, the construction industry has been at the forefront of efforts to implement proactive mitigation measures specific to COVID-19. Any attempts by OSHA to expand the ETS to cover construction is not supported by the evidence and would be impermissible under the Occupational Safety and Health Act of 1970 ("OSH Act" or "Act").

As in the Coalition's Aug. 20, 2021, comments on the "Occupational Exposure to COVID-19; Emergency Temporary Standard," 86 Fed. Reg. 32376 (June 21, 2021) ("ETS"), these comments support the Agency's original determination *not* to include the construction industry within the scope of this rule. An expansion of the Occupational Exposure to COVID-19 in Healthcare Settings Rule is inappropriate and expanding the rule to cover employers in low-risk industries, like construction, only months after the U.S. Supreme Court's ruling that OSHA's COVID-19 Vaccine and Testing: Emergency Temporary Standard was not authorized by the Occupational Safety and Health Act of 1970, is bewildering. As explained by the Court, "[t]he Act empowers the Secretary to set *workplace* safety standards, not broad public health measures." *Nat'l Fed'n Indep. Bus. V. Dep't of Labor*, 595 U.S. ___ (Jan. 13, 2022) (Slip Op. at 6). In proposing to expand the healthcare ETS to cover additional industries, OSHA risks the same type of "indiscriminate

approach" that "fails to account for [the] crucial distinction – between occupational risk and risk more generally – …" for which it was chided by the Supreme Court. *Id*. at 7.

For these reasons and those addressed below, the CISC respectfully opposes OSHA's proposal to expand coverage under any promulgated final rule to include certain construction work. OSHA has not provided sufficient information regarding its various "proposed rulemaking outcomes" to allow for meaningful substantive comment on the merits of its proposal. Instead, these comments address (1) deficiencies in the process taken by OSHA in promulgating this rule; (2) the low risk posed by COVID-19 in the construction industry; (3) difficulties in applying the healthcare ETS to construction; and (4) recommendations, based on industry experience, on how best to mitigate the risk of occupational exposure to COVID-19 in construction.[1]

1. The Development of the Rule Does Not Permit Expansion of a Final Rule to Construction.

A. OSHA has not provided sufficient notice to support applying the rule to the construction industry.

Despite the CISC's outreach efforts throughout the pandemic, OSHA has consistently refused to engage with construction industry stakeholders. OSHA refused to open a public docket to receive comments in advance of issuing the Healthcare ETS in June 2021 and did the same in developing the Vaccine and Testing ETS. In response to a letter from the CISC providing information based on real-world industry experience with mitigating the risks of COVID-19, OSHA stated that it was not receiving comments and would not consider the CISC's input. This pattern of complete non-engagement with affected industries continues here, as OSHA provided a mere 30 days, with no prior notice or indication of its intent to expand the scope of the Healthcare ETS to include the construction industry, to comment on the agency's "potential provisions or approaches" to a final rule.

Further, OSHA did not follow its own guidance regarding the requirements for issuing a proposed rule. According to guidance published by OSHA's Directorate of Standards and Guidance, OSHA is under a legal requirement to "draft proposed regulatory text and preamble" while developing and before publishing a proposed rule, among other requirements, which it did not do here. The OSHA Rulemaking Process, Directorate of Standards and Guidance (Oct. 15, 2012) (available at https://www.osha.gov/sites/default/files/OSHA_FlowChart.pdf). Without the regulatory text and preamble, OSHA's vague "potential provisions or approaches" to a final rule do not provide

[1] In addition, these comments hereby incorporate the Coalition's August 20, 2021, comments on the ETS and each of the concerns raised therein, as well as its January 19, 2022, comments on the COVID-19 Vaccination and Testing: Emergency Temporary Standard, and each of the concerns raised therein to the extent they are applicable to this rulemaking.

affected industries with the notice needed to provide meaningful comment to OSHA on its proposal.

Here, OSHA states that "it is considering the same coverage for workers engaged in construction work inside a hospital (e.g., installing new ventilation or new equipment or adding a new wall) as for workers engaged in maintenance work or custodial tasks in the same facility." At 16428. But the ETS does not include any provisions specific to "workers engaged in maintenance work or custodial tasks in the same facility." In fact, the words "maintenance" or "custodial" do not appear anywhere in the text of the ETS. Similarly, the preamble to the ETS does not address what provisions apply to these workers. And no since-issued OSHA guidance addresses this question.

Further, OSHA's proposal includes about eight other "potential provisions or approaches" that would change the current ETS, and notes that these are not "intended to list all of the potential changes from the ETS." At 16427. So even if the requirements for maintenance or custodial workers were clear under the ETS, because OSHA does not tell us what requirements they propose finalizing in a permanent rule, the construction industry cannot know what obligations would apply to it under a final rule. As a result, OSHA has not provided sufficient notice to would-be-newly-regulated parties of its proposal.

B. OSHA has not conferred with the Advisory Committee on Construction Safety and Health on the standard, as required under OSHA's own regulations, and has not convened a SBREFA panel.

The Advisory Committee on Construction Safety and Health ("ACCSH") was established by the Construction Safety Act to serve an advisory function for the Secretary of Labor in formulating safety standards applicable to the construction industry. The CISC objects that OSHA did not consult with ACCSH in advance of publication of the ETS, or its March 23, 2022, Notice of Limited Reopening of Comment Period, which will have a significant impact on the construction industry. While the consultation requirement in 29 C.F.R. § 1912.3 does not apply to interim final rules, OSHA's own regulations require that the Assistant Secretary consult with ACCSH "whenever occupational safety or health standards are proposed." 29 C.F.R. § 1912.3(a). It is required that before OSHA implement a permanent standard applicable to construction that the Agency consult with ACCSH and receive any recommendations that ACCSH may have regarding application of the rule in the unique construction environment.

The Small Business Regulatory Enforcement Fairness Act ("SBREFA") requires OSHA to notify the U.S. Small Business Administration's ("SBA") Office of Advocacy and convene a Small Business Advocacy Review Panel whenever a proposal is expected to have a significant impact on a substantial number of small entities. The SBA and its Office of Advocacy recommends small entity representatives to be consulted on the proposal and its effect on small entities and businesses. The CISC believes a permanent standard addressing Occupational Exposure to COVID-19 in Healthcare Settings with an expanded scope to include construction employers would no doubt have a significant impact on a substantial number of small entities, given the general make-up of the construction

industry, which is dominated by small employers. OSHA did not convene a SBREFA panel to elicit input on the Healthcare ETS, and likewise has not done so with respect to its proposed modifications to the ETS in a final rule. In its Cost Analysis for the Healthcare ETS, OSHA relied on information it obtained through a 2013 SBREFA Panel convened to review OSHA's pre-proposal for an infectious disease standard. While that proposal may have evaluated the impact of similar provisions on small healthcare facilities, there has been no review of the impacts and burdens to construction employers that would be covered under one of the proposals under consideration by OSHA for a permanent standard. OSHA must consider the impacts of its rulemaking on small entities, particularly as it considers expanding the scope to include the construction industry.**2. The Construction Industry is Low-Risk for COVID-19, and So Should Not Be Covered by This Rule.**

A. OSHA designated the construction industry as "low risk" early in the pandemic, and the factors contributing to this designation have not changed.

Construction operations are low risk with respect to the transmission and spread of COVID-19. Early in the pandemic, OSHA explained that the level of risk of occupational exposure to COVID-19 "depends in part on the industry type, need for contact within 6 feet of people known to be, or suspected of being, infected with SARS-CoV-2, or requirement for repeated or extended contact with persons known to be, or suspected of being, infected with SARS-CoV-2."[2] Workers, such as construction workers, that have minimal occupational contact with the general public or coworkers are generally considered to have a low exposure risk.

OSHA established a webpage further analyzing when certain types of construction work fall into the various COVID-19 risk exposure categories. According to OSHA's own assessment, most construction work poses "low exposure risk"; construction work only crosses into "high exposure risk" when it takes place at indoor work sites occupied by people such as other workers, customers, or residents *suspected* of having or *known* to have COVID-19, including when an occupant of the site reports signs and symptoms consistent with COVID-19. Therefore, construction work is unlikely ever to pose a "high exposure risk" or "very high exposure risk."[3]

B. The construction industry is keenly focused on efforts to keep its workers safe in all environments and protect them against recognized hazards, including COVID-19.

From the outset of the pandemic, the construction industry has been at the forefront of efforts to protect construction employees from the virus. The CISC developed a "COVID-19 Exposure Prevention Preparedness and Response Plan" (the "Response Plan")[4] in March of 2020, which has been made available in both English and Spanish and provided at no cost to the construction

[2] Guidance on Preparing Workplaces for COVID-19, OSHA (2020) (available at https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf).

[3] COVID-19 Control and Prevention: Construction Work, OSHA (last visited Feb. 23, 2021) (available at https://www.osha.gov/coronavirus/control-prevention/construction).

[4] *See* http://www.buildingsafely.org/covid-19-coronavirus/.

industry. The CISC updated the plan four times to account for changes in guidance from the Centers for Disease Control and Prevention ("CDC"). The Response Plan is tailored to the construction environment, which OSHA has generally classified as low risk (*see* discussion below). In addition to the Response Plan, the CISC organized several safety stand downs related to COVID-19.

As vaccines became more readily available, CISC members partnered with the CDC to conduct a "Vaccine Awareness Week in Construction" campaign to raise awareness of the safety, effectiveness, and benefits of COVID-19 vaccination among construction workers. The CISC encouraged participation in Vaccine Awareness Week, distributed education materials and a new industry public service announcement and encouraged participation in the CDC and National Institute for Occupational Safety and Health ("NIOSH") vaccination education webinars for the industry.

Today, CISC members continue to follow CDC guidance applicable to their workforce and seek ways to best protect construction workers from the hazards presented by COVID-19.

3. It Is Inappropriate to Apply a Healthcare Industry Rule to Construction.

A. The ETS is not applicable or even relevant to the construction environment.

The ETS is specifically tailored to the healthcare environment. As a result, with very few exceptions, the ETS is not at all applicable or relevant to the construction industry. Section 29 U.S.C. 1910.502(a), addressing the scope and application of the ETS, specifically acknowledges that the standard applies where an employee "provides healthcare services or healthcare support services." The section then narrows this application, carving out certain work that is tangential to healthcare services, such as the provision of first aid by a non-licensed healthcare provider and dispensing of prescriptions by pharmacists in retail settings, work performed in certain home health settings, healthcare support services performed in a non-healthcare setting, and other certain scenarios.[5] These carveouts are appropriate and recognize that, like construction performed in healthcare environments, these settings do not present the increased risk of exposure to COVID-19 that exists in other healthcare settings. Due to its scope, most of the requirements of the ETS are directly based on and applicable to healthcare settings where indoor unrestricted direct patient care occurs. For example:

- At 1910.502(d), the ETS requires an employer to engage in certain patient screening and management protocols. This requirement applies to "settings where direct patient care is provided." It requires an employer to limit and monitor points of entry, and to screen and triage all non-employee persons entering the healthcare setting. This type of protocol is not necessary and would be impractical for a construction employer to monitor.

- Section 1910.502(e) requires employers to develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions as espoused by the

[5] *See* 29 U.S.C. 1910.502(a)(2)(i)-(vii) and 1910.502(a)(3)(i)-(ii).

CDC in its 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated in July 2019.[6] This CDC Guideline identifies transmission risks associated with specific types of healthcare settings. It specifically identifies hospitals (including intensive care units, burn units, and pediatrics) and non-acute healthcare settings (including long-term care, ambulatory care, home care, and other sites of healthcare delivery).[7] In establishing the appropriate isolation precautions, this CDC Guideline acknowledges specific precautions are needed to prevent transmission in healthcare settings, including administrative measures that address nurse staffing and laboratory support; the surveying of healthcare-associated infections; educating healthcare workers and patients; personal protective equipment (PPE) appropriate for healthcare personnel, including isolation gowns; guidelines regarding patient placement and transport of patients; handling of patient care equipment; as well as safe injection practices and infection control practices for specific medical procedures.[8] These obligations should not be placed on construction employers given such employers are not in a position to monitor or enforce these policies. Each of these is clearly outside the control or expertise of a construction employer and have no applicability in construction worksites.

- Section 1910.502(g) provides protocols applicable to the performance of aerosol-generating procedures on a person with suspected or confirmed COVID-19. The employer is required to limit the number of employees present to only "those essential for patient care and procedure support." And as part of these protocols, the ETS provides that an employer should ensure such procedures are performed in an existing airborne infection isolation room (AIIR). A construction employer will never manage the settings in which such procedures are performed. There is clearly no plausible way these protocols for aerosol-generating procedures could be applied to construction work.

- Section 1910.502(i) provides that employers must install solid barriers to block face-to-face pathways between individuals who are not separated by at least 6 feet of distance, in fixed work locations outside of direct patient care areas. This is not practical in construction settings, where workers must frequently move throughout the worksite. Such physical barriers would likely introduce a new hazard to construction worksites, where open movement and communication are essential to worker safety. Requiring workers to navigate a maze of barriers would obstruct sightlines and conceal potential trip and fall hazards. It would also require workers to "work around" barriers that could not be moved which could result in increased muscle strain injuries as a result of increased twisting or reaching. The provision envisions a setting in which there are designated spots "where each person would normally stand or sit." This does not exist in a construction worksite, where a worker's specific work location changes day to day, or even within the day. Further, it is

[6] Available at https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf.
[7] *See* p. 32-39.
[8] *See* p. 43-75.

not appropriate to hold a construction employer responsible for these sorts of physical installments on premises it does not control.

- Section 1910.502(j) of the ETS sets out requirements for the cleaning and disinfection of patient care areas, resident rooms, and medical devices and equipment. Notably, the preamble to the ETS emphasizes the need for disinfection protocols "in indoor community settings where there has been a suspected or confirmed COVID-19 case in the previous 24 hours (CDC, April 5, 2021)."[9] As construction work is not conducted in patient care areas, and construction workers are not privy to patient medical information, this will not apply. The ETS also incorporated COVID-19 Infection Prevention and Control Recommendations and Guidelines for Environmental Infection Control in Health-Care Facilities, which are clearly written with healthcare settings in mind and could not be applied to construction worksites.[10] These include recommendations for air-handling systems and ventilation and recommendations for water distribution systems. Neither of these sets of recommendations make sense in a transient work environment, like construction work performed in healthcare settings. They also include cleaning and disinfecting strategies for patient care areas, including spills of blood and body substances, which is not applicable to construction work because it is not performed in patient care areas. Finally, the recommendations address procedures for handling laundry and bedding, addressing animals in healthcare facilities, and the handling and disposal of regulated medical waste. Each of these is clearly inapplicable to construction work.

- Section 1910.502(k) addresses ventilation requirements for existing buildings or structures with heating, ventilation, and air conditioning (HVAC) systems. The requirements address operation, maintenance, and upkeep of HVAC systems. Again, construction work in a healthcare setting, when indoors, will almost always occur in a building or structure owned or controlled by someone other than the construction employer. As such, this provision would also not apply to construction settings.

The above is not an exhaustive list of the ETS provisions that are not applicable or even relevant to the construction environment—especially indoor work environments in construction—but are provided as examples of why any expansion of the ETS to the construction industry would be inappropriate and unlawful. The Agency has provided no notice as to how these requirements could be extended to cover construction. OSHA may not assert such coverage in any final rule.

B. Construction work cannot be likened to maintenance or custodial work.

OSHA proposes to apply the same requirements under the ETS to construction work in healthcare settings as it applies to maintenance or custodial work in healthcare settings. OSHA offers no explanation as to why it would consider it appropriate for the same provisions to apply to construction as to maintenance and custodial work. There are several key reasons why it is

[9] 86 Fed. Reg. at 32448.
[10] *See* Guidelines, OSHA (Apr. 27, 2021) (available at https://www.osha.gov/sites/default/files/ CDC's_COVID-19_Infection_Prevention_and_Control_Recommendations.pdf).

inappropriate to liken these distinct types of work. First, unlike maintenance and custodial work, construction is generally not performed in public areas within a healthcare setting. While maintenance and custodial workers may go in and out of patient rooms and walk-through busy hallways, construction work is generally set off from any public areas. Usually, construction workers are given their own entrance and exit, and use barriers to ensure others do not enter the construction work site. Negative pressure is used to remove dust and any pathogens that may have traveled from patient treatment areas within the facility. This would be particularly inappropriate in a healthcare environment, given the many potentially hazardous materials and supplies at a construction work site.

In addition, due to the nature of the construction industry and applicable existing regulations, construction employers already implement thorough worker safety and health policies that may not be undertaken by employers in less specialized industries, such as maintenance or custodial work. Construction employers, supervisors, and workers undergo significant hazard recognition training on a regular basis. Crews that are designated to perform work at sites located within healthcare facilities receive specialty training on additional hazards that may be present. They also coordinate closely with the healthcare facilities to ensure that the site employer's premises safety and health policies, and other requirements, are followed.

Finally, aside from these practical differences between the types and methods of work, OSHA's own guidance acknowledges a distinction between "maintenance" and "construction" work. OSHA's regulations define "construction work" as "construction, alteration, and/or repair, including painting and decorating." 29 C.F.R. § 1926.32(g) and 1910.12(b). In determining whether work constitutes "maintenance" or "construction, OSHA looks to the scale and complexity of the project, whether the work is routine and done on a regularly scheduled or periodic basis, and whether the work is focused on improvement versus keeping the existing state, among other factors. Given these distinctions, it is not appropriate for OSHA to make a comparison between construction and maintenance or custodial work for the purposes of applying the same requirements to each.

C. OSHA's proposed expansion is an attempt to regulate "the hazards of daily life" over which OSHA has no jurisdiction.

For many of the same reasons discussed elsewhere in this comment, it is inappropriate for OSHA to eliminate the ETS's exceptions from its scope of coverage, or to in any other way broaden the scope of the rule. The existing exceptions to the scope of the ETS appropriately recognize that certain settings, even some healthcare settings, do not present the increased risk of exposure to COVID-19 that exists in direct patient care settings. Because the ETS's provisions are so closely tailored to the healthcare environment, the rule cannot be applied beyond those settings.

In addition, any such expansion would go beyond OSHA's authority under the OSH Act. The ETS was issued to address a specific hazard of COVID-19 transmission in the healthcare setting. In support of this approach, the Agency at the time explained that "the primary way the SARS-CoV-2 virus spreads from an infected person to others is through the respiratory droplets" and that

"most commonly this occurs when people are in close contact with one another in indoor spaces (within approximately six feet for at least fifteen minutes)."[11] And the preamble further acknowledged that "there are a number of factors – often present in healthcare settings – that can increase the risk of transmission: Indoor settings, prolonged exposure to respiratory particles, and lack of proper ventilation (CDC, May 6, 2020)."[12] As a result, OSHA believed the ETS provisions were necessary to protect workers in the healthcare and healthcare services industries from a grave danger presented by COVID-19 exposure in the workplace.

OSHA initially proposed in a draft rule submitted to the Office of Management and Budget to include all of industry in the healthcare ETS. OSHA reconsidered this, however, and ultimately limited the ETS to just healthcare services and healthcare support services. There is no evidence to justify expansion of this rule to the construction industry or to eliminate prior exemptions that were in place during the Delta and Omicron stages of the pandemic. Instead, this proposal seems to be an attempt by OSHA to regulate "the hazards of daily life" which occur everywhere, which the Supreme Court has made clear is beyond OSHA's regulatory authority.[13]

4. Contractor Requirements Should Be Managed by Healthcare or Other Primary Covered Entity.

A. Construction industry workers already follow appropriate safety procedures when working in healthcare settings.

When construction work at a healthcare facility occurs, appropriate protocols and controls are already implemented to separate construction workers from the facility population. Construction employers work closely with the host facility to ensure compliance with its safety protocols. Construction work in these settings is isolated and sealed off, often with negative pressure and dedicated entry and exit routes.

B. Contractor requirements, including COVID-19 protocols and training requirements, should be managed by the hospital or other contracting entity.

As described in detail above, because the ETS provisions are tailored to a healthcare setting, it does not make sense to apply them to a construction employer. When construction is being performed at a healthcare facility, the construction employers do not have control over all aspects of that facility. Instead, it is common practice for the construction employer to work with the healthcare facility to ensure that all safety and health practices and protocols, typically incorporated into a contract, are followed. The construction employer generally ensures barricades or other proper notices are posted to keep the public and/or healthcare staff out of the construction

[11] 86 Fed. Reg. 32,376, 32,392 (June 21, 2021).
[12] *Id*. at 32,393.
[13] *NFIB v. OSHA*, No. 21A244, slip op. at 7 (S. Ct. Jan. 13, 2022) ("Permitting OSHA to regulate the hazards of daily life—simply because most Americans have jobs and face those same risks while on the clock—would significantly expand OSHA's regulatory authority without clear congressional authorization.").

zones. However, it is ultimately the healthcare facility's responsibility to control these requirements and ensure the protocols are followed.

Because work in healthcare facilities often requires construction crews to follow additional protocols, many construction employers have dedicated personnel that are familiar with these additional requirements and are provided with, and use, additional precautions. These may include additional PPE, scheduling work at non-peak times to minimize the impact on operations and to prevent unnecessary exposures to any communicable illness. These specialized crews also receive training to implement and follow precautions specific to the healthcare industry. Construction employers will comply with the facility safety guidelines in locations where they work. It is unnecessary to add regulations requiring efforts by construction employers that are already ensured by healthcare facility rules and protocols. For this reason, any requirements for construction employers should be focused on facilitating a dialogue with the contracting facility regarding COVID-19 and other safety protocols.

5. Conclusion.

The CISC appreciates OSHA's consideration of these comments. Construction is generally low-risk for COVID-19 exposure and the industry has been proactive at protecting its employees throughout the pandemic. Application of a final Occupational Exposure to COVID-19 in Healthcare Settings Rule to construction is unnecessary and is unsupported. Likewise, renewal of the standard after the ETS's six-month expiration is unnecessary and unsupported.

Sincerely,

The Construction Industry Safety Coalition

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