

**Aerosol Transmissible Disease
Cal/OSHA Advisory Meeting – Draft Minutes
Non-Traditional and Community Based Operations
May 24, 2006 Oakland CA**

Chairs: Robert Nakamura, Deborah Gold

Participants

Phyllis Brown, California Nurses Association
Tamara K. Davidson, City and County of San Francisco, Dept. of Public Health
Tom Eller, American Medical Response
Heidi Fowers, County of Sonoma, Risk Management
G.G. Greenhouse, Alameda County Health Care for the Homeless
Donna Gregg, VNA -- CV
Karen Grimsich, California Association of Adult Day Services
Rosanne Harding, California Dental Association
Mike Horowitz, Cal/OSHA
Janet Macher, California Department of Health Services
John Mehring, SEIU – United Healthcare Workers West
Barbara Tuse, Cal/OSHA
Laura Vo, City of Sacramento
Kevin White, California Professional Firefighters
Darrell Wolf, California Department of Forestry and Fire Protection
Pat Wyatt, EHC LifeBuilders

Summary of Key Points

1. Participants identified gaps in communication between organizations regarding patients who were diagnosed as having reportable diseases. They supported including communications requirements in the standard, which included meaningful time limits. The standard should include clear, plain requirements to communicate so that it will address confidentiality concerns. Some participants favored extending the communications requirement to suspect cases.
2. Participants supported having clear guidance to medical and dental providers and others affected by HIPAA regarding what can be communicated. There is currently a lot of confusion.
3. Some participants favored expanding the scope of the section, to include social workers and home care workers and others in high risk environments.
4. Some participants reported a lack of systematic fit-testing for respirators and other gaps in respiratory protection programs. Some participants supported including oral and nasal pharyngeal airways as a high hazard procedure. There was discussion about requirements for annual fit-testing, and provisions in the proposed standard addressing this issue.
5. Some participants supported extending the period for providing newly recommended vaccinations to 90 days. Some employers are currently requiring or providing certain vaccinations. Participants varied in whether they supported requiring a declination for influenza vaccine.

6. There was discussion about what form of training would satisfy the requirements of the standard, and whether computer based formats could be used.

Detailed Minutes

Below are detailed notes of the advisory meeting. These notes do not represent a transcript of the meeting, and are simply a summary of the notes taken by the people conducting the meeting. Although every effort has been made to accurately reflect the opinions expressed in the meeting, they should not be considered to be a verbatim record of the proceeding.

Deborah Gold opened the meeting and reviewed the history of the project. She explained that the current effort began in 2004, when both unions and health care employers asked Cal/OSHA to develop a standard that would address TB and SARS. There were two meetings in 2004, but there was not good representation of community based services, so in March 2005 a meeting was specifically held for these non-traditional settings. Many of these organizations do not have a lot of resources. Since then, Cal/OSHA has developed the concept of “referring employer” for workplaces such as homeless shelters who do not treat people with airborne infectious diseases, but who refer them to hospitals or other health care settings. Airborne infectious diseases are certain specific diseases that require isolation rooms, such as tuberculosis. She said that this meeting will focus on subsection (b) which includes the provisions for referring employers, and on the communications requirements between referring employers and those who provide diagnosis. The reason for the communication requirements is to ensure that timely evaluation, prophylaxis, and treatment is provided to employees who have had contact with people who have a reportable aerosol transmissible disease.

Communications and Reporting

G. G. Greenhouse said that it is good that we are discussing communication, because it is not currently happening on the outside.

D. Gold explained that there are approximately seven diseases identified as requiring airborne infection isolation, in addition to novel and unknown pathogens. The idea of subsection (b) is to train employees of referring employers to recognize people who may have these diseases, and to ensure that they are referred or moved to an appropriate facility. The referring employer may transport them, or may refer them in other ways, such as making an appointment for them, or providing them with information regarding an appropriate facility. Basically, the proposal would establish a maximum 5 hour framework for the referral, but there is an exception for places such as homeless shelters, where people are initially seen in the late afternoon, and there may be no appropriate referral until the following morning. In that case, the standard would require them to be referred by 11 a.m. She asked if that was a reasonable time frame.

G.G. Greenhouse said that her program has mobile health vans that they bring to homeless shelters. They provide free TB tests. The clinics will do follow-up without charge. They give their clients bus tickets to get to facilities for the follow up. They also go out into the public, and provide PPD testing. They have a high percentage of people who return for the results because

the shelters require proof of TB testing for people to stay there. There is pretty good compliance, and they do advocacy to get sputums and x-rays on positives. But one to two positives a month do not return for follow up. They try to remove barriers to care. D. Gold asked what happens if someone has active disease. G.G. Greenhouse said that if someone shows symptoms, a public health nurse will screen the person. So far, nobody has been that sick. The program normally sends the person in first. There are procedures and protocols in place, but they need to be tighter. D. Gold asked if they are protocols met the requirements in the draft standard. G.G. Greenhouse said that she had not read the draft standard, but the communication is not that good. Bob Nakamura asked if people get treated. G.G. Greenhouse said that they did, but they often did not get the paperwork feedback. She said they only got about 10 per year back. Her program can't force accountability.

Pat Wyatt said that her organization provides a variety of services in short and long-term housing. One tenant died, and it turned out that the tenant had TB that was not diagnosed. Employees in leasing and janitorial who had interacted with the tenant are very concerned. She said it is unclear what their obligations are. D. Gold said that workplace exposures often end up in workers comp. P. Wyatt said she was concerned not only about providing services to exposed employees, but about other tenants. G.G. Greenhouse said that the county health department should go out. D. Gold suggested that P. Wyatt contact the county TB Controller, who may already be aware of the case and will conduct baseline and follow-up testing.

Donna Gregg asked if there were any concerns relating to HIPAA [Health Insurance Portability and Accountability Act]. Does there need to be a signed release to permit communication? D. Gold said that they had consulted the Cal/OSHA legal unit about HIPAA and other confidentiality issues. The lawyer said that some information can be transferred as "continuity of care." You can also communicate information back to the original provider without identifying the source patient. There are also provisions in HIPAA for information transmission required by law. The legal unit will be providing something in writing about this for the rulemaking process.

Kevin White said that the standard should include some very plain language about communications that makes it clear that the communication is required by law. Professionals need to be able to communicate with each other without breaking confidentiality. D. Gold asked him if the current language was not clear. K. White said that it needs to be less vague. He said the standard should state "you can report this because..." D. Gold said that might end up in supporting documents rather than the standard. Darrell Wolf said that he echoed his fellow fire fighter. HIPAA keeps too tight a veil on information. When they take someone to the hospital they can't get any information back, even if they have a long-standing relationship. They want the right to know.

D. Gold read subsection (g)(6)(A) which requires employers who diagnose a reportable ATD to notify employers. She asked if a time frame needs to be added to this requirement. Janet Macher asked if the issue is to whom the info is given. If you are the person who brought the patient in they might not give it to you, but they might well notify the employer. D. Wolf said that the question is who is getting notified. Who does the hospital notify in a large fire Department? D. Gold said that was the reason for requiring an effective communication plan. It would require that the fire department designate to the hospital how they should be notified.

John Mehring said that if the case is reported to the local health officer, the health officer may follow up. Is there a possibility the employer can say the Public Health Officer is doing this and the employer can say then they don't have to do anything further? Donna Gregg said that their procedure is to notify employees who may have had exposures by sending a letter that day stating 'you were exposed' but not identifying the patient. D. Gold said that Cal/OSHA is working with local health officers, and that Kathy Moser has been participating in this process. Under the draft, even if the local health officer does ultimately follow-up, at least a start has been made. She asked if participants got notified by the public health agencies about exposures. K. White said that in his experience, they did not. D Wolf agreed that generally they were not informed of exposures by the public health agencies.

K White read the wording in subsection (g)(6) requiring employers to notify other employers. He said that it gives the responsibility for notification to the hospital if the patient goes there. But frequently they get called to homeless shelters, and the individual will refuse transport after they provide some treatment. The staff of the shelter finds out a day or two later that the patient was TB positive. Does the homeless shelter employer have to notify us? D. Gold said that assuming the shelter has a record of the call, they should notify the paramedics. G.G. Greenhouse suggested that they find out the protocols of the shelter. In Alameda County, all new people have to get tested within a week, and they must have proof of TB testing. Therefore, first responders can be told if an individual is TB positive.

D. Gold said that generally, the intent of the draft is that if there is information held by employers it would be required to be passed along to responders. Hopefully, although not perfect, the standard will improve communication, by requiring effective procedures and providing a time frame for the communication. She said that the requirements regarding exposure incidents would apply to reportable ATDs. She said that one of the handouts contains the list from Title 17 of reportable diseases, and another contains draft appendix A, which is a list of ATDs. So these requirements would apply only to reportable diseases that are ATDs, and would not apply to blood or foodborne diseases. Also some rare diseases are not reportable, so they would not be included.

Tamara Davidson said that the provision on page 13, subsection (d) regarding consulting with the local health officer if the employer is unable to refer a patient within the required time frame, and following infection control recommendations from the local health officer, is not within the scope of duties of a local health officer. D. Gold said that the Health and Safety Code provides a very broad charge to health officers, and they do get involved. For example in one county there was a prisoner who could not be transferred, and the local health officer made some recommendations. Cal/OSHA is consulting with the Local Health Officers' association and the TB Controllers Association, so they will review this provision.

Karen Grimsich asked how a confirmed case would be reported. Does it require a written response or call? D. Gold said she would recommend a hard copy—such as fax, which is what most hospitals do. She said it depends on the communication system you set up. She said that employers need to talk with the organizations they refer to and work out a system. We are trying to leave it flexible.

K. Grimsich asked how you would know if a person is a confirmed case. J. Macher said the person would need to meet the CDC definition for a confirmed case. The diagnosis would have to be made by an MD. D. Gold said that some diseases have easy confirmatory tests, while others are more difficult, like pertussis. G.G. Greenhouse said that it didn't take that long. They had an outbreak of pertussis where they suspected a child in a shelter. They contacted public health department, and they took over. The public health department closed the shelter to new access, and consulted with the families. They educated and provided vaccine to the residents. It worked well.

K. White asked if subsection (g)(6)(A) can be changed to include suspect as well as confirmed cases. D. Gold said that not all reportable diseases have a clear definition of a suspect case. K. White said that they want faster notification down the chain of exposure, and reporting of suspect cases would improve that. J. Macher said it isn't an exposure incident until it's confirmed. G.G. Greenhouse said that some people test positive, and so they send them for confirmation. But what's the person's history? D. Gregg said that they have no consent on family members in the household. She said that they had a case recently involving a family member. The physician who suspected the person had TB didn't report it to them or the patient. When they found out that the doctor thought the person had TB, they investigated the case. The whole family ended up quarantined. The physician hadn't notified public health. Rosanne Harding said that if HIPAA doesn't prevent it, they should go ahead and report. She has concerns about waiving HIPAA, and we need clear guidance. D. Gold said that the reporting law permits reports in some situations where they may not be required. Any diagnosing MD has to report certain cases, but other may also report. R. Harding said that this needs to be very clear about when cases can and need to be reported. Doctors and dentists are always asking about confidentiality vs. reporting requirements.

D. Gold asked if there was any more feedback on the issue of communicating about suspect cases. Barbara Tuse asked if there needed to be a differentiation between an active case with a lot of symptoms. D. Gold said that diseases can be transmitted by people who don't show a lot of symptoms. For example, there's a published case study about TB transmission in a choir. It's not necessary that a person have an obvious cough. She said that once a case has been diagnosed, it would trigger a number of requirements. The people who have been exposed to the case will need to be evaluated. The employer has a choice whether to send everyone, or whether to determine which of the people may not have had a significant level of exposure. The evaluation is down the road from the requirement to report. D. Wolf said they had a case in Contra Costa County recently, where a patient showed signs of TB. Their department physician did an evaluation of the exposure. The patient had a chest X-ray and the physician decided employees didn't have any exposure. T. Davidson said that the city and county of SF had suggested inserting "or suspected," into subsection (g)(6)(A).

Scope

Heidi Fowers asked how this applies to non-medical personnel. Is there an intent to notify them also? What about social services? D. Gold said that there had been discussion at other meetings regarding including social workers, or at least medical intake social workers, in the standard. She said they couldn't find documentation in the literature to include them, unless they are employed

in a facility that is otherwise covered by the standard. For example, an intake worker in a hospital would come under the hospital's program. She said that Cal/OSHA was open to any information people could provide regarding revisiting this issue, either in general, or for specific groups such as street outreach teams.

G.G. Greenhouse said that they suggested TB testing for employees of homeless shelters, in order to monitor disease transmission. That's been successful. There was funding for testing the homeless population, but they needed to get funds to test the staff. They got approval from their department by saying that homeless people are in the work environment. All people who work with high-risk people should be tested. H. Fowers said that they do some annual TB tests. G.G. Greenhouse said that every county is different, and in Alameda County, every city is different.

Phyllis Brown said that she does home health, and she thinks the language on page 18, item 7 or 8, regarding fit-testing of respirators is excellent. She said that their safety officer does not believe that fit-testing is important. Initially, they weren't doing any fit-testing, and now they are doing 30 percent. Just as it took effort to implement universal precautions, and now they are working, you need to enforce the annual fit-testing, and tie it to the annual evaluation of the employee.

John Mehring said that he would like to add the term "home care" in addition to "home health care" in the note on the top of page 21, which provides examples of employers of employees who may have been involved in exposure incidents. D. Gold asked if he was talking about persons who do supportive care in the home. D. Gregg said that at a recent conference of the home health services providers, there was a real division between those who provide licensed home health care and those who provide non-licensed home care. P. Brown said that volunteers may spend an hour sitting with a patient. Even meals on wheels people will come in and talk with a client. D. Gold said that, with some exceptions such as volunteer firefighters, true volunteers are outside Cal/OSHA jurisdiction. She said that in considering who should be included in the standard, they looked at various people who are exposed to the public, including teachers, DMV workers and grocery clerks. But although they have public contact, they are not recognized as being at high risk. She said it seems that people here are saying that we need to cast a broader net.

H. Fowers said that it seems like we are defining this too tightly. She said that fire personnel may be notified, while social workers would not. If two people are working side by side one might be notified and the other not. D. Gold said that employees in homeless shelters would be included, including intake workers. G.G. Greenhouse said that it should also apply to mobile vans for the homeless. She recommends that all staff be tested. The risk is equal to everyone. Most shelters are not designed to house people. One is in an old Safeway administration building. The standard should apply to all intake workers, at least for TB. Alameda County used to have the 5th highest TB rate in the state. Public Health developed a TB unit, and it has gone down. R. Harding said that the schools require TB testing under the education code, so expanding to schools might not be necessary. D. Gold said that teachers have to be tested under other laws, but this standard would impose a requirement for the good of the employee, not for public health purposes. In this draft, people who cook in homeless shelters would be covered, but social services outside the shelters wouldn't be covered. Should we include intake workers wherever they are located? P.

Wyatt asked if people working outside of a shelter are not covered. D. Gold responded that how the draft is set up, all employees providing medical services, including emergency services, are covered, and in addition, employees in certain high risk settings, such as homeless shelters are also covered, even though they are not providing medical services.

P. Wyatt said that it sounds like if a client goes to a shelter, the employees are covered, but if the client gets other services, the employees are not. D. Gold responded that there is documentation for transmission of disease in homeless shelters, so that's why they were included, because it's a higher risk environment. So that's where we drew the line for inclusion in the standard – those environments which are at higher risk. The elderly are also a higher risk group, because of lowered immune systems and in some cases higher rates of latent tuberculosis infection. She asked people to e-mail or call Bob or her with any other information about who should or shouldn't be included in the standard.

H. Fowers asked if children's home services etc. are included. D. Gold said that generally in the draft standard, the line is drawn between DHS licensees, such as SNIFs (skilled nursing facilities) vs. social services licensees. Most DHS licensees have infection control programs in place. The standard includes both high risk settings, and high risk jobs. G.G. Greenhouse asked if residential substance abuse settings are included. D. Gold said that drug treatment facilities have been recognized as high risk, and TB testing is a condition of substance abuse block grants. In many of the work settings included in this standard, there are already guidelines or other regulations regarding infection control or TB programs. The point of this regulation is to make sure that things are being done for the benefit of employees.

D. Gold asked that people provide any feedback on the issue of who should be included in the standard by the end of May. She said that they hope to send the draft to California Occupational Safety and Health Standards Board (Board) by the end of May, so that rulemaking can begin under the California Administrative Procedures Act. This is a big change from the pre-rule making effort. The draft will go through a lot of editing with the Board staff, and when that is done, it will be sent to the Office of Administrative Law, who will publish the proposal for a 45 day written comment period. There will be a hearing at the end of the comment period. There will be responses to the comments. If there are no changes in response to the comment, the Board will vote, but likely there will be a 15 day notice of changes. The best case scenario is for it to be adopted by 2007. If avian flu becomes a pandemic in California, there may be emergency rulemaking on this issue. Right now, the process is still informal, and it's much easier to make changes.

Lunch Break

Written Procedures

D. Gold introduced the discussion of the requirements for written procedures. She said that employers who will be providing services to airborne infection isolation cases and are covered by subsection (c) of the standard will have to develop an exposure control plan. Referring employers do not need to develop a separate plan. Subsection (b) would require some written procedures, which could be incorporated into an injury and illness prevention plan. These

requirements are somewhat limited because referring employers are not expected to have engineering controls such as airborne infection isolation rooms, but with the exception of some field operations, all employers covered by this standard are required to implement source control measures such as cough hygiene. The requirements for written procedures can be found in subsection (c) on page 10 or subsection (b) on page 7.

Kevin White asked if the procedures can be incorporated into an injury and illness prevention plan or the blood-borne pathogens plan. D. Gold said that the procedures can be incorporated into any of these plans, so long as they meet the requirements.

T Davidson referred to the requirements on page 10, section (c)(2)(e) to list control measures for each task. She said this would be difficult to implement, because of the complexity of the organization, and the large number of different tasks. She said this will result in too many lists. D. Gold responded that the language of this section had been changed in response to their concerns, so that it reads task or group of tasks. The intent is to allow employers to group tasks or operations as appropriate.

Respiratory Protection

B. Nakamura introduced the discussion of respiratory protection. He said that the idea of the standard is that many referring employers would not have to implement a lot of engineering control measures for reducing exposures. But if an employee had to do a special task for example, entering into an area occupied by a person requiring isolation and awaiting transfer, and that person can not use source control measures, then the employee might need to use a respirator, such as an N95. For high hazard procedures, such as might be performed by some EMTs, the draft standard would require something better, such as an elastomeric facepiece respirator, or a powered air purifying respirator. The minimum respirator would be an N95.

G.G. Greenhouse asked what Cal/OSHA thinks should happen about respirators and fit testing. She said that her staff are considered first responders, because they operate mobile clinics. Last year the 22 people who work in her unit were required to be fit tested. They were not provided with training. They were not provided with instructions regarding ordering of respirators. Mike Horowitz, B. Nakamura, and D. Gold explained the requirements of the Cal/OSHA respiratory protection standard (8CCR 5144) which include a written program which clearly defines the use and selection of respirators, a confidential medical evaluation, training, and fit testing. Several participants commented on the implementation of respiratory protection programs. B. Nakamura said that under the proposal, N95 respirators would be considered appropriate for use in their mobile van, where no high hazard procedures are performed. G.G. Greenhouse said that they needed to develop ordering procedures for N95's. She said since they began testing the homeless population for TB the incidence has declined. But now they are taking the van to places where day laborers congregate, and they are more TB positive.

B. Nakamura asked if people had any comments about respirators required for high hazard procedures. T. Davidson asked if PAPRs [powered air purifying respirators] would be required when providing aerosolized treatment for asthma or for treatments of tuberculosis. B. Nakamura explained that a PAPR would be required for aerosolized treatment of a disease such as

tuberculosis, but not for asthma. D. Gold explained that the requirement to use a higher level of respiratory protection was triggered when a high hazard procedure was performed when there was an airborne infectious disease.

D. Gold explained that subsection (f) only applies if respirators are going to be used. For most respirator users, after the initial fit test the exception would allow biannual fit-testing. There would still be a requirement to refit test if there were changes such as major facial changes that would affect the fit. Employers would still have to provide annual fit tests to employees performing high hazard procedures. The Cal/OSHA staff and previous advisory meetings had considered other alternatives to annual fit-testing, but they didn't work out. Len Welsh finally decided to propose this exception, which would apply only to non-high hazard procedures, and which would expire in 2012. During this period NIOSH will be conducting a study to determine whether an annual fit test is appropriate. One purpose of this exception is to ensure that hospitals and other employers maintain an adequate number of employees who are fit-tested and ready to use respirators if necessary.

Tom Eller asked if EMTs perform high hazard procedures. Are intubations high risk? D. Gold responded that some of the procedures they perform are on the list of high hazard procedures. T. Eller said they would then continue with annual fit testing. K. White suggested adding oral and nasal pharyngeal airways (OPA/NPA) to the list of high hazard procedures. D. Gold requested that he, and anyone else who had feedback on what procedures should be considered high hazard, should send an e-mail.

John Mehring asked whether an employee who doesn't perform high hazard procedures but who wants to be fit tested more frequently than bi-annually, can request a fit test. Could this be addressed in the regulation? G.G. Greenhouse asked what the purpose of fit testing. She said that people think that more frequent fit testing is more protective, but what does it tell you about the size you need. Some people want more fit-testing because it makes them feel safer, but theoretically, if you don't change, then the fit shouldn't change. If you do change, then a new fit test would be required.

J. Mehring said that some people don't know or recognize how or if they have changed. The rest of the world does annual fit testing. What would the health care worker think that they do it every other year but others do it every year? The problem is that there's a huge learning curve in health care about using respirators. Some people still think that they can use a surgical mask as a respirator. Phyllis Brown said that she agreed with J. Mehring. She was fit tested once in ten years. She gained 40 pounds and wasn't re-tested. Their infection control nurse downplays the importance of MRSA and the importance of annual fit testing, so she didn't report the weight gain. Annual fit testing keeps it in everyone's mind, and people need a reminder. At her workplace, they weren't fit testing everyone. They thought they could do only two nurses. But then a patient was transferred in, and a public health nurse and several others were expected to provide care, but they had not been fit tested. So their director came in at night to fit test employees. Now, they do 100 percent of nurses.

T Davidson said that health care is coming late to respiratory protection. They need to establish ownership of the respiratory protection program, and to have an effective training program. Then

you get fit tested, and use a respirator. Then the emphasis on annual fit testing can go away as being the major point of contact. You have to get the program to the user, then the biannual exception won't be such an issue. B. Nakamura said that the proposal would still require annual training. G.G. Greenhouse said they had no training. P. Brown said that in her organization, if you failed a fit test on an N95, they were getting a PAPR. She asked how accurate fit tests are. R. Harding asked how the people conducting the meeting communicate with the publications unit of Cal/OSHA. There needs to be more outreach and guidance material for industry. D. Gold said that there is a NIOSH publication on respiratory protection in Health Care. She said they are planning outreach in regards to the ATD standard, including summary sheets for different groups. R. Harding said that educational materials should be rolled out at the same time as the standard. P. Brown said that everyone uses materials from Kaiser. J. Mehring said that OSHA did a good job educating people about the bloodborne pathogens standard, and R. Harding agreed. R. Harding asked about fit test methods, including irritant smoke. D. Gold said that for the N95, only bitrex or saccharine, or a quantitative method, is permitted. You can't use irritant smoke, because the filter isn't good enough. She noted that federal OSHA is not currently allowed to enforce annual fit testing of respirators used for protection against TB, so Cal/OSHA is using state funds to enforce it.

J. Mehring suggested that the standard should permit employees to request an annual fit test. K. White said that Section 5144 allows employees to request an additional fit test. T Davidson said that the employee would have to be effectively trained in order to know they can go to the supervisor to request a fit test. If the employee requests one, it must be provided, it's not optional. G.G. Greenhouse said that there needs to be training before people go in for a fit test. They had not been informed regarding why fit testing was being done, who should do it, or the need to follow protocols.

D. Gold mentioned that in terms of other personal protective equipment, the standard refers to the CDC guidelines for infection control.

Medical Surveillance

D. Gold then introduced the discussion of medical surveillance. She said that the medical surveillance section included the communications and exposure incident provisions discussed this morning. It also includes precautionary removal, which would apply to diseases such as mumps or measles, when a medical provider recommends removing the employee from the work place during an incubation period resulting from an exposure at work. In that case, the employer would be required to maintain the pay and other benefits for the employee, during the period when they would need to be reassigned or removed from the work place. She said that the Cal/OSHA attorney said that this would be required under the laws preventing discrimination, but putting it into the standard would make it clear.

T. Eller said that they had a situation like that with Norwalk virus. The employee had a 3-day quarantine, and they paid the employee. R. Harding asked if the precautionary removal provisions applied to a health care professional exposed off the job. D. Gold replied that the requirement was only for exposure incidents that happened at work. G.G. Greenhouse said that if employees are exposed at work, and need to be removed, they should be paid.

T. Davidson said that in regards to the vaccination provisions, section (g)(5)(B), the requirement to provide vaccine within 10 days is not practical. They are a large employer, the Department of Public Health has 8000 employees. D. Gold asked if, on June 1, the CDC published a recommendation to vaccinate health care workers against pertussis, how long people thought it would take, assuming there wasn't a vaccine shortage. She said the California Department of Health Service Immunization Branch also thought 10 days was not reasonable. Would 90 days be a reasonable period of time? T. Eller said that would be reasonable. T. Davidson said 90 days would come closer, given the size of their work force. D. Gregg said that 90 days was reasonable, and would give them a chance to catch up with people on leaves, etc. G.G. Greenhouse said the directive would have to come through the public health department, but they could do it immediately. They would cancel their schedule and vaccinate employees. They have a small enough staff that they could do it.

D. Gold asked what immunizations employers are currently offering. GG Greenhouse said that prior to hire, employees have to have a physical showing proof of vaccination. Alameda County provides TB testing and follow up for needle-sticks. The flu vaccine is voluntary. D. Gregg said that they currently provide Hepatitis B vaccine. Pneumonia is optional. R. Harding said that pneumonia is optional. P. Brown said they provide mumps, measles and rubella (MMR) if the titer is low. D. Gold asked if they provide tetanus. G.G. Greenhouse said they carry the tetanus and diphtheria vaccine on the van for clients. H. Fowers said they provide tetanus for emergency responders. They also provide rabies vaccine for animal control employees. P. Brown said that tetanus is available through their employer. D. Gold said that it turned out that the CDC recommendations for vaccination are not as clear as we need, and so the DHS is working to clarify which vaccines are recommended. She asked that people e-mail any further information about the immunizations currently being provided.

J. Mehring asked whether the declination statement in Appendix C would not apply to everyone. D. Gold responded that was only for the flu vaccine, because it must be given every year. There has been a lot of support to require a declination, because more people will get the vaccine, and studies show that vaccinating employees reduces transmission to patients. J. Mehring said that in southern California there was a big increase in vaccinations where the declination was made mandatory. G.G. Greenhouse said that an annual declination for flu vaccine is too hard to track. She asked where the declination would be kept. D. Gold said that it has to be kept confidential, and therefore can't be kept in the personnel file, it has to be kept in a separate medical file. P. Brown said that it is too hard to keep track of the annual declination, and it was one more piece of paper that you don't need. J. Mehring said that the declination increases the number of people who participate. This was the case with hepatitis B. P. Brown said she disagreed with the value of the declination. The people she works with don't get motivated by signing a declination.

D. Gold said that taking out the declination requirement would reduce the strength of the requirement, but it doesn't have the same impact as with hepatitis B (HBV). Knowing the vaccination status for HBV helps determine the treatment protocol after a needle stick. That is not true for influenza.

D. Gregg said she thinks the declination is important. It helps educate the employees, and increases compliance. If an employee decides to decline, it's up to them. She said it is just a part of employment, like criminal background checks. P. Brown said that she gets the flu vaccine, but as a shop steward, she knows that people believe there will be repercussions for declining, so it is not appropriate to require it. G.G. Greenhouse said that you would think people in homeless shelters would jump at the chance to get a flu shot, but that hasn't happened so far. Many mid-level practitioners won't get it. In some minority communities there is a huge disbelief in vaccinations.

Training

D. Gold then brought up the subject of training. She said that someone had pointed out that the word "effective" was not in subsection (b), and she asked if people agreed that it should be added. People did. She then directed attention to subsection (h). T. Eller asked whether the standard would address delivery systems for training. He asked whether the training needs to be person to person, or whether on-line systems, other alternate training modes could be used. D. Gregg said that they use an alternate method, Health Stream. T. Eller asked if a person is using a CD ROM, does there have to be a phone number which a live person answers for questions. P. Brown said that she can see the magnitude of the problem for employers to reschedule people so that they can have interactive training, but there is a need for interactive programs, with a real live person. GG Greenhouse said that with training programs people come in as a group, and just sign and sign out. The spontaneity of asking questions face to face, is important for the quality of the training. T. Eller said that he realizes that face to face training is good, but some on-line systems are better than they used to be. You shouldn't be able to defeat the system and just take the test. Some of the face to face training isn't that good either.

D. Gregg said that she does several jobs as risk manager, quality manager and infection control manager. The hardest part is infection control. With Health Stream, you need to read it, and you can get copies afterward. With 2800 employees she doesn't have time for face-to-face training. K. White said that he agreed there need to be alternate delivery systems. Fire departments range from 25 to 3800 in CDF. LA County has 2000 people. There are a lot of different training requirements. This can be incorporated with other training. They need flexibility. R. Harding asked how much training would be required for dentists who go into a jail for one day. What training would they be given? Who has the training obligation, the primary or secondary employer? B. Nakamura said that it would be up to the employer to use effective training methods. Alternate methods can be used so long as they meet the requirements for information that is specific to the operation and the location. J. Mehring said that there is a difference between the bloodborne pathogens training and this. The bloodborne pathogens standard has been around for a long time. For this standard, there are not as many resources; it's newer territory, and not as clear cut. It's a more dynamic area than BBP. On some level, this has to be face to face. It will be the only standard of its kind if it passes, and it has to be treated as such.

T. Eller said that he understands that on-line training needs to be job specific. He customizes their training. This is not like the old lifting films. D. Gold said that in the proposal, the training would have to meet the specific content requirements, and provide an opportunity for interactive questions. She explained that the reason for requiring the opportunity for interactive questions is

that a person may need to get the answer in order to understand subsequent material in the training. B. Nakamura said that this proposal would permit various training methods, so long as they meet the requirements for addressing the specific conditions and programs in the workplace, and provide the opportunity for interactive questions.

Pandemic Influenza

R. Nakamura introduced the topic of avian and pandemic influenza. He said that in addition to the federal plan, there is a California plan, which can be found on the internet by searching for California pandemic influenza plan. He asked what people were doing regarding preparing for pandemic flu. T. Eller said that they were doing a lot of planning, because of the broad impact it would have on their operations. J. Mehring asked how the meeting last week about exposures to animals went. D. Gold said that several representatives from the poultry industry had attended, as well as people from the California Department of Food and Agriculture (CDFA), and other agencies. She said that the poultry industry representatives had indicated that if avian influenza were to appear in an establishment, the operation would be shut down and control would be given to the CDFA. One concern is the incubation period in birds when they may be infectious but are not yet showing symptoms. So one issue Cal/OSHA raised was that when the biosecurity level is increased, the level of worker protection should also increase. The exotic Newcastle disease (END) experience demonstrates there is a potential human infection, although END doesn't generally have much impact on people beyond eye infections. With END, the contingent workforce came from the California Conservation Corps and laid-off poultry employees. We are considering changes in subsection (i) of this draft as a result of this meeting.

G.G. Greenhouse said that she is concerned because if the industry says they are going to shut down operations, how will public health authorities contact those workers for follow-up. Many migrant workers are sleeping in creek beds or other places. If there's a large migrant worker population, there needs to be an area to send the workers to, where they can be followed up, rather than just sending them off. They see a huge number of skin infections among the homeless; infections are passed due to their close living situations. Day laborers tend to sleep in clusters. This industry [poultry] needs to include a means to track their workforce. D. Gold agreed that there is an issue there. Some of this work is being done by the public health departments, but there is an occupational exposure issue. In Canada, for example, poultry workers are vaccinated for seasonal flu. Right now avian flu is an occupational issue, and has not become a public health issue here. She said that there are meetings on national and state levels to address avian flu, and that a lot of the work is being led by the US Department of Agriculture, which will reimburse the industry for birds.

The meeting was adjourned.