The Role of State Plans in the National OSHA Program

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The Occupational Safety and Health Act encourages states to participate in the administration and enforcement of state occupational safety and health laws, preempts states from enforcing occupational safety and health laws in issues for which Federal OSHA has promulgated standards, except through an approved state plan, and sets out minimum requirements for approval of such plans. There are currently 25 states with approved plans, two of which cover only the public sector. As plans have developed through the years, their roles have expanded, both within their own borders and within the context of the entire national program. Operational status agreements and final approvals have limited OSHA's enforcement roles within these states. States are given an early opportunity to participate in the development of standards and compliance policies, participate in OSHA's Integrated Management Information System and are invited to join with OSHA in analyzing performance data for monitoring purposes.

Analysis of Significant Exposures to Blood and Body Fluids of Emergency Medical Personnel in a Large Metropolitan Fire Department

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Incident reports of exposures to body fluids for a large metropolitan emergency medical service will be analyzed and discussed. The reporting system covers 150 paramedics and 950 emergency medical technicians. The reports reflect a period of 45 months including July, 1987 through March, 1991.

A total of 94 incident reports were completed with approximately 25% representing a significant exposure as defined by the Centers for Disease Control. Analysis of these reports includes route of exposure, type of procedure at the time of exposure and the future of the call.

In August 1989, a comprehensive AIDS law became effective in Ohio. The law has language that allows health care workers to request testing of patients for HIV seropositivity when a significant exposure has occurred. The effect of this law will be considered in the data analysis.

Evaluation of Occupational Mortality Surveillance

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Thirty-three states code the industry and occupation information from death certificates and many use the data as a component in their occupational health surveillance programs. The National Institute for Occupational Safety and Health has developed an occupational mortality surveillance system based on these data from selected states. We describe the surveillance system and an evaluation that focused on the use of occupational mortality data for identifying work-related disease. A review of the literature showed that occupational mortality data,

despite known limitations, have often been used successfully for development of hypotheses about work-related disease and for prioritization of epidemiologic research. We found good agreement between associations identified using the mortality data and those found in more rigorous studies using population-based cancer registries with interview data. We demonstrated a method to develop hypotheses of associations by comparing the results of occupational mortality analyses across countries. In addition to identifying work-related disease, states have used the data in union and industry educational programs, as a source of information for researchers, in reports on disease or occupation, and to identify worker educational needs.

Occupational Medical Services in the State: Markets, Medicine, Models

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The rationalization of occupational medicine services within the State of Connecticut has proceeded over the past three years from several different and independent sources. These include the development of academic clinics with a linked approach to surveillance data-base development, state initiated legislation covering workplace monitoring and medical surveillance, federal grants, particularly directed to the construction industry, and for profit out-patient services. Competitive and cost driven services, such as hospital provided case management of workers compensation and directed care may accelerate clinician reporting and reinforce secondary and tertiary occupational disease specialty clinics.

Overview of the National AIDS Reporting System

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AIDS is reportable in all 50 states and U.S. Territories. Case reports, sent to CDC from state and local health departments, contain demographic, clinical, and risk factor information; they also state whether the patient has worked in a health care setting since 1978. Those who have are considered to be health care workers for surveillance purposes. Health care workers represent about 5% of the U.S. adult AIDS cases, and are similar in age, race and sex to AIDS cases who are not health care workers. All AIDS cases for whom a risk for HIV infection is not identified are followed up by health departments. CDC is working with state and local health departments to expand reporting of occupationally acquired HIV infection to include those HIV infected individuals who may have been infected through occupational exposures, but do not meet the AIDS case definition.

State Occupational Health Programs (NON-OSHA)

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In the two decades since the creation of OSHA and NIOSH, state governments have assumed increasing responsibility and leadership in occupational safety and health. By 1990, 26 states had established State OSHA Plans. A growing number of states have also developed programs

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