

## CSTE Occupational Health Surveillance Subcommittee Meeting

Wednesday, December 10, 2014

Cincinnati, OH

### CSTE Update

- CSTE Annual Conference (AC) June 14-18 in Boston, MA
  - Due to cut in sessions, evaluate AC session allocation adjustment at the completion of the 2015 conference
- OH Consultation – Oct 8 Justine Weinberg (CA) to Conference for the Model Aquatic Health Code (CMAHC) Organizational Committee Meeting in Portland, OR
- OH Webinars – top five topics selected through member input; working with Sheila Higgins (NC) to help coordinate the webinars
  - Feb 27 - *“Assessing and Responding to the Health and Safety Needs of Workers in the Temporary Services Industry” with Linda Forst (IL)*
  - April 23 - *“American Community Survey 101: Overview and Application in Occupational Health Surveillance” with Kim Brown (US Census) and MyDzung Chu (MA)*
- Received agency responses from both 2014 CSTE Position Statements
  - 14-OH-01 Follow-up meeting with BLS Commissioner on CFI data access occurred April 28 at BLS HQ in DC; included NIOSH, OSHA, and other BLS representatives; states present were Ken Rosenman (MI), Tish Davis (MA), Bob Harrison-remotely (CA), Mack Sewell (formerly WY).
  - 14-OH-01 Follow-up meeting with CDC/CSELS and NIOSH on I/O inclusion in CDC surveillance systems has not yet been planned. Discussions still ongoing.
- Continued 2-3 monthly state submissions for NIOSH eNews publications
- Continued monthly SCG updates
- OHIP 2015 site selection announcement: National Guestworker Alliance and the Louisiana Office of Public Health on “Assessing Occupational Conditions faced by Immigrant Ironworkers in Southeast Louisiana” in New Orleans, LA
- 2011 OHI data posted on CSTE website
- New and proposed workgroups: Occupationally Acquired Infectious Diseases; Temporary Workers; and Oil and Gas
- 2013 Epidemiology Capacity Assessment (ECA) is posted on the CSTE website
- Soliciting more 1-page OH Success Stories submissions from states; template and how-to guide recently updated on posted online
- New CSTE Cross Cutting I Marijuana Workgroup
- The OH group would like to have representation on the CSTE RCKMS project development
  - *Accomplished in January - Several members of the CSTE OH Subcommittee with experience in blood lead surveillance participated as subject matter experts for the RCKMS (Reportable Conditions Knowledge Management System) project on their development of a lead reporting module.*

### New OH Indicators Discussion

- Summary: Two new OHIs passed; one will be revisited at the June CSTE AC Meeting
- Work-Related Severe Traumatic Injury Hospitalizations indicator – Approved for Addition
  - Will be included in the updated “How To” manual for calculation in 2015 of the 2012 OHI data
- Influenza Vaccination Coverage among Hospital Personnel indicator – Approved for Addition

- Amendments – change title to “hospital personnel” instead of “health care personnel” & change type to Intervention indicator instead of a Hazard indicator
- Bob will be confirming possible definition change (denominator would now include contractors)
- Vote: 16 for; 6 against; 1 abstention (flu indicator passed)
- Will not be included in the “How To” manual until the 2014 OHI data is calculated, which is currently anticipated in spring 2017
- Occupational Heat-related Emergency Department Visits – Approved to Further Pilot
  - Excludes man-made, different from EPHT indicator, ICD-10 concern; revisit in June
- The OHI Workgroup will continue to work with NIOSH regarding issues arising with the change to ICD-10-CM medical data coding, including the loss of external cause of injury codes (e-codes).

#### ECA Results

- One comment was that splitting injury epi, occupational epi, and env epi (CSTE “EOI” Steering Committee structure) really waters down the meaning of these data since capacity is generally shared between these areas in practice.

#### Ideas for CSTE AC Pre-Conference Workshop

- Summary of topic suggestions and interest level
  - Yes- Intro to OH in Massachusetts – brief OH history and look at issues today
  - 20- Building bridges with community partners to translate data to action - MA COSH, worker center reps, National Protecting Work Alliance
  - 20- Exploring other funding sources for states
  - 18- Total Worker Health – integrated approaches to worksite wellness/ and more
  - 13- Use of syndromic surveillance
  - 9- OH and Ebola – lessons learned for future
  - 8- Infectious disease surveillance
  - 8- Small area analysis /generating local occupational health data
  - 7- MA Young Worker Health and Safety project
  - 7- Use of I/O in BRFSS – examples and/or hands-on session on grouping/analyzing I/O data
  - 6- Home health workers: OH hazards and innovative interventions
  - 4- Use of social media, developing infographics
- Topics that were not selected should be added as a Roundtable or Webinar topic option

#### NIOSH Clearinghouse

- Partners/organizations for outreach:
  - ERCs/AG centers
  - Susan B. Harwood grantees
  - COSH groups (Protecting workers groups)
  - APHA OH Section
  - AOEC (Association of Occupational and Environmental Clinics)
  - Local health departments
  - State plan OSHA states
  - CDC-funded injury prevention centers
  - CDC prevention resource centers
  - R01 NIOSH grantees

- NIOSH sector councils (coordinators)
- NIOSH eNews article
- Internal distribution at NIOSH
- Hospital associations
- Occ health nurses association
- Safe States Alliance
- Emergency preparedness groups
- National Safety Council
- State labor councils
- Journalism community/bloggers/BNA (sometimes eNews are picked up by journalists, so this can be a mechanism)
- CPWR (Center for Protection of Workers' Rights)
- ASSE (American Society of Safety Engineers)
- AIHA (American Industrial Hygiene Association)
- OSHA consultations
- NIEHS hazardous waste worker training group
- Nurses association meeting is upcoming in Boston – Tish or other designee can participate
- Protecting Worker Alliance (National COSH) meeting – Is anyone attending?
- *Action:* CSTE will create a table or schematic of the partners for outreach and send to the subcommittee for sign up (meaning that they will personally reach out to designated partners). After distribution, please record it here: [https://www.research.net/s/CSTE\\_OH](https://www.research.net/s/CSTE_OH)

#### Leadership Group Members Update

- Members of the CSTE OH Subcommittee Leadership Group (LG) have recently reached the end of their three-year term. An email was sent out to invite current members to express interest in joining the LG.
- David Bonauto (WA), Karla Armenti (NH), and Kathy Leinenkugel (IA) are stepping down.
- Meredith Towle (formerly CO, now WY), Terry Bunn (KY), and Margaret Lumia (NJ) are joining the LG.
- Other members include: Tish Davis (MA) and Ken Rosenman (MI) as co-chairs, Barbara Materna (CA), Bob Harrison (CA), Marija Borjan (NJ) as ex-officio OHI co-chair, Rabeeha Ghaffar (WY) as ex-officio SCG co-liaison, Terri Schnorr as NIOSH ex-officio representative, and Sharon Watkins (FL) as CSTE Steering Committee Chair for EH, OH, and Injury (EOI).

#### CSTE Position Statement Process

- Position statements are due 13 weeks prior to meeting and posted for CSTE members to review 6 weeks prior to the business meeting on June 18
  - Once a position statement is submitted and revised, other CSTE members and Subcommittees have the opportunity to comment
- At least one active member from **ten** or more states or US territories must be present at the CSTE EOI Position Statement discussion
- Only Active members can vote at the position statement discussion meeting at CSTE AC
- A quorum has to be met in order for a position statement to be posted on the CSTE consent calendar
- *Action:* If anyone is considering submitting a CSTE Position Statement, please ensure timely and continued communication to Sharon. We (OH Subcommittee) currently have one anticipated Position Statement for 2015 regarding lead exposure in children.

- If there are position statements in other program areas that you feel that occupational health is not represented in, please let Sharon know and we can have subcommittee-wide discussions on revisions, comments, and recommendations.

## 2014 OH Position Statements Discussion

- 14-OH-02 Inclusion of Work Information Elements in CDC Surveillance Systems

Statement of the desired actions to be taken:

- As part of the current CDC strategic surveillance initiative, CSTE recommends that occupation and industry, and other work information as appropriate, be included as data elements within CDC surveillance systems where feasible.
  - To advance this recommendation, CSTE requests that the CDC Office of Public Health Scientific Services (OPHSS) collaborate with the National Institute for Occupational Safety and Health (NIOSH) to assess work information in existing CDC surveillance systems. CSTE recommends that during scheduled assessments of CDC surveillance systems, an examination be made of the data collection within each system related to work (e.g., employment status, usual and/or current occupation and/or industry, work-relatedness). OPHSS should collaborate with CSTE and NIOSH to determine the potential work information data elements to be evaluated.
  - Based on each assessment, CDC, with input from CSTE, should identify which work information data elements should be included in that data system and develop a timeframe for implementation.
- CSTE recommends that CDC OPHSS consult with NIOSH on the structuring of I/O data captured in surveillance systems and to adopt the use of a standardized system to code occupation and industry information within CDC surveillance systems.

CSTE supports the NIOSH recommendation for use of the CDC\_Census system. The CDC\_Census system augments the Census Industry and Occupation Classification Systems with NIOSH codes for unpaid workers and some military positions. NIOSH has recommended this system for electronic health records and public health surveillance.

- CSTE recommends that CDC OPHSS collaborate with NIOSH to further improve automated coding of I/O variables, given that manual coding is not a realistic expectation for surveillance systems.

NIOSH has developed the NIOSH Industry and Occupation Computerized Coding System (NIOCCS), which can accomplish automated coding of some I/O records. NIOSH has also begun to explore approaches for real-time coding of patient I/O to streamline this effort.

- Response from Directors of OPHSS and NIOSH: (Full letter emailed out in advance) – “We would like to suggest that CSTE, NIOSH, and OPHSS convene a meeting in which interested state epidemiologists, CSTE staff, and CDC program staff review the helpful actions outlined in the position statement, as well as other relevant ideas, and develop an action plan for consideration by CSTE, NIOSH, and OPHSS leadership.”
- Discussion
  - Should we prioritize: BRFSS, PRAMS, NEDSS, NVDRS, Cancer Registries
  - Peggy Filios put together a list of ID programs that we can use to select conditions and give NIOSH a recommendation
  - Recommendation:
    - First, provide general recommendations to NIOSH of the types of conditions that we are interested in;
    - Then, we can do a more collaborative and full recommendation - Create a matrix of all conditions by topic across CDC centers and then prioritize a list from each center and submit to NIOSH

- *Action:* The leadership group will look at Peggy’s list and determine what ID conditions we are interested in NIOSH focusing on and if others have ideas, forward to Sharon and Amy
- Next Steps: CSTE will be meeting with OPHSS and NIOSH shortly (in-person)

- 14-OH-01 Access to CFOT Case-Level Data for Public Health Purposes

Statement of the desired actions to be taken:

- United States Departments of Labor and Health and Human Services should convene a series of meetings to resolve and document data access issues for state-based epidemiologists and occupational health staff

The U.S. Departments of Labor and Health and Human Services should convene a series of meetings with appropriate stakeholders (state health and labor departments) to resolve and document the confidentiality issue that BLS cites as restricting it from sharing data on individual deaths with state agencies.

- United States Departments of Labor should establish provisions for state BLS agents to share CFOT data with public health authorities in a manner for timely public health case follow-up

Data collected under the CFOT system, including confidential data, should be available to public health authorities for case based follow-up. A major goal of these meetings should be state’s rights to access BLS source documents.

- Response from BLS Commissioner: (Full letter emailed out in advance) – “The Department of Labor would be pleased to participate in meetings with Health and Human Services and the Council of State and Territorial Epidemiologists (CSTE) to explore these issues further.”
- Results of assessment of state health departments regarding CFOT data access (as of Jan 2015)
  - Completed by 23 states; 14 (61%) had tried to access case-level CFOT data
  - Six of 13 were successful for some cases, seven of 13 for no cases and no response from two (see *Table 1* for response to which CFOT cases states health departments have had access).
  - Ten states responded they conducted surveillance of fatal injuries as part of a FACE program, six conducted surveillance of fatal injuries on their own, and seven did not conduct surveillance of fatal injuries. Seven states responded they referred cases to CFOT. Three states said CFOT referred cases to the state health department.
  - Twenty-one of 23 (91%) said if they had access to case data they would use the information, one said no, and one did not respond. The data would be used to: publish summary data report (17); publish individual case studies (9); conduct investigation (8); refer to another agency for investigation (9), and other (10) (see *Table 2* on description of other responses of how state health departments said they would use case specific CFOT data).
  - Table 1

Please describe which CFOT cases you have had access to
● Comparisons of lists from FACE and CFOT
● Provided a year of misc. fatalities but did not describe which were included in official in-scope/CFOT tally.
● Oil and gas injury fatalities and exposure.
● We oversee and implement the CFOT program in X State. All case-level source data are maintained by our program. To my understanding, only the case data as it resides in the BLS-maintained CFOT database is deemed “unavailable” for other public health use/analysis.

<ul style="list-style-type: none"> <li>We actually do the CFOI program in our state so our access to the data is not a real issue. The issue for us is what can we as a program release to the public. Since we also do FACE we have more options than other state programs.</li> </ul>
<ul style="list-style-type: none"> <li>Cases from newspaper reports</li> </ul>
<ul style="list-style-type: none"> <li>FACE cases</li> </ul>
<ul style="list-style-type: none"> <li>We have not received a response yet--we have a formal request for data pending with BLS.</li> </ul>
<ul style="list-style-type: none"> <li>We are able to get a subset of cases from one county.</li> </ul>
<ul style="list-style-type: none"> <li>The information comes from our Division of Vital Records Administration - they share some data with us from the death data, not specifically CFOI</li> </ul>

o Table 2

Other Activity
<ul style="list-style-type: none"> <li>Analyze county and region-level fatality data to better target prevention efforts in certain areas.</li> </ul>
<ul style="list-style-type: none"> <li>Training purposes</li> </ul>
<ul style="list-style-type: none"> <li>Use in cooperation with Violence and Injury Prevention Program</li> </ul>
<ul style="list-style-type: none"> <li>Would reduce workload for our program. Could spend less time redoing work CFOI has already done.</li> </ul>
<ul style="list-style-type: none"> <li>Use as a cross check of our FACE surveillance for completeness or discrepancies, more accurate/consistent surveillance reporting; not all investigations would be in-depth, but would attempt to gather minimal set of data element information for surveillance use; use to drill down into causation factors common or different for use in determining potential interventions within categories, industries, age groups, occupations, etc.</li> </ul>
<ul style="list-style-type: none"> <li>Planned future enhanced surveillance for a priority industry group.</li> </ul>
<ul style="list-style-type: none"> <li>We use case level data to target fatality investigations.</li> </ul>
<ul style="list-style-type: none"> <li>Link to NVDRS, publish map of locations of deaths.</li> </ul>
<ul style="list-style-type: none"> <li>Compare to other data sources to validate completeness.</li> </ul>
<ul style="list-style-type: none"> <li>Educational activity.</li> </ul>

• Discussion

- o WI, IA, and NYC elaborated upon their experiences accessing CFOI data
- o Meet with BLS with the thought process that these data are generated in the states and kept away from the states from accessing. This is a fundamental conceptual issue. If this were an HIV case or TB case, this would never happen. Let's not assume that just negotiating access to non-confidential data should be our primary goal.
- o Recommended issues for OH leadership to share with BLS in in-person meeting: How to provide data; respond to data requests; training on online training databases.
  - Michael Hodgson (OSHA) would like to participate in this discussion between CSTE and BLS
  - Dave Schmidt (OSHA) wants to better understand where the BLS CFOI program is and asks if this is the best place for this assessment; ideally FACE programs are the model that we want to promote, so:
    - Can we develop labor funds for capacity building of FACE?
- Next steps: There will be a meeting in Spring with BLS; there should be an ad hoc meeting to lay out pros/cons of different models and come up with an agenda for this in-person meeting
- Aim: Have written documentation from BLS that states can share with their CFOI counterparts as a result of our in-person meeting discussion with CSTE

- *Update: On Tuesday, April 28, 2015, Letitia Davis (MA), Ken Rosenman (MI), and Mack Sewell (formerly WY) met with the BLS commissioner, Erica Goshen, to follow up on CSTE position statement 14-OH-01. Bob Harrison (CA) was present on speaker phone. Also present at the meeting was Dawn Castillo from NIOSH, Dave Schmidt from OSHA, Bill Wiatrowski from BLS, Hilery Simpson from BLS and Kate Newman from BLS. Subsequent to our 1-hour meeting with the commissioner; Davis, Rosenman, Sewell, Castillo, Schmidt, Simpson, and Newman met for 1.5 hours.*
- *The major point made to the Commissioner was that we were interested in improving the Census for Fatal Occupational Injuries (CFOI).*
- *The Commissioner was receptive but reminded us of BLS's constraints. Discussion included a mechanism for ongoing dialog and a report back to the Commission on progress. Specific points for future discussion included: (1) evaluation project(s) of CFOI; (2) changes in the new CFOI technical memorandum no. S-15-04, dated 3/16/15; (3) ways to identify individual causes of death/case services both within and across states; (4) pilot project(s) to see if CFOI data could be collected in a way that made the data more available; (5) document to states of what was available from CFOI and how to obtain it; and (6) plans for Hilery Simpson to present at the next CSTE business meeting.*
- *The discussion also led to an understanding that narrative data on deaths was available from OSHA.*

#### OHIP Presentation

- “Safety and Health Capacity Building for Day Laborers and their Employers”
- Host site: Centro Humanitario Para Los Trabajadores
- Mentors: Meredith Towle – Colorado Department of Public Health and Environment; Sarah Shikes and Marco Nuñez – Centro Humanitario
- OHIP Students: Melissa Bowman – BA(c), Saint Mary’s College of Maryland; and Jeff Vredenburg – MA(c), University of Iowa
- Background – “Day laborers are some of the most vulnerable workers in the job market, as they often are unskilled workers, have limited English skills and are sometimes homeless. They also are frequently undocumented. Many employers take of advantage of these vulnerabilities and use day-laborers for the most difficult and dangerous tasks. Wage theft and unreported injuries are very common in this work sector.”
- Project goals
  - Identify areas for improvement
  - Orient workers towards workplace H&S
  - Educate employers
- Health and safety orientations (Eight 45-minute sessions)
  - 110 workers trained
  - Interactive and visual training
  - Worker feedback
  - 118 water bottles distributed
  - 2-sided color pamphlet
    - PPE
    - Safety Checklist
    - Heat Sicknesses
    - Emergency Procedure
    - Language Phrases
- *PPT slides available upon request from CSTE*

## OHS Integration in Public Health Infectious Disease Programs

- NIOSH – LCDR Marie de Perio, MD: “Occupational Health Surveillance Integration in Public Health Infectious Disease Programs: Campylobacter, A Case Study”
  - Transmission via poultry
  - Poultry processing plant, Virginia – employed 1,000 individuals over three 8-hr shifts; processed 300,000-350,000 birds/day; employed 24-35 diversion center residents at any time
  - HHE request
    - Previous investigation and recommendations by VA Dept of Health (VDH) in 2008
    - VDH referred plant to HHE program after more cases identified
    - Plant management submitted HHE request in Feb 2011 regarding Campylobacter infection
    - Specific concern about employees in live hang area
  - HHE methods
    - Visited plant May 2011
    - Reviewed encounter records from plant medical office
    - Observed work practices
    - Reviewed lab-diagnosed Campylobacter cases among plant employees
    - Observed plant’s ventilation system
    - Interviewed current plant employees
    - Reviewed carcass sampling program for Campylobacter
  - Review of lab diagnosed cases
    - 29 cases from Jan 2008 – May 2011; 1 hospitalization; no deaths
    - Work location of cases: live hang (n = 18); evisceration (n=8); other (n=3)
  - Recommendations
    - Engineering controls; Administrative controls; PPE
  - Followback visit in Nov 2013 showed decrease in cases
    - 21 in 2011; 6 in 2012; 6 in 2013 (to Nov 13)
    - Plant had implemented many recommendations
    - Adjusted air vents in live hang
    - Hands-free handwashing stations
    - No water coolers in live hang
    - PPE at no cost
    - Chickens misted before being dumped on conveyor
    - Diversion center residents no longer assigned to live hang
- OSHA – Michael Hodgson, MD MPH: “Occupational Infectious Disease: Diarrhea and Poultry”
  - Ohio turkey plant case
    - Job: flipping turkey carcasses as they passed by on overhead conveyor belts
    - PPE: smock, hairnet, latex gloves, and boots
    - Symptoms began Nov 16, 2013 but continued to work; went to MD office in Indiana on Nov 25; Ab CT scan negative; stool culture showed Campylobacter
  - OSHA Citation
    - Inadequate PPE assessment (employees not required to wear gloves and eye and face protection)
    - PPE Assessment had no written certification
    - Employees required to pay for PPE such as hairnets, rubber boots, latex gloves and cut resistant gloves

- Eye and face protection not being required to be worn when flipping the turkeys to prevent splashes of feces
    - Hand protection not being required to be worn when flipping the turkeys
  - Outcome
    - Proposed penalty reduced to \$10,000 and settlement removed mention of *Campylobacter* infection
  - Reasons for under-diagnosed and underreported illness:
    - Self-limited illness;
    - Stool culture not routine for most diarrhea;
    - Worker do not seek care or afraid to seek care
  - New workers generally mild cases that are not reported, but new workers are the typical campy case
  - Some immunity from further infections (1, 2)
  - Most promising strategy is separating colonized flocks (5, 7)
  - Engineering controls, hand-washing, provision of appropriate, no cost PPE, training, and hazard communication (10)
  - Maryland: rural / agricultural zipcodes 45% higher campylobacter rates
  - Next steps:
    - Explore geographic relationships (replicate Maryland study)
    - Examine occupational risk in other States in “chicken belt”
    - Encourage reporting / surveillance of gastrointestinal illnesses
    - Medical staff to recognize potential work-relatedness
    - State Health Depts contact OSHA Area Offices to explore occupational risk
- Colorado – Dara Burris: “Outbreak of Diarrheal Disease Associated with an Animal Research Laboratory”
  - Initial outbreak investigation timeline
    - On July 14, 2014, two 3-day old calves were delivered to Animal Research Laboratory A and housed in a low-oxygen chamber
    - On July 18, two additional calves arrived to serve as controls and were housed in a regular atmospheric environment
    - Control calves were sacrificed on July 21, and experimental calves were sacrificed on July 29 and 31
    - On July 30, CDPHE was notified of a possible *diarrheal disease* outbreak associated with Animal Research Laboratory A. They noted 3 workers with +cryptosporidium stool samples and 10 staff with severe gastrointestinal illness.
  - Methods
    - Epidemiological investigation: Case interviews; Cohort study
    - Environmental investigation: Environmental assessments
    - Laboratory testing: Human; Environmental
  - Results/Discussion
    - 20 cases of probable (15) or confirmed (5) *Cryptosporidium*
    - Significant morbidity and attack rate (74%)
    - Training inadequate
    - Increased exposure associated with decreased likelihood of getting disease
    - Tasks most associated with exposure to calf feces had highest attacks rates
    - Overall inconsistency and confusion around PPE and hand-washing
  - Conclusions and public health action
    - Recommendations for improvement sent to Animal Research Laboratory A on Sept 15, 2014

- Stakeholders meeting held Sept 16, 2014 to discuss recommendations. These include 5 specific areas of concerns:
    - Room design
    - Training
    - PPE
    - Administrative controls
    - Disease reporting
- Discussion: NE noted that CSTE had a campy case definition position statement that was passed this year; example of where cross-communication is needed because OH should've been involved in this discussion, echoing Sharon's point.

#### Ebola Response and Coordination

- NIOSH Updates – Renee Funk
  - 10 external folks deployed to EOC
  - NIOSH Ebola webpage
    - 5 new fact sheets
  - Fatigue is an issue, constant work, and expanding to 45 day deployments
    - She's been advocating for 1 day of rest per week and a buddy system; took a lot of work but is being implemented
    - Documents in clearance
      - General business guidance
      - Water and wastewater FAQ
      - Revised mortuary guidance
      - Guidance for employers- PPE purchasing, like gowns
        - Not a change, just more explanation
      - Q&A document
      - Law enforcement fact sheet
      - Fatigue management fact sheet with OSHA
  - PPE guidance will remain the same
    - Recently a clarification came out, but not a big change
  - PPE studies
    - Heat stress in Africa
      - Had started to update the guidance last winter (was really outdated)
      - They've moved up in the suits to wear that they're too much to wear for long
      - Tested WHO and MSF ensemble with the sweating mannequin and with human subjects in heat chambers
    - Glove integrity
      - Alcohol hand rubs before taking off PPE (doffing) thought could interfere with glove integrity but findings are that it does not; it softens but doesn't make it tear
  - PPE supply issues
    - Push packs for enough PPE for 5 days for HCWs
      - Trying to find out what's in it
- State Discussion
  - NH called to be an SME on a training; MA has been involved; ICS structure; CA OSHA had more going on; NJ not really been able to participate

## New OSHA Reporting Rule on Work-Related Hospitalizations, Amputations, and Enucliations: Do States Have Data to Help Evaluate Employer Reporting?

- OSHA – Dave Schmidt (*from PPT slides*)
  - “OSHA has **expanded** the list of severe injuries & illnesses that employers must report & **updated** the list of industries who are partially exempt from routinely keeping OSHA records.”
  - Effective date
    - For workplaces under Federal OSHA jurisdiction
      - Final rule becomes effective **January 1, 2015**
    - For workplaces in State Plan States
      - States encouraged to implement new provisions on **January 1, 2015, or as soon after as possible.**
      - Check with your State Plan for their implementation date of the new requirements.
  - Industry exemptions
    - New list based on NAICS and BLS data
    - Automobile dealerships are newly covered
    - Restaurants continue to be exempt
  - Expanded reporting requirements
    - “All covered employers must report
    - 1) All work related fatalities to OSHA within 8 hours:
    - 2) All work related in patient hospitalizations to OSHA within 24 hours (previous requirements were to report only 3 inpatient hospitalizations)
    - 3) All work related amputations to OSHA within 24 hours
    - 4) All related losses of any eye to OSHA within 24 hours [*Does not include blindness; more physical loss of eye*]

Please note:

- In-patient hospitalization is defined as a formal admission to the in-patient service of a hospital or clinic for care or treatment.
- Only fatalities occurring within 30 days of the work-related incident must be reported.
- Only in-patient hospitalizations, amputations, or losses of an eye occurring within 24 hours of the work-related incident must be reported.

Employers do not have to report an event if:

- It resulted from a motor vehicle accident on a public street or highway, except in a construction work zone (employers **must report** the event if it happened in a construction work zone).
- It occurred on a commercial or public transportation system (e.g. airplane, subway, bus, ferry, street car, light rail, train).
- It occurred more than 30 days after the work-related fatality or more than 24 hours after the work-related in-patient hospitalization, amputation, or loss of an eye.
- If the in-patient hospitalization was for diagnostic testing or observation only.

We will not respond to every report with an on-site inspection. We expect to address many of the reports through other types of investigations, but we will engage with employers whose workers have been hurt. We are developing the process to determine which incidents to inspect and which to handle using other types of investigations and interventions.”

- Employers can report to OSHA by
  - Phone to the nearest OSHA office during business hours; or to the 24-hour OSHA hotline (1-800-321-OSHA or 1-800-321-6742)
  - Online at [www.osha.gov/report\\_online](http://www.osha.gov/report_online)
- For more information and compliance assistance resources on the updates to OSHA's recordkeeping and reporting requirements, visit [www.osha.gov/recordkeeping2014](http://www.osha.gov/recordkeeping2014)
  - Website has: The final rule; Fact sheets (Overview, What has to be reported, Who has to keep records); How to find your NAICS code; The list of exempt industries; Frequently asked questions; Additional information
- What happened? → Intake form;
- Why did it happen, and how can future incidents be prevented? → RRI (includes engineering controls, work practice controls, administrative controls, PPE)
- Michigan – Ken Rosenman
  - Ken Rosenman presented data from Michigan on the number of work-related amputations in Michigan and results of OSHA amputation follow back inspections in Michigan.
  - He showed Michigan data that Occupational Health Indicator (OHI) #4 captured approximately 66% of all amputations and OHI #5 captured approximately 33% of all amputations. Eighty eight percent of the companies' violations identified during inspections were directly related to the hazard causing the amputation, and in 61% of the companies, the hazards were not corrected at time of inspection. He also showed Michigan data for OHI #2.
  - He discussed how states could use their OHI data to assist OSHA in evaluating the completeness of employer reporting on the new OSHA rule described by Dave Schmidt.
- Discussion
  - Concern for field offices- Are there enough resources?
  - No epi at CAL-OSHA
  - Currently informing employers that were previously not required to compile the OSHA 300 log and informing them about the new reporting requirements
  - Can the states generate data over the course of the next year and give OSHA an idea of what occurs (implementation of the new guidance) in their states in the form of a multi-site study or project?
    - OSHA doesn't collect data for national reporting; they do it in increments; they have been recognizing the need, but the national significance needs to be clear
  - False reports are a concern and may make it harder for comparisons
  - OR asked about data quality; Dave noted that you can still use data reports that don't meet their criteria but it makes things harder, especially for the area officers
    - Have to think strategically about what criteria you include
  - Dr. Michaels has just created a new office of analysis and evaluation to improve epidemiology capacity among OSHA

#### Other Updates

- John Myers (NIOSH) mentioned that with the switch to ICD-10, there are some conditions where obtaining location and other information will be lost

## Recommendations and Action Items

- Steve mentioned that the NIOSH eNews articles and SCG is an opportunity to hear about state activities throughout all of NIOSH (outside of the surveillance program), so do we need a better mechanism of getting updates from states for including in these updates?
- Additionally, states should directly email Steve or Terri regarding newsworthy program outcomes
- Steve recommended that states provide advice to extramural programs about including language to RFAs for funding that grantee applicants include a stipulation to reach out to state based surveillance programs – Alan Robinson is the NIOSH contact
- Share NIOSH eNews Sign Up with Marie and Kerry
- Share your state Twitter handles with NIOSH
- Send ideas for an updated title for the NIOSH State-Based Surveillance Clearinghouse to Marie to entertain a potential name change
- CSTE will create a table or schematic of the partners for outreach and forward this to the subcommittee to fill in contact information and volunteers
- Think about OH consultation opportunities, such as outreach at national meetings
- OH Subcommittee would like to have input on RCKMS development
- Flu and traumatic injury indicators were passed (Flu had two minor amendments); heat indicator will continue pilot (Michelle and Patty) and revisit addition in June
- States provide input for the CSTE AC Workshop; unused topics can be webinar topics
- Dave Bonauto-WA, Karla Armenti-NH, and Kathy Leinenkugel-IA will be rotating off of the OH Leadership Group and new members include: Terry Bunn-KY, Meredith Towle-CO/WY, and Margaret Lumia-NJ
- CSTE will conduct an assessment to identify what states applied for in the new state-based OH capacity program RFA
- 14-OH-02 Position Statement discussion recommendations:
  - First, provide general recommendations to NIOSH of the types of conditions that we are interested in; and
  - Then, we can do a more collaborative and full recommendation - Create a matrix of all conditions across CDC centers, and then prioritize a list from each center and submit to NIOSH
  - The leadership group will look at Peggy Filios' list of CDC ID programs and determine what conditions we are interested in NIOSH focusing on and if others have ideas, forward to Sharon and Amy
- Next steps for CFOI 14-OH-01 Position Statement:
  - States complete CFOI data survey
  - Likely meeting in January with BLS; there should be an ad hoc meeting to lay out pros/cons of different models; develop agenda for this in-person meeting
- Susan Payne and Kathy Leinenkugel would like to work with Sharon, Martha, Steve M, and other EH subcommittee members to update the lead CSTE position statement
- Develop amputation recordkeeping definition and collect state data
  - Volunteers: LA, TX, IL, CA, NE, WA
- Submit success stories by Jan 31
- Complete webinar speaker and objectives suggestions survey
- Develop comments to submit on EHRs
- CSTE AC abstracts due Jan 6
- Join CSTE as a member!
- If you have ideas for 2015 CSTE Position Statements, let Amy and Sharon know soon