

## SB702 Environmental Health Tracking Draft Report, Oct. 9, 2003 version

### Comments from CDHS Occupational Health Branch, 12/6/03

Thank you for the opportunity to comment on this extensive report which clearly represents a huge amount of work and a careful attempt to consider the viewpoints of many individuals and organizations. We would be happy to discuss any of our comments in person with EHIB staff or respond to any questions about them. Where we are suggesting added or changed language, we will show those additions by underlining. Our comments are presented following the chronological order of the report.

#### Executive Summary

**p. 8** - Case for EH Surveillance - This section does not present clearly and strongly enough an explanation of what EH tracking is for and how the data would be used for prevention work. There is too much emphasis on the research applications (linkage studies, hypothesis generation), and not enough of a link with prevention. It does not make the case for how this work fits into the context of the public health infrastructure, i.e., how it would be used by state and local public health agencies and environ. health agencies to guide prevention efforts. The general reader (including legislature) will not know how surveillance data are used currently, and will find it difficult to make the leap to use of EH tracking data. It may help to give a salient example or 2 (if necessary, make analogy with what is done with infectious or chronic disease surveillance). The last sentence in paragraph 1 of this section is awkward and unclear.

Recommendations – There are many findings/recommendations in Ch. 8, and it is not clear how it was decided which would make it into the exec. summary; consider explaining that somewhere.

**p. 9** – 1<sup>st</sup> recommendation - Leading off the recommendations with suggestion of a “clearinghouse” seems very weak. It is not clear how much more analysis and dissemination the OEHT can do with a very small staff, beyond what the original programs that collect the data do on their own (especially if they had adequate resources). It’s not clear what “integration” of the data means at this point in the report.

**p. 10** – rec. on eroding resources – The erosion of the public health infrastructure is a very important issue that needs to be highlighted and emphasized. Consider moving this up in the list of recs. It is inaccurate to only mention the loss of resources to BDMP (at least identify it as an example); *all* of our general fund-based prevention programs have been gutted over the years (EHIB and OHB/OHSEP too), and not just in the last year or 2. Funding lost in the early 90s has never been restored. For example, DHS’s resources for OHSEP (Occupational Health Surveillance and Evaluation Program) are now limited to funding a technical staff of 2 MDs, an epidemiologist, and a portion of the OHB Chief; this cannot even be considered “core funding” for the mandates to do surveillance, investigations, and make prevention recommendations for a workforce of 16 million; these activities rely heavily on competitive federal grant funding, and OHSEP just lost its only state industrial hygienist in the budget cuts.

The last sentence should go earlier for emphasis. The point needs to be made strongly that without a vastly improved PH infrastructure, it will be impossible to use EH tracking data even if it gets collected. A later recommendation “existing systems need to be improved” (p. 11) is

weak; it doesn't come across that the main requirement for making improvement is by investing adequate resources in basic public health functions.

**p. 10** – rec. on hazard data – It would be clearer/more understandable in the boldface bullet to use the term “chemical hazards” instead of “environmental hazards.”

**p. 12** – rec. on improving existing systems – Replace last sentence on occ. data with: Since, in many cases, occupational groups are the most highly exposed and are likely to include the most easily identified cases of environmentally-related disease, State resources need to be invested in improving systems within the Department of Industrial Relations and DHS to collect and effectively utilize occupational illness data for public health prevention.

## Chapter 1

**p. 18** – Purpose – Make it clearer when it refers to “our” recommendations that this means the Expert Working Group (not DHS/OEHHA/UC).

**p. 19** – Definition of hazard – It is unclear what an example of a “biomechanical stressor” would be; consider providing one.

## Chapter 2

**p. 27** – Table 2.4 – Add examples under Occupational Exposures: latex, fire smoke, cleaning products, molds

**p. 29** – Health Outcome Tracking – you could drop “childhood” and just use “lead poisoning” to be more comprehensive.

**p. 32** – Env. hazard & exposure tracking – This section could more clearly state the need to know *where and which chemicals are used*; this is important from the standpoint of worker exposure as well as community exposure through release to the environment, and also for disaster response (fire, explosion, etc.). It is essential to know where chemicals are used, in order to be able to target prevention activities appropriately. Some of these existing systems were initially developed under community right-to-know, and for firefighter response.

**p. 36** – Tracking to Guide Prevention Strategies – Overall, this section states the link between tracking and prevention more clearly and strongly than the Exec. Summary does; some of the information here can be pulled into the Exec. Summary. However, the first paragraph should say more about use of data for prevention, i.e., a clearer explanation of how public and environmental health agencies currently do or could use this information to target prevention activities.

For example, you could discuss the type of case-based surveillance done by OHSEP/OHB in which we use various data sources to identify cases of chemically-related diseases (such as asthma, pesticide illness, lead poisoning, silicosis, etc.), and follow up with workers/cases (and sometimes employers) to find out about the circumstances of exposure (job task, chemicals or chemical products, etc.). We use the overall data to see which industries or occupations are “high-risk” for the specific health outcome (i.e., high numbers or high rates), and the case-based follow-up to tell us more about the specific risk factors. This information is used by OHB to develop interventions and prevention recommendations, and is also disseminated to stakeholders such as unions, trade associations, other agencies like Cal/OSHA, for use in their

prevention efforts. For example, we follow up workers with asthma to find out what chemicals they are exposed to that may or may not have yet been identified as causes of asthma; our overall data identify occupations or industries that should be targeted for asthma prevention initiatives.

Surveillance using only de-identified, large data sets and data linkages or epidemiologic studies is not likely to uncover causal relationships between chemicals and disease.

You may also want to make analogies with how infectious disease surveillance is used (e.g., figuring out how HIV was transmitted, determining how to address the resurgence of TB, where interventions were needed).

**p. 41** – items 1 and 2 – Add or populations at higher risk after “hot spots” and after “geographic areas”. The utility of tracking is not limited to identifying geographic areas with higher risk.

**p. 42** - #4 – Do you have a reference to cite for the economic benefits of preventing env. disease through policy? (e.g., child lead poisoning article.)

**p. 43** – Healthy Cities – add references for link between traffic density and adverse repro. outcomes?

**p. 48** – Cost of env diseases – Consider adding a sentence on the cost of occ disease from Leigh article:

Leigh JP, Cone JE, Harrison R. 2001. Costs of occupational injuries and illnesses in California. *Prev Med* 32:393-406.

In this article (commissioned by OHB), the costs of occ illnesses in the year 1992 were estimated at \$2.9 billion; this includes an estimated 7,079 deaths from diseases and 133,000 illnesses. The author is an economist who used well-accepted methods for this analysis, which produces estimates known to be low, particularly because it is known that occ. illnesses are very likely to be undercounted.

### Chapter 3

**p. 46** – Table 3.1 – Consider adding a “check” in the boxes under Occupation for learning impairment (via occ. lead exposure to the fetus) and diabetes (via dioxin exposure).

**p. 53** – Occ disease – change last sentence to:

Given the inextricable relationship between work and health for many Californians, it is imperative that ~~health tracking systems build upon~~ existing occupational health surveillance systems be strengthened and utilized as a key data source to help assess the threat of environmental sources of illness.

### Chapter 4

**p. 55** – Background – Appendix D probably contains a description of ELVIS; OLPPP would like to review it for accuracy.

**p. 55** – Characteristics – Change “Occupation and Occupational history with SIC (for adults)” to: Occupational history including occupation (Standard Occupational Classification [SOC]) and industry (North American Industry Classification System [NAICS]) for adults (note: the SIC

system is being replaced by NAICS; also, you really need both occupation and industry to understand occupational risks.)

Also, add date of diagnosis to the list (necessary for any trend analysis).

**p. 56** – Replace the sentence on Occupation and Occupational History with:  
*Occupational history including occupation and industry should be available since the highest environmental exposures for many agents occur in the workplace.* The system used for coding occupation is SOC, while industry is coded by NAICS. (You could reference the sources for these systems, and add these acronyms to the big list.)

**p. 61** – Asthma – Add:  
Data on work-related asthma is collected by the CDHS Occupational Health Branch from physician reports to workers' compensation insurance carriers. This program is funded by the National Institute for Occupational Safety and Health for a limited period of up to 5 years.

**p. 62** – Asthma recs. – Add the following bullet:  
State resources should be provided to CDHS' OHB, to continue surveillance of occupational asthma initiated under a federal grant, and to promote interventions targeting high-risk industries and occupations.

**p. 68** – Cancer recs. – Add:  
Routine coding of occupation and industry should be performed by the California Cancer Registry.

Or, alternatively, repeat the rec. that shows up in Ch. 8 re: investigating the feasibility of setting up a new system to obtain occupational histories. (Note: it seems that most of the recommendations that appear in Ch. 8 are mentioned earlier in the report too, but we didn't check this out systematically and are not sure about how the authors decided which recs. were to appear in multiple places, such as Exec. Summary, Ch. 4 & Ch. 8).

**p. 69** – Rec. on pharmacy-based surveillance – Wouldn't this type of system be useful for multiple health outcomes, not just diabetes?

**p. 73** – MS recs. – Here the CEHTP acronym starts to be used. It's not clear how this is different from the OEHT, or if you mean the same program. (This confusion occurs in other places in the document as well.)

**p. 76-77** – Lead poisoning – This section does not follow the established format of Finding 1/Data sources, Finding 2/Limitations, followed by Recommendations, although it looks like paragraph 2 is the limitations section and the bullet is a recommendation.

Specific text changes suggested:

### *Lead Poisoning*

#### Finding #1: Data Sources

Lead poisoning surveillance is well established in California. There are two systems in place at the CDHS that routinely collect blood lead level data on adults and children. The Childhood Lead Poisoning Prevention Branch maintains a surveillance and case-management system of child lead poisoning in its Response and Surveillance System for Childhood Lead Exposures (RASSCLE) database; whereas the Occupational Health Branch's Occupational Lead Poisoning

Prevention Program (OLPPP) collects data on elevated adult blood lead levels in its Elevated Lead Visual Information System (ELVIS) database. RASSCLE is both a surveillance and case management system, containing thorough demographic, exposure, and health care utilization data. All adult blood lead levels above 40 ug/dL are verified for occupational exposure and referred for case management at Occupational Lead Poisoning Prevention Program (OLPPP) which does follow up interviews. ELVIS contains demographic, employer, lab and medical provider information, as well as certain data elements from OLPPP's statewide case management activities.

## Finding #2: Limitations

~~CLPPB and RASSCLE and ELVIS~~ data previously did not capture all elevated blood lead levels. Prior to January, 2003, laboratories were only required to report blood lead levels above 25 micrograms per deciliter (ug/dl) but many laboratories reported lower values voluntarily. Some of these laboratories reported blood lead levels at and above 10 ug/dl (which is the CDC legal definition of an elevated blood lead level for children) while others reported all blood lead testing results – regardless of level. Universal reporting of all blood lead tests to the CDHS CLPPB began in January 2003, and all results must be reported electronically by January 1, 2005.

Although the CLPPB is working to establish a comprehensive electronic laboratory reporting system as part of its RASSCLE update (called RASSCLE II), database information on the prevalence of elevated blood lead levels is still incomplete. The denominator data contained in the current RASSCLE system is limited ( i.e., most children who were tested but who have blood lead levels below 10 ug/dl are not currently being entered into the database due to resource limitations, though the presence of testing is being noted in many cases). A further limitation of the surveillance system is that all high-risk children are not tested for elevated blood lead, so they are not captured by the system.

~~OLPPP and Adult blood lead (ELVIS)~~ data with respect to prevalence are also limited. Although OLPPP does enter into ELVIS the results of all blood lead tests received, not all employers who are required to send adults for blood lead testing do so and, prior to January 2003, not all laboratories were reporting adult blood lead levels below 25 ug/dl to the state. In addition, many of the reports received by OLPPP do not contain complete information (demographics, employer), and resource limitations prevent the follow-up that would improve data quality.

## Recommendations

- The CLPPB should investigate how RASSCLE\_II might interface with other environmental health surveillance systems to identify children at risk from exposure to multiple environmental agents.

**p. 78 – Occupational illness –** Before going into individual occupational conditions, there should be an introductory section that describes the basic data sources available for occ. health surveillance, limitations, and general recommendations. It is a little confusing how some occupational conditions are described here (pesticide illness [which is both occupational and nonocc.], dermatitis [for which no surveillance currently exists and which can be occupational and nonocc.], and occupational asthma), but not occupational cancer (such as mesothelioma) and occupational lead poisoning which are mentioned earlier in the general sections. If you add an introductory section on occ. illness data sources, you can likely delete repeated explanations that appear later under specific conditions about DFRs and WCIS. Also, some specific

condition sections include language about limitations and recommendations that pertain to occupational illness surveillance more broadly.

We suggest these changes:

### Occupational Illness

Occupational illness can be seen as early sentinels or warnings that chronic diseases are occurring in highly-exposed populations. ~~Therefore, the following~~ For this reason, and in recognition of the fact that our definition of “environment” includes the work environment, occupational diseases should be included for tracking in an environmental health surveillance system. Several important work-related conditions (i.e., pesticide illness, dermatitis, and asthma) are described in more detail below.

### Finding #1: Data Sources

The two most extensive statewide data sources of occupational health information are: 1) Doctor’s First Reports of Occupational Injury or Illness (DFRs), which all physicians are required to submit to DIR or the workers’ compensation insurance carrier after seeing a patient whose illness/injury they suspect as being work-related, and which are required to be submitted by workers’ compensation carriers to the Department of Industrial Relations Division of Labor Statistics and Research (DLSR); and 2) the electronic Workers’ Compensation Information System (WCIS), which was created in 1999 and is a repository of information on workers’ compensation claims which insurers are required to submit to DIR’s Division of Workers’ Compensation (DWC). Other sources of occupational illness data include laboratory reports (e.g., blood lead or cholinesterase levels), the Cancer Registry, data on hospital admissions and emergency room visits, death certificates, and administrative encounter data (e.g., from Kaiser).

DFRs are currently used by the Occupational Health Branch in CDHS as a source for identifying and following up individual cases of illness for priority work-related conditions such as pesticide illness and asthma through pilot project funding from the National Institute for Occupational Safety and Health (NIOSH). Workers are interviewed to identify the conditions in the workplace (including specific chemicals) believed to be the cause of the illness. Surveillance data are analyzed to identify high-risk occupations and industries, and recommendations are made and disseminated for appropriate interventions.

### Finding #2: Limitations of Current Tracking Systems

Existing systems are likely to be incomplete because they rely on one or more of the following: a sick employee seeking medical care; a sick employee reporting his/her condition to the employer; an employer providing required medical monitoring to chemically-exposed employees; a physician recognizing an illness as potentially being work-related; a physician completing and submitting a DFR; a workers’ compensation insurer passing the DFR on to DIR; and/or a workers’ compensation insurer submitted required data to WCIS. [Note: you have language under specific conditions like pesticide illness that could be reduced once these points are made here.] The systems are also highly biased toward acute conditions; because many chronic occupational illnesses have long latency (e.g., cancers, mesothelioma), they are rarely reported as being work-related.

Although DFRs and WCIS are rich data sources for surveillance and prevention work (which are not available in many other states), the State has not invested adequate resources to allow for

their effective use. For example, DFRs are currently submitted as paper copies which OHB/CDHS grant-funded staff hand sort to select out cases of priority conditions under surveillance (e.g., pesticide and respiratory illness). Because of limited resources, only a few conditions can be addressed.

Recommendations [note: these likely should go in Chapter 8 as well.]

- Sufficient resources should be provided by the State to DIR and OHB/CDHS to allow existing data systems (DFRs, WCIS) to be improved and fully utilized for surveillance and prevention. Data should be routinely analyzed and disseminated in reports to stakeholders statewide.
- Physicians should receive education about occupational illness to improve recognition, and education about the requirement to submit DFRs.
- DIR should enforce the requirements for physicians and workers' compensation insurers to submit DFRs, and for workers' compensations insurers to submit required data to WCIS.
- The State should explore the feasibility of creating a data system and requirement for electronic submission of DFRs by physicians.
- If provided additional resources, OHB/CDHS should identify additional occupational conditions to place under surveillance using available data sources.

**p. 79-80** - Pesticide Illness - see recommended re-writes below:

#### Finding #1: Data Sources

Physicians are required to report any suspected pesticide poisoning to the local health officer, who generates a pesticide illness report (PIR). For occupational as well as non-occupational poisonings, the health officer transmits this report to the county agricultural commissioner (CAC), who provides copies of the report to the CA Dept. of Pesticide Regulation (DPR), the Office of Environmental Hazard Assessment (OEHHA), both within Cal/EPA, and to the Department of Industrial Relations (DIR), which has enforcement authority for the reporting requirement. For occupational cases, there is an additional reporting requirement, the Doctor's First Report of Occupational Injury or Illness (DFR). The DFR is sent to the workers' compensation carrier, who is responsible for sending copies to DIR.

The SENSOR Pesticide Illness Database, maintained by the Occupational Health Branch of the Department of Health Services through a NIOSH-funded grant, tracks occupational pesticide illnesses. Data sources for SENSOR include DFR reports of pesticide-related illness, PIRs, and others. Among data included are medical, demographic, residential location, occupational, industry, and exposure information. Selected cases receive a public health investigation from which prevention recommendations are developed and disseminated.

DPR also reviews illness reports submitted to the State workers' compensation system, as well as PIRs. The DPR conducts surveillance for occupational as well as non-occupational pesticide illness. Surveillance data are maintained in the Pesticide Illness Surveillance Program (PISP). California agricultural commissioners, in coordination with DPR, follow up each case of acute

pesticide poisoning and conduct a more thorough investigation, primarily for enforcement of regulatory violations such as non-compliance with field re-entry intervals.

#### Finding #2: Limitations of Current Tracking Systems

Reporting is likely to be incomplete. Physicians often do not report or delay reporting potential pesticide illnesses. For example, in 1997 only 30% of physicians reported cases which had been detected by the PISP through the workers' compensation system. Other sources of underreporting include lack of access to health care by workers, not seeking care due to fear of reprisal on the job, under-recognition of the conditions by health care providers, and lack of reporting to DIR by workers' compensation insurers. The reporting systems are biased toward acute effects of pesticide exposures rather than chronic effects.

#### Recommendations

~~• DPR should routinely provide the complete follow-up information of pesticide illness incidents with CDHS and the Office of Environmental Health Hazard Assessment, (OEHHA) Cal/EPA, to facilitate a public health surveillance perspective. A feasibility study should also be conducted jointly by CDHS, DPR, and OEHHA on how this system could be enhanced to assess the chronic effects of pesticide exposure, not just acute effects.~~

*Recommend replacing the previous recommendation with the following:*

CDHS, OEHHA, and DPR should collaborate on data collection for pesticide illness surveillance. Reports of pesticide incident investigations conducted by County Agricultural Commissioners should be routinely shared with CDHS. Information on incidents, including field data and outcome should be shared to ensure a cohesive pesticide illness surveillance system that incorporates a public health perspective in addition to ensuring compliance with regulatory requirements. A feasibility study should also be conducted jointly by CDHS, DPR, and OEHHA on how this system could be enhanced to assess the chronic effects of pesticide exposure, not just acute effects.

**p. 80** – 2<sup>nd</sup> bullet – Please change last sentence as follows:

Physician reporting to the workers' compensation insurance system needs to be increased as well as workers' compensation carriers' reporting to DIR and DIR's reporting to OHB.

Note: we are not sure what was meant here; DIR currently provides all (hard copy) DFRs to OHB, since OHB is the only entity that uses them.

This recommendation (improving physician recognition and reporting, completion and transfer of DFRs) actually applies to all occ. disease, not just pesticide illness. These points could be addressed only in the initial section on occ. illness as suggested. This is also true for the recommendation on p. 82 (occ asthma).

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**p. 80** – Dermatitis – You may want to state here that dermatitis is the most commonly reported occ. disease. It is incorrect to say that admin encounter data and private sources are the only data sources. DFRs are definitely an available source of data (for all occ. conditions including dermatitis), as is the Workers' Compensation Insurance System; there just needs to be some resources (preferably for OHSEP/OHB) devoted to using this data system more effectively. OHB has an interest in doing dermatitis surveillance.

**p. 82** – Occ asthma – Revise as follows:

The State should provide resources to the Department of Industrial Relations (DIR) and the Occupational Health Branch of CDHS to improve the existing reporting systems by increasing

compliance with Doctors' First Reports (DFRs) submission by insurance carriers; increasing the capability to analyze currently available electronic workers' compensation data; performing outreach and education to health care practitioners to improve the recognition of work-related asthma; and targeting interventions to industries and occupations at high risk for asthma.

## Chapter 5

**p. 83** – Background – Geoff had a graphic that illustrated the continuum between hazard, exposure, and health outcome that could be added in here to better make the distinction between hazard and exposure tracking. Some of our staff found the text to be unclear.

**p. 85** – Characteristics - Change “Occupation and Occupational history with SIC (for adults)” to: Occupational history including occupation (Standard Occupational Classification [SOC]) and industry (North American Industry Classification System [NAICS]) for adults. Also, consider adding dates/duration of exposure.

**p. 90** – Table 5.1 – Under “Occupational,” list: Radiation, Lead, Pesticides, Prop. 65 Carcinogens and Reproductive Hazards

**p. 94-96** – Pesticides – Edit paragraph on p. 94 as follows:

[delete 1<sup>st</sup> 2 sentences] As part of a project to evaluate the utility of laboratory reports as a surveillance tool for pesticide illness, three participating clinical laboratories have voluntarily provided individual cholinesterase test results to CDHS' Occupational Health Branch. Abnormal cholinesterase test results reported by laboratories offer the opportunity to detect pesticide exposure and illness even in the absence of physician evaluation for clinical illness.

Additionally, California participates in the USDA's Pesticide Food Residue Monitoring program, which collects and analyzes food samples for pesticide residue. USDA makes inspections at food distributorships (not markets) for pesticide residue in fresh commodities and some processed commodities (e.g., peanut butter, apple juice). Accepted samples are prepared emulating consumer practices; the data include sampling results, type of commodity, commodity place of origin, name of grower, name of packing distributor, and date of sample. The pesticide air monitoring program of the California Air Resources Toxic Air Contaminant Program and the California Air Resources Board is one of the few in the U.S. to monitor pesticides in community air (Baker, 1996).

Finding #2: Limitations of Current Tracking Systems

*Substitute the following for paragraph 2:*

Biomonitoring is one of the best ways to estimate actual current exposures and to limit clinical illness and further exposure. CDHS' current system of laboratory-reported cholinesterase test results is influenced by the voluntary nature of reporting. This limits both the number of clinical laboratories that report cholinesterase test results to CDHS as well as the type of information that is reported. A considerable amount of effort is required to obtain information required for case follow up because there are currently no mandatory requirements to ensure reporting of data.

Recommendations

- *[others appear here]*
- The California DPR should provide structural pesticide use data...

*Add:*

In cooperation with OEHHA and DPR, CDHS should introduce legislation to require clinical laboratories to report cholinesterase and other pesticide-related test results to the State. This effort should build upon other related efforts, such as the recent requirement to report cholinesterase results in standardized units. CDHS should use the reported data to enhance current pesticide illness surveillance. These data should be examined for use to track other environmental and occupational health-related issues.

**p. 101** – 4<sup>th</sup> paragraph of Finding 1 – replace “collects data on elevated adult blood levels” with collects data on adult blood lead levels; DHS collects all BLLs now.

**p. 105** – 3<sup>rd</sup> paragraph – replace last sentence with:  
Cal/OSHA enforces California’s occupational asbestos standards in construction, shipyards, and general industry, and therefore may conduct asbestos personal exposure monitoring in workplaces. Cal/OSHA maintains a data system that summarizes results from air monitoring (for any contaminant) conducted during inspections. (There is no “Cal/OSHA Enforcement Unit”.)

## **Chapter 8**

**p. 134** – Finding 1 – Replace “exposure to pollution” with environmental exposures, which is broader; pollution often refers to air and water only.

**p. 136** – bullet on COEH scientific panel – This group should include an occupational health surveillance expert.

**p. 138** – Finding 3 & recs – It should be made clearer (as stated above under Exec. Summary) that *many* public health programs (including EHIB and OHB) have been severely eroded over the last 15 years or so, not just the last year or 2. The 2 recommendations as they appear contain a lot of “findings,” which should be moved up into the Findings section. The recommendations should be rewritten to more clearly state that funding needs to be restored to all state public health programs involved in EH tracking, and provide a listing of all the programs, not just single out BDMP and the Cancer Registry. This section should make clear to the legislature the danger of thinking CA can do anything about EH tracking without a solid infrastructure to both collect and use the information.

**p.139** – Finding #4 – It is confusing to use the term “environmental hazards” when what is specifically meant is “chemical hazards.”

**p. 143-4** – Occ data recommendations – Revise as follows:

- The OEHT, the OHB of CDHS, the Dept. of Industrial Relations, and Cal/OSHA should work with the California Health Information Association (a nonprofit association that provides leadership, education, resources, and advocacy for California’s health information management professionals who work throughout the healthcare industry) to assess the feasibility and cost of establishing an employer-based reporting system for occupational history or other means of improving occupation and industry information for use in environmental health surveillance.

Cost: none.

Add:

- The State should restore lost funding and positions and provide adequate resources to DIR and OHB of CDHS to jointly improve existing occupational health surveillance data systems (e.g., DFRs, electronic Workers' Compensation Information System [WCIS]), to regularly analyze and disseminate data, and for OHB to continue case-based surveillance of occupational health endpoints initiated through federal grant funding of pilot projects and expand surveillance activities to include other occupational conditions.

Cost: ???

*Note: it doesn't make sense to make the following recommendation about improving/increasing submission of DFRs (or Employer Reports, which go into the WCIS) if the State doesn't provide the resources to effectively use these rich data sources.*

- The State should provide resources to the Dept. of Industrial Relations (DIR) to work jointly with the Occupational Health Branch of CDHS in improve insurer submissions of Doctor's First Reports (DFRs). DIR should enforce the requirements for physicians and insurers to submit DFRs. The State should provide resources to the Occupational Health Branch of CDHS and to OEHHA of Cal-EPA to provide outreach and education for health care practitioners about work-related illness. *[Note: Shouldn't this money designated for OEHHA go to DPR's Worker Health and Safety Unit instead? Does OEHHA actually do physician education? Or maybe this could just say OHB & suggest we collaborate with other relevant partners, e.g., DPR on pesticide illness education?]*

Cost: \$360,000

*[Note: you could alternatively repeat our recommendations from the Occ Illness section in Ch 4 here.]*

**p. 144** – Finding #6 – Add:

The State should provide resources to the Department of Industrial Relations (DIR) and the Occupational Health Branch of CDHS to improve the existing reporting systems by increasing compliance with Doctors' First Reports (DFRs) submission by insurance carriers; increasing the capability to analyze currently available electronic workers' compensation data; and performing outreach and education to health care practitioners to improve the recognition of work-related asthma.