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

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

Dear Assistant Secretary Parker,

I am pleased to submit these comments on the Occupational Safety and Health Administration's ("OSHA")'s permanent COVID-19 standard ("Occupational Exposure to COVID-19; Emergency Temporary Standard" ("ETS"), Docket No. OSHA-2020-0004, published in the Federal Register on March 23, 2022) on behalf of the National Electrical Contractors Association ("NECA") and its members.

NECA represents electrical contractors that erect, install, repair, service, or maintain electrical wiring, devices, or equipment. NECA serves as the voice of the electrical construction industry. Its members bring power, light, and communication technology to communities across the United States. NECA contractors are the technical professionals responsible for the most innovative and safest electrical construction in the country.

NECA understands that OSHA has reopened the comment period in part to solicit comments on an expansion of the Emergency Temporary Standard ("ETS"), which did not seem to apply to NECA members, to expressly include coverage of construction activities in healthcare settings. *See* 87 FR 16426, 16427 (March 23, 2022) ("Limited Coverage of Construction Activities in Healthcare Settings"):

> OSHA did not expressly include employers that engage in construction work in hospitals, long-term care facilities and other settings that are covered by the ETS. The construction industry was not included in OSHA's industrial profile for the rule. OSHA is considering clarifying this coverage and seeks comment on this approach. For example, OSHA 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. OSHA could consider exceptions for construction work in isolated wings or other spaces where construction employees would not be exposed to patients or other staff.

As a fundamental backdrop to these comments, we would like OSHA to recognize and focus on the critical distinction between construction activities and patient care in healthcare settings. New construction, demolition, and renovation (contemplated by OSHA as installing new ventilation or new equipment or adding a new wall) largely occurs away from patient, staff, and visitor areas, which are the primary sources of increased exposure risk to COVID-19 in healthcare settings.

As explained below, we urge OSHA to maintain an exclusion of construction activities in any permanent COVID-19 standard developed.

I. Construction Workers in Healthcare Settings Do Not Have the Same Risk Exposure as Healthcare Providers

As a threshold matter, employers that engage in construction activities in hospitals, long-term care facilities and other settings covered by the ETS, do not face risks of exposure to COVID-19 that even approach the risk that healthcare employees potentially face in these settings. From the outset of the pandemic, the Centers for Disease Control and Prevention ("CDC") has recognized that healthcare employees face a uniquely grave danger of COVID exposure. The ETS acknowledges the elevated risk associated with providing healthcare services. *See* The Preamble 86 FR 32376, 32381 (explaining "OSHA has determined that *healthcare employees* face a grave danger from the new hazard of workplace exposures to SARS-CoV-2.") (emphasis added).

The CDC's Morbidity and Mortality Weekly Report ("MMWR") in its *Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices ("ACIP")* publication defines a healthcare worker as: "all paid and unpaid persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air." It is a virtual certainty that construction workers working in healthcare settings would not be subject to these exposures while performing construction activities.

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 suspected of having or known to have COVID-19. COVID-19 Control and Prevention: Construction Work, OSHA (last visited April 19, 2022) available at https://www.osha.gov/coronavirus/control-prevention/construction. Although, construction activities in healthcare settings are indoor work sites, they are not occupied by people suspected of having or known to have COVID-19 because new construction, demolition, and renovation occurs away from patient, staff, and visitor areas.

To ensure the separation of construction activities from areas where healthcare is provided, the Joint Commission[1] standards require that temporary construction partitions be smoke tight and built of noncombustible or limited combustible materials (sheet rock, gypsum board) that

[1] The Joint Commissions provides accreditation to and publishes safety and health standards for U.S. health care facilities.

will not contribute to the development or spread of fire. Partitions that do not permit the transmission of smoke similarly inhibit aerosol transmissions, such as COVID-19.

In fact, any interaction that construction employees have with patients is momentary (e.g., passing in hallways or aisles). Construction activities simply do not occur in patient care areas.[2]

A central requirement of OSHA's ETS is compliance with the terms of the CDC's "Guidelines for Isolation Precautions." ("Employers must develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions in accordance with CDC's 'Guidelines for Isolation Precautions.'" 29 C.F.R. 1910.502(e).) However, construction employers are not healthcare providers; they do not have the potential for exposure to patients or to infectious materials, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. It not only would be extremely burdensome and completely unnecessary to apply this type of patient-based requirement on construction contractors, but it actually is nonsensical.

II. Construction Activities in Health Care Settings Already Have Infection Control Measures In Place That Protect Against COVID-19

While OSHA has considerable expertise in controlling workplace hazards, the coronavirus hazard is not uniquely a workplace hazard – it does not originate or emanate from the workplace or work practices; it is not a by-product of an operation or task performed at a workplace. Rather, it is a community hazard coincidentally, inadvertently, and unknowingly carried into the workplace by employees and the public. The pandemic is, first and foremost, a public health concern rather than a workplace hazard, and as such, the principal policymaker for defeating it should remain the CDC, the preeminent U.S. authority on public health and infectious disease. This is especially true when considering the hazards created by construction in healthcare facilities, where infection control measures are greater in scope than COVID-19. This is not to say that OSHA lacks jurisdiction to establish a standard requiring mitigation protocols, but that standard is not required where infection control authorities like the CDC's Healthcare Infection Control Practices Advisory Committee's ("HICPAC"), the Center for Medicare and Medicaid Services ("CMS"), and The Joint Commission have established significant infection control requirements for construction activities in healthcare facilities. Indeed, OSHA has noted in its Infectious Disease Request for Information, the HICPAC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare

[2] When construction employers engage in general maintenance work, rather than traditional construction and demolition, the Joint Commission requires organizations to have a process that allows for minor work tasks to be performed in established locations or under particular low risk circumstances using predetermined levels of protective practices. The assessment covers potential risks to patients, staff, visitors, or assets for air quality, *infection control*, utility requirements, noise, vibration, and any other hazards applicable to the work. This Joint Commission requirements already address and cover maintenance work conducted by contractors in healthcare settings.

Settings recommends an Infection Control program for addressing the transmission of airborne and other infectious diseases. OSHA Docket No. OSHA-2010-0003.

Also, in certain settings, CMS and The Joint Commission require that health care facilities have such programs.

The requirements and/or recommendations of HICPAC, The Joint Commission, and CMS are carried forward into the contracts between healthcare companies and their contractors. Thus, construction contracts for work in healthcare settings already have substantial infection control protocols in place. However, because these are based on the recommendations or requirements of these other government bodies and/or the best practices of the healthcare company, they will differ in various ways with OSHA's standard. To be required to comply with both OSHA's standard as well as the many infection control requirements carried into hospital/healthcare contracts would create confusion, but, more importantly, would be unnecessary.

Any interaction that construction employees have with patients is momentary (e.g., passing in hallways or aisles). Construction activities occur apart from patient care areas. When construction employers are engaging in general maintenance work, rather than traditional construction and demolition, the Joint Commission requires organizations to have a process that allows for minor work tasks to be performed in established locations or under particular low risk circumstances using predetermined levels of protective practices. The assessment covers potential risks to patients, staff, visitors, or assets for air quality, infection control, utility requirements, noise, vibration, and any other hazards applicable to the work.

Under the proposed standard's Standard and Transmission-Based Precautions, "[e]mployers must develop and implement policies and procedures to adhere to Standard and Transmission-Based Precautions in accordance with CDC's 'Guidelines for Isolation Precautions.'" 29 C.F.R. 1910.502(e). The CDC's 'Guidelines for Isolation Precautions apply to patient care and are "based on a risk assessment and make use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient." Construction employers are not healthcare providers; they do not have the potential for exposure to patients or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. The Standard and Transmission-Based Precautions are nonsensical for construction activities.

III. It Would be Technologically Infeasible or Operationally Challenging and Burdensome to Apply the Permanent COVID-19 Requirements to Construction Activities in Healthcare Settings

It would be technologically infeasible and/or operationally challenging and burdensome to apply many of the requirements of the ETS, that likely will be carried into the permanent COVID-19 standard, to construction activities occurring in healthcare settings. Contractors in healthcare settings have very little control over the workplace. Importantly, contractors also do not have the institutional knowledge or actual information to make informed judgments about the risk of exposure to SARS-CoV-2. Construction contractors do not know which

patients have COVID-19, where the sources of exposure are in the hospital, and/or what the level and type of exposure is for patients with undiagnosed illnesses that arrive at the hospital for treatment in emergency rooms of hospitals or urgent care centers in ambulatory care settings. *See* 86 FR 32376, 32377. Accordingly, construction contractors should not be obligated to perform hazard assessments for COVID in these healthcare settings. They should be able to rely on the hazard assessments performed by the host healthcare employers to ensure their own employees are protected. This, of course, would require coordination and a review of the healthcare employer's COVID-19 plan prior to commencement of work. As described below, NECA supports inclusion of a coordination element and requirement in the permanent standard.

The physical distancing and barriers requirements of the COVID-19 standard also are infeasible and impractical to implement for construction activities, and, again, completely unnecessary. The proposed standard states, "[t]he employer must ensure that each employee is separated from all other people by at least 6 feet when indoors unless the employer can demonstrate that such physical distancing is not feasible for a specific activity (e.g., hands-on medical care)." *See* 29 C.F.R. Section 1910.502(h)(1). And, "[a]t each fixed work location outside of direct patient care areas . . . where each employee is not separate from all other people by at least 6 feet of distance, the employer must install cleanable or disposable solid barriers, except where the employer can demonstrate it is not feasible." *See* 29 C.F.R. Section 1910.502(i).

It is not possible to maintain physical distances and erect physical barriers on an active construction site. For safety and operational reasons construction requires that employees can work side-by-side. Requiring physical distancing and barriers would disrupt these activities. Moreover, barriers assume that a worksite is stationary, but on an active construction site employees are not static. Construction, demolition, and renovation activities requires continued movement.

Although the physical distancing and barrier provisions expressly incorporate an element of feasibility into the requirements, OSHA provided guidance that "[t]he burden is on the employer to demonstrate that it is infeasible to comply with the required physical distancing for a specific activity or workspace. If the employer can demonstrate that the space cannot be expanded, and that multiple employees must be in that space at the same time (i.e., that there are no other feasible alternatives that would permit 6 feet of physical distancing), the employer satisfies its burden under the physical distancing requirements. However, in such cases, employers must ensure that employees maintain as much physical distance as possible." *See* OSHA Healthcare ETS FAQs #28. Employers are greatly concerned about having to prove infeasibility, particularly because compliance officers might issue citations without a thorough review of infeasibility, leading employers to then have to expend, if they can, significant resources towards defending (meritless) citations.

Another example of an infeasible requirement, as applied to construction contactors, is the obligation to wear facemasks at all times. Under OSHA's proposal, "[e]mployers must provide, and ensure that employees wear, facemasks that meet the definition in paragraph (b) of [the ETS]; and [t]he employer must ensure a facemask is worn by each employee over the nose and mouth when indoors and when occupying a vehicle with other people for work purposes. The employer must provide a sufficient number of facemasks to each employee to comply with this

paragraph and must ensure that each employee changes them at least once per day, whenever they are soiled or damaged, and more frequently as necessary (*e.g.*, patient care reasons)." *See* 29 C.F.R. Section 1910.502(f)(1)(i)-(ii).

It may be obvious why this is not feasible or at all practical in construction settings, but in case it is not clear, NECA members have shared that wearing facemasks during construction activities can create additional hazards that certainly would be potentially far greater than the hazard of exposure to COVID-19 because the employee is working on the grounds of a hospital or nursing home. As we believe OSHA is likely aware, wearing facemasks and safety googles often causes the googles to fog, which can lead to reduced visibility. This poses a serious safety hazard on an active construction site, where visual awareness of surroundings in imperative to safety.

On top of all this, unfortunately, masking has become a political issue, and requiring construction employees to wear masks has become a very difficult challenge that has gotten more difficult as states and private entities drop their mask mandates and requirements. For these reasons combined with an increasingly tight labor market, NECA members are highly concerned about the masking requirement being applied to its employees working in healthcare settings.

OSHA's guidance has already contemplated that it may not be feasible in the construction context to meet this requirement. *See* OSHA's COVID-19 Control and Prevention Construction Work Guidance (explaining "it may not be practical for workers to wear a single cloth face covering for the full duration of a work shift (e.g., eight or more hours) on a construction site if they become wet, soiled, or otherwise visibly contaminated during the work shift.") For these reasons combined with an increasingly tight labor market, NECA members are concerned about the inclusion of a masking requirement.

IV. If OSHA Must Include Construction Activities in Healthcare Facilities, Construction Employer's Should be Required Only to Coordinate with Healthcare Facilities

To the extent that OSHA determines that construction activities in healthcare settings should be covered by the COVID-19 permanent standard, we recommend OSHA adopt limit application of the full requirement of the standard to construction employers and simply impose on these contractors a requirement to coordinate with healthcare employers covered by the standard prior to conducting work at a covered facility. This approach is consistent with the expectation OSHA had built into the ETS for facilities at which employees of multiple employers are present.

In multi-employer situations, OSHA states that employers must effectively communicate their COVID-19 plans with all other employers; coordinate to ensure that each of their employees is protected as required by the standard; adjust their COVID-19 plans to address any particular COVID-19 hazards presented by the other employees when employees of different employers share the same physical location; and notify the controlling employer when an employees of that employer working in a physical location controlled by another employer are exposed to

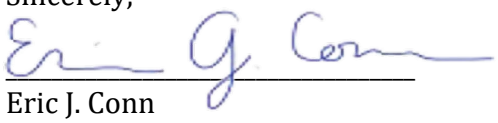
conditions at that location that do not meet the requirements of the ETS. *See* 29 C.F.R. Section 1910.502(c)(7)(ii)(A); 1910.502(c)(7)(ii)(B).

NECA does not believe the permanent standard should include the level of specificity included in the ETS. In particular, NECA does not believe contractors should be required to develop a written COVID-19 plan, so it would not make sense to require a specific plan document to be shared. However, it would make sense for contractors to coordinate with the host (the hospital, nursing home, etc.) and with all other contractors that will be working in the same location of the host's facility at the same time, regarding infection control protocols that are suitable to prevent transmission of COVID-19 to their workforce.

V. Conclusion

NECA respectfully requests that OSHA give meaningful consideration to the comments and recommendations provided herein as OSHA develops a permanent COVID-19 Standard for Healthcare.

Sincerely,



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On Behalf of the National Electrical Contractors Association (NECA)