the overall cost of using sharps with engineered sharps injury protections and needleless systems is substantially cheaper than the costs of contending with unnecessary needlestick injuries associated with the use of less safe devices.

The under-utilization of safer medical devices is a national issue. As of August 31st, sixteen States had already enacted legislation requiring the use of safer medical devices and a seventeenth was in the process of doing so. The State laws, however, only partially address the concern. They may not be applicable to private health care sector workers and impose differing requirements that may create burdens for both employers and medical equipment manufacturers. Legislation introduced earlier in this Congress by the Hon. FORTNEY PETE STARK and the Hon. MARGE ROUKEMA to address this same issue, the Health Care Worker Needlestick Prevention Act, H.R. 1899, currently has 187 cosponsors.

To its credit, the Occupational Safety and Health Administration (OSHA) has already acted to ensure that there is greater use of sharps with engineered safety protections and needless systems. In November 1999, OSHA issued a revised Compliance Directive on Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens and has sought to highly publicize the new compliance directive. One of the principal purposes for issuing the new directive was to emphasize the requirement that employers identify, evaluate, and make use of effective safer medical devices in order to minimize the risk of occupational exposure to bloodborne pathogens.

The legislation that Mr. BALLENGER and I are introducing today builds on OSHA's efforts. By making modest changes in the bloodborne pathogen standard, this legislation, if adopted, will help to achieve substantial improvement in the safety and health of American health care workers. This legislation will help to ensure that health care workers use the safest available medical devices, that they are trained to ensure proper usage, and that employers and workers review and learn from experience to ensure continued improvement.

Specifically, the legislation amends the standard to provide for definitions of ''engineering controls,'' ''sharps with engineered sharps injury protections,'' and ''needleless systems'' in order to provide greater clarity of the requirements of the standard. The legislation ensures that employers regularly monitor and assess the development of ''appropriate commercially available and effective safer medical devises'' and implement use of the such devises appropriately. It further ensures that those who must use the equipment will have a voice in its selection and will be properly trained in its use. Finally, the legislation promotes greater awareness and more active vigilance by ensuring that needlestick injuries are monitored and tracked.

In developing this legislation, Mr. BALLENGER and I have sought the greatest possible consensus. For example, I have reluctantly agreed to leave aside for now the issue of extending the protections of the bloodborne pathogen standard to health care workers employed by state and local governments. We have sought to address the concerns of both health care employers and health care workers. While reinforcing the requirement that safer medical devices be used where they are commercially available, this legislation does not mandate the use of engineered controls where such controls are not commercially available. Neither this legislation, nor the underlying standard it amends, requires anyone to use any engineering control, including a safer medical device, where such use may jeopardize a patient's safety, an employee's safety, or where it may be medically contraindicated. This legislation leaves intact all of the affirmative defenses available to employers related to the use of engineered controls under the Bloodborne Pathogens Standard. Finally, we have worked closely with OSHA to ensure that this legislation appropriately builds upon and compliments the existing standard.

In conclusion, I want to thank the many people who have worked with Mr. BALLENGER and I to develop this legislation. For my part, I want to especially thank Madeleine Golde and Lorraine Theibaud of the Service Employees International Union; Barbara Coufel of the American Federation of State, County, and Municipal Employees; Bill Cunningham of the American Federation of Teachers; and Stephanie Reed and Karen Daley of the American Nurses Association. Finally, I would like to pay special tribute to Peggy Ferro. At a 1992 hearing by another committee entitled ''Healthcare Worker Safety and Needlestick Injuries,'' Ms. Ferro testified about how she contracted HIV from a conventional needle. Ms. Ferro died in 1998. I sincerely commend Chairman BALLENGER for his efforts to ensure that we are more responsive to Ms. Daley than we were to Ms. Ferro.

INTRODUCTION OF THE NEEDLESTICK SAFETY AND PREVENTION ACT

HON. CASS BALLENGER

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Monday, September 18, 2000

Mr. BALLENGER. Mr. Speaker, I am joined by my colleague and ranking member of the Subcommittee on Workforce Protections, the Honorable MAJOR R. OWENS, in the introduction of the Needlestick Safety and Prevention Act. This bipartisan legislation will address an important public health issue confronting our nation's health care workers.

The Needlestick Safety and Prevention Act derives from the convergence of two critical circumstances that have a profound effect on the safety of health care workers. The first circumstance is the increased concern over accidental needlestick injuries suffered by health care workers each year in health care settings. ''Needlesticks'' is a term used broadly, as health care workers can suffer injuries from a broad array of ''sharps'' used in health care settings, from needles to IV catheters to lancets. The second circumstance is the technological advancements made over the past decade in the many types of ''safer medical devices'' that can be used in health care settings to help protect health care workers against sharps injuries.

The Needlestick Safety and Prevention Act would modify the Bloodborne Pathogens Standard (29 CFR 1910.1030), one of the leading health and safety standards promulgated by the Department of Labor's Occupational Safety and Health Administration (OSHA). The legislation builds on the most recent action taken by OSHA related to the Bloodbome Pathogens Standard—the November 1999 revision of OSHA's Compliance Directive on Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens.

The concern about accidental injuries to health care workers from contaminated sharps first entered the public consciousness in the mid-1980's as concern over the AIDS epidemic grew, along with concern about the spread of hepatitis B. By the end of the decade, there were a number of documented cases of health care workers contracting the HIV virus by accidentally getting stuck with a needle when treating a patient. In 1991, responding to many of those concerns, OSHA issued the Bloodborne Pathogens Standard, which specified workplace safety requirements to protect against occupational exposure to bloodborne pathogens.

Since that time, numerous studies have demonstrated the continuing serious risk to health care workers of percutaneous injuries from contaminated sharps. In March of this year, the Centers for Disease Control and Prevention estimated that more than 380,000 percutaneous injuries from contaminated sharps occur annually among health care workers in United States hospital settings. Estimates for all health care settings are that 600,000 to 800,000 needlestick and other percutaneous injuries occur among health care workers annually. At an average hospital, workers incur approximately 30 reported needlestick injuries per 100 beds per year. While most reported needlestick injuries involve nursing staff—laboratory staff, physicians, housekeepers, and other health care workers are also injured.

At a Subcommittee on Workforce Protections hearing in June, Mr. Charles Jeffress, the Assistant Secretary of OSHA, testified about the most recent federal action to address this issue—OSHA's revised Compliance Directive on Enforcement Procedures for Occupational Exposure to Bloodborne Pathogens. While the goals of the Bloodborne Pathogens Standard are clearly stated, many aspects of the standard give employers considerable flexibility in choosing the methods most feasible for accomplishing those goals. Thus, the standard directs employers to use engineering controls and work practices to eliminate or minimize employee exposure to bloodborne pathogens, but it does not list or specify particular engineering controls (such as which medical devices) that employers must use. This approach allows the rule to take into account the continual progress of medical research and technology and the diversity of workplaces and workplace operations and processes, and allows the employer to detennine what engineering controls will provide the best protection.

A highlight of the revised Compliance Directive, and indeed one of the main reasons for its revision, is the emphasis on the need for employers to identify, evaluate, and make use of effective commercially available engineering controls, including ''safer medical devices'' to reduce or minimize the risks of occupational exposure to bloodborne pathogens. These devices are also referred to as ''safety devices'' or ''safe-needle devices,'' but their common element is that they have a built-in safety mechanism that reduces or eliminates exposure to the needle or sharp. Neither the Compliance Directive, nor the current bloodborne

pathogens standard advocates the use of one particular device over another.

At the Subcommittee hearing, a consensus among all of the witnesses was that choosing and using a safer medical device is a complicated process for many reasons, not the least of which is that most health care settings, particularly hospitals, are enormously complex work environments. While no one type of intervention in the workplace will completely eliminate the risk of exposure, numerous studies have demonstrated that the use of safer-medical devices, when they are part of an overall bloodborne pathogens risk-reduction program, can be extremely effective in reducing accidental sharps injuries.

Witnesses also stressed the importance of including health care workers in the selection and evaluation of newer devices. This is particularly so because there are many types of safer medical devices available on the market and using them may involve some adjustment in technique on the part of the health care worker. It is also important for facilities to have some type of surveillance system, such as a sharps injury log, in place to monitor the sharps injuries. This type of system is useful both for helping a facility track its high risk areas and for evaluating which types of devices are most effective.

While the revised OSHA Compliance Directive emphasizes ''safer medical devices,'' the Bloodborne Pathogens Standard does not include safer medical devices in its examples of engineering controls. And so, this legislation would include that language in the Bloodborne Pathogens Standard.

The bill requires that the Bloodborne Pathogens Standard explicitly state that employers must document in their Exposure Control Plans the consideration and implementation of appropriate commercially available and effective engineering controls, such as safer medical devices. This legislation does not advocate the use of one particular device over another and it would not change the flexible-performance-oriented nature of the Bloodborne Pathogens Standard.

In addition, the bill would add two new sections to the Bloodborne Pathogens Standard. The first section adds a new part to the Standard's recordkeeping section, specifying that employers maintain a ''sharps injury log'' for the recording of percutaneous injuries from contaminated sharps. Through the use of this log, employers would be able to better monitor sharps injuries and by doing so, better evaluate high risk areas and the types of engineering controls and devices that are most effective in reducing or minimizing the risk of exposure. Employers may decide what information is useful and the information must be recorded in such a manner as to protect the confidentiality of the injured employee. The log would record the type of device used, an explanation of the incident and where it occurred. Employers who are exempt from maintaining OSHA 200 logs, such as employers with 10 or fewer employees, would likewise be exempt from maintaining a sharps injury log.

A second section would be added to the Bloodborne Pathogens Standard to specify that employers solicit input from frontline health care workers (non-managerial employees responsible for direct patient care) in the identification, evaluation and selection of effective engineering and work practice controls and to document that solicitation in the Exposure Control Plan.

Sixteen states have already passed some type of safe needle legislation over the past two years and many other states are considering similar legislation. These state actions result in coverage of state public health care facilities and state public employees both of which are not reached by federal OSHA, except in those states which are OSHA state plan states. I hope that our action on the federal level will encourage more states to take similar action—as it is well within their prerogatives to do—and adopt the same standards as those we are putting forward today for inclusion in the federal Bloodborne Pathogens Standard.

I also want to point out that many of the state bills that have passed and been signed into law during the past two years, beginning in California, have included a number of explicitly stated exceptions to the requirement for the use of safer medical devices. The lack of explicitly stated exceptions in this legislation may cause some concern for those upon first review. I emphasize there should be no cause for concern. The current Bloodborne Pathogens Standard, which we are revising through this legislation, does not contain explicitly stated exceptions. Therefore, all of the traditional defenses, including affirmative defenses available to an employer related to the use of engineering controls under the current Bloodborne Pathogens Standard, remain in effect even as to the use of safer medical devices. I would point out also that the requirement in this legislation for the consideration and implementation of safer medical devices is hinged upon the ''appropriateness'' and the ''commercial availability'' of such devices. Finally, while this may be stating the obvious, it is not the intent of this legislation, nor for that matter of the current Bloodborne Pathogens Standard, for employers to implement use of any engineering control, including a safer medical device, in any situation where it may jeopardize a patient's safety, an employee's safety or where it may be medically contraindicated.

Finally, I would like to commend the many groups who have worked so diligently on this issue over the past few years and worked so hard to reduce sharps injuries for health care workers. The broad consensus we have reached on this issue is due in no small part to the work of the American Nurses Association, the American Hospital Association, manufacturers and many others who represent health care workers. I especially want to thank Karen Daley, who testified at the hearing in June about her personal experience on behalf of the American Nurses Association.

More than 8 million health care workers in the United States work in hospitals and other health care settings. I urge my colleagues to support the Needlestick Safety and Prevention Act, which is designed to make their work places safer.

BLUE RIBBON SCHOOL WINNER

HON. RANDY "DUKE" CUNNINGHAM

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, September 18, 2000

Mr. CUNNINGHAM. Mr. Speaker, I rise today to congratulate Black Mountain Middle School in Penasquitos and its leaders, Principal Miguel Carillo and Superintendent, Dr. Bob Reeves. Black Mountain has been designated by the U.S. Department of Education as a National Blue Ribbon School for 2000. I am proud to inform my colleagues that my district had an amazing record of eleven schools selected for that prestigious honor this year. I would also like to note that the Academy of Our Lady of Peace right outside my district in San Diego County was also named a Blue Ribbon School. I applaud the educators, students and communities in each of the San Diego County schools who pulled together in pursuit of educational excellence.

Blue Ribbon Schools are recognized as some of the nation's most successful institutions, and they are exemplary models for achieving educational excellence throughout the nation. Not only have they demonstrated excellence in academic leadership, teaching and teacher development, and school curriculum, but they have demonstrated exceptional levels of community and parental involvement, high student achievement levels and strong safety and discipline.

After schools are nominated by state education agencies for the Blue Ribbon award, they undergo a rigorous review of their programs, plans and activities. That is followed with visits by educational experts for evaluation. Ultimately, those schools which best demonstrate strong leadership, clear vision and mission, excellent teaching and curriculum, policies and practices that keep the schools safe for learning, family involvement and evidence of high standards are selected for this prestigious award. I am pleased that they are now receiving the national recognition they are due.

As school and community leaders head to Washington for the Department of Education awards ceremony, I want to thank them once again for a job well done. More satisfying than any award, these leaders will have the lifelong satisfaction of having provided the best education possible and a better future for thousands of children. I am proud of what they have achieved, and want to share their achievements so that more people benefit from their accomplishments. I ask that a summary of Black Mountain Middle School's superior work be included in the record:

Black Mountain Middle School, located in Rancho Penasquitos, a suburb of San Diego, California, is a vibrant, progressive school community that continually strives to reach the district's mission of all All Students Learning—Whatever It Takes. They have a 25-year tradition of excellence, high expectations, and strong support for student learning, Staff, parents, and students work together to create a dynamic learning environment which engages students in learning and achievement. A caring, committed staff provides the cornerstone while standards, varied learning opportunities, and enriched curriculum provide the foundation for our successful school. As a California Distinguished School and former Blue Ribbon School recipient, Black Mountain meets the needs of a diverse student population in a residential area in the north county of San Diego.

Black Mountain recognizes the challenges its students will face as they enter the 21st century. Therefore they provide them with a solid academic program that lays the foundation of basic skills through a standards-based curriculum. Their three-period basic education configuration provides the framework for the study of language arts and social studies.