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INSIDE

RELIAS MEDIA

Illinois Becomes Latest State to Enact Law to Prevent Healthcare Violence

Nurses demand action after attack by escaped inmate

By Gary Evans, Medical Writer

With a national wave of violence in healthcare resulting in little substantive federal action, states are moving to enact laws to protect nurses and their colleagues from workplace violence. Effective Jan. 1, 2019, Illinois has passed a sweeping state law to protect healthcare workers from violence after a horrific assault on two nurses last year by a prisoner who had disarmed a guard.

"We spent over a year crafting the law and got true input from nurses on the ground that are experiencing these acts of violence every day," says the bill's sponsor, State Rep. **Stephanie Kifowit** (84th District). "We made it as all-encompassing as possible. Other states may want to use this at least as a base."

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The state law requires hospitals in Illinois to have violence prevention protocols in place and includes specific requirements for handling of inmates under medical treatment. The law also provides whistleblower protections for workers who report violent incidents and requires specific action by healthcare facilities in response.[1] *(See requirements, page 137.)*

The 2017 incident that led to the law

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occurred at a hospital in Geneva, IL. An inmate brought in for treatment stole his guard's gun and took two nurses hostage, sexually assaulting one before being shot by police.

"I have heard from a lot of nurses that were very happy that this law passed, from the nurses that were engaged in the incident and nurses in general," Kifowit says. "It's tragic that such a horrific thing had to happen for us to take a long look at the procedures, but I think we've made a safer environment for all nurses — we extended this to all healthcare workers."

Though violence in healthcare is a longstanding problem, there are signs that it is getting worse. In a study published this year, the National Institute for Occupational Safety and Health (NIOSH) analyzed workplace violence injury surveillance data from 2012 to 2015.[2]

Overall, 105 participating hospitals reported an increase in the rate of workplace violence injuries by 72% over the time period. The rate went from 4.4 injuries per 1,000 full-time equivalent (FTE) workers in 2012 to a high of 7.6 per 1,000 FTE before declining to 7.2 in 2015.

At the federal level, the Occupational Safety and Health Administration (OSHA) announced last year that it would develop a standard to protect healthcare workers from violence. But so far, the OSHA action has been a nonstarter.

And the Health Care Workplace Violence Prevention Act (H.R. 5223), a bill introduced at the federal level in March of this year, also is facing opposition. If passed, it would essentially require OSHA to develop a violence prevention standard for healthcare.

States Take Action

Given these circumstances, individual states have acted with a wide variety of antiviolence laws and regulations. According to the American Nurses Association (ANA), California, Connecticut, Maryland, Minnesota, New Jersey, and New York also require workplace violence programs in healthcare. New York's law is limited to public healthcare employers, and Washington requires reporting of violent incidents. Many other states have established specific penalties for assaulting nurses and other healthcare workers beyond existing statutes.

The ANA does not lobby at the state level but has continued to push for national action to prevent violence in healthcare. More than laws alone — at any level — will be needed to stem the tide of violence in healthcare, says **Janet Haebler**, MSN, RN, senior associate director of policy and state government affairs at the ANA.

"Illinois and other states have passed laws, but it's just one tool in the toolkit," she says. "Legislation alone will not reduce workplace violence. Additionally, with any law, the details captured in the regulations and whether there is a provision for enforcement make a difference as to the effectiveness."

While many healthcare employers may have zero-tolerance policies on the books, the reality is that healthcare workers can be reluctant to report violence. That means the current high level of incidents actually underestimates the problem.

"ANA convened a large group of nurses from across the country to identify why zero-tolerance workplace policies are insufficient,"

Haebler tells *Hospital Employee Health*. "Not surprisingly, we are hearing that underreporting is based on a fear of retaliation by the employer and/or a belief that no action will be taken."

Discouraged From Reporting

This has become a common theme and was specifically cited in support of the Illinois law at an April 10, 2018, hearing. **Alice Johnson**, RN, of the Illinois Nurses Association (INA) said only 15% of roughly 200 state nurses recently surveyed said when they reported violence, management was supportive and tried to find solutions. Thirty-four percent said management was supportive, but nothing was done to solve the problem. Another 27% said that management was not supportive of reporting, she testified.

"And 6% said that management was intimidating or discouraged them from reporting the incident," Johnson said. "Another 6% said that management harassed or blamed them when they reported the incident."

Based on such reports, whistleblower protections were put into the bill, Kifowit says.

"We heard that individuals feared for their job if they reported violence," she said. "We put some protections in so they can feel they are working in a safe environment."

While providing such protections, the law assigns some responsibility to healthcare workers. The law requires that those who contact law enforcement about a workplace violence incident must notify their facility management within three days of filing the report.

The law also requires healthcare employers provide immediate post-incident care for assaulted workers, including medical treatment and access to psychological evaluation.

"What is the impact of this pervasive violence on our members?" Johnson said. "They experience difficulty concentrating on the job, psychological symptoms such as anxiety and sleeplessness, and physical symptoms such as headache and stomachaches."

Interim results from the unpublished INA study show that three-quarters of the nurses responding said violence and abuse have been "serious problems" in their workplace in the last 12 months, she said.

A similar percentage of respondents said they "feared or anticipated violence" over the last year, and 41% said in general, they do not feel safe at work, Johnson testified.

Workers Experience PTSD

The psychological effects may be more difficult to quantify than physical injuries, but some reports are suggestive of a kind of post-traumatic stress disorder.

For example, **Sonja McCarthy**, RN, an ED nurse in a Level I trauma center in Chicago, said a co-worker who was attacked by a patient required months of counseling before she could return to work.

"I worked a shift last night and drove straight here because I feel like this is an important bill to support," McCarthy testified at the hearing. "Every night in the ER, I am caring for patients that are verbally and physically aggressive toward our staff."

A former Marine, McCarthy said she can take care of herself, but said a younger nurse who looks up to her as her "work mother" was attacked.

"She was violently attacked by a patient — slammed into a wall and beaten on her head," McCarthy said. "She missed work because of her injury. When she came back after she was cleared of her injury, she could not stay at work. She had to leave and seek counseling to continue working in her chosen profession."

Several months of counseling were necessary before she returned to work in the ED. "To this day, if we have a violent patient, she is reluctant to provide care," she said. "Without a bill like this that provides some protection and guidelines, I don't have a means to protect her if I am not there."

The attack on the nurse was traced to a violent offender brought to the ER and left with little collaboration or communication with law enforcement, McCarthy said. The new law calls for protocols and communication between the hospital and law enforcement if someone is brought in that could be potentially violent.

"They have to have prior notice," Kifowit says. "There is an enhanced protocol and understanding. The original [2017] incident involved a guard that was not properly trained, so we put in training as a mandate. They have to know how to handle these inmates and how to de-escalate a situation to ensure safety is a top priority."

An initial proposal that two officers be required to bring in a prisoner for care received some pushback from budget-strapped state law enforcement agencies. With training for appropriate use of restraints and shackling, only one officer is required to be present, she said.

"We addressed their concerns, and they eventually came around," Kifowit says. "The state hospital association was at the table from day one. They were very cooperative and had very good insights."

Although the 2017 incident was the catalyst of the law, as they got into hammering out a bill, Kifowit and other lawmakers realized the issue goes beyond policies for prisoners and nurses.

"We realized there was a whole other avenue with regard to safety during [all] patient interactions that we needed to address as well," she says. "So we also put in language for mandatory guidelines for general workplace safety."

The lawmakers in Illinois looked at laws in other states and held a series of stakeholder meetings, sometimes including 14 people around the table, Kifowit says.

"We looked at California and some other states," she says. "In the end, we worked together to craft a law that is very comprehensive, includes all healthcare workers, and sets protocols for prosecution of violent patients and those in custody if they seek medical treatment. I think ours is one of the better laws."

The law essentially codifies some OSHA recommendations and requirements, which in the absence of a specific standard, the agency can only enforce through its general duty clause.

As the bill was proposed and hearings began, many nurses came forward with stories to tell. At one point during the discussions, a nurse showed Kifowit a photo that had been taken after the nurse was punched in the the face by a patient.

"We need to hold patients accountable for their violence against nurses," the legislator says. "We need to be able to prosecute them."

Those calling for action in support of the law included **Paul Pater**, RN, a nurse who works in Chicago. Providing an unusual perspective to the issue, Pater submitted written testimony describing himself as an unlikely victim, being 6'2" tall, weighing 250 pounds, and having a full beard.

"As a registered nurse, working at two different emergency departments in my short career, I have been placed in a number of dangerous situations that have put my physical safety in danger," Pater stated. "I have been punched, kicked, had my genitals grabbed, been threatened at knifepoint, [and] been threatened to be shot. I want you to imagine the terrors my fellow nurses have had to endure, who do not share my physical features."

Noting he has been advised by management that such threats "are part of the job," Pater said nurses will remain in danger until healthcare systems accept accountability and encourage reporting of such incidents.

"This bill is the first step in making that happen," he said.

Various studies and surveys have cited factors contributing to the rising wave of healthcare violence, including the opioid epidemic and the lack of mental health treatment resources. In addition, workplace factors such as understaffing, high turnover, crowded conditions, and long patient wait times can contribute to violence. Until these variables are understood, laws can punish behavior but not always change it.

"Beyond reporting, there should be a process of analysis to identify the contributing factors," Haebler says. "This will happen when there is a culture change and a true commitment to improving the safety of the environment for everyone. And that can't be legislated." ■

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New Illinois Law to Protect HCWs From Violence

Effective Jan. 1, 2019, the Illinois Health Care Violence Prevention Act (HB4100) includes the requirements summarized below. The full text of the law is referenced at the end.[1]

Workplace safety:

• Healthcare providers may not discourage healthcare workers from exercising their right to contact law enforcement because of workplace violence. Healthcare workers who contact law enforcement must notify their facility of the action within three days.

• The Whistleblower Act applies to healthcare providers and their employees with respect to actions taken.

• Healthcare providers will display a notice stating that verbal aggression will not be tolerated and physical assault will be reported to law enforcement.

• The provider will offer immediate post-incident services for healthcare workers directly involved in workplace violence incidents caused by patients or visitors, including acute treatment and access to psychological evaluation.

Workplace violence prevention program:

• Healthcare providers shall create a workplace violence prevention program that complies with OSHA guidelines for preventing workplace violence for healthcare and social service workers, as amended or updated by OSHA.

• The program will include management commitment and worker participation, including but not limited to nurses. Other components include worksite analysis and identification of potential hazards, safety training, recordkeeping, and evaluation of the program.

Medical care for committed persons:

• To the greatest extent possible, notify the hospital or medical facility that is treating a committed person prior to the person's visit. Notify the hospital or medical facility of any significant medical, mental health, recent violent actions, or other safety concerns regarding the patient.

• To the greatest extent possible, ensure the transferred committed person is accompanied by the most comprehensive medical records possible.

• Provide at least one guard trained in custodial escort and custody of high-risk committed persons to accompany any committed person. The custodial agency shall attest to such training for escort of high-risk committed persons through training by the Department of Corrections (DOC) or an equivalent program.

• If a committed person receives medical care and treatment at a place other than an institution or facility of the DOC, then the custodial agency shall ensure that the committed person is wearing security restraints. Restraints will not be used on a committed person if medical personnel determine that they impede medical treatment.

• The hospital or medical facility may establish protocols for the receipt of committed persons in collaboration with the DOC, county, or municipality, specifically with regard to potentially violent persons. ■

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Burnout Difficult to Define, Measure in Prevalence Data

Widely cited physician syndrome is all over the map

"Physician burnout" is a catchphrase in employee health, but it turns out there is little agreement on how to define it, resulting in even less understanding of how to measure, treat, and ultimately prevent it.

A meta-analysis of 182 studies was literally all over the map, as 45 different countries were represented, but little common ground was found. This was all the more surprising because the authors reported 86% of the studies used a version of the Maslach Burnout Inventory for assessments.

"Studies variably reported prevalence estimates of overall burnout or burnout subcomponents: 67.0% (122/182) on overall burnout, 72.0% (131/182) on

emotional exhaustion, 68.1% (124/182) on depersonalization, and 63.2% (115/182) on low personal accomplishment," the authors noted.[1]

The devil emerged in the details, as the authors tallied "at least 142 unique definitions for meeting overall burnout or burnout subscale criteria, indicating substantial disagreement in the literature on what constituted burnout."

One takeaway seems to be that because prevalence estimates are so broad, they almost are meaningless.

"Overall burnout prevalence ranged from 0% to 80.5%," they reported. "Emotional exhaustion, depersonalization, and low personal accomplishment prevalence ranged from 0% to 86%, 0% to 90%, and 0% to 87%, respectively."

Standardized Tools Needed

The findings underscore the need to develop standardized tools to assess the effects of chronic occupational stress on physicians, says lead author **Lisa S. Rotenstein**, MD, MBA, a resident physician in general medicine at Brigham and Women's Hospital in Boston.

"We wanted to know how big of a problem this is across the world in attending physicians," she tells *Hospital Employee Health*. "Ultimately, when we started doing the research needed for a meta-analysis, there was so much variation in how burnout was defined and measured, it was not possible."

This conclusion is equally, if not more, important, she says.

"There really is not a consensus on how we define burnout, and that limits our ability to quantify it," Rotenstein said. "On a very basic level, it's difficult to understand how much of a problem you have. What really is the burden of what physicians are experiencing on their daily function and their interaction with the healthcare system?"

The findings do not question the legitimacy of what physicians are experiencing, she emphasized. "Burnout is a real feeling, and it is a response to stress on the job," she says.

Indeed, it is possible that initial feelings of burnout may culminate in clinical depression and suicidal ideation. Whether that represents an overlap or a line of causation is another gray area. It is estimated that between 300 and 400 physicians take their lives annually. Male physician suicide rates are slightly higher than men in the general population, but female physicians die by suicide at a rate of two to three times that of other women. Importantly, male and female physicians have a very similar suicide rate, in contrast to the general population where men are four times more likely to die of suicide than women. *(For more information, see the June 2017 issue.)*

Baselines and Interventions

In addition to difficulty quantifying the problem, there also is little way to establish baselines and measure interventions without standardization. The Maslach Burnout Inventory has three subscales: emotional exhaustion, depersonalization, and personal accomplishment. However, the thresholds for defining these conditions varied widely between studies, Rotenstein says.

"We found significant variations in the cutoffs for each of the subscales and in definitions for overall burnout," she says. "That has to do either with study author preferences or where in the world it was being studied. So even within that one [Maslach] metric, there was no standardization, which poses a big problem as we try to understand the magnitude of this issue."

A lot of these problems can be traced back to burnout being more of a catchall phrase rather than a clinical syndrome with diagnostic criteria.

"This contrasts with depression, which has an agreed-upon definition and ways of measurement that correlate with a clinical diagnosis," she says.

One way to bring burnout into focus is to determine where it overlaps with depression and correlates with its established clinical criteria.

"I think that would take us a long way toward understanding what we are trying to measure and subsequently measuring in the right way," she says. That is being looked at in subsequent studies, with the hope of eventually achieving a "reset" on burnout that reflects clinical consensus.

"We know that there is already a big issue around mental health for healthcare providers," Rotenstein says. "In a previous study, we showed that almost 30% of medical students were depressed and similar percentages of residents. We know this can have a downstream effect on patient outcomes, satisfaction, and quality of care. This is important for physician health and for health of the healthcare systems as a whole." ■

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Is Breakdown of the Physician-Patient Relationship Driving Burnout?

The lead author of a recent commentary on the elusive nature of burnout raised a few eyebrows with a provocative title, "Physician Burnout—A Serious Symptom, But of What?"[1]

"We received some feedback that was critical of us for seeming to suggest there was not a problem," says lead author **Thomas L. Schwenk**, MD, dean of the school of medicine at the University of Nevada, Reno. "Truly something important is happening. There is clearly a problem. We need a better understanding of what it is."

Schwenk has long been fascinated with the issue of burnout in physicians, linking some of it to the clinical depression famously described in *Darkness Visible,* a book by William Styron: "Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self — to the mediating intellect — as to verge close to being beyond description."[2] Schwenk corresponded with the late Styron and came to form a theory that a breakdown in the physician-patient relationship could be driving the widespread reports of burnout in the profession.

In a commentary, also published this year, Schwenk notes that physicians have lost a time-honored "deeply personal, reciprocal relationship with their patients. That caring relationship has been lost for many physicians in the current system of fragmented, rushed, dysfunctional, digitized, corporatized, and costly medical care — a system that prizes efficiency over relationships, profits over common good, and volume over value."[3]

In his more recent commentary, Schwenk looked at the meta-analysis by Rotenstein et al.[4] that found broad disagreement about definitions of burnout and widespread variation in assessing its prevalence. He offered more insights into this issue in the following interview.

HEH: Were you surprised at the wide variation of definitions and measurements of physician burnout in the Rotenstein study?

Schwenk: I was not. I have been following this work for a while, and it just never seemed to quite come together. We keep stabbing at this issue from many different perspectives, adaptations of different instruments, and I never could get to what the core is.

Our basic thesis in the editorial is that we have gotten too far over our skis here in terms of giving this condition a name that seems like a diagnosis. It sounds like it has clinical credibility, but it is really just a label for a very heterogenous group of dissatisfiers. It's sort of a misery list of labels. There is misery and dissatisfaction, but it is not well-specified. It is not well-understood, and yet here we are racing down a path that says use massage, yoga, and scribes for electronic medical records. We are throwing all kinds of stuff at this. I wish we could take a step back and get a little better sense of what is actually happening.

HEH: The study found wide variations and approaches using the Maslach Burnout Inventory.

Schwenk: I think there are a couple of problems. One is that it was not designed for physicians. Initially, it was designed [to assess] the caregiving burden for social service professionals. It is used in quite a wide range of populations, but it has not really been validated for those [other] specific circumstances. At the very least, it is supposed to be used for people that have clinical or caregiving responsibilities. So when it is used for medical students in the first or second year — who don't have clinical responsibilities — I don't know what that means, exactly.

Medical practice has always been stressful and always will be. The fact that physicians would answer a question that I feel burned out from time to time in my work doesn't surprise me too much. We all have our moments. I will say that there has been some work recently that will be interesting to see. That is the development of some instruments that are more specific to physicians and clinical work settings. That might be useful.

HEH: Rotenstein and colleagues suggested trying to develop clinical criteria similar to depression.

Schwenk: My bias is that at the very least we need to start out with all the physicians who score positively on depression questionnaires and burnout questionnaires. Pull them all out and label them more clearly as meeting criteria for depression. That would be a good start because that would be a clinical diagnosis. It has criteria and clear treatment approaches. A very high proportion who score positively on burnout questionnaires will naturally score positive on depression assessments. Let's pull those out for starters, and then see what's left in terms of all the other work dissatisfaction and try to figure out what that means.

HEH: As a practical matter, it is difficult to prevent something if you can't define it and measure it.

Schwenk: That's the main issue. I've been in medicine for 40 years, so

I have seen a fair bit come and go. I keep trying to put this in perspective and trying to understand — has something changed? If so, what and why? That is of great interest to me. In older days, physicians would frequently talk about exhaustion, being on call, and the demands of patient care. But you just never heard anybody use the word "burnout," and we didn't talk about depression that much.

HEH: You mentioned some stigma associated with the term "depression" in physicians.

Schwenk: There has always been a stigma related to depression. I think one of the reasons we coined this word "burnout" is because it sounds like it is saying something, but it doesn't have the stigma that the word "depression" has. I think we would be better off to just use the clinical nomenclature. Say it straight out, and talk about clinical diagnoses instead of burnout, which kind of trivializes the problem. It also causes physicians to feel like they are the victims. As if the system is doing something to me personally and I am the victim. I don't really like to think of physicians as victims. We should be taking charge of the system and making it work for our patients. That would help a lot.

HEH: In one of your commentaries, you trace some of this to a breakdown in the traditional physician-patient relationship.

Schwenk: A lot of the things physicians complain about detract from the reciprocal nature of the physician-patient relationship. Physicians give a lot to patients, but they also get a lot back. If the system has disrupted that relationship — which I think it has — then it deprives the physicians of that energy return, if you will. We always give a lot. That has always been true, but we always got a lot back. Now the system may be disturbing those relationships and making them less satisfying, powerful, and reciprocal. It has harmed some of that, and we are not getting back that energy.

HEH: It's tempting to say the changes in reimbursement, reporting demands, and the like are the cause, but even if that could be quantified, it wouldn't explain all depression in physicians?

Schwenk: There are studies going back a ways in terms of depression in physicians. It's pretty clear that the prevalence of depression of physicians has gone up, as it has in the general population. I'm really interested in the issue of being depressed *as* a physician vs. being depressed *because of being* a physician. We are taking in medical students who have a history of depression, who suffer recurrences, and they experience depression as a physician and some of the stigma attached to that. We also have physicians who have no history, yet they experience profound depression and suicidal ideation as physicians. And presumably, to some extent, because of being a physician — because they did not have prior episodes. I have a feeling those are two very different populations." ■

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CDC Issues Draft Guidelines for Infection Control in HCWs

The CDC has issued draft guidelines for infection control in healthcare workers, giving employee health professionals until Dec. 14, 2018, to submit comments.

Culminating a long process of reviewing and updating current guidelines that are two decades old, the CDC recently published Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services (Draft Guideline).

"The updated recommendations in the draft guideline are intended to facilitate the provision of occupational infection prevention and control services to healthcare personnel and to prevent transmission of infections between healthcare personnel and others," the CDC stated.

The CDC is seeking a balanced approach to new infection control guidelines for healthcare workers, trying to avoid overkill without sacrificing the necessary protections for a broad range of pathogens. *(For more information, see the August 2018 issue.)*

To review the draft and submit an electronic comment, visit: https://bit.ly/2Sx5ZNb. ■

The Secret of Working Sick: 'Don't Mask, Don't Tell'

Presenteeism policies — or the lack thereof

With the wide variation and limited effectiveness of healthcare policies to prevent presenteeism in sick healthcare workers, has the situation devolved to unspoken policies of "don't mask, don't tell?"

Michael A. Gelman, MD, PhD, turned the phrase recently in San Francisco at the IDWeek 2018 meeting after a presentation on the complex and continuing problem of presenteeism.

"It really speaks to the difficulty of getting hard data in a situation where you're looking at a behavior that is fundamentally a secret," said Gelman, medical director of infection control at the James J. Peters Veterans Affairs Medical Center in Bronx, NY. "It's 'don't mask, don't tell.' We need to have a mechanism for collecting data in a standardized way. We need to work with our colleagues in occupational health with support from our C-suites."

Gelman commented during the question-and-answer session after an IDWeek presentation on the issue by **Hilary Babcock**, MD, medical director of occupational health at Barnes-Jewish and St. Louis Children's Hospital.

Babcock concurred with the assessment, saying "I think the lack of data is one of the barriers to moving this forward, and it is very difficult to track. There are a lot of competing demands that I think create challenges in that area."

Babcock described numerous barriers to healthcare workers staying home when sick with the flu or influenza-like illness (ILI). The various loopholes and disincentives described made it clear that many healthcare workers are reporting for duty instead of sick bay, putting patients and co-workers at risk.

"Frankly, this is affecting patients and patient care in ways that we don't even fully understand," Gelman said.

Policies on Paper Only

The CDC recommends that healthcare workers with ILI not work until afebrile for 24 hours, Babcock noted. "But we know that in practice, this doesn't always happen."

She assessed hospital policies and practices on presenteeism in a national survey, netting 232 responses.

"Most institutions have work restriction policies regarding ill healthcare workers, but there is a lot of variability in terms of policy communication, adherence, monitoring, and enforcement," she said.

There was significant variability in the availability of flu testing, treatment, and antiviral prophylaxis, she added.

"Tracking of healthcare worker illness, presenteeism, and sick time taken is not standardized and really presents significant challenges," Babcock said. "It makes it more difficult to track adherence to existing policies and [assess the] potential impact of policy changes on presenteeism of healthcare workers."

Overall, 89% of respondents reported an existing work restrictions policy for flu or ILI.

"Only about 63% reported that this policy was communicated to staff on a regular basis, at least annually," Babcock said. "About half reported that adherence to the policy was not monitored."

Relaying a comment that summed up the sentiment of many, survey respondents said essentially, "We have a policy but it is mostly ignored. Healthcare personnel work with ILI all the time," she said.

Return-to-work policies were sporadically enforced at many hospitals. "The lack of enforcement varied by job title so that the 'not-enforced' category was highest for attending physicians," she said.

Overall, 79 of 169 respondents who answered this question listed fever as exclusion criteria, with most requiring the afebrile period of 24 hours. However, 12 of 169 respondents specified a set number of days excluded from work — usually five to seven days. In addition, 7% required occupational health clearance to return to work. Additional criteria at a few hospitals included wearing a mask, particularly around high-risk patients.

Overall, 44% of respondents reported they had a single pool of paid days off that they used for both vacation and illness.

"Multiple comments suggested that this model of a shared pool of days off really decreases compliance with work restriction policies," Babcock said. "People taking a sick

day have actually deprived themselves of a vacation day later in the year."

These types of arrangements as well as paid sick days and other factors varied by department, union status, and groups of workers.

"Policies in general were less likely to apply to physicians, residents, and students," she said. "It was noted that many private practitioners and attending physicians really don't have any sort of coverage scheme or [sick leave] arrangement, especially with busy clinics and surgical schedules. No one wants to cancel patients."

Essential Presenteeism?

One of the most telling findings of the survey was that many respondents said their healthcare facility needed sick workers on the job to keep the system running.

"People noted that without presenteeism, there would be a critical shortage of providers," she said. "They said, 'The system is not set up to actually have these people off when they are sick. We don't have enough providers to cover for that.'"

In addition, counterproductive policies like tying year-end bonuses to attendance certainly discouraged people from calling in sick.

"There are ongoing barriers to ill healthcare workers staying home, including financial impact, loss of vacation days, and the sense of responsibility to patients and colleagues," she said. "Some people feel irreplaceable."

About half of those surveyed said their facility offered influenza testing and treatment for any employee. Another 20% offered testing only after occupational exposures. About one-third offered treatment after an occupational exposure.

"After an occupational exposure, the majority of places offered antiviral prophylaxis, but about one-third based it on work location or complication risks," Babcock said.

However, many work places did not provide antiviral prophylaxis to workers who were non-occupationally exposed, including those, for example, who had a family member sick with flu.

"Commenters noted that occupational health was not really resourced to serve as urgent care during influenza season, and that led to a lot of practice variation," she said.

The facilities' workers' compensation policies may affect occupational health's willingness to provide care vs. refer out for treatment, she said.

"Policies for prophylaxis might be informed by the vaccine efficacy for that year," Babcock said. "So if there is lower vaccine efficacy, they may be more liberal with PEP [post-exposure prophylaxis], and in years with good efficacy they might limit that a little bit more." ■

One-third of Long-term Care Workers Skip Flu Shot

In a season where 90% of deaths were in elderly

Employee health professionals were probably not surprised that workers in long-term care had the lowest flu immunization rates among healthcare workers in a recent report by the CDC. That is a longstanding problem and was reflected in the 2017-2018 survey: Only 67% of long-term care workers were immunized.[1]

The damning detail is that 90% of the record 80,000 deaths were in people over age 65, with most of the elderly deaths likely exposed in the community. It was a glaring contrast that was highlighted by the Surgeon General at a recent flu press conference at the National Foundation for Infectious Diseases (NFID) in Washington, DC.

"While three out of four healthcare workers [overall] are getting vaccinated, I'm embarrassed to say that coverage is still lowest among some subsets of our healthcare workers — long-term care workers — who often work with patients who we know are at the highest risk for the complications of flu," Surgeon General **Jerome Adams**, MD, said at the NFID press conference. Adams called on "employers to take action to protect their staff from flu, to reduce absences, and to reduce the chances of their employees spreading the flu to others."

Currently, 24 states have some form of flu shot provision for long-term care workers, with varying levels of requirements and exemptions, the CDC reports.[2] While individual outbreaks of flu in long-term care facilities are sometimes reported in the news or medical literature, there really is no

active surveillance system for these infections, certainly not one linking them to unvaccinated healthcare workers. Many facilities do not actively push seasonal flu shots if their state has no such requirement.

A Fatal Combination

One will find no greater proponent of vaccination — influenza or otherwise — than **William Schaffner**, MD, professor of preventive medicine at Vanderbilt University. However, the epidemiology of the 2017-2018 flu season indicates the deaths in the elderly were driven by forces beyond long-term care facilities, he explains.

"First, we had a really fierce dominant influenza strain — H3N2," he says. "These H3N2 strains are notorious for having lots of complications in older persons. Also, the population in the U.S. that is older than age 65 is growing every day, so the denominator for the H3N2 virus was larger than it ever had been."

The other critical factor was that the H3N2 strain in the vaccine was only about 25% effective overall and certainly less so in the specific elderly population. That said, public health agencies and medical associations have been pushing flu shots in long-term care for years and will continue to do so.

"The data indicate it is people who work in long-term care, along with visitors, who introduce the influenza virus into the facility," Schaffner said. "We ought to be trying to vaccinate them on an annual basis, and I would love to see that as a requirement." Mandatory flu vaccination policies are effective but primarily have been established in hospitals. Facilities with such requirements immunized 95% of workers last season, but immunization fell off dramatically in settings where requirements were not in place, the CDC reported.

The 80,000-death toll in the 2017-2018 flu season is the highest since the CDC began reporting flu deaths in the mid-1970s. The previous record was 56,000 deaths in the 2012-2013 season, while the lowest estimate is 12,000 deaths in 2011-2012.

"It was a significantly bad year," **Daniel Jernigan**, MD, a medical epidemiologist at the CDC, said at the NFID meeting. "The same problem happened ... the season prior in the Southern Hemisphere."

While flu in the Southern Hemisphere is used to roughly predict the severity of the subsequent U.S. season, influenza is infamous for its unpredictability. This year, the Southern Hemisphere is coming off a milder flu season dominated by an H1N1 strain that is covered by the vaccine, Jernigan said.

"We're seeing a little of H1 now, but boy, I just would not take my chances," he said. "I think I would get the vaccine now, and you don't have to worry about whether it's a mild or severe season."

Beware of Complacency

Concerned about complacency, Adams emphasized that speculating on the severity of the 2018-2019 flu season is the "wrong question to be asking. Because at the end of the day, by the time we figure out if it's a bad flu season or not, then a lot of the damage has been done."

The emphasis this year is to promote widespread vaccination and administer antivirals as needed to those infected. Those who claim to never get the flu or cite other rationales for forgoing the annual shot were reminded of their civic duty.

"Getting the flu shot isn't just about keeping you safe and healthy," Adams said. "Getting the flu shot is about community. It's about everyone else around you. Those 80,000 people who died last year from the flu — guess what? They got the flu from someone. Someone passed it along to them."

While the deaths primarily hit the elderly, a record 180 children died of flu in the U.S. last season. **Wendy Sue Swanson**, MD, a pediatrician at Seattle Children's Hospital, framed this finding in stark terms at the NFID meeting.

"I care deeply about children and the suffering that comes from influenza, the thousands of children who were hospitalized last year," she said. "And think of it — 180 families put a child in a grave last year because of a vaccine-preventable infection."

Adams also interjected a personal note, saying that as a father he was struck by the pediatric flu deaths.

"This really just hit me hard as a father of three young children myself — 180 kids died last year from the flu, and most of them were unvaccinated," he said.

Eighty percent of the children who died of flu had not been immunized. ■

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HOSPITAL EMPLOYEE HEALTH

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CE QUESTIONS

1. **Alice Johnson, RN, said only what percent of some 200 nurses recently surveyed said that when they reported violence, management was supportive and tried to find solutions?**
   a. 5%
   b. 15%
   c. 35%
   d. 60%

2. **The new Illinois law to protect healthcare workers from violence includes whistle-blower protection for those reporting incidents.**
   a. True
   b. False

3. **According to Thomas L. Schwenk, MD, why is the Maslach Burnout Inventory an inappropriate tool to look at burnout in first- and second-year medical students?**
   a. It does not account for pre-existing conditions.
   b. It was designed to assess mid-career physicians.
   c. There is implicit bias in measures of female students.
   d. They do not have any clinical responsibilities yet.

4. **Hilary Babcock, MD, said return-to-work policies were sporadically enforced at many hospitals. Which group was subjected to the least enforcement?**
   a. ICU nurses
   b. Respiratory therapists
   c. Attending physicians
   d. Physician assistants

CE OBJECTIVES

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. Describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
3. Cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.