CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

February 26, 2021

Doug Parker
Chief, Division of Occupational Health and Safety
1515 Clay Street, Suite 1901
Oakland, CA 94612

Subject: **CHA's Comments Following the February 19 Advisory Committee Meeting**

Dear Chief Parker:

We appreciate the opportunity to submit comments after the February 19 Advisory Committee meeting. As the focus of that meeting was to discuss Cal/OSHA's plan to submit emergency regulations on the definition of "normal consumption" for purposes of determining compliance with the April 1 personal protective equipment (PPE) stockpile requirement, the California Hospital Association will limit our written comments to that topic. And rather than re-state our previous written comments, we have attached them for your convenience.

There are, however, two additional points we would like to call to your attention.

Definition of "normal consumption" for purposes of determining the amount of the stockpile

The sponsors of Assembly Bill 2537 have stated the intent in the 2019 reporting requirement was to establish a baseline for determining whether a hospital's stockpile met the statutory requirement. CHA agrees. Where we diverge is whether 2020 and other periods of abnormal consumption should be factored into the calculation. The sponsor's desire to include periods of time of abnormal consumption is simply inconsistent with the plain language of the statute and its legislative history.

As outlined in our November 5, 2020, communication, the rules of statutory construction dictate that "[t]he plain meaning of the words of a statute may be disregarded only when the application of their literal meaning would (1) produce absurd consequences that the Legislature clearly did not intend or (2) frustrate the manifest purposes that appear from the provisions of the legislation when considered as a whole in light of its legislative history." *Faria v. San Jacinto Unified School Dist.*, (1996) 50 Cal.App.4th 1939, 1944; *see Bob Jones University v. United States* (1983) 461 U.S. 574, 586 (a well-established canon of statutory construction provides that literal language should not defeat the plain purpose of the statute).

Labor Code 6403.3(c)(1) requires employers to "maintain a stockpile of [specified] equipment in the amount equal to three months of normal consumption." "Normal" is defined by the Merriam-Webster dictionary to mean "conforming to a type, standard, or regular pattern**:** characterized by that which is considered usual, typical, or routine" and "according with, constituting, or not deviating from a norm, rule, procedure, or principle."

Conversely, Merriam-Webster's antonyms for "normal" include "abnormal, exceptional, extraordinary, odd, out-of-the-way, strange, unusual." Here, a calculation that includes data from a once-in-a-hundred-years pandemic that required an extraordinary amount of PPE is by definition not normal but rather abnormal.

Even assuming the definition of "normal consumption" was ambiguous, the legislative history compels a conclusion that 2020 and other periods of abnormal utilization should not be factored into calculating the appropriate stockpile. While the August 25 amendments to the bill deleted the express reference to defining the stockpile in terms of the "highest seven day consecutive daily average consumption," the amendments did not include ***any*** language suggesting that 2020 data be included. The absence of any reference to 2020 is a further indication that pandemic-level consumption was not intended to be included. This bill was live and being amended through the end of session. If the Legislature intended 2020 data to be included, it certainly could have included that as a reference. It did not.

The regulatory timeline and enforcement

As we have shared since last October, creation of a PPE stockpile cannot be accomplished overnight nor within a matter of weeks. Procuring PPE to store in a stockpile at the same time hospitals, and other sectors, are continuing to demand the same items to meet current needs is challenging. In addition, there are other logistical issues such as where to store it (it must be stored in special conditions), and the need to create an inventory management system in order to minimize waste, etc. Furthermore, to the extent the regulations call for a calculation that includes data other than 2019, hospitals will need time to gather and process that information.

Under the current timeline, it appears that a final Emergency Temporary Standard on this subject would not be issued until late March — at the earliest. Simply put, that is not enough lead time for hospitals to meet the April 1 deadline if the stockpile is based, in whole or in part, on pandemic-level consumption data. CHA requests transparency, consistency, and fairness with respect to how this challenge will be met in terms of enforcement.

We appreciate the opportunity to provide additional comments on this very important issue.

Sincerely,

Gail Blanchard-Saiger
VP & Counsel, Labor and Employment

cc: Cora Gherga, Assistant Chief Enforcement, Division of Occupational Safety and Health
Chris Grossgart, Counsel, Division of Occupational Safety and Health

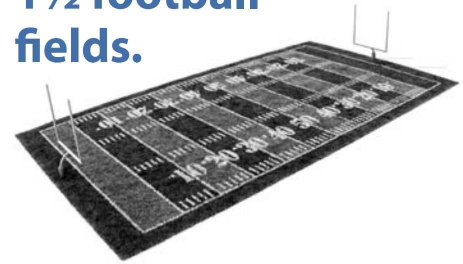
90-Day PPE Stockpile Mandates Increase Shortages And Drive Up Costs

Policymakers are considering mandates for healthcare providers to maintain 90-day stockpiles of critical supplies such as personal protective equipment (PPE). **These mandates are likely to *increase* supply shortages and drive up costs to hospitals.** A better solution is to stockpile government controlled pandemic supplies at the country's 500+ existing distributor warehouses across the U.S., positioning inventory close to healthcare providers for immediate surge needs during a crisis.

Large Stockpiles Create New Logistical Challenges

A 90-day supply for a 350-bed hospital requires 5,700 sq. ft. of space — the equivalent of **13–15 tractor trailers.**

A 90-day supply for a 5,000-bed system requires 81,400 sq. ft. of space — the equivalent of **1½ football fields.**



Supplies Needed On The Front Lines Get Moved To The Back Shelf...

July 8, 2020 The New York Times

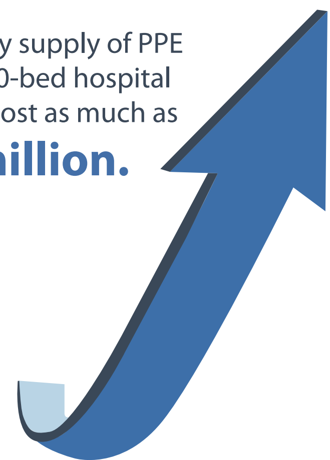
Grave Shortages of Protective Gear Flare Again as Covid Cases Surge

May 6, 2020 The Washington Post

"...demand continues to outstrip supply because hospitals, states and the federal government are trying to stockpile supplies."

...And Drive Up Costs

A 90-day supply of PPE for a 350-bed hospital would cost as much as **$2 million.**



Stockpiles need to be managed and the increased inventory rotated to avoid the risk of product expiration, theft, damage, and waste.

© Health Industry Distributors Association

90-day PPE Stockpile Data Based on Available 2019 PPE Utilization Data

On behalf of the more than 400 California hospitals and millions of patients served by them, the California Hospital Association remains deeply concerned with an approach to defining "normal consumption" for personal protective equipment using pandemic-period data. Drawing on a once-in-a-lifetime period of unprecedented PPE utilization to establish a baseline for "normal consumption" is both contrary to the intent of AB 2537 (Rodriguez, 2020) and in direct conflict with a plain reading of the statute.

Basing the stockpile on 2019 data would be consistent with legislative intent, and concerns that doing so would yield an artificially low or insignificant stockpile are inaccurate. As discussed in more detail below, **a 90-day stockpile statewide would be composed of a massive amount of PPE**. Also, AB 2537's stockpile requirement should not be viewed in isolation but rather in context of all of the other activity that has already been undertaken or is planned to ensure an adequate amount of PPE in the future. This includes SB 275's direction to the state to create a stockpile, manufacturers shifting to domestic production, changes to distributors' practices, and more.

These important efforts would be negated by a 90-day PPE stockpile based on 2020 data, which would create a significant strain on the PPE supply chain in California – not just for hospitals and medical providers, but all sectors of the state's critical infrastructure that rely on PPE.

During the Jan. 29th small working group discussion, CHA explained how the PPE procurement, purchasing, and distribution process typically worked for most hospitals and health systems on a "just-in-time basis." Prior to the pandemic, this model was highly efficient and effective in providing a rotation of fresh PPE to hospitals, their employees, and other medical providers. Following that discussion, Cal/OSHA requested CHA provide data that would help demonstrate how much PPE a 90-day stockpile requirement will result in based on 2019 consumption data.

CHA has obtained 2019 PPE consumption data from 40% of general acute care hospitals in California. Based on these 2019 sample data, the aggregate amounts for a three-month stockpile statewide would be as follows:

Statewide 90-Day Stockpile	
Eye Protection	909,227
Isolation Gown	16,385,552
N95 Mask	2,731,151
PAPR	20,339
Shoe Covers	8,626,526
Surgical Mask	24,759,497

The data demonstrate that, at 2019 levels, the aggregate amount of PPE that would be stockpiled is quite large. As previously noted, prior to the pandemic, hospitals generally had 4-14 days on hand of PPE. Depending on the individual hospital or health system, it is reasonable to expect that a 90-day stockpile requirement based on 2019 data would increase the amount of that hospital/system PPE by anywhere from 6-18 times what they would have normally had under a “just-in-time” procurement model.

Also, an approach that factors 2020 pandemic-level consumption into the definition of “normal consumption” will result in significant inequities as safety net hospitals and hospitals in communities hit hardest by the pandemic will bear a disproportionate PPE stockpiling mandate.

A hospital-specific view illustrates this point. While hospital specific 2020 PPE consumption data are not available, there are data on how many COVID patients each hospital cared for. When using these data as a proxy for PPE consumption, it is clear that basing a stockpile on 2020 data does not yield the desired result.

Rather, using 2020 data to determine a stockpile would disproportionately impact hospitals that happen to be in areas that experienced higher numbers of hospitalizations. This is an arbitrary measure and one that creates even greater burdens for hospitals that serve minority and underinsured communities. This approach especially burdens many safety net hospitals that continue to struggle to care for their communities during extremely challenging times.

	Licensed Beds	**Average of COVID Daily Cases From April 2020 Through January 2021**	**Max of Daily COVID Cases**	**Average Daily COVID Occupancy**	**Max Daily COVID Occupancy**
LA -area safety net hospital	130	56	178	42%	136%
Northern California hospital	135	8	44	6%	33%
Bay-area hospital	800	26	82	3%	10%

As this chart demonstrates, if 2020 data were used to determine stockpile amounts, a stand-alone safety net hospital in one of the hardest hit communities in the Los Angeles area would be required to acquire and store an excessive and unnecessary amount of PPE while a Northern California hospital of similar size would have stockpile that is closer to 2019 levels. Even more concerning, the use of 2020 data could create a scenario where a large Bay-area hospital with over 800 beds may have less in its stockpile than the LA-area safety net hospital, simply because it had a lower COVID caseload.

All of these data points reinforce why any inclusion of 2020 PPE consumption data is inequitable, inconsistent with the plain reading of the statute, and counterproductive to sound public health policy.

February 5, 2021

Doug Parker
Chief, Division of Occupational Health and Safety
1515 Clay Street, Suite 1901
Oakland, CA 94612

Subject: CHA's Comments on AB 2537 Discussion Document

Dear Mr. Parker:

As the backbone of California's health care system, hospitals continue to lead the fight against COVID-19. This means, as always, placing patient and worker safety as the top priority. In addition to implementing multiple safety measures and protocols, hospitals are working tirelessly to ensure their workforces have adequate and appropriate personal protective equipment (PPE) to safely carry out their life-saving missions of care.

While the California Hospital Association (CHA) shares the goal of Assembly Bill (AB) 2537's author and sponsors — to guard against the situation that occurred in the spring and through the summer which depleted global supply of PPE— we are deeply concerned about the unintended consequences of Cal/OSHA's discussion document, both for hospitals as well as other essential workers.

Comments on Definition of Normal Consumption

We continue to strongly object to a definition of "normal consumption" that includes a period of a declared state of emergency. The discussion document defines "normal consumption" as follows: "Normal consumption reflects an average demand, which includes fluctuations in equipment usage, as they occur over a 24-month period ... For each year beginning April 1, the quantity of each category, type and size of the specified equipment consumed in the facility during the preceding two calendar years shall be added up and then divided by 8. For example, three months of normal consumption for the year beginning April 1, 2021 and ending on March 31, 2022, shall be based on the total quantity of each category, type and size of the specified equipment consumed during the period January 1, 2019 through December 31, 2020, divided by 8." Below are the concerns we have with this definition:

1. As previously stated, the plain language of the statute and legislative history define "normal consumption" in reference to 2019 PPE consumption. (see attached).
2. Basing stockpile on lookback that includes pandemic will not account for the fact that during 2020 and continuing into 2021, hospitals had to buy things they would not have normally purchased (such as industrial N95s because they could not get medical grade).
3. While the PPE supply has improved, demand continues to outstrip supply. Thus, as hospitals purchase more PPE, less is available for other essential workers that need it. And of course the greater the demand, the higher the price.

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

CHA Proposed Definitions of Normal Consumption

Consistent with the language of AB 2537, CHA proposes the following definition of normal consumption and the associated calculation for a 3-month stockpile:

> *Normal consumption is the highest seven-day consecutive daily average of consumption for specified personal protective equipment during calendar year 2019. Stockpile amounts shall be based on the normal consumption multiplied by 12 weeks*.

As an alternative, we would consider the following language:

> "Normal consumption reflects an average demand, which includes fluctuations in equipment usage, as they occur over a 24-month period … For each year beginning April 1, the quantity of each category, type and size of the specified equipment consumed in the facility during the preceding two calendar years shall be added up and then divided by 8, *with the exception of any periods when a state of emergency is declared*."

Furthermore, we have concerns with a definition of "normal consumption" that includes the level of each "category, type and size." The discussion document states: "For purposes of (or, as used in) LC 6303.3, normal consumption means the average amount of the equipment specified by LC 6303.3(c)(1) for each **category, type and size of equipment**, used by all employees who provide direct patient care or who provide services that directly support care to patients." As it relates to this document, we want to note the following:

1. We have a concern that basing stockpile on each "category, type and size of equipment used by employees" during a specified lookback period will not account for the fact that changes in the workforce may require different sizes or types of equipment as well as there will most certainly be changes in PPE safety and technology.
2. Subsection (f) of the bill would appear to allow flexibility to account for such changes – "(f) An employer shall establish and implement effective written procedures for periodically determining the quantity and types of equipment used in its normal consumption."

Thus, CHA recommends incorporating subsection (f) as follows:

> For purposes of (or, as used in) LC 6303.3, normal consumption means the average amount of the equipment specified by LC 6303.3(c)(1) for each **category, type and size of equipment**, used by all employees who provide direct patient care or who provide services that directly support care to patients, *subject to any adjustment resulting from an employer's periodic evaluation of the quantity and types of equipment used in its normal consumption.*

Comments on Determining Types of Data to be used for Consumption

We appreciate the options for hospitals that do not have consumption data. Below are some minor modifications in italics:

> "The employer may determine consumption by any of the following methods *or a combination thereof*:
>
> 1. The total quantity received in the facility from all sources *for use by the facility*,
> 2. The total quantity ordered by the facility from all sources *for use by the facility*,
> 3. The average monthly inventory,

4. The quantity distributed to units in which employees provide patient care and to units providing services that directly support patient care, through all distribution methods, including separately chargeable and non-separately chargeable items."

Quantifying a 3-month stockpile based on 2019 data

Doug Parker, Chief Division of Occupational Safety and Health, requested data from CHA on what a 3-month stockpile would look like if based on 2019 data. While we are still attempting to gather that information from our members, we note the following:

1. Pre-pandemic, virtually all hospitals met their PPE needs through "just in time" contracting. Those contracts, between hospitals/health systems and suppliers/distributors meant that hospitals maintained anywhere from 3-10 days of PPE on hand and their contracts with the suppliers and distributors obligated those entities to be able maintain a minimum of a 30-day supply for that hospital/health system. With the global shortage of PPE beginning in early 2020 and every client of a supplier/distributor demanding the same PPE, suppliers/distributors were unable to meet their contract terms.
2. Thus, a 90-day (3-month) stockpile based on 2019 will be significantly more than hospitals had pre-pandemic – at least 9 times more PPE. And data from Cardinal Health, a major health care distributor, and the Health Industry Distributor Association, a health care distributor trade association, demonstrates the magnitude of that 90-day stockpile. (see attached).

CHA appreciates the ability to comment on the discussion document and look forward to our continued collaboration. If you have any questions regarding our comments, please don't hesitate to contact Rony Berdugo at rberdugo@calhospital.org or Gail Blanchard-Saiger at gblanchard@calhospital.org.

Sincerely,

Rony Berdugo
Legislative Advocate

cc: Cora Ghera, Assistant Chief Enforcement, Division of Occupational Safety & Health Division
Chris Grossgart, Counsel, Division of Occupational Safety & Health Division

Providing Leadership in Health Policy and Advocacy

November 5, 2021

Doug Parker
Chief, Division of Occupational Health and Safety
1515 Clay Street, Suite 1901
Oakland, CA 94612

SUBJECT: Defining Normal Consumption and the Legislative History of AB 2537

Dear Mr. Parker:

On September 29, 2020, Governor Newsom signed into law AB 2537 which requires, among other things, that hospital employers maintain a stockpile of certain personal protective equipment (PPE) in the amount equal to three months of "normal consumption" beginning April 1, 2021. *See* Labor Code Section 6403.3(c)(1). In addition, the regulation requires that by January 15, 2021, an employer be prepared to report its "highest seven-day consecutive daily average consumption of personal protective equipment during the 2019 calendar year." *See* Labor Code Section 6403.3(e). Together, these subsections create the baseline for normal consumption under the statute.

Although the term "normal consumption" is not expressly defined in the statute, the plain meaning of the term is obvious — the amount of PPE a hospital normally consumes. Accordingly, the 2019 data is an appropriate baseline for this calculation. Indeed, normal consumption, by its plain meaning, cannot include periods of abnormal consumption which have occurred during the COVID-19 pandemic. To determine otherwise would require a definition of "normal" that includes a year where PPE was consumed at a higher degree than ever before. AB 2537's legislative history also supports that subsection (e) was meant to be used as the baseline for normal consumption.

Further, SB 275 requires that starting on January 1, 2023, hospitals maintain 45 days' worth of PPE at a "surge consumption" level. *See* Labor Code Section 6403.1(d)(1). The statute gives Cal/OSHA express authority to promulgate a regulation to determine a definition for "surge consumption". On the other hand, AB 2537 provides Cal/OSHA no such authority to define "normal consumption." SB 275 and AB 2573, which were drafted and proceeded through the legislative process at the same time, clearly show that if "normal consumption" under AB 2573 was meant to include pandemic levels, it would have said so. However, the legislature has made a clear distinction between "surge consumption" and "normal consumption." Any other interpretation violates the intent of both statutes and is duplicative.

Despite the above, Cal/OSHA has told CHA it plans to promulgate an emergency regulation for the sole purpose of defining "normal consumption" under AB 2573. Not only is such a regulation outside of its statutory authority, Cal/OSHA's proposed definition includes a calculation over the "proceeding two calendar years." Such a calculation would require the inclusion of 2020 pandemic consumption data to determine "normal consumption". However, the plain meaning of normal consumption and the legislative history of AB 2573 and SB 275 clearly require otherwise.

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<u>The Plain Meaning of "Normal Consumption" Does Not Include 2020 Pandemic Data</u>
"Normal" is defined to mean "conforming to a type, standard, or regular pattern**:** characterized by that which is considered usual, typical, or routine" and "according with, constituting, or not deviating from a norm, rule, procedure, or principle." https://www.merriam-webster.com/dictionary/normal

Conversely, antonyms for "normal" include: "abnormal, exceptional, extraordinary, odd, out-of-the-way, strange, unusual." *Id.*

Here, a calculation that includes data from a once-in-a-hundred-years pandemic that required an extraordinary amount of PPE is by definition not normal but rather abnormal. Further, the most basic rule of statutory interpretation is that "[t]he plain meaning of the words of a statute may be disregarded only when the application of their literal meaning would (1) produce absurd consequences that the Legislature clearly did not intend or (2) frustrate the manifest purposes that appear from the provisions of the legislation when considered as a whole in light of its legislative history." *Faria v. San Jacinto Unified School Dist.*, 50 Cal.App.4th at 1944; *see Bob Jones University v. United States* (1983) 461 U.S. 574, 586 (a well-established canon of statutory construction provides that literal language should not defeat the plain purpose of the statute).

Cal/OSHA's attempt to use a calculation that means the exact opposite of the statutory language not only violates the statute, but is beyond their statutory authority.

<u>AB 2537's Legislative History Supports Using 2019 Data as the Baseline for Normal Consumption</u>
AB 2537's legislative history supports that assertion that "normal consumption" is defined by pre-pandemic levels and data from 2019. Below are the relevant AB 2537 legislative history excerpts (emphasis added):

The original version of the bill required one year of PPE at normal consumption. The legislative history explicitly contemplates using a measure from "*years prior to the COVID-19.*"

- 5/31/20 – Assembly Appropriations Committee Analysis (page 2 subsection {3])
  - "A year's supply of stockpile will create logistical challenges. This bill requires a hospital to maintain a year's supply of PPE, assuming normal consumption. It is unclear why a year's worth of PPE is necessary and maintaining that much PPE will result in significant inefficiencies and costs. Some hospitals may not have the physical storage space for that much equipment and will need to find storage space. As the PPE expires, hospitals will need to replace."
  - "Bill lacks definitions, hard to know true impact. This bill requires a stockpile of PPE assuming 'normal consumption.' This bill does not define this term, and normal may be different for different types of hospitals and different types of care. ***<u>One possible measure would be an average of past PPE purchases needed to provide employees adequate PPE in the years prior to the COVID-19."</u>***

The statute's language was amended to state that the stockpile should be based on 2019 consumption. The amendment also reflects the intent that subsection (e), which requires reporting of 2019 data, should be used as the stockpile baseline.

- 8/20/20 – AB 2537 was amended to add the following:

  - "*(e) (1) On or before January 15, 2021, the department, after consultation with the Office of Emergency Services, shall evaluate and make a determination as to whether there is a significant supply limitation of personal protective equipment facing purchasers in California. If the department determines there is not a significant supply limitation, commencing 60 days after this determination, employers licensed under subdivision (a) of Section 1250 of the Health and Safety Code shall maintain a stockpile equal to a minimum of six months of daily consumption.* ***For purposes of this subdivision, daily consumption shall be based on the highest seven-day consecutive daily average consumption of personal protective equipment in 2019.*** *If the department determines that there is a significant supply limitation, the department shall revisit this determination every 30 days until there is a determination that there is no longer a significant supply limitation, after which employers licensed under subdivision (a) of Section 1250 of the Health and Safety Code shall have 60 days to maintain an inventory equal to a minimum of six months of daily consumption.*
  - *(f)* ***On or before January 15, 2021, an employer licensed under subdivision (a) of Section 1250 of the Health and Safety Code shall report to the department under penalty of perjury its highest seven-day consecutive daily average consumption of personal protective equipment during the 2019 calendar year****. General acute care hospitals under the jurisdiction of the State Department of State Hospitals are exempt from this requirement. State hospitals shall make their highest seven-day consecutive daily average consumption of personal protective equipment during the 2019 calendar year available upon request to the Division of Occupational Safety and Health.*

The legislative history explicitly states the definition of normal consumption is tied to 2019 data.

- 8/25/20 – Senate Floor Analysis (page 3 subsection (4) and page 6 - staff comments):
  - "Requires that an employer maintain a stockpile of unexpired PPE in the amount equal to six months of normal consumption. Requires that the PPE in the stockpile be new and not previously worn or used. ***Normal Consumption will be based on the highest 7-day consecutive daily average consumption of PPE in 2019."***
  - "The author and stakeholders have since taken amendments that tighten up ***definitions of 'normal consumption,' tying that to the highest 7-day rate of consumption from 2019.*** This will ease compliance for employers by providing clarity about how much PPE they will need to maintain."

Although the statute was then amended to remove the express language linking the 2019 data to the stockpile calculation, the intent in doing so was not because some other calculation should be used, but rather to help hospitals with compliance if they are unable to maintain a 2019 level of PPE due to situations outside of their control (e.g., supply chain issues). This amendment was meant to alleviate the burden on hospitals in certain situations, not to open the door to imposing on hospitals an even higher burden (as is being pushed by Cal/OSHA). Indeed, it is clear throughout the legislative history that the legislative process gave careful consideration to the fact that requiring hospitals to stockpile too much PPE would be unrealistic, unnecessary, and may even result in the expiration of valuable PPE.

- 8/25/20 – AB 2537 Was Further Amended:
  - ~~(e)(1) On or before January 15, 2021, the department, after consultation with the Office of Emergency Services, shall evaluate and make a determination as to whether there is a~~

~~significant supply limitation of personal protective equipment facing purchasers in California. If the department determines there is not a significant supply limitation, commencing 60 days after this determination, employers licensed under subdivision (a) of Section 1250 of the Health and Safety Code shall maintain a stockpile equal to a minimum of six months of daily consumption. For purposes of this subdivision, daily consumption shall be based on the highest seven-day consecutive daily average consumption of personal protective equipment in 2019. If the department determines that there is a significant supply limitation, the department shall revisit this determination every 30 days until there is a determination that there is no longer a significant supply limitation, after which employers licensed under subdivision (a) of Section 1250 of the Health and Safety Code shall have 60 days to maintain an inventory equal to a minimum of six months of daily consumption.~~

- 8/26/20 – Floor Analysis (staff comments page 6):
  - Earlier versions of this bill were a bit vague on certain definitions and had a few ***questions about feasibility of its requirement***, given the still raging COVID outbreak. The author and stakeholders have ***taken amendments that allow DIR to take into account whether an employer's failure to maintain and equipment stockpile was due to circumstances outside their control***, such as an order of equipment arriving defective. ***These changes will certain[ly] ease complaint***, but members may wish to consider whether the definition of normal consumption could use a more explicit definition.

SB 275's Legislative History Demonstrates that AB 2537 was Intended to Use 2019 Data
During the legislative process there was an attempt to create one bill instead of two. At one point, AB 2537's language was incorporated into SB 275. This clearly demonstrates that "surge consumption" is meant to be different than "normal consumption" and that 2019 data was intended to be used in the normal consumption calculation. Below are relevant AB 275 legislative history excerpts (emphasis added):

- 8/24/20 – amendments:
  (d) (1) On or before January 15, 2021, the department, after consultation with the Office of Emergency Services, shall evaluate and make a determination as to whether there is a significant supply limitation of PPE facing purchasers in California. If the department determines there is not a significant supply limitation, commencing 60 days after this determination, only those health care employers licensed under subdivisions (a), (b), and (c) of Section 1250 of the Health and Safety Code shall ***maintain an inventory equal to a minimum of six months of daily consumption. For purposes of this subdivision, daily consumption shall be based on the highest seven-day consecutive daily average consumption of PPE in 2019.*** *If the department determines that there is a significant supply limitation, the department shall revisit this determination every 30 days until there is a determination that there is no longer a significant supply limitation, after which employers described in subdivisions (a), (b), and (c) of Section 1250 of the Health and Safety Code shall have 60 days to maintain an inventory equal to a minimum of six months of daily consumption.*

(e) (1) Commencing January 1, 2022, health care employers shall have an inventory at least sufficient for ***30 days of surge consumption****, as determined by the regulations adopted pursuant to subdivision (j).*
(2) Commencing January 1, 2023, health care employers shall have an inventory at least sufficient for ***45 days of surge consumption****, as determined by the regulations adopted pursuant to subdivision (j).*
(3) Commencing January 1, 2024, health care employers shall have an inventory at least sufficient for ***60 days of surge consumption****, as determined by the regulations adopted pursuant to subdivision (j).*
(f) On or before January 15, 2021, a health care employer licensed under subdivisions (a), (b), and (c) of Section 1250 of the Health and Safety Code shall ***report to the department under penalty of perjury its highest seven-day consecutive daily average consumption of PPE during the 2019 calendar year.***

CHA appreciates the ability to comment and look forward to our continued collaboration. If you have any questions regarding our comments, please don't hesitate to contact Rony Berdugo at rberdugo@calhospital.org or Gail Blanchard-Saiger at gblanchard@calhospital.org.

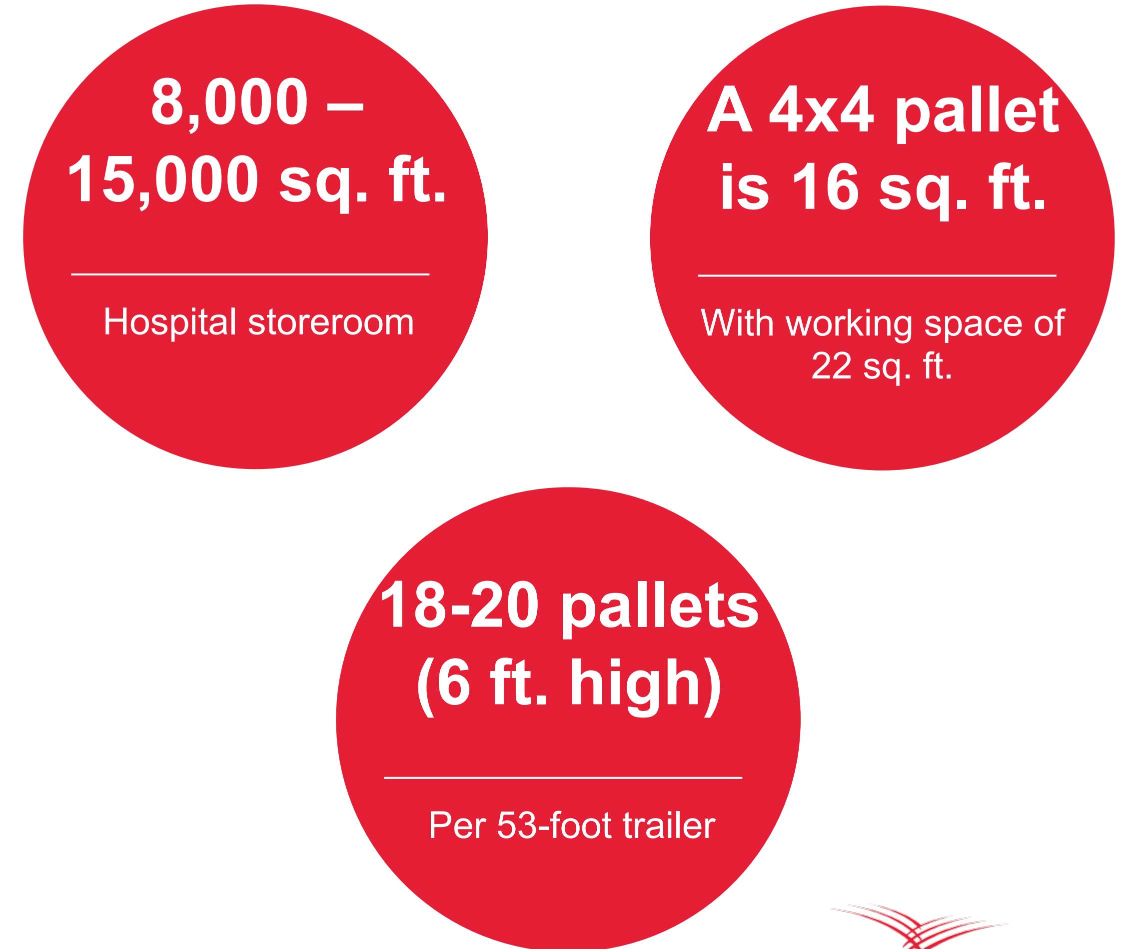
Sincerely,

Rony Berdugo
Legislative Advocate

Average hospital points of reference for a 300-400 bed hospital

Inventory under normal conditions:

Space:



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How much warehouse space do I need?

WHAT DOES 90 DAYS OF PPE INVENTORY REPRESENT?

Stand-alone 350 bed hospital

90 days of PPE inventory would roughly be:

260 pallets

3,500 sq. ft. of warehouse space

11 hospital IDN in large metropolitan market (~5,000 beds)

90 days of PPE inventory would roughly be:

3,700 pallets

50,000 sq. ft. of warehouse space

*Assumes use of racking in a warehouse; not floor loaded

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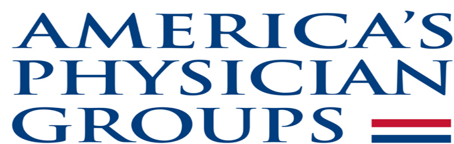

February 17, 2021

Doug Parker
Chief, Division of Occupational Health and Safety
1515 Clay Street, Suite 1901
Oakland, CA 94612

Subject: Comments on "Defining Normal Consumption" Advisory Committee Meeting

Dear Mr. Parker:

As the backbone of California's health care system, hospitals and medical providers continue to lead the fight against COVID-19. This means, as always, placing patient and worker safety as the top priority. In addition to implementing multiple safety measures and protocols, the health care system is working tirelessly to ensure their workforces have adequate and appropriate personal protective equipment (PPE) to safely carry out their life-saving missions of care.

We all share the goal of guarding against the situation that occurred in the spring and through the summer which depleted global supply of PPE. However, we are deeply concerned about the decision for Cal/OSHA to open an emergency rulemaking on defining the term "normal consumption" for purposes of implementing AB 2537 (Chapter 313, Statutes of 2020).

Although the term "normal consumption" is not expressly defined in the statute, the plain meaning of the term is obvious — the amount of PPE a hospital normally consumes. Accordingly, the 2019 data is an appropriate baseline for this calculation. AB 2537's legislative history also supports that subsection (e) was meant to be used as the baseline for normal consumption.

For purposes of defining “normal consumption,” we believe the definition provided below most closely captures the plain language and the spirt of the statute, even if technically it results in a higher than “normal” given that it uses a week during a period of peak consumption in 2019:

> *Normal consumption is the highest seven-day consecutive daily average of consumption for specified personal protective equipment during calendar year 2019. Stockpile amounts shall be based on the normal consumption multiplied by 12 weeks*.

Despite the above, Cal/OSHA has plans to promulgate an emergency regulation for the sole purpose of defining “normal consumption” under AB 2573. Not only is such a regulation outside of its statutory authority, Cal/OSHA’s proposed definition includes a calculation over the “proceeding two calendar years.” Such a calculation would require the inclusion of 2020 pandemic consumption data to determine “normal consumption” for the April 2021 stockpile. And considering that we are still in the midst of this pandemic, next year’s stockpile requirement would be astronomically large considering it would include two years of pandemic level consumption of PPE.

If Cal/OSHA insists on including consumption data during a two-year period, it should, at a minimum exclude periods where a state or local emergency has been declared. While it could be difficult to implement, such an alternative would at least recognize the surge in PPE usage and demand during state or local emergencies as being abnormally high.

We are also deeply concerned about the timing of the proposed rulemaking. The statute clearly sets this requirement to be met by April 1, 2021 which is less than two months away. While improvements have been made, global PPE supply challenges continue to persist. Without clear guidance from Cal/OSHA and the possible deviation from a clear definition of normal consumption, we worry that rushed implementation will create artificial strain on an already delicate supply chain.

Furthermore, we believe that even in its most basic interpretation of “normal,” the three-month stockpile required by AB 2537, in addition to the state and federal efforts to bolster state and national stockpiles will create a strain on the PPE supply chain and be more than sufficient to ensure healthcare providers are prepared for any future surges in this pandemic or future pandemics. Inclusion of any data that results in an artificially inflated stockpile requirement will create unnecessary uncertainty in an already fragile supply chain for all medical providers who are still trying their best to defeat this pandemic.

For these reasons, the undersigned express their concerns with the proposed rulemaking and appreciate the ability to share them ahead of the advisory committee meeting.

Sincerely,

California Hospital Association
America’s Physician Groups
Association of California Healthcare Districts
California Association of Health Facilities
California Association of Public Hospitals
California Children’s Hospital Association
California Dental Association
District Hospital Leadership Forum
United Hospital Association

cc: Cora Gherga, Assistant Chief Enforcement, Division of Occupational Safety & Health Division
Chris Grossgart, Counsel, Division of Occupational Safety & Health Division