STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS

OCCUPATIONAL SAFETY & HEALTH STANDARDS BOARD

COVID-19 PREVENTION SUBCOMMITTEE MEETING

In the Matter of:)
)
August 13, 2021 OSH)
COVID-19 Prevention)
Subcommittee Meeting)
_____________________)

TELECONFERENCE

PLEASE NOTE: In accordance with Executive Order N-29-20 and Executive Order N-33-20, the Subcommittee Meeting will be conducted via teleconference

FRIDAY, AUGUST 13, 2021

10:00 A.M.

Reported by:
E. Hicks

APPEARANCES

BOARD MEMBERS:

Chris Laszcz-Davis, Subcommittee Chair and Management Representative on the Board
Nola Kennedy, Public Member on the Board and Liaison for the Subcommittee to the Division
Laura Stock, Occupational Safety Representative on the Board

BOARD STAFF PRESENT AT OSHSB OFFICE IN SACRAMENTO:

Christina Shupe, Executive Officer
Michael Manieri, Principal Safety Engineer
Autumn Gonzalez, Chief Counsel
Sarah Money, Executive Assistant
Michael Nelmida, Sr. Safety Engineer
Jennifer Bailey, Sr. Safety Engineer

BOARD STAFF ATTENDING VIA TELECONFERENCE AND/OR WEBEX:

Lara Paskins, Staff Services Manager
Amalia Neidhardt, Senior Safety Engineer

TKO STAFF:

Brian Monroe
John Roensch
Maya Morsi
John Gotcher

ALSO PRESENT:

Dr. Amy Heinzerling, Public Health Medical Officer, California Department of Public Health, (CDPH)
Dr. Rajiv Das, Medical Officer, Cal/OSHA Medical Unit
Eric Berg, Deputy Chief of Health, Cal/OSHA

SPANISH INTERPRETERS:

Patricia Hyatt
Estela Moll

PUBLIC COMMENT:

Bruce Wick, Housing Contractors of California
Derrick Jarvis, Wine Institute
Anne Katten, California Rural Legal Assistance Foundation
Pamela Murcell, California Industrial Hygiene Council
Helen Cleary, Phylmar Regulatory Roundtable
Eddie Sanchez, SoCalCOSH
Bryan Little, California Farm Bureau, CAFB
Bethany Miner, HR professional
Madeline Stone, Self
Stephen Knight, Worksafe
Kevin Bland, Ogletree, Deakins, Nash, Smoak & Stewart
Rob Moutrie, California Chamber of Commerce
Michael Miiller, California Association of Winegrape Growers

I N D E X

Page

I. CALL TO ORDER AND INTRODUCTIONS 6

II. BUSINESS

A. Subcommittee Liaison Briefing (Nola Kennedy) 10

B. Division Briefing (Division Staff) 11

i. COVID-19 Complaints, Fatalities, and Illnesses:
February 2020 – June 2021

ii. Metrics and Implications

C. CDPH Briefing (Dr. Amy Heinzerling) 32

i. Overview of CDPH Outbreak Data (Including June, 2021)

1. How CDPH Collects COVID-19 Outbreak Data
2. Highlights from 2021 Outbreak Data:
Time Trends, Most Common Industries
3. Important Data Limitations

D. Emergency Temporary Standard: History and Process (Board Staff) 46

i. OSHSB's History with Emergency Temporary Standards

ii. Process:

1. Adoption
2. 1st Re-adoption
3. 2nd Re-adoption
4. Certificate of Compliance

iii. COVID-19 Prevention ETS: Where we are in the Process

E. Public Comment (30 minutes) 54

I N D E X (Cont.)

Page

III. SUBCOMMITTEE CONSIDERATION (if needed) 74

This portion of the agenda is for subcommittee consideration of items presented during the meeting, as well as an opportunity for its members to engage in robust discussion and to request additional information from staff, the Division, or stakeholders. Items listed under this heading have been identified as being of particular interest for discussion.

i. COVID-19 Prevention Metrics – Examples of Use

IV. FUTURE SUBCOMMITTEE AGENDA ITEMS 77

V. MEETING ADJOURNMENT 80

Next Meeting: August 27, 2021
Teleconference and Video-conference
(In accordance with Executive Orders N-29-20 and N-33-20)
10:00 a.m

Reporter's Certificate 81

Transcriber's Certificate 82

1 PROCEEDINGS

2 AUGUST 13, 2021 10:04 a.m.

3 BOARD MEMBER LASZCZ-DAVIS: Good morning. This
4 Subcommittee Meeting of the Occupational Safety and Health Standards
5 Board is now called to order. I am Chris Laszcz-Davis, Subcommittee
6 Chair and Management Representative on the Board. And the other
7 Board Members present today for this subcommittee are Ms. Nola
8 Kennedy, Public Member on the Board and liaison for the Subcommittee
9 to the Division; Ms. Laura Stock, Occupational Safety Representative on
10 the Board.

11 Also present from our staff for today's meeting are Mr.
12 Michael Manieri, Principal Safety Engineer; Ms. Autumn Gonzalez, Legal
13 Counsel; Ms. Sarah Money, Executive Assistant; and Mr. Michael Nelmida
14 and Ms. Jennifer Bailey, Senior Safety Engineers who are providing
15 technical support.

16 Supporting the meeting remotely are Ms. Lara Paskins, Staff
17 Services Manager. And Ms. Amalia Neidhardt, Senior Safety Engineer,
18 who is providing support to Ms. Kennedy and providing translation
19 services for our commenters who are native Spanish speakers.

20 Via teleconference we are joined today by Dr. Amy
21 Heinzerling, Public Health Medical Officer representing the California
22 Department of Public Health, Occupational Health Branch. We are also
23 joined by Dr. Rajiv Das, Medical Officer representing the Cal/OSHA
24 Medical Unit; Dr. Mike Wilson, Senior Industrial Hygienist; and Mr. Eric
25 Berg, Deputy Chief of Health, representing Cal/OSHA.

1 Today's agenda and other materials related to today’s
2 proceedings are posted on the OSHSB website.
3 In accordance with Executive Orders N-29-20 and N-33-20,
4 today’s subcommittee meeting is being conducted via teleconference,
5 with an optional video component.
6 This meeting is also being live broadcast via video and audio
7 stream in both English and Spanish. Links to these non-interactive live
8 broadcasts can be accessed via the “What’s New” section at the top of
9 the main page of the OSHSB website.
10 We have limited capabilities for managing participation
11 during the public comment period, so we’re asking everyone who is not
12 speaking to place their phones on mute and wait to unmute until they
13 are called to speak. Those who are unable to do so will be removed from
14 the meeting to avoid disrupting the proceedings.
15 As reflected on the agenda today’s meeting consists of two
16 parts. First, we will hold a business meeting for the subcommittee to
17 conduct its business. During the business meeting there will be an
18 opportunity for the subcommittee to receive public comments. These
19 comments are to be confined to the revised COVID-19 Emergency
20 Temporary Standard, or ETS, recently adopted by the Board.
21 Please be all aware that the committee is capping the public
22 comment period to 30 minutes. And each speaker during the public
23 comment period will be given two minutes to address the committee.
24 You are also invited to submit your comments in writing to
25 the committee at oshsb@dir.ca.gov. Please be sure to specify that your

1 written comments are for the COVID-19 Prevention ETS Subcommittee so
2 that they are directed accordingly by the Board staff.
3 During the public comment period please listen for your name
4 and an invitation to speak before addressing the committee. And please
5 remember to mute your phone or computer after commenting.
6 OSHSB staff can be contacted by email at oshsb@dir.ca.gov as
7 reflected in the agenda -- whoops, forgive me here. Forgive me here.
8 OSHSB staff can be contacted by email at oshsb@dir.ca.gov or
9 via phone at 916-274-5721 to be placed in the comment queue. If you
10 experience a busy signal or are routed to voicemail please hang up and call
11 again.
12 After the business meeting has been concluded we will conduct
13 the second part of our meeting, which consists of subcommittee
14 consideration and deliberation as needed.
15 For our commenters who are native Spanish speakers we are
16 working with Ms. Amalia Neidhardt to provide a translation of their
17 statements into English for the committee. And at this time Ms. Neidhardt
18 will provide instructions to the Spanish-speaking commenters so they are
19 aware of the public comment process for today’s meeting. Amalia?
20 MS. NEIDHARDT: [READS THE FOLLOWING IN SPANISH] Public
21 Comment Instructions.
22 "Good morning and thank you for participating in today’s
23 Occupational Safety and Health Standards Board COVID-19 Prevention
24 Subcommittee Meeting. Board members present are Ms. Chris Laszcz-
25 Davis, Subcommittee Chair and Management Representative on the

1 Board, Ms. Nola Kennedy, Public Member on the Board and liaison to
2 the Division for this subcommittee; and Ms. Laura Stock, Occupational
3 Safety Representative on the Board.
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11 yourself if you're using WebEx or dial *6 on your phone to unmute
12 yourself if you're using the teleconference line. Please be sure to speak
13 slowly and clearly when addressing the committee and please remember
14 to mute your phone or computer after commenting. If you have not
15 provided a written statement, please allow natural breaks after every
16 two sentences, so that we may follow each statement with an English
17 translation."
18 BOARD MEMBER LASZCZ-DAVIS: All righty, thank you. Thank
19 you, Amalia.
20 With that we'll move into the business meeting segment of
21 this. Ms. Kennedy, can you provide us with the Subcommittee Liaison
22 Briefing?
23 BOARD MEMBER KENNEDY: Hello. Yeah, I have just a couple
24 of comments, my briefing is brief. I have met twice with the Division
25 alone since our last subcommittee meeting and then a third meeting that

1 included Cal/OSHA and a representative from CDPH, Dr. Amy
2 Heinzerling. And they are going to be doing presentations today that will
3 cover what we have been discussing. And that's all I have to say.
4 BOARD MEMBER LASZCZ-DAVIS: Thank you, Nola.
5 So let's move on over to the Division Briefing. Dr. Das, Dr.
6 Wilson, and Mr. Berg will you please brief the subcommittee?
7 MR. MANIERI: Chairman Davis, Mike Manieri, may I just
8 make a brief statement before the presentations begin?
9 BOARD MEMBER LASZCZ-DAVIS: Absolutely.
10 MR. MANIERI: Yes, just a brief reminder that if you -- public
11 wishes to obtain copies of the presentations by the Division and Dr.
12 Heinzerling in accordance with the Public Records Act, please email your
13 PRA request to oshsb@dir.ca.gov,G-O-V. Thank you.
14 BOARD MEMBER LASZCZ-DAVIS: Thank you, Mike. And with
15 that let's go back to Dr. Das, Dr. Wilson and Mr. Berg.
16 MR. BERG: All right, thank you. Can I have the presentation
17 please? Thank you very much.
18 So we will give an update on COVID-19 in California, trends,
19 information on the Delta variant, and vaccinations. So with me is Dr.
20 Das, a medical doctor with the Cal/OSHA Medical Unit and Dr. Michael
21 Wilson, the Cal/OSHA Research and Standards Unit.
22 So first we will start with Dr. Das. And can you hear --
23 DR. DAS: Thank --
24 MR. BERG: Sorry, go ahead.
25 DR. DAS: Oh, no, no. Go ahead. Can I ask you to advance

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1 the slides for me then?

2 MR. BERG: Yeah, whoever is in charge.

3 DR. DAS: Yes. Okay, sure.

4 So if you could go to the first slide, please. I just would like
5 to give a brief overview of what we're talking about with respect to what
6 a variant is. And this is kind of just an image excerpted from an article of
7 what the coronavirus looks like. And I think you see the main body of the
8 virus. And the part of interest or the little things waving are the spike
9 proteins. And that's kind of the important part in terms of vaccines and
10 transmission. And hopefully it kind of gives a little bit of context with
11 what information follows in the rest of the presentation. Next slide,
12 please.

13 And so here we have kind of an enlarged image of what the
14 spike protein is. And the most important part of the spike protein is that
15 receptor-binding domain. If you can read that, that's at the top. And
16 that's the part that attaches to the cells and that's the part that our
17 antibodies from our vaccines target to prevent the virus from attaching
18 to cells. And so it's very important that we get what we call neutralizing
19 antibodies to bind to that area. And what happens is they are able to
20 camouflage it, block it, or mutate and change the configuration of that
21 receptor-binding domain, so it makes it more challenging for antibodies
22 to bind.

23 And that’s some of the challenge that we’re seeing in the
24 future, but hopefully that kind of gives a visual representation of what
25 we're dealing with. It's actually quite simple, but it's a challenging

1 process. Next slide, please.

2 So in summary, the spike proteins attach to the human cells

3 and that facilitates entry into the cells. And that allows the virus to

4 reproduce in our cells. And then they leave our cells and more virus goes

5 in and infects us.

6 The next issue is that the antibodies bind to the spike

7 proteins, and that prevents the virus from attaching to cells. And one of

8 the novel types of vaccines we have been using is the mRNA vaccine, and

9 basically it inserts instruction to our muscle cells and some of the lymph

10 node cells instructing our cells how to make the coronavirus spike

11 proteins. And in that way we can develop our own immunity before we

12 get exposed to the actual virus.

13 And when you see the term "neutralizing antibodies," those

14 are the particular types of antibodies that we develop that actually

15 prevent the virus from attaching. Certainly there is all different parts of

16 the protein that you saw and we can develop antibodies to those regions,

17 but the most important antibodies we develop are the ones of the

18 receptor-binding domain.

19 And I think to alleviate some people’s concerns the mRNA

20 that's in the vaccines actually breaks down after a few days and is no

21 longer active. And so it's a very nice novel way of introducing immunity

22 without having any long-term persistence of any type of outside mRNA.

23 Next slide, please.

24 And so when we talk about variants basically we are looking

25 at mutations of the spike protein as we go down the Greek alphabet.

1 Some things of interest is that even though the coronavirus mutates it
2 actually mutates less than the influenza virus.
3 It changes the shape of the spike protein. And one of the
4 differences between the Delta variant and the prior versions is that it
5 does a little bit better job of attaching to human cells than the prior
6 ones. And that's one of the challenges. Next slide, please. I think that's
7 going to transition to -- oh, actually one more.
8 And so in part, I believe from my perspective, one of the
9 goals of vaccination are basically seen from the literature that it
10 prevents serious illness. And we can see that we are able to develop
11 antibodies that stop the virus from attaching and replicating as easily.
12 And therefore we have less hospitalizations and less death.
13 And obviously if we have effective antibodies that prevent
14 transmission from person to person that also is a good public health goal.
15 And then the other big issue is there is decreased
16 opportunity for viral replication, which means that if more of us are
17 vaccinated there is less chance of transmitting infection, less chances of
18 viral -- the virus reproducing itself. And less likely that it’s going to get
19 the opportunity to mutate, because it's not replicating as often.
20 I hope that’s somewhat clear and that concludes my portion.
21 It's just a basic kind of understanding of kind of what the vaccine’s target
22 is and why we want to vaccinate.
23 Dr. Wilson with the next slide, as your guest.
24 DR. WILSON: Great, thanks. Thanks very much Dr. Das.
25 And so I’m going to talk a little bit about some of the trends

1 around vaccination and then also cases, deaths, and hospitalizations.

2 So this graphic is showing California fully vaccinated

3 individuals cumulative from January 1st to August 8th, and you can sort

4 of see a plateauing there. California has a little under 40 million people,

5 including children. And we have about 22 million who are fully

6 vaccinated. That's 56 percent of the total population. It's 65 percent for

7 individuals over 18.

8 But as you can see here the number of people being fully

9 vaccinated per day has dropped from about 250,000 in April to about

10 40,000 today. So next slide, please.

11 As we've all heard the new COVID-19 cases are occurring

12 primarily among unvaccinated Californians. And these are some of the

13 data showing that, about a week old, the statewide average COVID-19

14 case rate for the week of August 7th was unvaccinated, about 51 cases

15 per 100,000 per day. And among the vaccinated about 8.2 cases. So this

16 is about a 600 percent higher case rate among unvaccinated compared to

17 vaccinated. Next slide, please.

18 And I think Eric Berg will talk a little bit more about vaccine

19 effectiveness at the end of the presentation, but what we initially were

20 seeing was that against the Delta variant the vaccines are about 88

21 percent effective against symptomatic disease and 96 percent effective

22 against hospitalization. And when you compare that to the Alpha variant

23 the vaccines were about 94 percent effective against symptomatic

24 disease and 95 percent effective against hospitalization.

25 And again, these were numbers that are from July 31st from

1 Dr. Brooks from the CDC. Next slide, please.

2 And again, Eric will talk a little bit more about this. These

3 are numbers from England, Scotland, Canada and Israel looking at the

4 effectiveness of the vaccines against both Delta and Alpha with some

5 indication that we're seeing less effectiveness, particularly in this study

6 from Israel, and a recent study actually this week that Eric will talk

7 about. So let's move on and I'll let Eric review that aspect. So, next

8 slide.

9 MR. BERG: Okay.

10 DR. WILSON: Oh, yeah, go ahead yes. Go ahead, Eric.

11 MR. BERG: Okay, sure thanks.

12 Yeah, there's a real new study –- yeah, we can stay on this

13 slide for now. As you see from it's in the England, Scotland, and Israel

14 there's three different data points. One is confirmed infection and that

15 means the person tested positive for COVID. They might not have had

16 any symptoms, might not have been sick at all, but they did test positive.

17 And then there's symptomatic disease and hospitalizations. So kind of

18 the different severities of the illness, from almost none to very serious.

19 And you can see from the England-Scotland one it was much

20 more effective against actual illness and Israel's did not show that. And

21 in Canada they did not examine that. Next slide, please.

22 So there was a new study that was just published and it was

23 in the press quite a bit from Minnesota. And they looked at recent

24 trends in COVID and they found the Delta variant prevalence in

25 Minnesota went from 0.7 percent in May of '21 to over 70 percent in July

1 2021. So the Delta, a massive increase and then the reverse, Alpha
2 variant prevalence decreased from 85 percent to 13 percent over the
3 same period. So the Delta variant spike in California and the rest of the
4 country and the rest of the world, the Delta variant has taken over and
5 the Alpha variant has kind of faded away. Next slide, please.
6 So from this study they determine the effectiveness. And
7 effectiveness as it's used here is just testing positive. A person might
8 not have had any illness at all, but they tested positive. So the Moderna
9 vaccine effectiveness was 76 percent and the Pfizer vaccine was 42
10 percent. So this is showing much lower effectiveness for Pfizer than
11 previous studies, so there's more work to be done to see what's actually
12 the truth or what's the real data, but this is concerning. But again, this
13 is just for testing positive. Both of these vaccines are still extremely
14 effective, protecting people against getting sick, you know, severe
15 disease and hospitalization so that's really important.
16 The problem with being effective against just testing positive
17 is that it could be transmitted from vaccinated persons that test positive
18 to other people. So that's concerning, because they're still protected
19 against illness or severe illness and death, but they may be able to
20 transmit it to other people. Next slide, please.
21 And this goes back to you, Dr. Wilson.
22 DR. WILSON: Yeah --
23 BOARD MEMBER STOCK: (Indiscernible) excuse me a second,
24 excuse me, Mike. Eric, this is Laura. I just had a quick question.
25 MR. BERG: Sure.

1 BOARD MEMBER STOCK: Since all of your slides are about
2 Moderna or Pfizer, do you have any information of Johnson & Johnson?
3 MR. BERG: No. Not with the Delta, no sorry.
4 DR. WILSON: Okay, so let's look at sort of where we've been
5 both in the U.S. and in California. This is a graphic showing the seven-
6 day average for COVID-19 cases and deaths nationwide. And again, this
7 was from Dr. Brook’s briefing a couple of weeks ago. Cases and deaths
8 were dropping until July 1st and then cases increased about 400 percent
9 leading up to July 31st.
10 We've not seen a corresponding increase in deaths, at least
11 at this point. And there's some speculation or thought that that is
12 possibly due to vaccinations as well as to improved management of
13 COVID-19 patients.
14 And we've also heard that it, under management is also just
15 the consideration that hospitals up until recently, actually this week,
16 haven't been overwhelmed with cases and so that obviously has an
17 impact. That improves patient outcomes when staff aren't overwhelmed
18 with number of patients that they're caring for each day. But so let's
19 look at this a little more carefully. So next slide, please.
20 This is again from July 31st and this is showing nationwide
21 cases rising over 400 percent from July 6th to July 28th. And the way the
22 CDC looks at this is counties that are showing substantial to high levels
23 of transmission with substantial being in the orange, high being in the
24 red. On July 6th it was about 24 percent of U.S. counties. And two
25 weeks later it was 67 percent of counties reporting substantial to high

1 levels of transmission. Next slide, please.

2 Actually, let me go back –- why don’t you go back to the last

3 slide please, the previous slide? Just a couple more, just sort of to

4 update this. Again this was from July 31st, so as of this week there are

5 more than 100,000 new cases each day in the U.S. and those seem to be

6 driven primarily by cases in a number of case –- of states.

7 But as Eric just said Delta, what we're seeing is that the

8 Delta variant makes up about 3 percent of cases -- was making up about

9 3 percent of cases on June 1st, six weeks ago essentially. And now makes

10 up more than 90 percent of cases that we're seeing nationwide. Okay, so

11 let's go to California now. Next slide, please.

12 So we're seeing a similar trend here in California. This is the

13 top graphic is California’s seven-day average for reported COVID-19 cases

14 rising quickly. And as you can see in the bottom graphic it doesn't

15 appear to be causing a rise in COVID-19 deaths.

16 And so as of August 9th, four days ago, we had about a little

17 over 64,000 total COVID-19 deaths in California, with a positivity rate of

18 6.3 percent. As of yesterday California is reporting more than 10,000

19 new cases each day on average, which is a tenfold increase since July 1st.

20 So now let's look at hospitalizations. Next slide, please.

21 One of the things that's concerning is that hospitalizations

22 for confirmed or suspected COVID-19 cases have been closely tracking

23 the trend in cases since mid-July. So in that top graphic you can see the

24 sharp increase that's shown leading up to August 1st. And so to just sort

25 of compare where we've been, on June 12th there were a little over

1 1,100 hospitalizations in California for confirmed or suspected COVID-19
2 cases. This increases to over 6,000 by August 9th, so four days ago just a
3 500 percent increase. And August 9th showed a 4.3 percent increase
4 from the day before from August 8th.
5 Not surprisingly, as you can see on the bottom graphic, that
6 is showing the availability of ICU beds in California. On June 12th there
7 were 269 COVID-19 patients in ICUs in California. This increased to a
8 little over 1,300 ICU patients by August 9th, so also a 500 percent
9 increase. And that was a 4 percent from the day before on August 8th.
10 Yeah, we heard yesterday that UCSF had 1 COVID-19 patient on June 1st
11 and has 41 as of yesterday.
12 We've also seen some of the reports out of Texas where
13 health officials have been warning of overloaded hospitals more than --
14 so in that state they are experiencing about 10,000 Texas residents being
15 hospitalized. They were hospitalized this week in the last seven days.
16 But 53 hospitals were at maximum capacity in their ICU, even in their
17 intensive care units. And what we're seeing is that the vast majority of
18 those patients in ICUs are unvaccinated. So next slide, please.
19 So this is a way to sort of just give us a sense of sort of the
20 breakdown of the California workforce. And sort of again the folks who
21 are most vulnerable in frontline positions. And so this is from the
22 Legislative Analyst's Office work from last year on December, trying to
23 really get sort of a better understanding of who the frontline workers are
24 in California. And so they've classified these as frontline workers being
25 jobs that cannot be performed from home and have high contact with the

1 public and with coworkers. Remote workers are those jobs that can be
2 performed from home. And then the other category is jobs that can’t be
3 performed from home, but have low contact with the public or
4 coworkers. And they gave examples as sort of landscaping, long-haul
5 trucking, and certain types of construction work.
6 And so then just looking at the gross numbers there were
7 about 4.7 million frontline workers in California. That's about 25 percent
8 of the workforce who are covered by either 5199 or 3205; remote
9 workers working from home about 7.6 million, 40 percent of the
10 workforce not covered exempted from those regulations; and then
11 others, about 7 million or 35 percent of the California workforce who
12 would be covered by 3205. Next slide, please.
13 So this is the list of the top 20 most common frontline jobs.
14 And of course, frontline workers are most at risk of COVID-19.
15 The LAO’s report pointed out as we are all familiar that
16 Latinos, the Latinx population makes up 38 percent of all workers, but 49
17 percent of frontline workers are disproportionately represented in high-
18 risk jobs with respect to COVID-19. So you could sort of just see from
19 this list the folks that are most at risk and who we’re really talking about
20 when it comes to high-risk workplaces. Okay, so just one more slide. So
21 yeah, next slide, please.
22 And Dr. Heinzerling will be talking in more detail about this,
23 but as you know employers are required to report outbreaks under AB
24 685 and 3205 and that's defined as 3 or more cases in 14 days.
25 And I think as Dr. Heinzerling will discuss, there's

1 irregularities in the reporting. But in just looking at the numbers since
2 January of this year, there are outbreaks certainly appear to be more
3 common in certain sectors. And we then normalize the case numbers per
4 outbreak and so you can sort of see highlighted here manufacturing,
5 transportation and warehousing, and then healthcare.
6 The manufacturing sector, there were about 884 outbreaks
7 with nearly 13,000 cases, which was about 14 cases per outbreak. In
8 transportation and warehousing, there about half the number of
9 outbreaks, three quarters the number of cases. So there were about 22
10 cases per outbreak, so more cases per outbreak reported in that sector.
11 And then of course in health care and social assistance we're
12 seeing an order of magnitude greater number of outbreaks in that sector
13 with nearly 59,000 cases since January 1st. We don't know, and I think
14 maybe Dr. Heinzerling will be able to talk about this, the extent to which
15 we can sort of estimate what percentage of these might be driven most
16 recently by Delta or not or if we have enough granularity in the reporting
17 to be able to do that. But this is just as an overview of our outbreak data
18 to date.
19 So with that next slide please, and I'll turn it back over to
20 Eric.
21 MR. BERG: Okay, thank you Dr. Wilson.
22 So this slide shows the growth of the Delta variant in the
23 United States. As you can see by month it starts very small in April and
24 then increases and in July it really takes over as the predominant variant
25 in United States, making up 78 to 86 percent of all cases. In California

1 Delta is 86 percent of the cases in July, up from 56 percent of cases in
2 June. So Delta is now the predominant case in the United States as well
3 as California. Next slide, please.
4 So the Delta variant was first detected in October of 2020, so
5 about 10 months ago. Obviously the data was not available for a while.
6 And previous COVID-19 infection may be less protective against future
7 infection from Delta variant. So that means if someone was sick with
8 COVID previously they are less protected against being reinfected with
9 Delta than they were with previous variants.
10 Viral loads of Delta infections in one study were on average
11 1,000 times greater compared to the earlier COVID-19 variants, a much
12 higher viral load variant and it happens quickly. Next slide, please.
13 And the risk, this comes from another study, the risk of
14 COVID-19 hospital admission was approximately doubled than those with
15 the Delta variant when compared with the Alpha variant.
16 And then some other studies, the Delta variant compared to
17 wild-type, which means the original COVID-19 was increased slightly for
18 hospitalization. That doubled for ICU admission and 121 percent higher
19 for death.
20 And in another study again the Delta variant was associated
21 with 4.9 or close to 5 times higher risk for a patient needing oxygen, or
22 intensive care, or death. And the risk of pneumonia was 1.88 times
23 higher for those who were infected with Delta compared to the original
24 COVID-19 strain. Next slide, please.
25 And these are the studies that I just went over, the couple of

1 bullet points of the increased risks from Delta variant compared to
2 previous variants and the original COVID-19, so these are some new
3 studies that have come out on the Delta variant. And of course there's
4 many more, this is just a small sampling. Next slide, please.
5 And the CDC has published information on Delta variant, so
6 this comes straight from the CDC document which is noted below. So
7 CDC says the Delta variant is about twice as contagious or transmissible
8 as the previous variants. The Delta variant may cause more severe
9 illness than previous strains in unvaccinated people. And fully
10 vaccinated people with breakthrough, either symptomatic or
11 asymptomatic, either way can transmit to others. It was previously
12 thought that vaccinated people did not transmit to others, but that
13 changed with the Delta variant.
14 And lastly, this is from the CDC, given what we know about
15 Delta, vaccine effectiveness and current vaccine coverage, layered
16 prevention strategies such as wearing masks are needed to reduce
17 transmission. Okay. Next slide, please.
18 So overview of Delta, it's more transmissible than other
19 variants. It can be transmitted by vaccinated people. The vaccines
20 remain very effective in preventing serious illness and death from the
21 Delta variant as well as all other variants of COVID-19. And vaccination
22 remains an essential strategy for keeping workers and workplaces safe.
23 And the vaccine is safe for the vast majority of all people.
24 I think that's all I have. Thank you.
25 BOARD MEMBER LASZCZ-DAVIS: Dr. Das, Dr. Wilson, and Mr.

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1 Berg that was an excellent presentation and very, very helpful.

2 Are there any questions for any of the three or all three,

3 Laura?

4 BOARD MEMBER STOCK: Yeah, yeah I agree. Thank you so

5 much for that information, hugely helpful. And I guess, Eric, though this

6 might apply other ones. As you described in your summary slides about

7 how the Delta variant has impacted the transmission, and has highlighted

8 the need for a layered strategy and a multifaceted strategy, it really -- I

9 mean, your presentations are really highlighting that we are in an

10 extremely different place now from what we were in mid-June when we

11 voted to roll back some of the provisions that were in the ETS including

12 masking for vaccinated, including rolling back requirements for capacity

13 limits, distancing, etcetera. That those decisions were made based on a

14 previous situation that really is no longer applies.

15 We not only see from your presentation that vaccinated

16 people, workers can transmit, can get breakthrough infections, they can

17 transmit it. And as you said there is a need for this layered strategy or

18 multifaceted strategy that worked before where there was a range of

19 different solutions and preventive measures that we put in place. So I

20 just want to comment that this highlights the fact that the current

21 version of the ETS is falling behind what is needed, falling behind what

22 some of the CDC guidelines are.

23 And I haven't had a chance to read it very closely, but I just

24 saw an alert that OSHA issued new guidelines. Again, this is not a

25 regulation, but just today there were new guidelines that Federal OSHA is

1 issuing that seem to reinforce the need for universal masking and for
2 testing of exposed vaccinated workers even if they are not symptomatic,
3 which I think is at odds with ours.
4 So I'm just wondering if you have any comments on that and
5 where you see our regulation maybe now falling short?
6 MR. BERG: Yeah, it is true now that CDC and CDPH
7 recommend everyone wear masks in indoor situations. And the current
8 version of the ETS does say where CDC has an order requiring mask use
9 indoors beyond what's required now for unvaccinated people that goes
10 without being required. So that's where there's more flexibility I guess
11 in the regulation of CDPH with that order. And that would automatically
12 be incorporated into the ETS.
13 BOARD MEMBER STOCK: Oh, okay. So can we just kind of
14 clarify that a little bit more? So as the CDC has changed its guidelines
15 over the last few weeks, again sort of going beyond what the recent
16 version of the ETS has required, are you saying that that automatically
17 would result in different requirements? Or that would be automatically
18 included in the requirements that would be within the ETS? Can you just
19 explain that a little bit more Eric?
20 MR. BERG: Well that’s if there's an order mandating masks
21 from CDPH. So a recommendation won't change anything, but if a CDPH
22 order requiring mask use that is automatically incorporated into this,
23 into the ETS. So a recommendation, no. The recommendation is not
24 (indiscernible) or not.
25 BOARD MEMBER STOCK: Oh, so CDPH so far has not made

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1 that mandate? I mean local entities have. Is that correct?

2 MR. BERG: Yeah, that's correct. CDPH has not. They have

3 recommended it, but they don't mandate it. And several counties have

4 also mandated it, but the ETS does not require employers to follow the

5 local health department requirements, it doesn't incorporate those.

6 BOARD MEMBER STOCK: And just to ask you one other -- oh

7 sorry, just one last question. So given what you have said, and given

8 what we know about the Delta variant, would you agree that some of the

9 other provisions that were in place previously, including physical

10 distancing, would be a recommended prevention measure given the Delta

11 variant?

12 MR. BERG: Yes. Yeah, as CDC says and I agree with, multiple

13 strategies are needed to prevent transmission or at least reduce

14 transmission to the greatest extent possible. So yeah. Yes I agree.

15 BOARD MEMBER STOCK: Oh, I think somebody else was --

16 Chris, were you trying to say something?

17 BOARD MEMBER LASZCZ-DAVIS: No, I'm listening. I just was

18 just going to ask if anybody else had any other questions, but maybe

19 you're not done yet Laura.

20 BOARD MEMBER STOCK: Oh no, I'm done. Sorry, go ahead.

21 BOARD MEMBER LASZCZ-DAVIS: Any other questions,

22 observations? You know, actually I have one. Interesting and not

23 surprising is the drop in vaccinations over the last several months. Any

24 thoughts as to why?

25 MR. BERG: Sorry, what was the question? Why what?

1 BOARD MEMBER LASZCZ-DAVIS: The question is one of your
2 earlier slides indicated, reflected the drop in vaccinations per day over
3 the last several months. Do you have any observations or thoughts as to
4 why the drop in vaccinations, particularly given that California is only 56
5 percent vaccinated at this stage?
6 MR. BERG: I don't know. Dr. Das, do you have any thoughts
7 on that? I mean, sorry.
8 DR. DAS: Sure. It's hard to surmise. I guess the one obvious
9 or perhaps obvious response would be that everyone that wanted to get
10 vaccinated and was planning on getting vaccinated got vaccinated. And
11 then we've got the remainders who were kind of hesitant or had
12 questions, etcetera. And there hasn’t been that commitment. And early
13 on it was very challenging and difficult to get the vaccines and we had a
14 high rate. Whereas, now it's relatively simple to get one and we don't
15 have the same kind of demand, which is paradoxical. But I wish I had an
16 answer, sorry.
17 BOARD MEMBER STOCK: Oh, Chris, I had one more question.
18 BOARD MEMBER LASZCZ-DAVIS: Go ahead.
19 BOARD MEMBER STOCK: Unless Nola or you did, because I've
20 had my chance. Nola, did you want to go? I'll go after you.
21 BOARD MEMBER KENNEDY: Yeah, I would like to ask a
22 question.
23 BOARD MEMBER STOCK: Yeah, go ahead.
24 BOARD MEMBER KENNEDY: I'm just wondering, and there
25 may not have been enough time to see an influence yet, but with the

1 State of California requiring that its employees be vaccinated or be
2 tested, and with many other large employers doing the same throughout
3 the state, are we seeing any influence on vaccination rates from that?
4 DR. WILSON: I can respond to that Eric. From what we've
5 heard from UCSF yesterday is sort of three important numbers. One is
6 that just under 80 percent of Californians over 18 have had at least one
7 dose. The second number is that 65 percent over 18 are fully vaccinated.
8 And then the third number is that 56 percent of the total population is
9 fully vaccinated. So it's hard to know what one dose means, 80 percent
10 of Californians have had one dose. Does that mean that they are on the
11 path to getting a second dose? That would be good news. But all we
12 know is that and it's actually a pretty good number. We look at near just
13 under 80 percent, it's 79.6 percent have had one dose.
14 But in terms of what the impact of these, the vaccine
15 mandates has been among public employees and others that you've
16 noted, I guess it's hard to say. I don't know, Eric or Dr. Das, do you have
17 any thoughts about that?
18 DR. DAS: No.
19 MR. BERG: No, I don't have any at this time.
20 BOARD MEMBER LASZCZ-DAVIS: Any other questions,
21 comments? Laura?
22 BOARD MEMBER STOCK: Yeah, I had two more. Oh, were
23 you done, Nola?
24 Okay, so just following up on what you said, Eric, about if
25 there is a local mandate or a CDPH mandate that requires indoor

1 vaccination that would be incorporated into the ETS? I think those were
2 the words you used –-
3 MR. BERG: No, it’s not. The local is not. The local is not.
4 BOARD MEMBER STOCK: Oh, local was not.
5 MR. BERG: Yes.
6 BOARD MEMBER STOCK: But the statewide mandate would
7 be?
8 MR. BERG: Yes.
9 BOARD MEMBER STOCK: And that would then, as a result, be
10 then enforced by Cal/OSHA?
11 MR. BERG: Yes. That’s in the ETS right now that where if
12 CDPH mandates through a CDPH order then it's included in the ETS.
13 BOARD MEMBER STOCK: Whereas local mandates are not?
14 MR. BERG: No, that's correct.
15 BOARD MEMBER STOCK: Oh, okay. And then just a question
16 for Mike. Your outbreak data, the chart that you showed was from
17 January until now. And I'm wondering, and I think you alluded to this
18 and I think we saw some last month, but I am curious if we have data
19 about outbreaks since June 15th?
20 DR. WILSON: You know, I am going to defer to Dr.
21 Heinzerling, because there is some reporting anomalies within that data
22 set. And she's kind of broken them apart, so it's probably best for her to
23 -- and she’s going to discuss that, the outbreak data specifically.
24 BOARD MEMBER STOCK: Okay.
25 DR. WILSON: So let's see if she answers your question. And

1 if not then we'll go from there.

2 BOARD MEMBER STOCK: Thank you.

3 DR. WILSON: Yeah.

4 BOARD MEMBER LASZCZ-DAVIS: Anything else, Laura?

5 BOARD MEMBER STOCK: No. I'm done, thanks.

6 BOARD MEMBER LASZCZ-DAVIS: I've got one question. It
7 actually follows the questioning that you had with Eric as regards to
8 mandates.

9 And it's just a matter of clarification, Eric. You were very
10 careful to say that the CDPH mandates really become one with the ETS
11 standard in terms of regulatory enforcement. Do we have any situations
12 where there is, I'll call it a non-alignment between a CDPH mandate, and
13 the CDC guidelines as they come out?

14 MR. BERG: Oh, inconsistency between CDC and CDPH?

15 BOARD MEMBER LASZCZ-DAVIS: Yes.

16 MR. BERG: I mean CDC might come out earlier and it might
17 take a little bit of time for CDPH to examine that and decide if they do
18 the same thing, so it might be a different timing on those issues. But
19 yeah, I can’t really speak for CDPH since I don't know all of their orders
20 and such.

21 BOARD MEMBER LASZCZ-DAVIS: I mean it would suggest,
22 Eric, and I hope I'm not misunderstanding that the CDC guideline does
23 not automatically flow down or cascade to a CDPH mandate I think is
24 what I'm hearing.

25 MR. BERG: Yeah, that's correct, they analyze it and

1 determine it.

2 BOARD MEMBER LASZCZ-DAVIS: All right, any other

3 comments or questions? All righty.

4 All right with that what I'd like to do is turn this over to Dr.

5 Heinzerling. Dr. Heinzerling?

6 DR. HEINZERLING: Yes, I'm here. Can we go ahead and pull

7 up my slides?

8 MR. GOTCHER: Sorry, I'm taking just one second to get those

9 pulled up, sorry for the delay.

10 DR. HEINZERLING: Great. Good morning everyone and

11 thanks for having me. Today I'll be sharing some information about

12 COVID-19 outbreak data from the California Department of Public Health.

13 And you just got a little bit of a preview of that from Mike.

14 And I'll be sharing some background information on how the

15 data are collected and analyzed, some important limitations to keep in

16 mind when interpreting the data. And finally I'll provide a brief overview

17 of what we're seeing in the data so far this year. I'll also be happy to

18 answer any questions from the subcommittee along the way or at the

19 end. Next slide, please.

20 First of all I wanted to share the general workflow for a

21 workplace outbreak reporting. When an employer becomes aware of 3 or

22 more cases of COVID-19 in a workplace within 14 days as we know they

23 are required to report to the local health department, or LHD.

24 Once an LHD receives a report they will typically conduct an

25 investigation to determine whether or not those cases constitute an

1 outbreak. Depending on their capacity the LHD may prioritize certain
2 potential outbreaks for investigation and intervention based on size, type
3 of location, etcetera.
4 They would then work with the employer to respond to the
5 outbreak to determine what protections are already in place and what
6 additional interventions might be needed.
7 LHDs then report confirmed outbreaks with CDPH via one of
8 several possible electronic reporting systems.
9 Once we receive that information we collect and compile the
10 outbreak data from the different systems. And a team at CDPH then
11 reviews and assigns standard Census industry codes to reported
12 outbreaks.
13 The numbers of outbreaks and outbreak associated cases are
14 posted by industry to the Health and Human Services Open Data Portal.
15 I've included a link here at the bottom of the slide. And those data
16 updated every two weeks. Next slide, please.
17 These data provide us with important information about
18 where COVID-19 outbreaks are taking place in California. But it's
19 important to keep in mind some limitations when we interpret the data.
20 First of all, each of the subsets outlined in the previous slide takes time.
21 It takes time for an employer to learn about cases and report them to the
22 LHD. And for the LHD to investigate and determine whether or not the
23 cases constitute an outbreak.
24 Once they've made this determination it can then take some
25 time for local health departments to report to CDPH as they typically

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1 focus first and foremost on responding to the outbreak itself. When
2 things are busy and particularly during COVID surges these steps can take
3 even longer.
4 Once we receive the data at CDPH it takes us a little bit of
5 additional time to compile it and assign industry codes before we post it
6 to the Open Data Portal. All of this means that it may be weeks or even
7 sometimes months from when the first case in an outbreak is identified
8 to when that outbreak gets included in the CDPH data. Next slide,
9 please. Oh that's too fast, sorry jump back a little bit, back one more.
10 There we go.
11 So those of you who are familiar with the outbreak data on
12 the Open Data Portal, I want to provide a clarification about how
13 outbreaks are classified. The data set includes total numbers of
14 outbreaks reported to CDPH in 2021 as well as numbers reported in the
15 past 30 days. These outbreaks are currently classified by date reported
16 to CDPH rather than date of outbreak onset. Because of the time
17 involved in the reporting process as I outlined in the past slide this
18 means that the number of outbreaks reported in the past 30 days include
19 outbreaks that may have occurred weeks or months ago. They are not a
20 reflection of outbreaks that have actually occurred in the past 30 days.
21 The data that I will share with the subcommittee today,
22 however, are categorized by date of outbreak onset in order to better
23 reflect trends over time. So they're not directly comparable to the data
24 that are currently posted on the Open Data Portal. We are actually in
25 the process of updating our Open Data Portal data set to classify

1 outbreaks by date of onset rather than by date of report in order to
2 better reflect those trends.
3 But for the time being please do keep in mind when
4 referencing the data set posted to the Open Data Portal that the past 30
5 days numbers do not mean outbreaks are actually occurred in the past 30
6 days. They're simply outbreaks that have been reported to CDPH in the
7 past 30 days. Next slide, please.
8 And the second limitation I want to highlight is that while
9 numbers of outbreaks in each industry do provide important information
10 about where outbreaks are occurring, they don't equate directly to
11 relative transmission risk in the different industries for a couple of
12 reasons. During the time period covered by this data set some industries
13 as we all know have been closed or open with capacity restrictions at
14 various times, while others have remained fully open. We will therefore
15 expect to see fewer outbreaks in industries that have been closed or
16 opened with limited capacity.
17 Additionally, these data are not adjusted for a number of
18 businesses in each industry. We'd expect to see more outbreaks in large
19 industries with many businesses compared to smaller industries with
20 fewer businesses. Next slide, please.
21 Third, while most of the outbreaks in this data set occurred
22 in occupational settings that involved workers some outbreaks also
23 involved nonworkers, in particular outbreaks in congregate residential
24 settings such as residential care facilities, correctional facilities and
25 homeless shelters, which involve residents. Or outbreaks in schools

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1 which involves students.

2 Based on how the data are reported to CDPH we can't

3 reliably distinguish workers from nonworkers, so counts of outbreak

4 associated cases include workers as well as others. And it's important to

5 keep this in mind in particular in those types of settings where we know

6 that there are many nonworkers present. Next slide, please.

7 It's also important to note when looking at these data to

8 inform the subcommittee’s decisions, discussions, that the data include

9 outbreaks that occurred in both ETS covered and non-ETS covered

10 workplaces such as health care facilities. Next slide please.

11 Finally, while the outbreak data can help us look at big

12 picture trends it's more limited in its ability to answer more detailed

13 questions. For example, whether or not outbreak cases have been

14 associated with a particular COVID variant or whether a given outbreak is

15 associated with employer-provided housing or transportation. Next

16 slide, please.

17 So now that I have shared some caveats I will provide an

18 overview of what we're seeing in the data itself. This graph shows

19 numbers of outbreaks reported to CDPH since January 1st by month of

20 onset. CDPH considers outbreak onset to be either the date that a local

21 health department reports that an outbreak began or the date that the

22 first associated case tested positive for COVID, whichever is earlier.

23 As you can see we saw the numbers of outbreaks beginning

24 to decrease after the winter surge in early 2021, reaching their lowest

25 point in May and June though outbreaks did continue to occur during

1 those months. This is consistent with the overall trends that we were
2 seeing in COVID case rates in California. However, you can see here in
3 the July numbers, numbers of outbreaks have once again begun to
4 increase, which again is consistent with the current COVID-19 surge that
5 we're seeing statewide.
6 And it's also important to note that this graph only includes
7 data reported to CDPH through August 2nd. Because of the reporting
8 delays that I had discussed earlier numbers of outbreaks for the most
9 recent months are likely to increase even further in the coming weeks as
10 additional outbreaks that began during those months are reported to
11 CDPH by local health departments. In other words, if I show you this
12 same graph again in a few weeks it's likely that those June and July
13 numbers would be higher. Next slide, please.
14 This graph provides a breakdown of COVID-19 outbreaks by
15 sector in California for outbreaks with onset from January to July 2021.
16 As you can see the largest number of outbreaks occurred in the
17 healthcare and social assistance sector followed by retail, education and
18 manufacturing. I'll give folks just a second to look at this more carefully
19 and absorb it before we move on to the next slide. Okay. Go ahead and
20 move on to the next slide, please.
21 This slide also shows outbreaks with onset in 2021, but this
22 time categorized by individual industries for the industries with the
23 highest numbers of outbreaks. As you can see, we've seen outbreaks in a
24 variety of ETS and non-ETS covered types of workplaces, with the highest
25 numbers being seen in residential care and skilled nursing facilities as

1 well as schools, restaurants, childcare, construction, and other settings.
2 This brings me to the end of the information I wanted to
3 share with you today, but I'm happy to answer any additional questions
4 about the outbreak data. Thank you.
5 BOARD MEMBER LASZCZ-DAVIS: Any questions, comments?
6 Laura?
7 BOARD MEMBER STOCK: Yes, thank you so much that was
8 hugely helpful. I really appreciate your presentation.
9 I actually had a question on one of your early slides that
10 talked about the process of getting this data and I think -- and it went by
11 pretty quickly, so correct me if I'm wrong -- but what was interesting to
12 me was the process of when there's an outbreak and it goes to local
13 health departments. And then you said local health departments
14 investigate that, see if preventive measures are in place, etcetera. So I
15 was curious about that process and I have two questions related to that.
16 One is, are there kind of consistent guidelines that have
17 been given to local health departments so that there's some way that is
18 consistently taking place across the state? Or is it up to individual health
19 departments what they do in response to outbreaks?
20 And then I am curious, how is that process coordinated with
21 Cal/OSHA and where there may be Cal/OSHA investigations?
22 DR. HEINZERLING: Sure. And so CDPH does have guidance
23 for local health departments on responding to workplace outbreaks.
24 Ultimately local health departments have jurisdiction in how they
25 investigate and respond to those outbreaks and the process will look a

1 little bit different. But for the most part they are following CDPH
2 guidance about workplace outbreaks and in other matters like isolation
3 and quarantine and everything else.
4 In terms of the relationship with Cal/OSHA I would say that
5 also probably varies a little bit by jurisdiction. Certainly if Cal/OSHA, if
6 there is a complaint filed and Cal/OSHA is conducting an inspection and
7 there is sometimes some communication between a local health
8 department and Cal/OSHA. But I think that that varies a little bit based
9 on the situation. I think, you know, we're very used to -- CDPH and our
10 branch, we're very used to working with Cal/OSHA closely. I'd say some
11 local health departments are not as used to that process, but many have
12 gotten more familiar with it during this pandemic.
13 BOARD MEMBER STOCK: So just one follow-up question. So
14 in that early stage it seems clear that there are certain aspects that are
15 very consistent with things that local health departments are used to
16 doing, quarantine, etcetera. You also though mentioned that they may
17 go into workplaces and investigate whether preventives are required, or
18 needed preventive measures are in place. I guess that's where I am
19 wondering if you can share anything about -- I guess you're saying that
20 there is statewide guidance that CDPH has issued about how to do that
21 kind of investigation? Or like whether local health departments are kind
22 of able or up to speed on what to be looking for, so I'm interested in that
23 process and more comments. And is it possible to see those guidance --
24 is that guidance that you mentioned, that's statewide guidance, available
25 to be looked at?

1 DR. HEINZERLING: Yeah, there’s a couple of things. I think
2 the details of exactly what local health departments are looking for and
3 what that process looks like on going to vary a little bit from local health
4 department to local health department. And so it's hard for me to say at
5 the state level kind of exactly what they are looking for in a given
6 section.
7 But I think in general local health departments will develop
8 their own systems based on CDPH guidance, based on CDC guidance for
9 what measure employers should be taking. And most of them are also
10 now quite familiar with the ETS and requirements under the ETS and
11 making sure that those are being followed as well.
12 Our workplace outbreak guidance for responding to COVID in
13 the workplace, there's a now quite outdated version actually posted to
14 the CDPH guidance website. But we've been in the process of updating
15 to reflect recent changes in the ETS and everything else. As you can
16 imagine things change more quickly sometimes than we are able to get it
17 updated, so we have been through a few revisions but I’m hopeful that
18 an updated version will be publicly posted soon.
19 BOARD MEMBER STOCK: Thank you very much.
20 BOARD MEMBER LASZCZ-DAVIS: All right (indiscernible).
21 DR. WILSON: Chris? Oh I'm sorry, Chris. If I could respond
22 to Laura's question as well? Okay, great.
23 Laura, I think it's a really, really important question, which is
24 as I understand it is what's the extent to which local health officers are
25 working with Cal/OSHA? Because local health officers don't have

1 enforcement authority over private sector workplaces, but they have a
2 really good sense of what's going on within their jurisdiction. And
3 Cal/OSHA has the enforcement authority, but might not have eyes on the
4 ground as well as the local health offices do.
5 And so CDPH and Cal/OSHA provided review of report that
6 was published by Health Impact Partners with the chief author Solange
7 Gould, who sort of described that problem and pointed out that we're in
8 this unique situation now where we have –- we're in a pandemic. And so
9 workplace cases are emerging with community cases and so there is a
10 very important and a real need for local health officers to work with
11 Cal/OSHA more closely.
12 And so that report and sort of analysis that her organization,
13 Health Impact Partners, put out describes that problem. And sort of
14 gives recommendations on how local health officers can work effectively
15 with the Cal/OSHA district offices and how they can -– yeah, just across
16 their different jurisdictions and the value that local health officers can
17 bring to Cal/OSHA and vice a versa. So that came out I will guess 6 to 8
18 weeks ago, like maybe a couple of months ago. It's sort of putting a fine
19 point on the question you just raised.
20 DR. HEINZERLING: Yeah, and just to clarify for you, local
21 health officers do have some authority over workplaces. Obviously it's
22 different from Cal/OSHA's authority, but they do have authority to for
23 instance close down a workplace if it's determined to be unsafe. They
24 can fine workplaces for not complying with local health officer orders
25 such as a mask mandate and that kind of thing, so they do have some

1 authority that I think often compliments Cal/OSHA's authority.

2 BOARD MEMBER STOCK: Thank you for that. And thank you

3 for that further clarification, Mike. I agree that that's a really important

4 area to look at. And I'd be really interested in seeing that report, so if

5 you are able to help provide a link to that that would be great. So thank

6 you for that.

7 DR. HEINZERLING: Great, sure.

8 BOARD MEMBER LASZCZ-DAVIS: Thank you all for that. I

9 wonder if I might ask a question on the heels of the good doctor's

10 presentation. We had Dr. Seward make a presentation at a previous

11 subcommittee meeting, whereby he presented us with six metrics that

12 were being used. One of them was vaccination rates, the second one

13 vaccination access availability, a third one new case rates, a fourth one

14 percentage of the population vaccinated, a fifth one positivity rate, and

15 sixth one a calculated value of the degree to which viral transmission

16 would be generated. And there was actually one that I would consider an

17 honorable mention, California healthcare facility capacity to handle

18 increased COVID-19 caseloads.

19 So we've got this bucketful of metrics and you just presented

20 some additional ones for us. How would you -- and I realize this might

21 just be a personal opinion, but I'm curious with all the metrics that we're

22 presented with -- how would the data points that the CDPH presents fit

23 in with these others, in terms of it being a reliable indicator with

24 California in terms of what it should or should not be doing, boots on the

25 ground?

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1 DR. HEINZERLING: All right yeah, so I think one important
2 distinction to make between the outbreak data and some of those
3 metrics you just mentioned is that most of those metrics you just
4 mentioned are going to be much more real-time in terms of what's
5 happening right now in California. We have much more real-time
6 information about case rates, test positivity, vaccination rates.
7 As I mentioned because of the reporting delays getting to
8 CDPH with the outbreak data ultimately if you look at our outbreak data
9 compared to, say, case rates in California the trends follow each other
10 very closely over time. But it takes some time for the outbreak data to
11 catch up. So I think it's important, it provides important perspective. I
12 think what it adds is where are outbreaks happening, which types of
13 workplaces should we be focusing on, to think about prevention efforts.
14 But I think in terms of following in real time what's happening with
15 COVID in California there tends to be a bit of a lag with the outbreak
16 data compared to some of those other metrics.
17 BOARD MEMBER LASZCZ-DAVIS: All right, thank you for that.
18 And I wonder if I might follow up another question. What has been the
19 experience in both transportation and housing?
20 DR. HEINZERLING: Do you mean employer-provided
21 transportation and housing?
22 BOARD MEMBER LASZCZ-DAVIS: Yes.
23 DR. HEINZERLING: Yeah, so unfortunately we don't really
24 have enough granularity in our outbreak data to be able to look
25 specifically at employer-provided housing and transportation. There are

1 almost certainly some outbreaks in our data set that have involved in
2 some way employer-provided housing or transportation, but we don't
3 have a systematic way of separating those out from the way that our
4 data are collected.
5 BOARD MEMBER LASZCZ-DAVIS: All right, thank you. Any
6 other questions? Laura?
7 BOARD MEMBER STOCK: I just want follow up on that, your
8 last question, Chris. Thanks for bringing that up, because that has been
9 something that the Board has been interested in trying to be sure we are
10 capturing with the employer-provided transportation and housing. So do
11 you have any thoughts of the best way that that information can be
12 gathered, so that we can be sure we're monitoring what's happening
13 there?
14 DR. HEINZERLING: Well I think there are a couple of issues. I
15 think one is that it's sometimes hard to suss out exactly where
16 transmission is happening in a given workplace. So if you have a
17 workplace where there's the workplace itself and then there is workers
18 who use employer-provided transportation and employer-provided
19 housing and you have cases in that workplace, sometimes a careful
20 investigation can tell you, can really trace transmission back to one of
21 those things. But often it's hard to know exactly where transmission is
22 happening. And it may be happening in multiple places. So I think that's
23 sort of the basic challenge in terms of determining the role that
24 employer-provided transportation or housing might be happening.
25 The other challenge is that the way that we collect the

1 outbreak data, there's a lot of information that we ask local health
2 departments for. And in practice, especially when things are very busy
3 with COVID surges, it's hard for them to sometimes provide all of the
4 information that we're asking for. And so right now we're not asking
5 them in a sort of consistent way, did this outbreak involve employer-
6 provided housing or transportation? And sort of adding questions, every
7 time we add a question I'd say it's harder and harder for local health
8 departments to provide us with all of that information.
9 So there is certainly a good possibility that we could kind of
10 go back and do some manual review of some of the information that we
11 have already, but it's challenging based on the way that we are currently
12 collecting the information.
13 BOARD MEMBER LASZCZ-DAVIS: Laura? Laura, you're muted.
14 BOARD MEMBER STOCK: I was just going to say that that has
15 been a really important issue to a number of our stakeholders,
16 particularly in agriculture. So it would be great to continue to think
17 about how we can better capture that data. And it does make sense to
18 add questions or etcetera, so I'd appreciate more thoughts on that as
19 time goes on.
20 DR. HEINZERLING: Yeah, it's certainly something that's on
21 our radar. I think a lot of effort has gone into just getting this process
22 up and running ever since AB 685 passed and was implemented. And so
23 we have come a long way, but I think now we're kind of at the point
24 where we can think about what more can we do with this data? And
25 what more do we need out of it? And that is definitely one of the things

1 on the radar.

2 BOARD MEMBER LASZCZ-DAVIS: Any other questions or

3 comments?

4 Dr. Heinzerling, thank you very much for that excellent

5 presentation. Again, additional insights that I think are tremendously

6 value-added for our deliberations. And as indicated on the screen, if you

7 wish to obtain copies of those presentations please email

8 oshsb@dir.ca.gov.

9 Now with that we are now into the segment of the agenda

10 called The Emergency Temporary Standard, its History and Process. This

11 question has come up several times so we are going to have Christina

12 Shupe and Michael Manieri provide us with a briefing to the

13 subcommittee as to the ETS standard, its history and process.

14 Mike? Oh okay, good. (No audible response.) If you are

15 talking, Christina, you're muted.

16 MS. SHUPE: Great. Can you hear me now?

17 BOARD MEMBER LASZCZ-DAVIS: Not very loudly.

18 MS. SHUPE: Let's see if I can move the mic over a bit. How

19 is that?

20 BOARD MEMBER LASZCZ-DAVIS: A little better.

21 MS. SHUPE: I'll just project, I'm pretty good at that.

22 BOARD MEMBER LASZCZ-DAVIS: All right, you're good now.

23 MS. SHUPE: I just wanted to highlight for everybody in case

24 the camera view looks odd it's because we're using a different display

25 screen in the media room here today.

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1 So as far as the history of the ETS I wanted to just go over
2 that for the Board and the Board's experience with it. So prior to the
3 Wildfire Smoke Exposure Prevention ETS that was promulgated in 2019
4 this Board had not actually adopted an emergency regulation for nearly
5 ten years. And those prior adoptions were single-page regulations. So
6 really what we're talking about when we talk about the current evolution
7 of these emergency temporary standards and the way this Board uses
8 them is they're really brand-new. And it's because the challenges that
9 are facing California are really unprecedented. The challenges that we're
10 facing with wildfires are astronomical and as is the challenge to respond
11 to the COVID-19 pandemic.
12 I'm going to go ahead and go over just a brief outline, just
13 recap how the emergency temporary standard process works. And then
14 Mike has some specific questions that were provided by subcommittee
15 members that he has drafted responses to. And then after that we'll
16 open it up for questions from the subcommittee members and make sure
17 that we have a clear understanding of where we are and where we are in
18 the process.
19 So just to recap for everybody an emergency temporary
20 standard is just that, it's a temporary regulation that is put in place to
21 address an emergency situation.
22 The life cycle of that emergency regulation is that there is an
23 initial adoption that generally lasts for six months. We're allowed two
24 90-day readoptions. And then at the end of that second readoption in
25 order to make that temporary standard permanent you have to adopt

1 what is called a Certificate of Compliance.

2 So I'm going to go back to the wildfire smoke, because that's

3 our most recent experience here. And so we adopted the Wildfire Smoke

4 Emergency Regulation in July of 2019. We subsequently adopted a

5 readoption where we made some changes and updates to it based on

6 evolving knowledge. Then a second readoption took place. And then we

7 had a final adoption where we made it permanent.

8 If we take that model and we apply it to where we are with

9 the COVID-19 Prevention ETS we've had our initial adoption. We've had

10 our first readoption. So what is left to us is the second readoption and

11 then the Certificate of Compliance.

12 And at this point I'm going to pause because I want

13 everybody -- this is where we are right now. We're looking at a second

14 readoption coming up, and then a Certificate of Compliance after that.

15 So are there any questions from the subcommittee members at this

16 point?

17 BOARD MEMBER LASZCZ-DAVIS: Hey, Christina, could you

18 clarify Certificate of Compliance?

19 MS. SHUPE: So the easiest way to think of a Certificate of

20 Compliance is to think of it as a permanent regulation. The Certificate of

21 Compliance is a term that we use because it's in the Administrative

22 Procedures Act, but it is the permanent regulation.

23 BOARD MEMBER LASZCZ-DAVIS: Okay, thank you. Nola?

24 BOARD MEMBER KENNEDY: Yeah, so how much -- I assume

25 the Certificate of Compliance comes pretty quickly after the second

1 readoption, 90 days right?

2 MS. SHUPE: Correct.

3 BOARD MEMBER KENNEDY: So I'm guessing the regulation as

4 it looks with the second readoption, should be fairly similar to how it's

5 going to look at the Certificate of Compliance or is there an opportunity

6 to change? That's part one of the questions. And to get the Certificate

7 of Compliance, and I should remember this but I don't, does there need

8 to be the economic analysis?

9 MS. SHUPE: There does need to be an economic analysis for

10 the Certificate of Compliance. It does need to be adopted within 90 days

11 of the second readoption, so we are talking about a very short

12 timeframe.

13 And if the subcommittee members may recall that when we

14 went through this process with Wildfire Smoke my advice to you was that

15 there should functionally really be almost no changes at all between the

16 second readoption and the permanent Certificate of Compliance.

17 Because that timeframe is so short and staff will be completely consumed

18 with making sure that we pass through the financial reporting

19 requirements that are in place for permanent regulations.

20 BOARD MEMBER LASZCZ-DAVIS: Any comments, questions,

21 Laura?

22 BOARD MEMBER STOCK: First, Christina, you are pretty faint,

23 so if you could talk a little bit louder that would be great though I was

24 able to make out what you were saying.

25 And so the reason not to make changes before the Certificate

1 of Compliance is kind of associated with a short timeframe and with the
2 workload involved in doing that, which is of course critical issues. But it
3 doesn't sound like procedural or legally or whatever that right word is,
4 it's not like -- it is possible to do it. It just would make -- it might not be
5 not feasible, but there is nothing precluding in this process or the Labor
6 Code if for the sake of discussion, we needed to, wanted to do a second
7 readoption in the near future to reflect the kinds of things we're hearing
8 now. But then knew that we needed, we wanted to –- have that 90 days
9 to see what happened and then do the Certificate of Completion.
10 Is it conceivable that some adjustment could be made?
11 Recognizing, again, that it will make the job of the Division and the Board
12 very complicated. But I'm just curious like what is the possibility?
13 MS. SHUPE: So you're correct that there is no legal
14 restriction in making changes between the second readoption and the
15 Certificate of Compliance. However you said, and I think that this is
16 important to highlight, you said the second readoption and then wait 90
17 days and then new version. That is not functionally possible, because
18 you only have 90 days. There's zero possibility to wait 90 days and then
19 draft and come up with all the supporting legal required documentation
20 for a Certificate of Compliance.
21 I mean, we saw in July but there are certainly extreme
22 situations that can trigger new possibilities. But I would also strongly
23 encourage the subcommittee to keep in mind that the workload that's
24 here is present. And what we experienced in July was not without
25 fallout. It absolutely impacted the workload for both the Division and

1 the Standards Board. It impacted our other operations. We had a
2 failure in our variance program that could be directly linked to the
3 amount of work that went into the COVID-19 prevention readoption. And
4 I'm sure that the Division saw a similar slowdowns on their side in their
5 impacted programs.
6 So is it possible legally? Yes. Will it have ramifications?
7 Yes.
8 BOARD MEMBER STOCK: And so assuming that we have that
9 one bite of the apple like, I think we've been characterizing it, what
10 would you say the timeframe, what's the most reasonable timeframe that
11 we could follow to get to a readoption? A revised proposal for a
12 readoption even if we're wanting it to be the same one, not changing it
13 in second time for this certificate.
14 MS. SHUPE: So we're currently in the first readoption. The
15 first readoption is in place until January 14th of 2021. The most
16 reasonable timeline would be for this Board to contemplate a second
17 readoption at your December meeting and then to consider the
18 Certificate of Compliance at your March meeting.
19 BOARD MEMBER LASZCZ-DAVIS: Any further questions,
20 Laura?
21 BOARD MEMBER STOCK: No, that's it. Thank you, Christina.
22 MS. SHUPE: Absolutely.
23 BOARD MEMBER LASZCZ-DAVIS: You know, given what you've
24 just shared, Christina, you're going to love my question. I'm sure we
25 can't appreciate the workload that the Division and the Standards Board

1 staff have. I mean, we just don't have any idea how overwhelming all of
2 this. And it's easy enough for us to make a request, but let me ask you
3 this.
4 One of the frustrations that I think we’ve all heard from time
5 to time from our stakeholders is why don't we have an advisory
6 interactive committee process, so that there is input, boots on the
7 ground input? So that when we get to a point where we are into the
8 second readoption for the Certificate of Compliance we've had more
9 robust input as to what that ought to look like in terms of operational
10 feasibility. So how would you respond to that?
11 MS. SHUPE: Well, I would say that this subcommittee is one
12 of the factors that is going into informing that process. We’ve had a lot
13 of data that's been presented by the Division, a lot of data that’s been
14 presented by CDPH. We've seen some direct interfacing between our
15 subcommittee and liaisons and the Division as well as stakeholder
16 engagement with the other subcommittee members. But I want to say
17 that that is all in addition and extra engagement that we've added,
18 because COVID-19 is so important.
19 But we also have the Division and the process that they use.
20 And so, Eric, do you want to talk about where you are with that? (No
21 audible response.) You may be muted.
22 MR. BERG: Sorry about that. Yeah, we did have an advisory
23 committee prior to the first readoption. So the plan would be to have
24 another, before there is a Certificate of Compliance, have another
25 advisory meeting.

1 BOARD MEMBER LASZCZ-DAVIS: And, Eric, would that take
2 the form of the advisory committee meeting that was orchestrated by
3 Doug Parker? Would that be similar in format?
4 MR. BERG: Yeah, it would be similar in format.
5 MS. SHUPE: And that was a three-day advisory committee
6 meeting.
7 BOARD MEMBER STOCK: Sorry, Eric, did you say that that
8 would be before the Certificate of Compliance or before the second
9 readoption?
10 MR. BERG: I don't have the exact timing.
11 BOARD MEMBER STOCK: But just sort of conceptually is the
12 idea that before we would be voting on a second readoption, which we
13 do understand based on what we just heard would have to be -- would
14 not have to be really feasible to change again before the Certificate of
15 Compliance. So it does seem that if there was going to be like that, it
16 seems like the timing would need to be before that second readoption.
17 MR. BERG: Yeah, we would have the timing and if what
18 changes are going to be made. We have no significant changes planned,
19 we don't have anything yet. But if we didn't have any significant changes
20 planned, it might not. But I don't know though.
21 BOARD MEMBER LASZCZ-DAVIS: Let me ask the question a
22 little bit differently. But, Laura, you may have understood the response.
23 I guess I'm the slow learner here.
24 I heard Christina indicate that it would be up for readoption
25 possibly January of 21st of 2021. Would that be the time to have an

1 advisory committee process, so you have some interaction between the
2 stakeholders and the rest of (indiscernible) is that when that would
3 occur?
4 MS. SHUPE: Chris, I need to make a correction. You just said
5 that we would have the readoption in January of 2021. And actually
6 what I said was that the current ETS will expire in January 14th of 2021.
7 So this Board would need to reconsider its second readoption most likely
8 in its December meeting.
9 BOARD MEMBER LASZCZ-DAVIS: Oh, okay. So back to the
10 question, when would the advisory committee process take place? When
11 would that forum take place?
12 MR. BERG: Yeah, I don't know when it would take place.
13 BOARD MEMBER LASZCZ-DAVIS: Any other questions,
14 comments? (No audible response.) Well thank you very much, Christina
15 and Michael, appreciate that input. I know there have been a number of
16 questions about this process and I think that's helped clarify a few
17 things.
18 We are now moving into the public comment period. We will
19 now proceed with the public comment period. Anyone who wishes to
20 address the committee regarding the revised COVID-19 Emergency
21 Temporary Standard, or ETS, recently adopted by the Board is invited to
22 comment.
23 Once again, please listen for your name and an invitation to
24 speak before addressing the committee. When it's your turn to address
25 the committee please be sure to unmute yourself if you're using WebEx,

1 or dial *6 on your phone to unmute yourself if you're using the
2 teleconference line. Please be sure to speak slowly and clearly when
3 addressing the committee. And please remember to mute your phone or
4 computer after commenting.
5 Mr. Gotcher, do you have any commenters in the queue?
6 MR. GOTCHER: Our first commenters are Bruce Wick, Derrick
7 Jarvis and Anne Katten, with first Bruce Wick from the Housing Contractors
8 of California.
9 MR. WICK: I'm trying to get my video -- there we go, thanks,
10 John. Thanks for the opportunity.
11 I want to talk about what is often not given the gravity it needs.
12 I am one of those many on this call who have to turn and train the trainer.
13 And the effectiveness with which we do that, and those trainers then turn
14 around and train frontline supervisors, employees in following an ETS is
15 huge. We can write a reg on paper, but what translates to the employee on
16 the front who's doing the work, that's our job. And along that way the
17 credibility of the process, the decision-making process is really important.
18 There are three things this subcommittee ought to have every
19 meeting that is available. The data from the Appeals Board, which will tell
20 you how is enforcement actually going with both the IIPP, the ATD, and the
21 ETS. That information is updated now monthly, there are COVID citations,
22 appeals and so forth. And we know that as of the last meeting August 4th,
23 36 employers have settled under 3203, 15 of those represented by
24 attorneys. That's important information that's updated monthly. This
25 subcommittee and we as the public ought to have it.

1 The outbreak data, again, is broken down by all these NAICS
2 and subcodes, 250 breakdowns, and it's updated every two weeks. You
3 ought to have the new update. What is the trend of each workplace –-
4 MR. GOTCHER: Thirty seconds.
5 MR. WICK: -- represented? Thanks, John.
6 And lastly, the Workers' Comp data, the most relevant data is
7 being ignored. And yes, we understand employees who take two weeks paid
8 sick leave if they test positive and do not seek actual medical treatment
9 don't usually turn in a Workers' Comp claim. But anybody who is sadly a
10 fatality, you know that's going to be a Workers' Comp claim. There's 1,046
11 Workers' Comp fatalities versus 64,000 in the public. That information
12 should be presented to you and to us at every meeting updated. Somebody
13 in DIR has the ability to take that raw data and present it to you and us and
14 inform our decision-making as we go. Thank you.
15 MR. GOTCHER: Our next commenter is Derrick Jarvis from the
16 Wine Institute.
17 MR. JARVIS: Good morning and thank you for the opportunity.
18 My comments are really a cautionary tale of the limitations on the outbreak
19 data that kind of supplements what Dr. Heinzerling was trying to tell you.
20 Let me put some context into it.
21 When an employer dutifully calls into a local health department
22 that they've had 3 employees with positive COVID that have been onsite
23 within the last 14 days basic information is given to the local health official,
24 which is very important as you seen both locally, regionally, and statewide.
25 But what isn't conveyed and what isn't -- what's hidden in that

1 outbreak data is the source of the exposure, whether it's a social exposure,
2 a household exposure, an occupational exposure or unknown. If I was to say
3 that the vast majority, over 90 percent are non-occupational exposures, I'd
4 probably be pretty close. But who knows because the information just isn't
5 there.
6 So I just felt that I need to comment from the employer's
7 perspective of using that information and being cautious not to make
8 erroneous assumptions, whether by area or by type of manufacturing or
9 whatever the case may be. There is some limitations and wanted you to
10 understand the context of where that information is coming from.
11 Thank you, and have a safe and restful weekend.
12 MR. GOTCHER: Our next commenters are Anne Katten, Pamela
13 Murcell and Helen Cleary with next Anne Katten from the CRLA Foundation.
14 MS. KATTEN: Hi, good morning. This is Anne Katten from
15 California Rural Legal Assistance Foundation. And I'm encouraged to hear
16 about the development, plans to develop a multifaceted strategy to increase
17 protection.
18 In this process it's really important to consider that all outdoor
19 work is not the same. Many agricultural workers on harvest machines work
20 shoulder to shoulder and face to face and so they are working in very close
21 proximity even though they are outdoors. And you also have to consider
22 situations such as hoop houses where the air circulation is quite limited. So
23 with the Delta variant we worry about the elimination of outdoor masking
24 and physical distancing for vaccinated outdoor workers.
25 We also just want to comment that the source of exposure

1 really doesn't matter, because if there are people who come to the
2 worksite who may have been exposed and been infected at home they put
3 other workers at being in danger of being infected.
4 We are also extremely concerned to learn that the local and
5 state health departments are not consistently including employer housing
6 and transportation data, given the past history of outbreaks including
7 fatalities. Most of the workers in this housing are very isolated and
8 vulnerable workers here temporarily, so there need to be proactive efforts
9 by Cal/OSHA and the health departments to check both for compliance with
10 the ETS and whether the revised weakened regulation is preventing
11 outbreaks in this housing.
12 It's also very important to make --
13 MR. GOTCHER: Thirty seconds.
14 MS. KATTEN: -- this outbreak data available on the county and
15 individual worksite level to make it more transparent and useful for workers.
16 Thank you.
17 MR. GOTCHER: Our next commenter is Pamela Murcell from the
18 California Industrial Hygiene Council.
19 MS. MURCELL: Good morning, thank you for your time. This is
20 Pamela Murcell with the California Industrial Hygiene Council, the current
21 President of the group. The CIHC appreciates the opportunity to comment
22 on the COVID-19 Emergency Temporary Standard. We appreciate the
23 challenges this issue has presented and the hard work and countless hours
24 from Board staff and DOSH staff on this issue.
25 CIHC represents occupational health and safety professionals in

1 California and we are working to enhance their professional practice.
2 The ETS stakeholders, which includes the CIHC were asked by
3 the subcommittee to provide input on the pros and cons of certain metrics
4 for use in guiding the path forward on what to do with the ETS. We
5 comment actually that with or without metrics, applicable or not, the
6 Standards Board and the Division cannot move rapidly enough for
7 occupational health and safety regulations to keep up with the constantly
8 changing information and guidance related to COVID-19.
9 The version of the ETS that went into effect on June 17th is the
10 version that should be allowed to play itself out as an emergency standard
11 without further changes in a futile attempt to try and keep up with the
12 bouncing ball.
13 Another readoption is allowed under the emergency regulation
14 process. And if this is approved, presumably at the December 2021
15 Standards Board meeting it will carry the ETS to March of 2022 before it
16 expires. CIHC supports no –-
17 MR. GOTCHER: Thirty seconds.
18 MS. MURCELL: -- changes to the ETS and expiration of the ETS
19 without a Certificate of Compliance. Changes would only add to further
20 confusion.
21 Workers and employers, especially employers are allowed to
22 establish policies in addition to compliance with the ETS that are in the best
23 interest of their employees and their specific work environments. I refer
24 you to the Standard 3205 (a)(2) specifically.
25 While obviously there are numerous guidance documents --

1 MR. GOTCHER: Three minutes.
2 MS. MURCELL: -- available to assist the employers, so we think
3 the stakeholders would be better served if everyone moves forward
4 expeditiously with a permanent regulation to address worker protection in
5 all industries from infectious diseases and to make changes as needed to the
6 ATD to assure clarity that COVID-19 is covered by that regulation for the
7 healthcare-related industries.
8 The CIHC looks forward to further advisory committee
9 participation to assist the Board and the Division with a path forward on this
10 issue. And again, we encourage expediting this approach. Thank you.
11 MR. GOTCHER: Our next commenters are Helen Cleary, Eddie
12 Sanchez and Bryan Little, with next Helen Cleary from the Phylmar
13 Regulatory Roundtable.
14 MS. CLEARY: Good morning everybody, thank you for the
15 opportunity today. I'm Helen Cleary, the Director of the Phylmar Regulatory
16 Roundtable. The presentations were excellent, great information was
17 shared. We'll take a look at that. It was a lot to digest, so we'll review that
18 and we'll have some suggestions or discussion points later.
19 And we also want to encourage that the advisory committee
20 discussion start sooner than later. We have touched on this previously, and
21 again at this meeting. This timeline is going move really fast as we've
22 experienced, so if we could start looking at when those conversations will
23 take place I think that will be helpful to all stakeholders to kind of ease that
24 understanding of where we're headed and what we need to do to prepare
25 for that before it gets in front of us.

1 I wanted to highlight just one issue that's been brought up by
2 members and sort of stakeholders about quarantine pay requirements and
3 would like to have some discussion on that, maybe add this to a future
4 agenda item. Since vaccinations have been so readily available now
5 employers are consistently paying for time off and to recover from the
6 vaccine. There have been hosting vaccine clinics on site. And we'd like you
7 to consider amending the quarantine pay requirements to exclude
8 individuals who have made non-protected, non-EDA or religious-belief
9 decisions for voluntary choice not to get vaccinated.
10 The paid leave benefit for a non-vaccinated individual who
11 experiences a close contact exposure is actually created as an incentive for
12 some individuals to one, not disclose their vaccination status and two, not
13 to get vaccinated.
14 MR. GOTCHER: Thirty seconds.
15 MS. CLEARY: So this is making it difficult to encourage vaccines
16 when there is an actual monetary benefit not to. So we'd just like to have
17 some discussion around that and consider that as one of the unintended
18 consequences and challenges to this requirement.
19 So that's all I have for today. And thank you for your time and
20 have a good weekend.
21 MR. GOTCHER: Our next commenter is Eddie Sanchez from the
22 Southern California Coalition for Occupational Safety and Health.
23 If you dialed in on WebEx you will need to press *6 to unmute
24 yourself.
25 MR. SANCHEZ: Okay, I'm here. Hello everyone my name is

1 Eddie Sanchez with the Southern California Coalition for Occupational
2 Safety and Health, SoCalCOSH. We are here in continued support for
3 strengthening the COVID-19 Emergency Temporary Standard. I want to
4 thank you, committee and staff for your work on this process, and for
5 considering our comments today. And an additional thank you to Dr. Das,
6 Dr. Heinzerling and the other presenters today.
7 So it’s been an unbelievable turn of events from where we were
8 just a little bit over a month ago, which speaks to the need for an ETS that
9 has additional protections. I just want to point out that we're going to need
10 more information, more regulation and more resources if you want to turn
11 things around. And supporting technologies that it's not too late.
12 I would ask that this body present if possible present state-by-
13 state comparisons for ETS-like models and regulations, so we can see what is
14 happening across other states and maybe identify best practices.
15 Overall we need a trigger for these additional protections asap,
16 even for those working outdoors in close proximity for each other.
17 We also need language to address the vaccination self-
18 attestation and the challenges that come with that.
19 We need data transparency on outbreaks and eventually a
20 permanent standard to address COVID.
21 I wanted to unpack a few of those asks starting with data
22 transparency. We need to see the outbreaks by geography to see what
23 specific communities and geographies are being impacted. Currently the
24 data is accessible across the state by industry, which won't tell anyone what
25 is occurring in their own community.

1 We need triggers tied to hospitalization for our case
2 percentages. If not, the trigger will be essentially an unidentifiable disaster.
3 I also want to ask that we begin to think --
4 MR. GOTCHER: Thirty seconds.
5 MR. SANCHEZ: Thank you, we begin to think about workplace
6 violence protections what do the ETS for workers who are enforcing safety
7 measures at work. Workers are experiencing threats and hazards when
8 enforcing local protections.
9 This week at Sutter Creek Elementary School a teacher was
10 attacked for enforcing mask mandates and the teacher was left bleeding and
11 bruised from this encounter. So we also need the ETS to be at least as
12 protective as the CDC or local ordinances.
13 So of all that just to say that we need it a whole lot, there's a
14 lot of ground that needs covered. Ultimately, I want to thank the Board and
15 staff for your time and consideration to work on this effort. We know you
16 will make the best decision to protect workers and working-class families.
17 Thank you.
18 MR. GOTCHER: Our next commenters are Bryan Little, Bethany
19 Miner and Madeline Stone, with next Bryan Little from the California Farm
20 Bureau.
21 MR. LITTLE: Good afternoon, or morning. Can you hear me?
22 MR. GOTCHER: Yes, we can.
23 MR. LITTLE: Great, thank you. Just wanted to offer a couple of
24 brief comments. First I associate myself with the remarks by Mr. Jarvis and
25 Ms. Murcell and with Helen Cleary and Bruce Wick. I'd like to note that it

1 would be useful to be able to have access to some of the presentations we
2 saw earlier today a day or two at least ahead of these meetings. It would
3 greatly inform our capacity to be able to comment meaningfully on the
4 information that's presented there.
5 And also to note that I thought it interesting that, at least as I
6 understood Dr. Heinzerling's comments it's pretty clear that we don't have
7 any good data indicating, which cases are acquired in the workplace and
8 which cases are acquired in the community. And it would be useful to be
9 able to have that information and be able to discern how many cases are
10 community acquired, how many cases are workplace acquired, and what the
11 appropriate remedies would be or might be for that.
12 I don't have anything further to say than that. And I thank you
13 for the opportunity.
14 MR. GOTCHER: Our next commenter is Bethany Miner who is an
15 HR professional with over 400 retail employees.
16 MS. MINER: Good afternoon, my name is Bethany Miner. I am
17 an HR professional in a retail environment with over 400 employees. I want
18 to thank all of the subcommittee members for all of your continued hard
19 work.
20 There has been some discussions about vaccine verifications, so
21 I just wanted to comment on that. Currently the FAQs state that
22 documentation is required. The FAQs also say this record must be kept
23 confidential. I believe the goal is to ensure that employers are documenting
24 and getting accurate information about their employees' vaccination status.
25 I also believe that employers are expected to use that

1 information to determine which employees are permitted to work without a
2 face covering. It's not possible to both keep that information confidential
3 and use that information to allow some employees to go without a mask.
4 For our workplace setting we would need to have multiple managers to have
5 access to a list of the employees who are permitted to go without a mask,
6 which would mean that information is no longer confidential.
7 I'd urge you to immediately update the FAQs and remove the
8 confidential requirement or create a work-around for employers to follow.
9 One option would be to say that there is no requirement to keep vaccination
10 information confidential. Another option would be to say employees'
11 vaccination status is not confidential. If there is a medical record such as an
12 actual vaccination card, the actual document, not the information on the
13 document is confidential and must be maintained in a separate confidential
14 file.
15 I also have one other comment on –-
16 MR. GOTCHER: Thirty seconds.
17 MS. MINER: -- regards to ongoing dives into the data, it seems
18 prudent to focus on the objectives and avoid the endless rabbit hole as we
19 will never get perfect data. It makes sense to keep up on data which
20 informs us how well the vaccines are working. It also makes sense to keep
21 up on data about hospital capacities. If there are clear goals in mind when
22 seeking other data points then it might be worth exploring. However, to
23 keep digging further into data that will never be perfect or timely seems to
24 be a waste of your resources --
25 MR. GOTCHER: Two minutes.

1 MS. MINER: -- losing precious time. I have a lot of concerns
2 about any long-term standards being inappropriate as we have seen that our
3 situations change quickly. And what is appropriate for one county is not the
4 right call for another county. I hope there is a way to pivot as needed in a
5 timely manner. It seems that has not been a strength so far. It might be
6 wise to set triggers such as hospital capacity for particular restrictions to
7 turn on or off.
8 I think it would also be helpful to consider moving away from
9 the path of readoption –-
10 MR. GOTCHER: (Indiscernible.)
11 MS. MINER: -- to Certificate of Compliance and look to adding
12 to IIPP. Thank you very much for your time.
13 MR. GOTCHER: Our next commenters are Madeline Stone,
14 Stephen Knight and Kevin Bland, with Madeline Stone who is a San Francisco
15 resident, a Google engineer and a Novavax trial participant.
16 MS. STONE: Hi, my name is Maddie and I have no real fancy
17 title or affiliation, but I am an employee here in California and participated
18 in the Novavax vaccine trial. And I volunteered for that trial despite the risk
19 to myself, and in the hopes that the risk could help all of us get out of the
20 pandemic.
21 And I received the full course and I have a CDC card that does
22 state the individual can be considered fully vaccinated for public health
23 purposes. But when I went into work to verify my vaccination status I
24 learned that per the ETS requirements I am not considered fully vaccinated,
25 since the definition prior to the ETS states that the vaccination needs to be

1 FDA emergency use authorization approved, which Novavax is not.

2 The Novavax trial results have been published, which do show

3 efficacy greater than some of the other vaccines in the current definition, so

4 it does not seem required for health, workplace health, in order to continue

5 excluding Novavax.

6 I really hope that you all will consider modifying the definition

7 of fully vaccinated to include Novavax as long as the vaccine's trials are still

8 underway. Because otherwise us trial participants only options are to drop

9 out of the trial and get another vaccine which is currently against medical

10 device. And I don't think having volunteers drop out of these medical trials

11 is in our societal best interests.

12 As an additional note, cities like San Francisco as of yesterday

13 are using Cal/OSHA's definition of fully vaccinated for their own mandates.

14 So it's seeming to be the cycle of continually being punished for trying to

15 help and participate in this. And I know that that may or may not be the –-

16 MR. GOTCHER: Thirty seconds.

17 MS. STONE: -- intention to have your definitions and standards

18 used elsewhere, but that's the reality for us right now. So please, please,

19 please consider changing that so that we can return to work and go about

20 our lives as vaccinated individuals. And as a note this request was also

21 presented at the last subcommittee meeting in July. Thank you.

22 MR. GOTCHER: Our next commenter is Stephen Knight from

23 Worksafe. It looks like you're muted right now.

24 MR. KNIGHT: Yes, thanks. Good morning everybody and thank

25 you all for your hard work on this process. I just had a focused comment

1 about the Sacramento Bee's reporting in February that California employers
2 have reported only 1,600 serious worker illnesses or death to Cal/OSHA from
3 the very start of the pandemic through the end of last year, raising many
4 questions about compliance and quality of that data.
5 And while I certainly can understand there are many factors of
6 play, my comment today is just to raise that issue of business compliance
7 with reporting cases to Cal/OSHA and/or local health departments. The data
8 we have to work with is only as good as the data that's reported to the
9 agencies. So I also just want to support the comments made by the CLRA
10 and SoCalCOSH this morning. Thank you very much for the opportunity
11 MR. GOTCHER: Our next commenters are Kevin Bland, Robert
12 Moutrie and Michael Miiller, with next Kevin Bland from Ogletree, Deakins,
13 Nash, Smoak & Stewart.
14 MR. BLAND: Hello, good afternoon everyone. Kevin Bland,
15 representing the California Framing Contractors Association, Western Steel
16 Council, and the Residential Contractors Association here today.
17 My comments are brief. Basically it's a request. It's very
18 difficult to make good, well-intentioned comments on data that's presented
19 10 minutes that's very complicated and very in-depth that we get in the
20 morning of our comment period in the afternoon. It would be very helpful if
21 that could -- even if you got it a couple days before it would be very helpful
22 to us, because it's very difficult to make wise and informed comments
23 without the data to be looked at and considered.
24 And I think there's been kind of a common theme between
25 labor and management on here is that the data is not always what we

1 understand it to be, because we haven't had opportunity to look at it. And
2 there's arguments about whether it's valid, invalid, takes anything and the
3 right things into consideration or doesn't, and that's across the board. And
4 so what would be helpful in making those determinations to make informed
5 comments is to have that in front of us before the meeting, so we can
6 address those concerns across the board.
7 The other thing that has kind of come up a little bit already is
8 this connection between community spread and workplace spread. I think
9 that's important, because I know a lot of clients that I advise on when they
10 have outbreaks a lot of times it is a community spread event, because that
11 counts as an outbreak number in the workplace --
12 MR. GOTCHER: Thirty seconds.
13 MR. BLAND: -- even though it didn't occur inside the
14 workplace, but it gets reported because someone had it from outside
15 whenever the contact tracing is done. So I think that's an important thing
16 for us to try to ferret through and distinguish so we can make informed
17 decisions of what we're doing in the workplaces to keep people safe.
18 Also I would incorporate by reference the comments made by
19 Bryan, Bruce and Helen earlier, I appreciate it. And thank you for your time
20 today. Look forward to the next opportunity.
21 MR. GOTCHER: Our next commenter is Robert Moutrie from the
22 California Chamber of Commerce.
23 MR. MOUTRIE: Good morning everyone, hopefully you can hear
24 me all right. Oh good, thank you. Well, I will get through my two minutes
25 then. First I'd like to thank the presenters for their information. I found it

1 very helpful and very thorough and I know it takes time to put together
2 that kind of presentation. I'd also like thank the Board staff and Division
3 staff. As Christina Shupe noted the workload has been insane and continues
4 to be insane.
5 Regarding the advisory committee I'd like to echo the
6 comments of Helen Cleary that to the extent that we are going to have an
7 advisory committee, which we would certainly prefer on behalf of the
8 business committee, it needs to be before that readoption, because that
9 three-month time in there between the second readoption and potentially a
10 permanent regulation expiration is just not long enough to do substantive
11 work.
12 I would also like to flag that I think I made comments about
13 how public health, local officials and others can move past the ETS on mask
14 mandates. It really highlights one of the central problems with the ETS is
15 there is lack of flexibility in the ETS. And whether that has shifted by going
16 to a guidance-based method that could be adapted, changed more quickly as
17 with local public health and CDPH orders, or as some other multi-tiered
18 system I think that that lack of flexibility is a massive concern going forward
19 in both directions.
20 I'd like to also comment briefly on requests about information
21 with the variables use looking forward or the best pieces of data. I think
22 that case rates by themselves and others are rather insufficient. If I had to
23 pick then I'd like to just put in plug for hospitalization rates as likely the
24 best variable, because we don't want data that includes vaccinated people
25 who caught COVID, but are okay or we expect to be okay. We want data

1 that separates that out, because at some point in the hypothetical future
2 enough of us will be vaccinated this will not be common to have serious
3 consequences with. And I think at that point we can agree that the
4 precautions can (indiscernible) –-
5 MR. GOTCHER: Thirty seconds.
6 MR. MOUTRIE: Thank you.
7 The last point I would like to flag is that I'd like to respond to
8 the comment from Pamela Murcell of the CIHC. I would say on our side we
9 are concerned about holding the present ETS through the expiration, or
10 excuse me, through the second readoption for the reason I flagged earlier.
11 That once you -- if you don't start those discussions, advisory committee
12 discussions about changes before the second readoption your time window
13 is very short. And I believe Pamela Murcell referred to the expiration and
14 I'm not sure that the date was correct, so maybe if you could have Ms.
15 Shupe or others reflag the expiration date after the second readoption I
16 would appreciate that. Thank you for your time.
17 MR. GOTCHER: Our next commenter is Michael Miiller from the
18 California Association of Winegrape Growers. (No audible response.)
19 Michael Miiller, are you with us? And if you dialed into the WebEx you will
20 need to press *6 to unmute yourself. It looks like, Michael Miiller, you are
21 muted in the WebEx right now.
22 And Michael Miiller is the last commenter on my list right now,
23 so if you can hear us Michael Miiller it is your turn to speak.
24 MR. LITTLE: It appears Michael dialed in. Does he need to
25 press *6 to unmute?

1 MR. GOTCHER: I can see him in the WebEx, but Michael
2 Miiller, if you did dial in as well you will to press *6 to unmute yourself.
3 MR. MIILLER: This is Michael Miiller. Can you hear me now?
4 MR. GOTCHER: Yes, we can.
5 MR. MIILLER: Oh good, thank you. I apologize for the
6 confusion. I had to dial in, because my audio is not working on my
7 computer. I have just a couple of really quick comments. One is I really
8 appreciate the information today and I want to just to reiterate that a lot of
9 the information was focused on the community spread issue of the virus
10 without actually focus on the workplace spread of virus. And I think absent
11 that data the information needs to be really viewed with the knowledge that
12 we don't know how many cases are spread at work, what those work
13 situations are, and how to best protect employees from workplace spread of
14 virus.
15 And second, I do want to make one quick comment to that.
16 This Board's best work is done when it's done collaboratively. And you bring
17 everybody together where we can talk up the issue, the employer side of it,
18 the labor side of it. And you as a regulating lawmaking body where we can
19 come together find the best solutions that work for everybody.
20 When the COVID deniers and the anti-vaxxers kind of co-opted
21 the process early on and created this situation where we all get only two
22 minutes to comment, and we're commenting at the end of getting data that
23 we have never seen before, it does really impede our ability to give
24 important information that the Board could consider and think about and
25 deliberate. And I don't know how to resolve that, because I get why we

1 have these two-minute limitations. But I think there needs to be some kind
2 of a process for us to get information sooner and for us to have a more
3 deliberate conversation where we can talk the issue out and work towards a
4 more viable solution then.
5 Thank you again very much for your time, I really appreciate it.
6 Sorry for the confusion about me calling in. Thank you.
7 MR. GOTCHER: There are no further commenters in the queue
8 at this time.
9 BOARD MEMBER LASZCZ-DAVIS: Thank you very much for your
10 testimony, that was very helpful.
11 I would like to comment and I know several of you did comment
12 that it was frustrating to just receive, or actually just to hear and see the
13 information today and then to expect you to comment on this substantively.
14 That is a frustration. But let me suggest the following, in fact we have
15 deliberated as to how best do this. We could have posted this 2-3 days in
16 advance. But as to the discussion and interpretation I don't know how much
17 value that would have been, so this is what I'd suggest.
18 We listened to several presentations. We've heard a fair
19 amount about the data, its meaningfulness. We have certainly heard
20 suggestions for additional data that should be presented. I think our next
21 subcommittee meeting, August 27th, ought to be devoted to if you will, a
22 rehearing, a discussion of the data that was presented today. So if you feel
23 like we have shorted an opportunity to really discuss it let's make that
24 happen on August 27th.
25 You know, I think we all appreciate the frustrations that we

1 deliberated to give it to you in advance, and then that might have been
2 subject to misinterpretation. But now that you have heard what the
3 presenters have to say second let's really discuss this at the August 27th
4 meeting. I don't know if that would help, let's get that as a start and see
5 where that takes us.
6 You know, at that point I think we're into subcommittee
7 consideration at this point. Do any of the subcommittee members have any
8 further items that they wish to discuss? Laura?
9 BOARD MEMBER STOCK: Yes, thank you Chris. Thank you
10 everyone for the testimony and I do think it definitely suggests further
11 conversation that we should have, and maybe this is going to overlap with
12 our like what are our next agenda items. And so I'll say that. And then I
13 have another point I'm going to say.
14 But yeah it seems like I think some of the issues that were
15 raised by our commenters, including the sort of unintended consequences of
16 the quarantine pay issue I appreciate that comment. It feels like something
17 worth looking into and discussing more.
18 And I think there's also again more information about data. I
19 just want to highlight that we are asking to see if we can get some of that.
20 If we're going to have more conversation about data I do want to highlight
21 the importance of getting employer-provided housing and transportation, so
22 we can add that to our conversation.
23 Another thing, I'm curious -- and this may be a discussion for
24 the future -- I mean, obviously as everybody has commented and is
25 frustrated by, I share the frustration about how difficult it is to respond in a

1 timely manner to the changing circumstances, that the regulatory process
2 is very slow and cumbersome.
3 And I think maybe there are some opportunities to address
4 some issues through modifications to the FAQ. I feel for our commenter
5 who got the Novavax vaccine who is now not able to use that vaccine to
6 allow her to go into bars and other things in San Francisco now that the new
7 requirement is there, let alone in the workplace.
8 And that's just one example of whether there might be
9 circumstances where the FAQs can be tweaked. I know that's a very difficult
10 line, because there's regulatory language. But then there is language where
11 in the regulation it might be relatively less defined, that allows further
12 definition to made in the FAQ. And that might be something that would be
13 interesting.
14 I mean, Eric, you might have some comments on that now.
15 And/or we could look again at what are the opportunities to address some
16 of the things that we are hearing, even before we do our formal second
17 readoption. So I guess I don't know, Eric, do you have a comment on that
18 now by any chance?
19 MR. BERG: Yeah, I mean we're always open to adding to the
20 FAQs or clarifying anything that needs clarification. Or if there is any
21 specific questions that you would like to be included in the FAQ or where an
22 FAQ needs to be further clarified. We would appreciate that, I'm sure.
23 BOARD MEMBER STOCK: So that might be an example of where
24 we could look at some of the testimony that we're hearing about
25 quarantining and etcetera, and see where we might make -- what are the

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1 options related to adjusting things if, and when we think it's appropriate to
2 do so. And I mean, there's a range of ways that the FAQ –-
3 I think another issue that I know I have been concerned about
4 and I think others have brought up too is the whole issue of vaccine
5 verification and what that really means.
6 Again, we are having some concerns now about the whole
7 approach that was predicated on the assumption that if you are vaccinated
8 you don't need to wear a mask indoors nor do you need to tested, because
9 you can't transmit it. So we already know that there are some shifting in
10 our understanding. That said that the regulation still definitely is a
11 vaccination status is hugely important. And how that's being verified and
12 what kind of documentation is being used is of concern and is another area.
13 It will be interesting to see how it could be clarified and
14 another area that we might want to ask our stakeholders specifically to
15 comment on at our next meeting about how that's working and what issues
16 are coming up for that. So I think those are my comments.
17 BOARD MEMBER LASZCZ-DAVIS: Thank you, Laura.
18 Nola, any thoughts, observations?
19 BOARD MEMBER KENNEDY: I guess I'm trying to think
20 forward. And I see our second readoption date is coming up very quickly.
21 If we're going to be voting on something in December it seems to me that
22 the language has got to be pulled together. I don't know the dates, but
23 probably in November sometime.
24 And that's going to be here before we know it, so I'd kind of
25 like maybe as we move forward at our next meeting to start thinking

1 about with inputs from Cal/OSHA and maybe even the Standards Board
2 staff, what kind of changes can be made, should be made. So that we can
3 have a discussion about that, which might also inform a future advisory
4 committee discussion. So those are my thoughts.
5 BOARD MEMBER LASZCZ-DAVIS: All right, thank you, Nola.
6 Where does that take us right now at this point?
7 Let me tell you what I think I've heard, and I'm sure you guys
8 will correct me if I am not faithfully representing this. As we have had
9 the chance to deliberate over the last two, two-and-a-half hours this is
10 where I think we'll land at our August 27th meeting. Certainly, as
11 indicated earlier we need to present an opportunity for people to
12 comment on their experience as regards to data that was presented
13 today. The frustration I think we all heard, everybody got this morning,
14 and it's just not enough time to comment. Well let's have that discussion
15 ask the August 27th meeting.
16 In addition to that we certainly heard a plea on some
17 additional metrics of standard reporting on the front end of our
18 subcommittee. I'm not opposed to it, as it probably does make sense.
19 Bruce Wick certainly cited three data sets that could just be part of the
20 standard reporting format: Workers' Comp, enforcement data, and then
21 there was a third one that I don't recall at this point.
22 The first two subcommittee meetings Amalia did an excellent
23 job of reporting out on the benchmarking that she had done across the
24 states. I think that if there is an update to that or a summary I know I'd
25 appreciate Amalia providing an update on best practices and what other

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1 states are doing. I mean, we're not taking this journey alone. It would
2 be helpful to have some benchmarking there and update for sure.
3 We certainly went down the road and began to talk about
4 the Emergency Temporary Standard, whether or not we're moving
5 towards a permanent standard. At what point do we have input from an
6 advisory committee process. Nola just suggested that we at least open
7 that door and have some discussion as to when input can be provided.
8 We can open that door, but I am with you. If in fact
9 November is when we need to begin to think about it seriously, those
10 discussions need to be had now. So certainly I think an advisory
11 committee process of some sort, some of a forum so that people can
12 render their opinions in terms of operational practice are critical before
13 we go any further consideration out of readoption.
14 And then Laura recommended a report-out on vaccination
15 status, clarification and documentation and what have you. And that's
16 what I've heard today.
17 Having said that, all of those will take more time than we'll
18 probably have at the August 27th meeting, but let me just put that on the
19 radar screen. And I think amongst us we can figure out what the next
20 agenda should reasonably take, that that directionally is what I heard
21 today. Does that make sense or did I miss something?
22 BOARD MEMBER STOCK: Yeah thank you, that was a good
23 summary, Chris. The one thing I might add, and Amalia maybe this is
24 related to like reviewing other states, but as I mentioned earlier I did see
25 this morning -- and I just saw the alert -- these new Fed OSHA guidelines

1 for workplace COVID practices. And I do know that until they are a
2 mandate they're just guidelines that were not required to be at least as
3 effective as those guidelines. But I think it would be great to hear more
4 about them. I know I want to read more when we have a minute to do
5 so, so I might just add that to something that if we have an opportunity
6 to hear more about the Fed OSHA guidelines that would be really helpful.
7 And one commenter, or it may be a question Christina or
8 others can consider, because I know a lot of people are feeling like in
9 order to move forward to develop that readoption proposal a lot of
10 people are talking about the importance of an advisory committee
11 process.
12 And the workload of the Division and the Board staff is
13 incredibly high. And one contribution to that workload are the
14 institution of these subcommittee meetings. So all the sudden, that’s a
15 new process that didn’t exist before. So now in addition to the potential
16 advisory committee that needs getting set up, there are now up to two
17 additional meetings that also need preparation, these subcommittee
18 meetings.
19 And I wouldn't want that process to interfere with the need
20 to have advisory committee meetings. So that might be something that
21 we could think about going forward about once we have launched that,
22 what does that mean about the schedule of these meetings? How can
23 these meetings not be contributing to a workload that does not allow
24 advisory committees. So I just think we should think about how going
25 forward and just looking at the whole range of efforts that Board and

1 Division staff are doing, how we can streamline it in order to allow some
2 of the processes that we need to go forward.
3 BOARD MEMBER LASZCZ-DAVIS: Laura, did you expect a
4 response from Christina on that or just a deliberation post-subcommittee
5 meeting?
6 BOARD MEMBER STOCK: I mean, certainly if Christina has a
7 comment I'd welcome it. And otherwise I just want to try to put that
8 into mix as we're thinking about what's needed going forward in
9 scheduling advisory committees or others, I think I would recommend
10 that we be flexible around the number of these meetings and the
11 schedule of these meetings, so that they don't interfere with that other
12 process.
13 BOARD MEMBER LASZCZ-DAVIS: All right, sounds good.
14 -Any further comments before we begin to close? (No
15 audible response.) So with that the next subcommittee meeting is
16 scheduled for August the 27th via teleconference and video conference.
17 Please visit our website and join our mailing list to receive the latest
18 updates.
19 We thank you for your attendance today. There being no
20 further business to attend to this meeting is adjourned. Thank you for
21 joining us.
22 (The Subcommittee Meeting adjourned at 12:21 p.m.)
23 --oOo--
24
25

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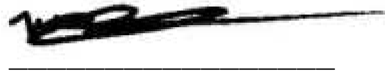

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