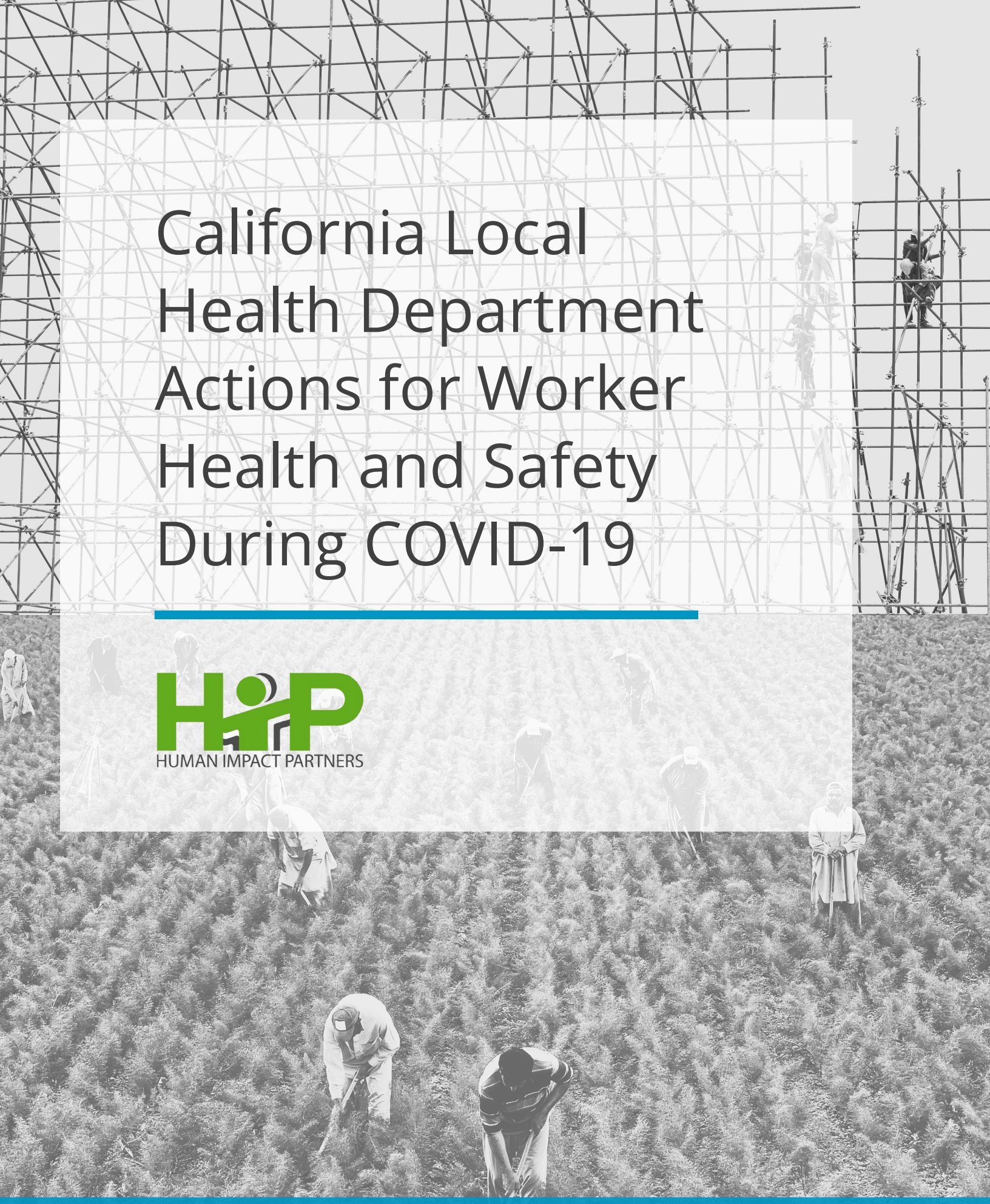

California Local Health Department Actions for Worker Health and Safety During COVID-19

HUMAN IMPACT PARTNERS

HumanImpact.org/**CDPH-WorkerSafety**

April 2021

Acknowledgments

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Key contributors: We thank the following public servants and community organizers for generously sharing their work, challenges, and hopes in protecting California workers during this unprecedented year:

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- Hazel Davalos, Organizing Director; and Zulema Aleman, Santa Maria Organizer, Central Coast Alliance for a United Sustainable Economy
- Arcenio Lopez, Executive Director; and Ana Huynh, Program Director, Santa Maria, Mixteco Indigena Community Organizing Project

Thank you to Logan Rockefeller Harris and Megan Gaydos for writing and editing support, and Nirmala Nataraj for copyediting.

We also extend our deepest gratitude to California's essential workers, especially those who are working in low-wage jobs, lacking workplace protections, and facing various forms of institutional racism.

This report was supported by generous funding from the California Department of Public Health (CDPH) and the Centers for Disease Control and Prevention (CDC) under Agreement No. 20-10477 with the CDPH Office of Health Equity. The analyses, interpretations, or conclusions reflected in this report are those of the author(s) and do not necessarily reflect the positions or views of the California Department of Public Health or the California Division of Occupational Safety and Health (Cal/OSHA).

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Introduction

Due to policies and systems that reflect and reify our US social, economic, and racial hierarchies, many people work in unsafe conditions that harm their health and well-being. During the Coronavirus Disease 2019 (COVID-19) pandemic, workers face additional concerns that threaten their own health and safety, as well as that of their families and communities. Local health departments (LHDs) play a necessary and critical role in ensuring everyone has the protections needed to stay safe and healthy at work during public health emergencies. Most LHDs do not have occupational health expertise or staff, and lack the time, resources, and information about the types of activities they can do to support worker health during COVID-19. However, COVID-19 has forced health departments into unprecedented territory, and the scope of their work to protect public health must now include worker protections.

California Local Health Department Actions for Worker Health and Safety During COVID-19 is a resource for LHDs in California. This report includes:

- The state and federal policies that have affected or protected workers during COVID-19
- A review of the data and research on workers and COVID-19
- Recommendations for LHDs to enhance and protect worker health and safety, based on a review of actions for worker health that some LHDs have implemented. We include both broad and specific recommendations for LHDs to support worker health and safety in innovative ways in California, including recommendations to:
    - Issue health officer orders for worker health and safety
    - Partner with Cal/OSHA district offices to manage problematic worksites
    - Develop and disseminate guidance based on local industries and worker needs
    - Develop and disseminate communications materials with trusted community partners
    - Collect, analyze, and disseminate data by work sector to identify inequities
    - Activate relationships with community partners to build power for systems changes
    - Facilitate intersectoral Health in All Policies work
    - Create worker-focused practices, programs, and services
- Case stories of three LHDs' innovative worker-protection policies and practices
- Barriers and lessons learned from LHDs in protecting worker health during COVID-19
- State-level recommendations for California to increase its capacity to protect and build the power of our most vulnerable and essential workers

How to use this guide

LHDs can use this guide as a starting point to assess what actions are most critical and implementable locally to protect workers. LHDs can use this guide to:

- Understand the current landscape of COVID-19 inequities among workers in various sectors and job types
- Understand the range of actions and policies within LHD purview to protect workers
- Find examples of innovative programs, procedures, and policies of California LHDs to protect workers during the COVID-19 pandemic
- Read case stories for inspiration and steps on how two LHDs successfully enacted strong worker protection policies
- Learn more about community power-building and collaboration in support of worker health
- Reflect on lessons that this pandemic highlighted for public health in terms of systemic and local barriers and solutions, so that we may be better prepared to prevent and protect workers during vaccination, recovery, other pandemics, as well as other occupational health conditions that LHDs may encounter

About this report

Over the last year of the COVID-19 pandemic, it has become clear that there are many categories of workers who are at higher risk for contracting COVID-19 and dying from it. Impacted workers include healthcare, agricultural, warehouse, and transportation workers, as well as meatpackers, grocery store cashiers, waiters, custodians, and countless other occupations. In addition, there are numerous contexts and determinants that shape the risk of contracting or spreading COVID-19.

When the pandemic first emerged, worker organizing and advocacy groups contacted Human Impact Partners requesting our assistance in connecting them with their LHDs, understanding what authority the local health officials have, and urging them to act on these authorities. LHD partners were largely overwhelmed with the COVID-19 response and under-resourced to perform this function, much less branch out into occupational health and safety, for which they may not have had training, skills, or staff. As the pandemic wore on, politics around reopening and the backlash against LHDs using their authority further limited their capacity to intervene to protect workplace and worker health and safety.

Human Impact Partners authored this report in partnership with California Department of Public Health, Office of Health Equity to respond to the need LHDs expressed to help them better understand the range of actions they can take to protect workers during the pandemic.

Approach

Human Impact Partners (HIP) interviewed governmental public health practitioners, community organizers, and academics to uncover the main issues affecting worker health and safety during COVID-19, understand which workers were most vulnerable and why, and discern what types of resources or support were needed. We did a scan of all actions LHDs can take to protect workers, compiled a list of actions, and distilled the most pertinent findings. We also reviewed literature and policies on worker health during COVID-19 in California and the US. Through this screening, it became clear that while Cal/OSHA is the main regulatory agency in charge of worker protection, LHDs also have a critical support role. Yet many California LHDs did not have the basic information, staffing, capacity, or resources needed to protect workers during COVID-19 and would greatly benefit from a resource pointing them to the existing policies protecting workers, what actions they could take, and the innovative work their peers were doing to protect workers during the pandemic.

Between October 30, 2020, and February 10, 2021, we conducted seven interviews with California public health leaders from seven health jurisdictions to gather what they did to protect workers, what barriers they faced in protecting workers, what they wished they could still do, and what type of resource would most support them in protecting workers during this time. These seven interviews were held with leadership at:

- California Department of Public Health, Occupational Health Branch
- Yuba and Sutter County Public Health
- Stanislaus County Health Services Agency
- Santa Barbara County Public Health Department
- Los Angeles County Department of Public Health
- Monterey County Health Department
- Riverside County Public Health

We also held interviews with two community power-building organizations in March 2021 to understand how they worked with LHDs to protect workers:

- Central Coast Alliance for a United Sustainable Economy (CAUSE)
- Mixteco Indigena Community Organizing Project (MICOP)

Interviewees were identified by the CDPH Occupational Health Branch, by participants of the California Chronic Disease Leadership Prevention Program, and by community organizing partners. Interviewees were selected based on their demonstrated experience in worker health during the pandemic. Interviewers used a standard interview guide, and each interview took place over Zoom and lasted about one hour. Interviews were recorded for reference and accuracy with interviewees' consent.

Literature and policy landscape of COVID-19 and worker health in California and the US

To provide context for the work of California LHDs and action recommendations, we conducted a literature and policy review of relevant research and policies for worker health and safety during the pandemic. This included research on relevant COVID-19 inequities by work sector, wage level, and race and ethnicity — as well as research on the social factors that shape these inequities, and the state and federal policy response landscape.

It is widely understood that workplace conditions, occupational type or sector, and workers' rights and protections are social determinants of health. It is also known that COVID-19 disproportionately exposes, sickens, and kills Black, Indigenous, Latinx[1], Asian American and Pacific Islander, immigrant, and workers in low-wage jobs at rates far higher than White, non-immigrant, and higher-income workers. However, this finding is based on very limited data, because we don't collect adequate information about work (e.g., occupation, industry, employer) or race in our public health surveillance data systems. A history of structural racism in education, employment, housing, health care, and social policy has created the inequitable exposures to COVID-19 in workplaces, which continue to produce and are compounded by existing health inequities. The interrelated social determinants of health that contribute to inequities in worker health — such as housing, government austerity, and politics — are described briefly below.

COVID-19 transmission and mortality are inequitable across work sector and race

Across the US, Black, Indigenous, and People of Color (BIPOC) are more likely than White workers to have jobs that require them to work in person or in close proximity to others. This type of work puts BIPOC at disproportionate risk for COVID-19 transmission in the workplace. These opportunities for transmission can also threaten the health of workers' families, particularly BIPOC households that are more likely to be multigenerational. These factors, alongside other social determinants of health, contribute to a higher burden of disease, illness, and death from COVID-19 among BIPOC workers. Additionally, due to the *digital divide* — a term used to describe the lack of access to computers and high-speed internet for some

[1] Human Impact Partners uses the term Latinx as a gender-neutral descriptor for Latino and Latina populations

communities — essential workers may face delays registering for vaccinations, since this requires both computer and internet access, as well as the time away from work to monitor for quick-moving vaccination appointments.

A recent publication from researchers at the University of California, San Francisco, described excess mortality associated with COVID-19 among adults in California (18–65 years of age) by occupational sector and occupation, as well as race and ethnicity. *Excess mortality* describes the burden of death related to COVID-19 and is essentially the difference between observed and expected deaths in a specific time period. Using death certificate data, researchers estimated that there were more than 10,000 excess deaths among Californians aged 18–65 from March to October 2020.

People working in food, agriculture, transportation, or logistics saw the greatest percentage increase in mortality.

Below, Figures 1 and 2 show which sectors had the highest percentage increases in risk of mortality and excess deaths during this time period compared to pre-pandemic times for that group:

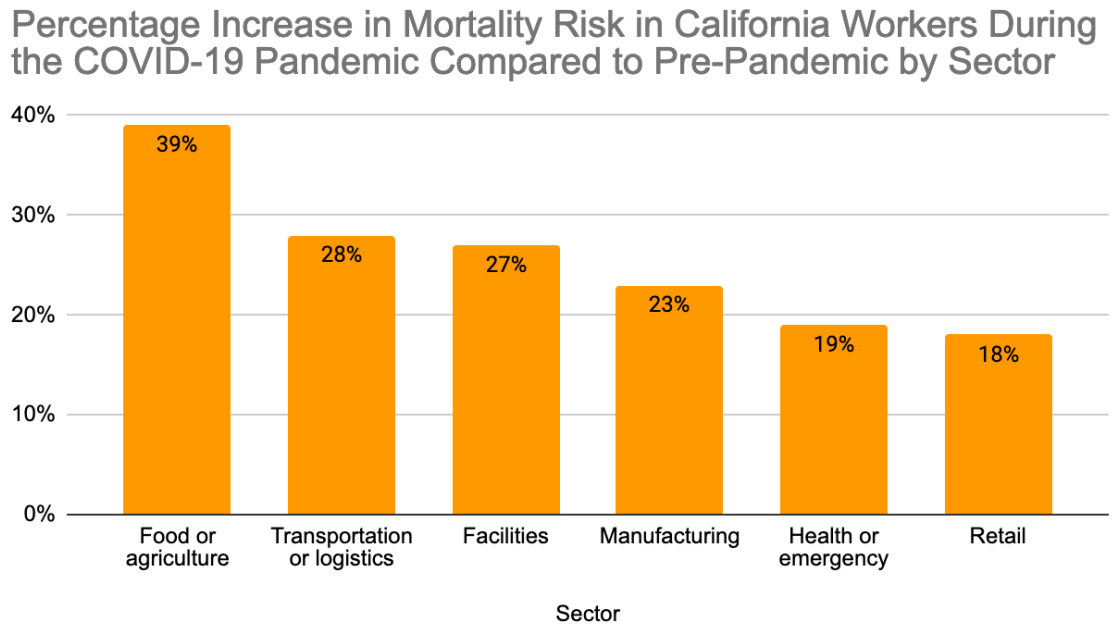

Figure 1. Percentage Increase in Mortality Risk in California Workers During the COVID-19 Pandemic Compared to Pre-Pandemic by Sector (Adapted from Chen et al. 2021)

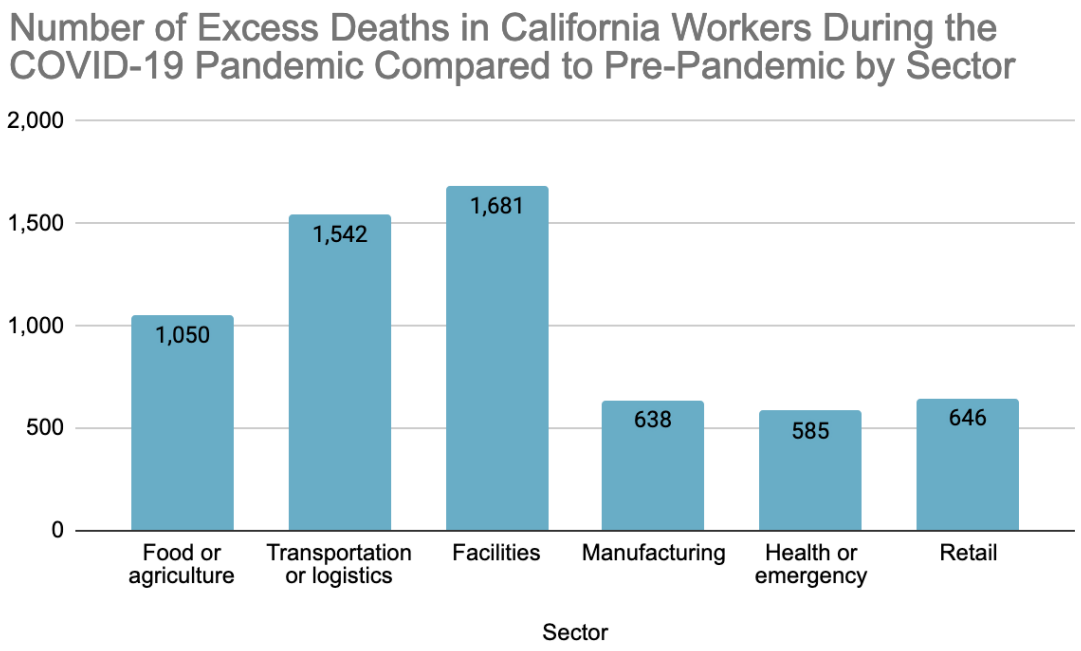

Figure 2. Number of Excess Deaths in California Workers During the COVID-19 Pandemic Compared to Pre-Pandemic by Sector (Adapted from Chen et al. 2021)

The same study also found disparities in mortality based on race and ethnicity. The average risk for mortality during the pandemic for workers of all sectors was 22% higher compared to before the pandemic. However, the risk of death was 36% higher among Latinx workers, 28% higher among Black workers, 18% higher among Asian workers, and 6% higher among White workers. There were also disparities in risk of death within racial and ethnic subgroups based on occupational sector.

These disparities in death from COVID-19 by occupation and race are shaped by workplace exposures and protections, inequities in COVID-19 health risk factors, structural racism, and other social determinants of health. For instance, the following table shows which intersections of racial/ethnic subgroup and occupational sector had elevated mortality risk compared to workers of all sectors within their specific racial group. Table 1 includes racial/ethnic worker categories with elevated mortality risk compared to workers of all sectors in their specific racial group.

Table 1: Excess mortality associated with COVID-19 by race, ethnicity, and work sector in California, March–October 2020.

Category	% Increase in Mortality Risk compared to Pre-Pandemic
Workers of all races and sectors	**22%**
Latinx Workers of all sectors	**36%**
Latinx Food or Agriculture Workers	59%
Latinx Manufacturing Workers	44%
Latinx Government or Community Workers	42%
Latinx Transportation or Logistics Workers	40%
Latinx Retail Workers	40%
Black Workers of all sectors	**28%**
Black Retail Workers	36%
Black Transportation or Logistic Workers	35%
Black Food or Agriculture Workers	34%
Asian Workers of all sectors	**18%**
Asian Health or Emergency Workers	40%
Asian Transportation or Logistics Workers	26%
Asian Facilities Workers	24%
Asian Government or Community Workers	22%
White Workers of all sectors	**6%**
White Food or Agricultural Workers	16%
White Facilities Workers	11%
White Transportation or Logistics Workers	10%
White Retail Workers	8%

Source: Adapted from Chen et al. 2021

Front-line essential workers without access to benefits or union representation are at greater risk of COVID-19

Over half of the workers in low-wage jobs in California (defined as those who make two-thirds of the state median wage or less, or $14.68 per hour) work in front-line essential jobs (as designated by the California State Public Health Officer). Some essential job sectors have disproportionately higher percentages of low-wage jobs compared to the California state average of 32% across all sectors. In California, low-wage jobs make up:

- 80% of farmworker jobs
- 77% of janitors and building cleaner jobs
- 73% of cashier jobs
- 71% of personal-care aide jobs
- 69% of cook jobs

Many low-wage jobs across the US do not provide paid or unpaid sick leave or family leave. Without paid sick leave, workers may come to work ill despite the risk of spreading COVID-19. Researchers have found that access to paid sick leave for workers reduces the transmission and spread of infectious diseases like the flu, and researchers estimate that during the H1N1 flu epidemic, an additional five million cases of influenza in the general population could partly be attributed to a lack of access to paid sick leave, which lessened people's ability to self-quarantine while sick.

When workers don't have paid sick leave, they risk losing pay and possibly also their jobs if they want to go to the doctor, get tested for COVID-19, quarantine, care for sick family members, or attend to children who are distance-learning. The consequences of losing one's job or having reduced hours may be too great to justify taking time off of work. Jobs without employer-provided health insurance also present barriers for workers. In the US, essential workers are more likely to be uninsured than non-essential workers (13% compared to 8%).

Through the power of collective bargaining, unionized worksites can gain higher earnings, paid sick leave, health insurance, and improved health and safety practices in the workplace. Many of these benefits could provide protections against risk factors for COVID-19; however, 90% of essential workers are not covered by a union contract. Despite a rising trend in remote work due to the pandemic across the US, less than 30% of all workers can actually work from home. Only 16% of Latinx workers, 20% of Black workers, and 9.2% of workers in low-wage jobs (those in the lowest quartile of wage earnings) can work from home.

Structural racism is a driver of COVID-19 inequities among workers

The pandemic has made clear that the racial and ethnic inequities in COVID-19 infection, illness, and death are the result of hundreds of years of structural racism. Structural racism — racism enacted through multiple mutually reinforcing inequitable systems, national and state policies, and historical processes — manifests in racial inequities in worker health. Many systems have racism baked into them, including education, incarceration, housing, city planning and zoning, income, lending, and wealth, public transportation, and many others — and together result in racialized inequities in occupation type, work sector, workplace conditions and protections, and economic security. These pre-existing inequities then shape COVID-19 risk, illness, and death. For example, a recent study on older African American and Latinx adults found three mechanisms or pathways that made these populations more susceptible to detrimental impacts from COVID-19. The three pathways — a) risk of exposure to the virus, b) chronic stress and weathering processes, and c) healthcare access and quality — are all impacted by structural racism, and then in turn lead to inequitable outcomes in COVID-19. Indeed, structural racism and COVID-19 can be seen as a *syndemic* — multiple epidemics that are not merely co-occurring, but building and interacting with each other.

The UC Berkeley Labor Center found that in California, 55% of Latinx workers are employed in front-line essential jobs, as are 48% of Black workers, 38% of "other race" workers, 37% of Asian workers, and 36% of White workers. This differs based on occupation. BIPOC Californians are overrepresented in jobs as farmworkers, construction laborers, and cooks.

BIPOC healthcare workers are at higher risk of COVID-19. One study conducted in the US and UK found that BIPOC healthcare workers had five times the increased risk of COVID-19 compared to the White general population. BIPOC healthcare workers were more likely to work in higher-risk clinical settings, care for more patients with suspected or documented COVID-19, and have personal protective equipment (PPE) shortages. And 36.7% of BIPOC front-line healthcare workers reported PPE shortages, compared to 27.7% of White front-line healthcare workers.

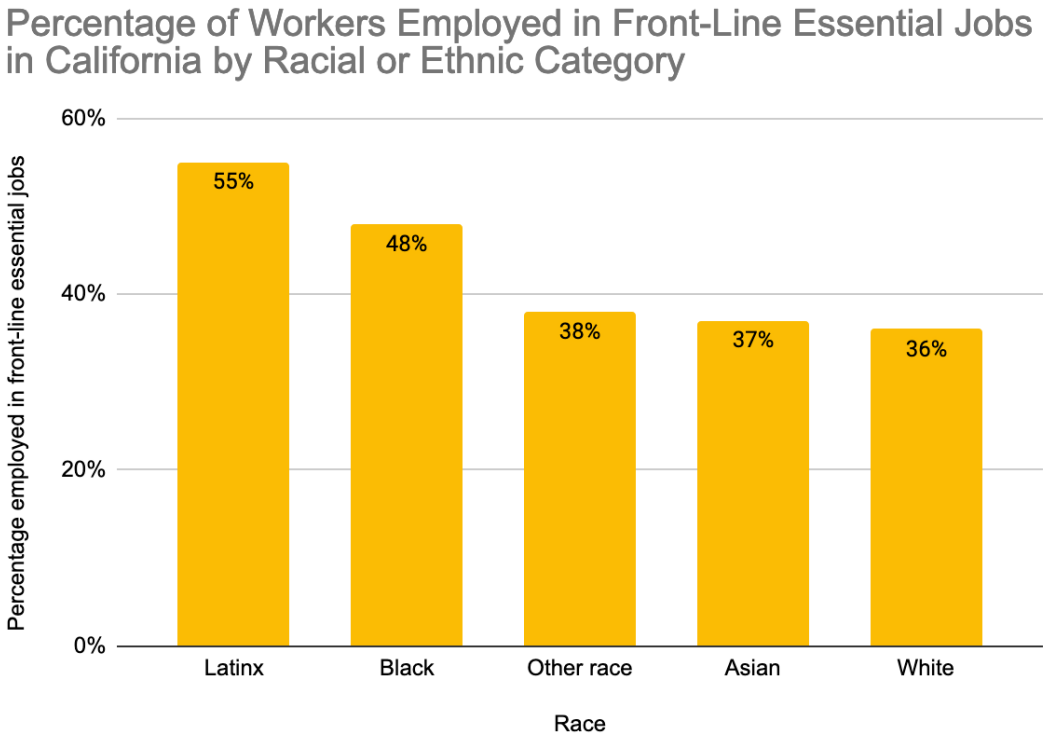

Figure 3. Percentage of Workers Employed in Front-Line Essential Jobs in California by Racial or Ethnic Category (Adapted from: UC Berkeley Labor Center, 2020)

COVID-19 inequities among Filipino Americans and Native Americans may be driven in part by their front-line worker status. The mortality rate among Filipinos in California is 40%, far higher than the 3.7% mortality rate in the US as a whole (though this may be skewed by the small sample size). Filipinos make up almost 20% of all registered nurses in California. California Native Americans have also been disproportionately affected by COVID-19, while simultaneously facing barriers to accurate data collection. The Urban Institute found that 32% of Native Americans in the US work in essential jobs, compared to 26% of White workers. Over half (51%) work in essential and nonessential jobs that require close contact with others. California also has the nation's largest population of Native peoples.

Nearly half (48%) of immigrant workers in California are employed in front-line essential jobs, and this is likely to be an undercount. Immigrants are overrepresented in most of the top 15 largest front-line essential occupations, including farmworkers, food preparation workers, and construction laborers. Immigrant workers, especially undocumented workers, face additional barriers such as lack of access to health insurance, lack of worker protections, and fear of deportation and state violence, which can impact their COVID-19 risk.

State and federal COVID-19 policies and worker health

Many policies have been put in place quickly at the federal and state levels to respond to the pandemic. Many of these are intended to address health inequities, as well as to protect worker health more broadly. There are many roles LHDs can play within the context of these developing local orders, policies, and laws to address the pandemic.

California COVID-19 guidance and policies

When COVID-19 first arrived, California issued a set of policies broadly about and in support of stay-at-home guidance, followed by a number of orders, guidances, and regulations, and state legislation specifically related to workers. These include:

California's Stay at Home Order

On March 19, 2020, an Executive Stay at Home Order from Governor Newsom and a Public Health Order from Public Health Officer Sonia Y. Angell were released. Both orders directed all Californians to stay home, unless they were employed in a designated essential job or they had to shop for essential needs. The orders also directed people to practice social distancing. The Stay at Home order was modified May 4, 2020, and then again on August 28, 2020, as the Blueprint for a Safer Economy was rolled out to permit the reopening of certain businesses and activities.

Additional Stay at Home orders issued throughout the year provided a variety of additions, including the enactment of curfews, social-distancing guidelines, and mask-wearing guidance. The additional orders issued throughout the year include the Limited Stay at Home Order, active November 21, 2020–January 25, 2021 (with a supplement order effective December 22, 2020), the Regional Stay at Home Order, and the Hospital Surge Order. Many of these orders were based on the state's color-coded tier system to assess each county's case rate and risk level for COVID-19 community spread. Tier 1, or Purple tier, indicates COVID-19 is widespread in the county, Tier 2, or Red, indicates substantial cases; Tier 3, or Orange, is moderate; and Tier 4, or Yellow, covers minimal cases. This framework replaced the former County Data Monitoring metrics.

Blueprint For a Safer Economy Guidance

The Blueprint for a Safer Economy is a statewide requirement to determine the conditions under which businesses and sectors of the economy can reopen safely while reducing COVID-19 throughout the state, according to specific health-related criteria. The Blueprint also

contains guidance recommending industry-specific modifications that businesses should make to stay safe. The Blueprint and the metrics used to determine which businesses can open have shifted throughout the year of the pandemic, as agencies are constantly updating the response to COVID-19 based on new data and science. Most recently, counties have been assigned weekly tiers that are determined by the county's case rate and test positivity rate. Local jurisdictions may also implement more restrictive local orders than what is assigned to them by the state, based on their tier.

Vaccine Equity Metric

In March 2021, Governor Newsom announced a new rule to determine equitable distribution of the COVID-19 vaccine to communities most disproportionately impacted by the pandemic. The state set aside 40% of available vaccines for these communities and also established a vaccine equity metric to increase vaccinations in the communities. This move is in response to California's wealthiest populations being vaccinated at nearly twice the rate of the most vulnerable populations, while 40% of COVID-19 cases and deaths have occurred in the lowest quartile of the Healthy Places Index (HPI) — an index that provides overall scores and data that predict life expectancy and community conditions.

State commitment to health equity

- A California for All, California's commitment to health equity webpage, details California's dedication to addressing health equity as part of the state's response to COVID-19. This site details how counties must address COVID-19 health inequities in their case reporting, metrics, responses, and economic reopening plans.
- CPDH has mandated the use of a health equity metric (i.e., the county COVID-19 test positivity rates by California Healthy Places Index quartile) to ensure equitable resource allocation, program planning, and service delivery regarding local response efforts to COVID-19.
- The state also developed the *COVID-19 Health Equity Playbook for Communities* to serve as a resource for local communities to achieve their Health Equity Measure as part of the Blueprint for a Safer Economy and building an equitable recovery.

Coronavirus (COVID-19) Disaster Relief Assistance for Immigrants

Beginning May 18, 2020, California Disaster Relief Assistance for Immigrants funds provided a one-time $500 emergency income replacement for undocumented immigrants. The state created the fund for undocumented Californians who didn't qualify for the Coronavirus Aid, Relief, and Economic Security (CARES) Act or other pandemic unemployment benefits, because of their immigration status.

AB 685 (Reyes)

On September 17, 2020, California State Assembly Bill 685 was signed by Governor Newsom. This bill supports LHDs and the state's Division of Occupational Safety and Health (DOSH) — also known as Cal/OSHA — to better prevent the spread of COVID-19 infections. Effective January 1, 2021, the new law requires changes in three areas: worker right-to-know, public information, and enforcement by Cal/OSHA.

Regarding worker right-to-know, AB 685 requires employers to:

- Provide written notice of potential COVID-19 exposures to employees, their union, and subcontractor employers, and to retain a record of these notifications for three years
- Communicate information on sick leave and other benefits available to employees, anti-retaliation and anti-discrimination rights, and the employer's disinfection and safety plan
- Not discriminate against employees who report COVID-19 test results or diagnosis

Regarding public information, AB 685 requires:

- Employers to notify the LHD within 48 hours of an outbreak (three cases in 14 days) with incident details, business address, and North American Industry Classification System (NAICS) code (business type or sector); and to continue notifying the LHD as new cases are identified
- CDPH to post outbreak information to its website, an open data portal to allow the public and LHDs to track outbreaks by industry
- Employers to retain record of LHD notifications for three years

Regarding enforcement, AB 685:

- Clarifies the existing authority of Cal/OSHA to issue an Order Prohibiting Use for COVID-19 hazards, immediately closing certain business operations or the facility itself
- Exempts Cal/OSHA's 15-day pre-citation notice requirements to employers for serious violations related to COVID-19, which also motivates quicker corrective actions
- Removes the right of employers to rebut a serious violation by claiming that the serious violation "could not have been known"

Cal/OSHA COVID-19 Emergency Temporary Standard (ETS)

The COVID-19 Emergency Temporary Standard went into effect November 30, 2020, and requires all California employers to have a COVID-19 Prevention Program to reduce and mitigate the spread of COVID-19 infections at a worksite. The ETS requires employers to identify and correct unsafe and unhealthy conditions in the workplace, and to provide testing and personal protective equipment for employees. It also requires employers to provide

information to employees and their union about the employer's COVID-19 cleaning and disinfection practices, as well as available benefits should an employee become infected. It prohibits retaliation against employees who report COVID-19 hazards, and it allows for employee participation in the identification and evaluation of COVID-19 hazards at the worksite. It also includes additional requirements in the event of an outbreak or major outbreak.

The ETS requires that employers pay full wages and benefits to workers who must stay home from work due to work-related COVID-19 exposure, and it requires employers to maintain an employee's seniority and their right to return to their previous job. For workers sick with COVID, employers need to tell them about available federal or state benefits, sick leave, workers' comp, or other benefits. The standard includes specific requirements around employer-provided housing and transportation, which is especially important for farmworkers, a population that has been disproportionately harmed by this pandemic.

The ETS covers about 7.2 million California workers who are not covered under the existing Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard, which was adopted in 2009 to protect about 2 million workers in high-risk workplaces — like healthcare facilities, emergency medical services, correctional facilities, and homeless shelters — who may be exposed to a range of infectious diseases, including a novel virus. California is the only state that has an ATD Standard; this enabled hospitals to activate the ATD respiratory protections and other measures, and more quickly respond to COVID-19.

The ETS is enforced[2] by Cal/OSHA compliance officers, who conduct inspections, issue citations, require abatements, and if necessary, close an operation or a facility until COVID-19 hazards are corrected. They can be a key resource for LHDs, as noted below in Section III.

Housing for the Harvest

This state program offers temporary hotel housing to agricultural workers who need to isolate or quarantine due to COVID-19, with a focus on the Central Valley, Central Coast, and Imperial Valley regions.

Federal-level COVID-19 policies for worker health

[2] Note: We do not support the use of law-enforcement to uphold public health laws and orders. Please see Policing During COVID-19: A Public Health Messaging Toolkit to Invest in Health, Not Punishment for more information on how to ensure the public health response to the pandemic advances racial and health equity, upholds human dignity, and prioritizes healing — not policing and incarceration — for all people, and especially for workers or communities of color.

In response to the nationwide emergency of COVID-19, different federal-level policies and legislation were passed in response to the pandemic, impacting communities across California.

Coronavirus Aid, Relief, and Economic Security (CARES) Act

On March 27, 2020, Congress passed and President Biden signed the Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act. The legislation (which was effective April–December 2020) guaranteed paid sick leave, wage replacement, and other benefits for workers impacted by COVID-19. While this legislation helped many, it also excluded millions of workers — including people who work for private employers with 500 or more employees and undocumented workers. Additionally, the first COVID-19 legislation, the Families First Coronavirus Response (FFCRA) Act allowed employers of healthcare providers and emergency responders to opt out of providing paid sick days and paid family and medical leave.

Presidential Executive Order on Protecting Worker Health and Safety

On January 21, 2021, President Biden signed an Executive Order on Protecting Worker Health and Safety during the pandemic. The order mandates that the federal government take action to better protect workers from COVID-19, including directing the federal Occupational Safety and Health Administration (OSHA) to update COVID-19 safety recommendations for businesses, review its enforcement efforts, as well as study and decide if an emergency temporary standard is necessary.

Federal OSHA Guidance for Employers

In response to the Presidential Executive Order, on January 29, 2021, OSHA released *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace*. This report contains recommendations and descriptions of existing mandatory safety and health standards, and strategies to prevent exposure and the spread of COVID-19 in the workplace. The federal OSHA guidance is advisory only and therefore of little relevance in California, where Cal/OSHA's ETS is the governing, mandatory standard for all employers not covered by Cal/OSHA's Aerosol Transmissible Diseases (ATD) Standard.

Recommendations for California LHDs to protect workers during COVID-19

The COVID-19 pandemic pushed many LHDs to act quickly and creatively to support the unique needs of their communities. The LHDs that we interviewed have been actively protecting worker health during COVID-19, with all seven counties describing a wide variety of policies and initiatives they have pursued to protect workers. Several key categories of actions that were successful made reappearances from county to county, signaling that these actions could be utilized in counties throughout the state. Based on the commonalities and success stories, we've distilled the following eight recommendations for LHDs to protect worker health and safety during COVID-19:

1. Issue health officer orders for worker health and safety.
2. Partner with Cal/OSHA district offices to manage problematic worksites.
3. Develop and disseminate guidance based on local industries and worker needs.
4. Develop and disseminate communications materials with trusted community partners.
5. Collect, analyze, and disseminate data by work sector to identify inequities.
6. Activate relationships with community partners to build power for systems changes.
7. Facilitate intersectoral Health in All Policies work.
8. Create worker-focused practices, programs, and services.

What follows is a description of each action recommendation, equity-focused guidance for taking action, as well as examples of how LHDs put the action into practice. Where available, we include links to specific department policies and actions. **Throughout all of these recommendations, we strongly advise investing in building long-term, trusting relationships with community-organizing groups and community-based organizations in your jurisdiction.** Cultivating power-building relationships between LHDs, community power-building organizations, and community members is deeply important work — and holds the power to transform the landscape of what is possible in moments of crisis.

1. Issue health officer orders for worker health and safety

Each county in California is required to appoint a health officer, whose role is to preserve and protect public health. California law gives local health officers broad authority to take action to prevent disease. Health officers can declare local health emergencies and issue enforceable health officer orders (HOOs). HSC 101030 gives health officers the authority to enforce and observe orders related to public health and sanitation, quarantine and other regulations, and other statutes related to public health. For instance, Shelter in Place orders issued by local health officers across the US are examples of HOOs.

Issuing and enforcing HOOs that protect worker health and safety is one way that LHDs can ensure workers are kept safe, especially if an employer is a repeat offender or seeks to retaliate against workers who report unsafe conditions to their LHD or Cal/OSHA. HOOs should be issued with racial and health equity in mind, with a particular focus on marginalized worker populations, workers' rights, and social determinants of health.

Initial steps for implementing this recommendation

- Issue health officer orders that address vulnerabilities and risks specific to the workers, work sectors, and working conditions in your jurisdiction
- In addition to HOOs related to public health measures to control COVID-19, focus on social determinants of health, and racial and health equity
- Work closely with employers to get buy-in with HOOs

Examples

Stanislaus County: Stanislaus County issued a health order on May 12, 2020 specific to all food and beverage manufacturing facilities in the county — a large part of the county's business community and economy. It requires food and beverage manufacturing employers and employees to take preventative measures, including:

- Screening all who enter the facilities for COVID-19 symptoms
- Providing hand sanitizer and encouraging its use
- Wearing face coverings at all times when within six feet of another person for more than ten minutes
- Maintaining social distancing in break rooms

Stanislaus County worked closely early on with employers on the language for the health order. This helped prevent pushback from employers, and in fact, many large employers wanted an

order to be put in place. However, there were times when the LHD had to shut down businesses not following HOOs, primarily if they had outbreaks.

They also passed a Congregate Living Order in May 2020 with implications for the safety of workers at congregate living facilities and emergency medical service (EMS) workers. All visitors to congregate living facilities (e.g., healthcare facilities, residential care facilities, shelters, and group homes) and EMS/first responders must be screened through self-evaluation and temperature checks. Masks are required for visitors and staff, and medical-grade masks should be prioritized for staff at patient-care facilities and EMS/first responders.

Santa Barbara County: On September 14, 2020, Santa Barbara County issued Health Order 2020-14.1, which covers H-2A housing and homeless shelters. H-2A housing is housing provided by employers to agricultural migrant workers. Under the order, employees staying in H-2A housing must be screened for COVID-19 symptoms (including temperature screening). If they have symptoms, they must self-isolate and notify the housing operator/employer. The operator/employer must notify the LHD if there are any cases within H-2A housing. The order also recommends the creation of stable groups, or pods of fewer than 14 people in H-2A housing who reside, travel, and have social time together.

2. Partner with Cal/OSHA district offices to manage problematic worksites

Cal/OSHA's Emergency Temporary Standard (ETS) for COVID-19 Prevention is enforceable and comprehensive, and there is a reasonable body of evidence showing that, in general, Cal/OSHA standards and their enforcement bring about improvements in workplace safety and health across industry sectors, beyond the immediate facilities that are subject to inspections and citations. LHDs must respond to infectious disease in their jurisdictions, but have little to no occupational health capacity and no mandate. LHDs have needed an enforcement arm to deal with major outbreaks at workplaces and with employers who are unwilling or reluctant to implement worker protections. This is now possible with Cal/OSHA's enforceable ETS.

With proper planning to facilitate coordination, the local district office of Cal/OSHA can be a key partner with LHDs in working with and, where necessary, bringing enforcement actions against employers who might otherwise be reluctant to implement COVID-19 workplace protections. Like most state agencies, Cal/OSHA's resources have been particularly stretched thin during the pandemic, so establishing a working relationship with the district office today will facilitate an effective partnership when the need arises. LHDs can play a key role in protecting workers by communicating with employers about the requirements of the ETS; collaborating with

Cal/OSHA to prevent, respond to, and improve conditions at problematic worksites; and supporting Cal/OSHA compliance inspections. Cal/OSHA also provides non-enforcement safety and health consultation support to employers through the Cal/OSHA Consultation Service, which can be an effective partner for LHDs in working with small and medium-sized employers on COVID-19 prevention strategies.

As a precedent, Cal/OSHA partners with local Certified Unified Program Agencies and the US Environmental Protection Agency to conduct inspections at the state's 14 oil refineries. This partnership has improved the capacity and expertise of the agencies involved. It has allowed for effective implementation of the state's new oil-refinery regulations and has significantly improved the safety of the refineries, to the benefit of workers, residents, and the environment. This partnership demonstrates how agencies can work together to improve safety and ensure compliance with complex regulations.

LHDs investigating a workplace outbreak might not think of checking in or collaborating with Cal/OSHA, which has the authority to investigate worksites, issue citations, and require abatements in response to worker complaints or by referral from a public agency. During COVID, however, some LHDs have worked closely with Cal/OSHA in conducting joint inspections at facilities experiencing a major outbreak — they have sometimes been joined by CDPH's Occupational Health Branch. For the LHD, Cal/OSHA is a key resource, particularly when the LHD is faced with a noncompliant employer. Moreover, the local knowledge and experience of the LHD can be an important resource for Cal/OSHA in identifying problematic worksites where workers might feel uneasy about contacting a state agency for help. To improve the effectiveness of both the LHD and Cal/OSHA, each party should take steps now to build the foundation for collaboration. LHDs can learn more about Cal/OSHA's enforcement process and how sharing information can improve the outcome. Cal/OSHA district managers and compliance officers would benefit by knowing more the case information LHDs have and how to access it, as well as a public health prevention approach. Both entities need to know that it's acceptable and legal to share confidential medical information between them when doing so is for the purpose of protecting public health. LHDs should consult with their County Counsel regarding confidentiality and other legal matters.

Initial steps for implementing this recommendation

- Get to know your Cal/OSHA district and regional managers, worker centers, unions, labor organizers, academic labor centers, businesses, and employers so when an emergency hits (such as a large outbreak), the relationships are already there — making partnerships and coordination easier
- Meet with Cal/OSHA district manager and senior staff to discuss:

    - The LHD's and Cal/OSHA's approach to worker health and shared goals
    - Areas of respective strengths, resources, authority, and gaps
    - When and how to share data and other information
    - Worksite problems in the LHD's jurisdiction
    - Plans and processes for collaboration
- Create systems of coordination and collaboration between LHD environmental health inspections and CalOSHA workplace safety inspections and enforcement
- Participate in and support Cal/OSHA inspections and, where requested, enforcement actions
- Strengthen relationships with local employers and businesses, to gain their buy-in and support for worksite requirements and ETS implementation

3. Develop and disseminate guidance based on local industries and worker needs

Guidance and protocols are documents developed at the federal level by the CDC, the state level by CDPH, or by LHDs that offer instruction and recommendations on what an employer should do if there are confirmed positive COVID-19 cases among workers at a workplace. They also provide sector-specific instructions for businesses on what they should do or provide to protect people from COVID-19 while they are at work. Guidances offer recommendations that act as public health resources for employers, employees, and the wider community, but they are not generally enforceable. After AB 685 and the Cal/OSHA ETS became effective, they were updated to include enforceable legal requirements.

Initial steps for implementing this recommendation

- Consider which worker populations are most at risk in your jurisdiction and create and/or disseminate guidance to support these workers
- Consider the health equity issues unique to your jurisdiction when creating guidance, taking into account the diversity of communities most impacted by the pandemic
- Pay special attention to workers that are systemically marginalized from protections, such as undocumented, non-union, and gig workers
- Work with employers to ensure buy-in to guidance, and that PPE and other safety equipment are being properly provided to workers

Examples

Santa Barbara: The LHD issued guidance for employers to report cases to a hotline or web address, and worked with different employers of residential and skilled nursing facilities, restaurants, and other industries. In addition, businesses were required to self-attest to their employees and the public that their business had taken the necessary steps to ensure a safe reopening, as well as register with the county before reopening to the public. The county created a RISE (Reopening in Safe Environment) Guide and assembled RISE Ambassadors, made up of members of the Santa Barbara Community Wellness Team, who assisted employers with one-on-one help to reopen safely with consideration to the public health guidelines.

Los Angeles: The LHD created sector-specific guidance and white papers through a series of focus groups in industries such as manufacturing, retail, and film and TV. Many protocols are available in multiple languages, such as Spanish, simplified and traditional Chinese, Tagalog, Arabic, Russian, Farsi, Armenian, Cambodian, Vietnamese, and more.

4. Develop and disseminate communications materials with trusted community partners

Public health communications is one of the ten essential public health services. Communications and outreach to the general public and specific populations, especially underserved ones, is critical in order to promote and protect health.

Collaborating with community partners who are trusted messengers can help bridge the gap between LHDs and the public. Many LHDs formed relationships with community-organizing groups to disseminate information to communities, using communications materials that are both linguistically and culturally appropriate. LHDs that were already working with community-organizing groups had an advantage when the pandemic hit. The pre-existing relationships supported the fast-moving work of getting crucial information from the LHD to workers. In turn, community-organizing groups provided critical political support when LHDs put out stronger worker protections.

Initial steps for implementing this recommendation

- Build relationships with community-organizing groups so LHDs have trusted community partners to develop and disseminate culturally relevant materials and services to protect worker health — in turn, LHDs will have powerful allies, sources of critical information, and a base of residents who can support the LHD in County decision making
- Contract with community partners to do outreach and education for workers in multiple languages
- Distribute information to workers (e.g., know your rights, violation reporting hotline, FAQ about what to do if you're sick, supports that are available, where to get vaccinations) in multiple languages and using multiple media (e.g., radio, video, print) to ensure access for all literacy levels
- Establish a hotline/resource center, staffed by people speaking the most common languages

Examples

Los Angeles County: Los Angeles County has done extensive outreach to the many sectors of employers in their county, and holds telebriefings three to four times a week across a variety of sectors, such as nail salons, film and TV production, fitness facilities, and restaurants. Hundreds call in with questions and comments, and the briefings serve as a way to provide updates and build connections with both workers and employers. The department has also held telebriefings specifically for unions. Los Angeles utilizes liaison teams that take calls from the public about health officer orders and protocols. Oftentimes, this includes calls from employers and employees. These teams provide consistent responses to common questions and refer businesses to the Environmental Health Division if there is a workplace COVID-19 outbreak.

Santa Barbara County: Santa Barbara has a large Indigenous language speaking community. Mixteco is one of the most common Indigenous languages in the area, but within Mixteco, there are up to 40 different specific dialects — making it hard for one Mixteco interpreter to be understood by all Mixteco speakers. Santa Barbara County partnered with the community-organizing group Mixteco Indigena Community Organizing Project (MICOP) to conduct a focus group with Mixteco farmworkers to identify the best way for the LHD to engage with these communities, as well as how to provide culturally and linguistically appropriate services for Indigenous language speaking residents.

Stanislaus County: Stanislaus County conducted outreach to large employers, such as food manufacturers, meatpacking plants, farms, and wineries, early on in the pandemic. With these employers, they discussed best practices and ways to implement workplace precautions, such as social distancing in break rooms, plexiglass dividers, as well as communication and testing strategies. This laid the groundwork for their health order for food and beverage manufacturers.

Yuba and Sutter Counties: In Yuba and Sutter counties, there was a focus on outreach to immigrant communities. Across these two counties, there are large populations of Punjabi, Hmong, and Hispanic or Latinx immigrants. In order to reach these communities, Yuba-Sutter utilized multiple channels for communication, including TV ads on Univision funded by the CARES Act, appearing on local Spanish and Punjabi radio stations, and working with local faith-based leaders.

The Yuba Enterprise Solutions Team (YES Team) and the Sutter COVID-19 Outreach Resiliency Effort (SCORE) Team were formed in June 2020 to help both employees and employers navigate health guidance and begin recovery efforts. Acknowledging that a single reopening solution may not be suitable for different businesses, the YES and SCORE Teams aimed to reach a wide variety of employers, from small businesses to big-box stores.

5. Collect, analyze, and disseminate data by work sector to identify inequities

Data, particularly data on occupation, industry sector, or workplaces, have uncovered important disparities in COVID-19 transmission and death based on work sector and race, and have informed LHD actions. However, there is currently very limited occupational data collected in public health surveillance systems, for testing, COVID-19 illness or death, or vaccination. Under AB 685, the LHD's role is to receive employer reports on outbreaks (3 or more positive results in a non-healthcare worksite within a 14-day period) and report it to CDPH, and post a link from the LHD website to the CDPH outbreak data display.

Collection of data on the occupation and industry sector for COVID-19 surveillance can help LHDs focus their efforts, policies, and interventions to better understand and protect workers at risk of contracting COVID-19. Occupation and industry sector data transparency can help

workers and the general public understand their COVID-19 risk. Regular and systematic data collection can also reveal changes over time.

Initial steps for implementing this recommendation:

- Collect occupational data in public health surveillance systems to ensure equity in policies, programs, testing, and vaccination rollout
- Publicly release data that help inform the public about health impacts to workers

Examples

Santa Barbara County: The LHD established a survey for contact tracers to help identify and track working and living conditions among those testing positive for COVID-19. These social determinants of health data helped the LHD better understand the COVID-19 data and enabled shifts in policies guided by the data.

Los Angeles County: In LA County, workplace outbreak data is published online with employer and/or worksite name. This is done in order to inform the public about outbreaks, noting that it does not indicate wrongdoing on the employers' part. Most other counties throughout California do not report cases by industry sector, due to concerns about privacy and stigmatization.

6. Activate relationships with community partners to build power for systems changes

Given the complex connections between worker health, housing and educational inequities, and structural racism, LHDs alone cannot create health equity. To best support worker health during a crisis like COVID-19 and beyond, LHDs should build lasting relationships with community-organizing groups and social movements that are advocating for upstream, population-level interventions.

As government entities, LHDs have a certain power. Community-organizing groups have another power that comes from building community and relationships. When combined, both entities — LHDs and community-organizing groups — are able to build off of their respective roles and power, and create even greater coordinated change for health equity during a crisis like COVID.

To build an ecosystem of public health, health equity, and racial-justice actors who can work in a coordinated effort to achieve our shared vision of healthy communities, LHDs must shift organizational practices to make space for directly impacted communities to advocate for themselves. Investing in power-building relationships is a great way to cultivate these transformative connections and create a larger ecosystem among LHDs, community power-building organizations, worker centers, unions, and academic labor centers to support worker health.

Initial steps for implementing this recommendation

- Partner closely with community-organizing groups and community-based organizations to both better understand community needs and support community-organizing efforts to build community power
- Devote time and resources to work on racial equity — this is necessary before, during, and after emergencies to ensure existing racial inequities are not exacerbated

Examples

Santa Barbara County: In 2018–2019, the LHD participated in Powerbuilding Partnerships for Health (PPH), a project coordinated by Human Impact Partners, to build relationships between LHDs and community power-building organizations. Through PPH, the LHD spent one year building understanding and trust with their partner Central Coast Alliance United for a Sustainable Economy (CAUSE), a base-building organization committed to social, economic, and environmental justice for working-class and immigrant communities in California's Central Coast. The LHD and CAUSE developed a shared understanding of health equity, community organizing, and power building, and worked to address field sanitation for farmworkers. In 2020, the LHD and CAUSE continued to participate in PPH and invited Mixteco Indigena Community Organizing Project (MICOP) to join subsequent collaborations. This partnership was already strong and in place when the pandemic started. The Santa Barbara County Public Health Department Director Van Do-Reynoso notes that through their relationship building in PPH for two years prior to the pandemic, the LHD and CAUSE learned to trust each other, "better understand who can advocate for what in which circumstances," and use a coordinated inside/outside strategy to enact stronger worker-protection policies.

Case story on building relationships with community partners: Santa Barbara County's partnership with community organizers

Across California, farmworkers and farmworking communities were greatly affected by the pandemic. In Santa Barbara County, the $1.5 billion agriculture industry employs thousands of mostly Latinx workers. The majority of these workers speak Spanish or an Indigenous language, and face barriers to getting care, as well as the risk of contracting COVID-19 at their workplace.

In the wake of the pandemic, the Santa Barbara County Public Health Department (SBCPHD) recognized the need to prevent outbreaks in employment settings in order to protect workers. SBCPHD's pre-existing partnerships with community-organizing groups like the Central Coast Alliance United for a Sustainable Economy (CAUSE) and the Mixteco Indigena Community Organizing Project (MICOP) — along with established relationships with UC Santa Barbara (UCSB) and others — turned out to be critical as the LHD strategized how to best protect farmworkers, one of the county's most vulnerable populations.

As a result of these pre-existing partnerships, the Latinx Indigenous Migrant Health COVID-19 Task Force launched at the end of March 2020. The task force was created to strategize and take action to build a "broader county-wide health equity collaborative effort to include Black, Pan Asian, LGBTQ and other communities, centering the voice and leadership of historically marginalized peoples."

The group began meeting weekly on Zoom and today includes more than 150 participants representing over 60 organizations. A key feature of the task force was ensuring that information about COVID-19 was accessible in linguistically and culturally appropriate ways. This included radio campaigns, YouTube videos, Facebook livestreams, as well as public service announcements and large educational posters for community members with lower literacy skills available in Spanish and various dialects of Mixteco, Zapoteco, and other Indigenous languages.

SBCPHD noticed that there were a disproportionate number of Latinx people with COVID near Santa Maria, many of whom were farmworkers with H-2A visas. Because H-2A housing was regulated by the US Department of Labor, SBCPHD was not aware of H-2A housing in Santa Barbara County. The community group CAUSE hosted a webinar for SBCPHD staff about H-2A housing and used the Department of Labor's database to identify and track H-2A housing operators for potential COVID-19 outbreaks. In July 2020, SBCPHD discovered that

there were 12 COVID-19 cases with different addresses or no address, all tied to one H-2A employer.

SBCPHD shored up the reporting mechanism related to H-2A operations and aggressively mitigated the outbreak, but realized that they needed a broader and stronger mandate to protect people in congregate living places (such as H-2A housing and homeless shelters). In response, SBCPHD developed their H-2A Health Officer Order (H-2A HOO). This HOO was the result of their research to understand what was legally defensible, as well as a discussion and negotiation with employers and growers, the county agriculture commissioner, and community members and organizations.

Although the SBCPHD had the authority to issue the H-2A HOO, the SBCPHD Director needed the support of the community and the County Board of Supervisors. It's here that the community partner, CAUSE, played a critical role. CAUSE helped convene diverse community members to hear about what the SBCPHD had been doing to address COVID-19, why SBCPHD was issuing the HOO, and how the HOO would help protect community health. CAUSE also helped identify a local city council champion for the H-2A HOO, broker relationship building between the SBCPHD Director and the city council member, and turn out significant community support at the County Board of Supervisors meeting for the passage of the order. CAUSE's community-awareness work built the support needed for the H-2A HOO and helped diffuse racially divisive tensions and pushback from some residents who were pushing for the county to reopen.

The H-2A HOO went into effect in September 2020 and has been renewed on a monthly basis since then. The order requires homeless shelters and H-2A housing to check residents for COVID-19 symptoms and report cases. Soon after the Santa Barbara H-2A HOO passed, CAUSE worked with the Ventura County Health Department, policymakers, and community members to pass a similar H-2A HOO in Ventura County.

As one of the first of its kind in the nation, the HOO on H-2A Housing is an important precedent for how health departments can leverage their own administrative powers to protect farmworkers. Although the Latinx community is still disproportionately impacted by the pandemic, the number and proportional rates of COVID-19 cases among farmworkers have decreased since the passage of the H-2A HOO. The strong, trusting relationship between SBCPHD and community-organizing groups allowed them to lean into conflict, understand and leverage their respective roles and power, build trust with other important allies, and center the voices of impacted communities.

SBCPHD wanted to also enact cohort-oriented transportation and routine testing of farmworkers to protect public health, but these aspects were found to not be legally defensible in this mandate. Instead, SBCPHD worked with the task force to ensure that farmworkers in H-2A housing had access to community testing sites. Moving forward, SBCPHD is planning to continue working closely with CAUSE, MICOP, and others in the task force to roll out vaccine distribution, explore development of a farmworker resource center, support labor protections, and expand language access.

7. Facilitate intersectoral Health in All Policies work

It is now widely understood that health is produced mainly by factors beyond the traditional scope of health, such as housing, economic justice, and transportation. A Health in All Policies (HiAP) approach is necessary to facilitate collaboration across sectors to integrate the consideration of health — especially racial and health equity — into policymaking.

LHDs with pre-existing Health in All Policies, racial equity plans, tools and training, and long-term partnerships with community organizers leveraged those assets during the crisis, allowing health departments to provide stronger worker protections and withstand the political pushback that public health faced during this time. LHDs that did not have this foundational work grew their racial and health equity work, and strengthened partnerships with other government and community partners during this time that they will continue to leverage to improve public health during recovery.

Examples of HiAP work include providing worker housing to prevent the spread of COVID-19, offering wage replacement, and supporting economic policies such as paid sick leave. LHDs also stated that their previous work through the Government Alliance on Race and Equity (GARE), which aims to bring racial equity into government and policy, provided them with the infrastructure, tools, and lens to implement their COVID-19 response with a racial-justice lens.

Initial steps for implementing this recommendation

- Map out the social determinants of health most likely to be impacting workers' ability to stay safe and healthy during a short or prolonged crisis — doing root-cause mapping with community partners is a great way to quickly identify areas of highest concern
- Build relationships with governmental agencies and community organizing and advocacy groups in your jurisdiction that work on relevant social determinants, such as housing and economic security, transportation, and immigration protections

- Work with these partners to pass local policies and adopt coordinated plans to improve living/working conditions and economic security for vulnerable workers

Provide housing to farmworkers

In the past year, many Californians have experienced housing insecurity or loss of housing as a result of the pandemic. Due to the unprecedented job loss, many are unable to afford rent. Policies that provide safe and healthy housing options to people in need of housing support are important to support the overall health of people and families, as well as serve as a COVID-19 intervention.

Examples

Yuba and Sutter Counties: Yuba and Sutter counties provided hotels and motels for farm workers while isolating during COVID-19 infection. Dr. Phuong Luu, Bi-County Health Officer of Yuba and Sutter Counties, emphasized the importance of such programs, especially given that farmworkers often live in crowded housing and multigenerational households.

Stanislaus County: Stanislaus County offered hotels for farm workers through the statewide Housing for Harvest program. However, Dr. Julie Vaishampayan, Health Officer of Stanislaus County, noted that many workers did not participate in housing services. This may be related to fear of US Immigration and Customs Enforcement (ICE), as well as fear of accessing government services due to "Public Charge" rules. Workers did engage with other wraparound services.

Monterey County: Local grower-shipper organizations made up of agricultural businesses offered hotel rooms for farmworkers to quarantine prior to the Housing for Harvest program. Kristy Michie, Assistant Director of Monterey County Health Department's Public Health Bureau, also noted that not everyone who was offered alternative housing chose to accept it. For example, case investigators anecdotally reported that some young women were worried about being separated from their families. However, the County had an overall good uptake in use of housing services.

Santa Barbara County: Santa Barbara County is currently working with community partners to advocate that health departments be informed of H-2A operators in their jurisdiction, since H-2A housing in their jurisdiction needed public health intervention to address the spread of COVID-19 and to help protect the health of the H-2A residents and the community at large.

Paid sick leave and wage replacement as a public health intervention

Many Californians have experienced — and are continuing to experience — economic hardship as a result of the pandemic. Hundreds of thousands have lost jobs or have experienced a reduction in hours due to the pandemic, and many continue to live in economic precarity, unable to afford rent, groceries, and other basic necessities.

Income replacement has become an important tool to both address the hardship many families are experiencing, as well as serve as a COVID-19 prevention intervention. Many essential workers in low-wage jobs cannot afford to take unpaid time off work to get clinical care, much less take off two weeks of work to quarantine if they have a COVID-19 diagnosis or symptoms. Studies have found that without paid sick leave, workers are less likely to get preventative care even when they have health insurance. Counties around the US and other countries have implemented wage-replacement measures to pay people to isolate when they are sick with COVID-19.

Examples

Yuba and Sutter Counties: In Yuba and Sutter counties, public health officials partnered with the Mexican Consulate to notify undocumented residents within the greater Sacramento region about the availability of the $500 assistance from the California Disaster Relief Assistance for Immigrants, which provided undocumented immigrants with a $500 emergency income replacement. The state created the fund for undocumented Californians who didn't qualify for the Coronavirus Aid, Relief, and Economic Security (CARES) Act or other pandemic unemployment benefits, because of their immigration status. Undocumented residents may feel safer going through the Mexican Consulate as opposed to state or local government.

Stanislaus County: In Stanislaus County, the LHD created a local program to provide an $800 paycheck support for workers who had to isolate or quarantine due to infection or exposure. Utilizing CARES Act funding, they contracted with a local community organization to implement the program. Dr. Julie Vaishampayan emphasized the importance of such a program to keep people at home and prevent further spread of COVID-19, but she stated that one round of paycheck support wasn't enough, especially in the case of recurring exposures or multiple infections within a household.

Important worker protection and economic-security policies for health

LHDs can facilitate a Health in All Policies approach of convening partners across sectors to adopt coordinated plans and pass policies to improve living and working conditions and economic security for vulnerable workers.

- Universal paid sick days and paid leave when childcare and schools are shut down
- Right of return to jobs
- Protection against retaliation by employer for worker whistleblowing
- Workplace public health councils (e.g., LA County model)
- Unemployment benefits, paid sick days, and expanded emergency income replacement for undocumented workers
- Workers' comp for those who get COVID-19 (presumption of exposure at work)
- Universal hazard pay
- Strengthened wage-theft laws
- Protection against termination for workers when they are not able to work due to their own or family members' exposure or illness
- Rent/housing payment relief for unemployed (including undocumented residents)
- Utility payment relief for unemployed
- Financial assistance for internet access
- Increased access to quality subsidized childcare and early learning opportunities for low-income working parents
- Strengthened economic protections for small businesses

8. Create worker-focused practices, programs, and services

LHDs can implement public health practices, programs, and services aimed to directly address worker health issues and needs during the pandemic. Public health practice can prioritize deeper engagement of vulnerable workers to inform and tailor programs, integrate worker health needs across public health programs, and expand the mandate of existing environmental health programs. Worker housing, transportation, geographic location, language, and culture should be taken into consideration in order to deliver accessible and relevant public health programs. Rather than hoping impacted workers will come to them, equity-oriented LHDs are bringing services and resources to workers who are most impacted by the pandemic at their workplaces.

COVID-19 might be with us for a long time. It could become like the flu, and workers may have to contend with it annually — and as a result, may need to get vaccinated for it every year. In order to prevent continued COVID-19 inequities related to workplace safety, and housing and healthcare access, LHDs would benefit from strengthening their occupational health practice in preparation.

Initial steps for implementing this recommendation

- Bring essential COVID-19 services like provision of PPE, testing, and vaccinations to workplaces with workers at high risk
- Work with employers to coordinate vaccination times and encourage paid time off to get vaccinated so that workers do not have to choose between getting vaccinated or getting paid
- Integrate worker health and safety across public health programs (e.g., beyond environmental health and lead poisoning prevention and into chronic disease and injury prevention programs)
- Integrate worker health and safety into Community Health Assessments and Community Health Improvement Plans
- Create opportunities for worker input when designing and implementing programs to support worker health
- Work with partners inside and outside of local government to empower workers to monitor and report workplace health and safety concerns
- Spend time building a larger ecosystem of organizations working together in a coordinated inside/outside approach to protect workers, including LHDs, Cal/OSHA regional offices, labor advocacy and organizing groups, unions, worker centers, academic labor centers, businesses, industries, and employers

Examples

Monterey County: Monterey County organized drive-through sites where assisted living facilities and nursing homes could pick up PPE resources. PPE was also given to workers providing childcare for essential workers. In addition, the LHD had a hospital preparedness coordinator who connected with hospitals to provide additional PPE.

Policies were put into place to protect workers within the health department itself. Eighty hours of additional special leave were granted to all county employees, and pay for overtime hours was approved for employees working on COVID-19 who were not normally overtime-eligible.

Stanislaus County: In Stanislaus County, the health department worked in collaboration with the agricultural commissioner to bring testing to migrant worker housing and on site to farms. They utilized trusted community partners to conduct door-to-door outreach.

Case story on worker-focused programs: Riverside County's mobile vaccine teams for agricultural workers

Agricultural workers throughout California, who are essential for maintaining the national food system, have been hard-hit by COVID-19. Many of these agricultural workers are migrant workers, undocumented, and live and work in crowded conditions, which increases their risk of contracting COVID-19. To reach underserved agricultural workers, the Riverside County Public Health Department (RCPHD) has organized mobile vaccine teams to farms all across Riverside County. The initiative began in January 2021 — and as of March 2021, more than 5,200 agricultural workers in Eastern Coachella and 2,400 in Western County have received their first dose.

This is no small task, given that agricultural workers face several barriers when it comes to vaccinations, including lack of internet and transportation, as well as linguistic barriers, with the majority of the community speaking Spanish and Indigenous languages. The RCPHD is collaborating with local community-based organizations (CBOs) as trusted messengers to liaise with both growers and agricultural workers.

The county utilizes equity mapping, a combination of Healthy Places Index and their own vaccine priority index, which consists of case rate, death rate, and vaccine rate by census tract. They add race, ethnicity, and age layers to provide a clearer picture of COVID-19 inequities and the most vulnerable communities, and to make data-driven policies.

The RCPHD provided funding to local CBOs to form the Eastern Coachella Valley Collaborative, in partnership with Desert Healthcare District and Foundation. The collaborative includes several local CBOs assisting with community outreach, messaging, education, wraparound services, pre-registration, translation, and triage. With the majority of the agricultural workers being Latinx and Roman Catholic, a critical component of this work has been the partnership with the Catholic Dioceses. They assist with mass messaging and education, and host mobile vaccine teams in the local parish.

Collaborative outreach workers, who are trusted messengers and promotoras, visit the fields with WiFi hotspots and iPads to pre-register workers for vaccination. These efforts allow for

further discussion, education, and myth debunking to increase vaccine uptake. The vaccine mobile teams then visit the farm and administer vaccines during work hours, in order to ensure accessibility. The collaborative and LHD work with the organization Growing Coachella Valley to obtain lists of all farms in the region to ensure they reach all agricultural workers who want to receive the vaccine. Given the wide variety of farm sizes and infrastructure, some farms are better equipped to accommodate these operations, and the larger farms typically host the smaller farms.

As Riverside County continues to expand their mobile vaccine teams in Western County, the LHD is mindful of local and state dynamics with immigration and law-enforcement agencies. For instance, a location that might be centrally located and an excellent choice for a vaccination hub might also be a town with heavy ICE enforcement. The LHD aims for vaccine sites to be in locations considered safe by workers, and staffed with trusted messengers.

Riverside County emphasizes the importance of mobile testing sites and mobile vaccination efforts targeted to agricultural workers at their worksites, with trusted messengers.

Case story on worker-focused programs: LA County's Public Health Councils

In July 2020, six months after the start of the pandemic, the Los Angeles County Department of Public Health (LACDPH) was facing a new surge in COVID-19 cases. The positivity rate jumped from 5.8% to 9%, with an average of 2,000 new cases each day. LA County continued to have substantial workplace outbreaks in a variety of sectors. One hundred fifty workers at nine meatpacking facilities, 22 grocery-store workers, 100 grocery distribution-center workers, and 300 garment factory workers (four of whom died) tested positive.

Although LACDPH implemented HOOs and public health protocols for reopening, the county had limited resources to investigate COVID-19 safety violations in the workplace. There are more than 240,000 businesses across the county, the vast majority of which are small businesses. One inspection of 2,000 bars and restaurants in June 2020 by LACDPH found that about half were not following physical-distancing or face-mask requirements, although a follow-up inspection in July 2020 found a large improvement in compliance. In addition, Cal/OSHA has a limited number of inspectors to carry out enforcement, with only one inspector for every 102,000 workers in the state. Compare this to Washington State, which has one inspector per 25,000 workers.

How could LACDPH solve their issue of rising workplace infections with limited capacity? One potential solution may lie in galvanizing workers themselves and increasing workers' rights. The Public Health Council program was proposed in July 2020 and established in November 2020 by the LA County Board of Supervisors. This novel pilot program trains workers on workplace protocols and how to monitor and report workplace health violations. It also strengthens anti-retaliation protections and workers' connections with LACDPH.

The Public Health Council program began with four industries hardest hit by the pandemic: food manufacturing, apparel manufacturing, warehousing/storage, and restaurants. The program establishes certified worker organizations (CWOs). Eligible organizations must have at least three years of experience providing outreach and technical assistance to low-paid workers. LACDPH and partners train and certify these organizations to educate their members on health orders and public health protocols. CWOs can then provide training, guidance, and technical assistance to workers in Public Health Councils, and liaise with LACDPH. LACDPH contracts CWOs through a fiscal sponsor.

The Public Health Councils are made up of workers at a worksite who voluntarily choose to form a council. With guidance from CWOs, they promote peer-to-peer education and training on health orders and protocols with others at their worksite. Public Health Councils will hold regular meetings, which occur on workers' own time and off site, unless they have permission from the employer. They will also develop recommendations for improved compliance with health orders and protocols that they can discuss with their employer. If workers fear retaliation from their employer, they may also choose to report health order violations directly to LACDPH rather than speak with their employer about them.

Employers are encouraged to collaborate with their Public Health Council on the implementation of these orders and guidelines. In conjunction with the implementation of Public Health Councils, the LA County Board of Supervisors adopted an anti-retaliation ordinance in November 2020 to prevent retaliation against workers who report public health violations or participate in Public Health Councils. It establishes steep fines of up to $10,000 per violation for employers who retaliate against workers who speak up about health orders. There is additional funding for a unit to investigate retaliation claims, including staff for the online and call-in reporting system.

The Public Health Councils program and its implementation plan were established after a concerted effort to solicit feedback from both businesses and labor organizations. The

department held eight listening sessions attended by 60 members of the business community and two listening sessions with 17 worker organizations.

LACDPH contracted with a training organization to provide trainings for CWOs on COVID-19 disease transmission, the content of County HOOs, how to file a report of HOO violations, and how to file a complaint of retaliation. Public Health Councils will be established and work to improve implementation of health orders and protocols through 2021, or as long as Health Officer Orders are in place.

This innovative model strengthens worker protections and relationships between workers, LHDs, and community organizations, and builds an ecosystem of organizations collaborating for worker health protections. It could serve as a model for protecting worker health and safety during vaccination and economic recovery. For example, in LA County, CWOs will educate workers about why getting vaccinated is important for protecting themselves and their coworkers.

Barriers to protecting worker health during COVID-19: Lessons from local health departments

Many lessons emerged from the work of LHDs in the past year to quickly strategize, plan, and release urgent guidances and actions to protect workers. These lessons are valuable to reflect upon for continued worker protections, vaccination rollout implementation, recovery efforts, and post-COVID-19 public health practice. Importantly, the LHDs described six major barriers that stand in the way of current and future plans to protect worker health during the pandemic:

1. Local health departments have faced years of disinvestment

Decades of government austerity — specifically, loss of public health and Cal/OSHA infrastructure — has made it difficult for government agencies to protect worker health and safety. In the past decade, according to a KHN and Associated Press analysis, funding for public health departments in the US has dropped by 16% per capita on the state level and 18% on the local level. In addition, more than 38,000 state and local public health department jobs have been cut nationally since the 2008 recession.

As a result, government agencies tasked with workplace and worker protection — such as Cal/OSHA, CDPH, regional federal OSHA offices that enforce protections for federally employed workers, and LHDs — have been overwhelmed by the COVID-19 response, with limited staffing, budgets, capacity, and training. While many LHDs have environmental health programs, most LHDs do not have occupational health staff, training, budgets, or programs.

Health officers have the authority to enforce HOOs within their county, but many counties don't have the capacity to enforce the orders and protect workers. Cal/OSHA has additional enforcement authority throughout the state under the COVID-19 Emergency Temporary Standard and AB 685, yet they have also been unable to address all workplace violations across the state.

A reinvestment in the state and local public health infrastructure will strengthen capacities to protect the most vulnerable workers — many of whose unions, labor rights and protections, and immigration protections have also been eroded in the same time period. Cal/OSHA, CDPH, and California LHDs were not adequately equipped, staffed, or funded to face the scale of the COVID-19 emergency.

Separate from government austerity and disinvestment from public health infrastructure, occupational health is not a strong area of public health training, practice, funding, staffing, advocacy, or attention. Most LHDs do not have any infrastructure to address worker health and safety, even though the field has long known it is a critical social determinant of health.

LHDs that we spoke to named shortages in resources, funding, and staffing. For instance, shortages in rapid testing and labs caused major delays in test results for workers, which impacted contact tracing. Staffing shortages meant that counties were left with no epidemiologists to review death-certificate data. PPE shortages, felt across the country, were so acute that one county reported that PPE intended for healthcare workers was stolen from doctors' offices and storage facilities.

2. Polarized political environment

In some counties, LHDs found themselves at odds with local elected officials. These officials openly rejected public health quarantine orders, encouraged businesses to push back against shutting down, or refused to enforce the health orders. Local health officials faced growing backlash and protests against public health orders, school and business closures, and other measures to control the spread of the virus — with direct consequences for worker safety.

Local public health jurisdictions lacked consistent leadership as a wave of health-officer resignations, firings, threats, pressure, and loss of authority spread across the state. Sometimes, when workers or worker organizations reached out to governmental agencies for assistance or partnership, they were met with a delayed response or no response from overwhelmed or politically pressured local health officials. LHDs often looked to the state for the leadership and action needed to support, protect, and assist them with accomplishing necessary public health measures.

3. Pushback from employers and businesses

Many LHDs reported significant pushback against public health measures from employers and businesses. For instance, counties faced pushback from agricultural companies, small businesses, and homeowners who hire contract landscapers and gardeners.

In one county, a business refused to provide contact information for employees potentially exposed to a positive COVID-19 case until Cal/OSHA stepped in. In another, some businesses refused to follow HOOs. This county utilized their HOO enforcement authority to put out restraining orders and shut down these businesses, prioritizing those with outbreaks due to

constrained resources. At times, businesses refuted enforcement, refusing to shut down — these cases went to hearing. However, the LHD reported that some businesses only paid small portions of total fines, resulting in fewer businesses following HOOs and protocols over time.

Even counties that were able to work successfully with employers still faced difficulties along the way. One county found that even though they were able to work closely with many of the large employers in their county, they were less successful when trying to connect with agricultural contracting companies, who hire migrant workers on a contract basis and bring them to various worksites. LHD staff found them to be extremely secretive, and some of the contracting companies refused to work with the county. In one instance, the health department gave the contractors PPE to distribute to farmworkers free of charge, and the contracting company sold the PPE to the workers and kept the profits.

Another issue faced in one county involved health insurance companies. Local schools wanted to regularly provide rapid COVID-19 tests to their staff for COVID-19, but their health insurance company threatened to increase their premiums if they did so. As a result, costs for testing had to come out of the school's budget, rather than being billed to their insurance.

4. Community mistrust of government due to immigration policy, deportations, and racial profiling

Undocumented workers experience reasonable fear of accessing government services such as testing, contact tracing, quarantine housing, and the California relief fund for undocumented people. This is due to the increasingly anti-immigrant, xenophobic, anti-labor, and racist rhetoric experienced and vocalized in many California communities by both elected officials and residents. In addition, policies, policing, and enforcement by the federal government — sometimes in cooperation with local government — are also causes of fear and loss of trust.

LHDs discussed how worker mistrust in government negatively impacted uptake in health programs. LHDs represent the government and, for many undocumented immigrant workers, this entails a connection to ICE, family separation, and loss of a job or wages. This impacted the utilization of programs such as contact tracing and free housing services for those who need to quarantine, and it contributed to the LHD's inability to contain the virus transmission.

The state Housing for the Harvest program was created to offer hotel rooms to agricultural workers who tested positive for COVID-19, so they could safely isolate and quarantine — but the program has been highly underutilized. The partnership between LHDs and local community-organizing groups allowed health departments to understand that the

underutilization stems from workers' distrust of the government, as well as fear of ostracization by co-workers, deportation, employer retaliation, and family separation. This nuanced understanding has helped LHDs reflect that they need to be more creative in funding their community partners to deliver goods, materials, and services to where families are, rather than putting people in isolation and quarantine.

5. Pre-existing inequities across multiple social determinants of health

In addition to diminished protections for worker health and safety, erosion and widened inequities across other interrelated social determinants of health affected COVID-19 inequities among workers. Inequities in housing, economic security, health care, immigration policy, and social inclusion and belonging were shown to be significant barriers to LHDs' ability to protect workers. Emergencies show us the interrelated nature of systems and living conditions, and that we cannot address one system at a time. Our public health practice in social determinants and Health in All Policies must necessarily be as multi-systemic and complex as the material conditions we seek to improve.

6. Lack of data and data transparency

Although data collection and analysis are fundamental LHD duties, some LHDs experienced barriers in reporting data to CDPH due to outdated systems. Others simply did not have enough staff to dedicate to data collection and review. At the time AB 685 was passed, the state's infectious disease surveillance system required under AB 685 did not systematically collect work-related variables such as occupation, industry, or employer, and while there were some variables such as "healthcare worker" and "setting," the information from LHDs has often been incomplete. Changes to the system were subsequently made to accommodate the fields employers must report to LHDs for outbreaks — this enables CDPH to post on its open data portal and periodically update the statewide number of reported COVID-19 outbreaks and associated number of cases by industry, as required by AB 685.

State-level recommendations for COVID-19 and beyond

Many LHDs across the state took bold and urgent moves to protect worker health during the pandemic — yet there are still more actions they wish they could accomplish to protect workers in COVID-19, vaccination, and recovery. Many state-level actions would change conditions at the local level, including more testing, faster test results, translated health information in more languages, and the collection and publication of more detailed data. Outside of the health sphere, economic-security programs, immigration protections, affordable and secure housing, health care, access to broadband internet, climate change impacts (e.g., extreme heat and wildfire smoke), government austerity, and political polarization have also contributed to COVID-19 inequities among workers.

LHD leaders interviewed for this report wanted the state to enable more upstream interventions to protect workers, naming affordable housing, paid leave, unemployment insurance, living wages, and increased funding for local health departments. They also wanted the state to play a strong role in equitable vaccine prioritization and prioritize essential workers in low-wage jobs.

A specific area in which government relationships can grow is between regional Cal/OSHA offices and LHDs, whereby they can spend time further understanding their respective roles, what public health prevention for worker health and safety could look like, and how to leverage each other's authorities and relationships to best protect workers.

During this time, leaders at LHDs showed courage and strategic risk-taking — moving beyond public health's tendency for risk aversion. Some public health leaders used their previous racial and health equity practice as the foundation for innovative and aggressive actions to protect workers during the pandemic. We also witnessed many public health leaders who were not supported by the leadership or decision makers above them. They reflected a need to be supported and authorized to do the work of protecting people from harm, whether the public health actions are politically popular or not.

Recommendations for California

Based on our research, we propose state-level approaches to address the harms that workers in low-wage essential jobs in California are experiencing. Lawmakers, government agencies, and employers need to work in partnership with community organizers, worker centers, academic labor centers, unions, and advocacy organizations to promote policies and programs that advance worker protections. In this way, millions of workers in California can work safely through this and future pandemics, and also thrive from overall improved worker health and safety, economic and housing security, and other recovery efforts.

There are a number of ways in which stronger state-level actions can help LHDs better protect workers. Cal/OSHA and CDPH can help support and enable LHDs to support workers in their communities. Other state agencies with authority over economic security, housing, and immigration protections can help to address related social determinants of worker health. In this sense, if the state acts more boldly, LHDs can do so, too. We recommend the following:

To support LHDs in general:

- Create a comprehensive online clearinghouse for the range of worker health resources and LHD guidance examples from across the state, as well as templates for local ordinances and health orders so they can be adopted across the state
- Create user-friendly guides and resources for LHDs, workers, and employers on the guidance and workers' rights — these guides would break down complicated public health recommendations and orders into reader-friendly summary documents
- Create guidance and training for how to work with the range of entities in the agricultural community (growers, processors, contractors, agricultural commissioners, farmworkers, etc.)
- Increase the ability of Cal/OSHA and its regional offices to conduct enforcement and reinforce LHD efforts
- LHDs expressed that increased and sustained funding to use flexibly, especially during emergencies, and to respond to local conditions would be particularly valuable
- Local-assistance grants to LHDs to support development of worker health programs and establish relationships with local partners would also be valuable

To address polarized political environments and pushback from employers and businesses:

- Provide strong worker protection messaging, resources, and supports to public health leadership from the state level. Because LHDs are under political pressure from local electeds and constituents, clear messages from the state can help protect LHDs from

local political vitriol and political pushback from anti-mask, anti-vaccination, or reopening activism. CDPH could increase direct communications and assistance to county elected officials to discuss guidance, authorities, and local barriers to policies to protect worker health.

- Dedicate resources for communications and messaging to support public health leaders through the political pushback experienced during COVID-19, such as these communication resources from Public Health Communications Collaborative. These resources include economic security, COVID-19 testing, and trust building, and the Berkeley Media Studies Group COVID-19 vaccine communications guidance.

To address pre-existing inequities across multiple social determinants of health:

- Convene California Health in All Policies partner agencies to adopt coordinated action plans to strengthen worker protections and related housing and economic-security protections, and to expand inclusion of people who are undocumented in state worker, economic security, and safety-net programs
- Consider extending current policies and enacting stronger policies outlined in the CDPH COVID-19 Health Equity Playbook, including:
    - Economic-security policies, such as paid sick leave, unemployment insurance, inclusion of domestic workers in worker health and safety and economic-security protections, and additional income replacement to undocumented workers — to protect all people, regardless of work or immigration status, or employer-provided protections
- Coordinate actions, enforcement of workplace safety orders, and share data at the regional level through regional governments and organizations (e.g., metropolitan planning organizations, associations of local governments, public health associations), to address the way that COVID-19 can spread at a regional level due to the regional nature of some types of work (e.g., during agricultural growing or picking seasons)
- Assist essential workers in low-wage jobs getting the COVID-19 vaccine:
    - Prioritize all workers in essential and low-wage jobs in vaccine delivery
    - In partnership with local organizations trusted by essential worker populations (e.g., worker-organizing groups, community-organizing groups, faith institutions), encourage and incentivize LHDs and healthcare providers to bring mobile vaccination programs to worksites that employ essential workers (e.g., meatpacking facilities, manufacturing plants, agricultural worksites)

Suggested Citation

California Local Health Department Actions for Worker Health and Safety During COVID-19. Human Impact Partners, March 2021.

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About Human Impact Partners

Human Impact Partners (HIP) transforms the field of public health to center equity and builds collective power with social justice movements.