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Association collaborations prove strength in numbers helps in job performance

Many organizations overcoming fear of competition

There is strength in numbers; there also is risk. While health care associations recognize the advantages of collaborating on matters of common interest, they also are keenly aware it can be fraught with problems. After all, exposing your membership to the benefits offered by other organizations potentially puts your own group's lifeblood in jeopardy.

Despite the potential risks, however, a number of leading health care associations have been collaborating successfully for years, and that trend appears to be growing. The benefits, many agree, far outweigh the risks.

"Basically, you recognize the expertise and value in another association that's taken years to create, so rather than recreate that expertise yourself, you look for opportunities to share and trade value," explains **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of Little Rock, AR-based Case Management Society of America (CMSA). "Other organizations tap into the same type of things with your organization, so it becomes a value for both associations and a tremendous value for the members."

Members will join the association they feel most closely aligned with, she notes, "but no organization can provide virtually everything its members need. You can't put a lot of money into every subcategory, but if you can identify an organization that really has put a lot of money into developing those resources and has the expertise, and you can

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Heavy computer use may *not* cause CTS after all
Debunking a widely held theory, researchers at the Mayo Clinic have shown that there's no direct link between heavy computer use and the development of carpal tunnel syndrome. In a recently published study, they found that employees who spent numerous hours at the computer were no more likely to develop CTS than those workers who did not 104

New program helps meet HIPAA security rules
Although its putative intent was to ensure portability of health care coverage, the Health Insurance Portability and Accountability Act of 1996 also carried with it a long list of security requirements that have forever changed the way occupational health facilities do business. A new program, called ZixMail, offers the hope of complying with these regs with just the click of a mouse 105

Employee survey shows impact of 'presenteeism'
Absenteeism has long been a major concern of employers, and a prime mover in the effort to reduce injuries and improve treatment of chronic diseases. But more recently, presenteeism — when an employee is at work but performing far below par — has become recognized as an important component of lost productivity. A new study on the impact of depression on work place performance brings the import of presenteeism into focus 106

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connect to part of that expertise, you supplement what you have developed. Your members are extremely well-served, and their loyalty is still to the primary association."

"All of us are in the helping professions," says **Anne R. Cox**, CAE, executive director of the American Association of Occupational Health Nurses (AAOHN) in Atlanta. "We have to leverage everything we have: resources, expertise, and impact."

"We recognize the other organizations for the specialty they represent, and we respect that," adds **Deborah V. DiBenedetto**, president of AAOHN. "We're not the only kid on the block."

Keeping membership levels high is a challenge, she admits, and collaboration can help. "It lets our members know we're here, and it reminds them of the services we provide. Fortunately, our membership has been very stable."

"We've been working pretty closely with AAOHN on a number of issues, and in the last couple of years, more closely than we ever had in the past," says **Gregory Barranco**, director of government relations for the American College of Occupational and Environmental Medicine (ACOEM). "That's partly because I'm our first on-staff director of government relations, and partly because my AAOHN counterpart Kae Livsey and I get along really well." Barranco is based in Washington, DC.

On some issues, it just makes sense to have a united policy front, he says. "We probably talk every week or so, fill each other in on certain issues. It's always good to have the two key players in occupational health aligned."

"I'd say that probably in the last six years, we have really begun to collaborate more with other professional associations and government agencies," says **Mary Ann Gruden**, MSN, CRNP, COHNS/CM, executive president of the American Association of Occupational Health Professionals in Healthcare (AOHP) in Reston, VA. "I think the driver behind that was that we really felt the people out there didn't know about us. We were a specialty occupational health group, and we wanted to gain recognition as experts in the field." **(For a summary description of each of these associations, see box, p. 99.)**

Gruden says her organization's increased collaborative efforts are in response to what she sees as a series of new challenges facing health care associations. "These challenges include decreasing support from employers to allow their occupational health providers to be members of associations,"

she observes. "There may be consolidations involving the elimination of positions, and people also seem to have less time to devote to associations. From an educational standpoint we clearly need to be more collaborative."

One of the oldest collaborations is that of ACOEM and AAOHN, which began nearly 60 years ago with the American Occupational Health Conference (AOHC). "We are two very different organizations within the same business," says DiBenedetto. "But there are common issues of confidentiality, worker health and safety, and so on." The two organizations have issued joint position papers, for example, that appeared on both of their web sites.

"We've also had joint ergonomics statements with AOHP," DiBenedetto adds. "We've been able to go to its conferences, to start dialogues and find commonalities."

"Our collaboration [with AAOHN] has started

Health Care Associations

The following is a brief synopsis of the organizations featured in this month's cover story:

- **American Association of Occupational Health Nurses** (AAOHN)
  Philosophy: Advance the profession of occupational and environmental health nursing as the authority on health, safety, productivity, and disability management for worker populations.
  Membership: AAOHN is the connection to a nationwide network of more than 12,500 occupational and environmental health nursing professionals. Occupational and environmental health nurses are registered nurses licensed to practice nursing in the states in which they work. It is preferred that nurses entering the field have a baccalaureate degree in nursing and experience in public or community health, ambulatory care, critical care, or emergency nursing.
  National office: American Association of Occupational Health Nurses Inc., 2920 Brandywine Road, Suite 100, Atlanta, GA 30341. Telephone: (770) 455-7757. Fax: (770) 455-7271. World Wide Web: www.aaohn.org.

- **American College of Occupational and Environmental Medicine** (ACOEM)
  Philosophy: ACOEM is a group of physicians and encompassing specialists in a variety of medical practices united to develop positions and policies on vital issues relevant to the practice of preventive medicine both within and outside the workplace.
  Membership: The ACOEM represents more than 6,000 physicians specializing in the field of occupational and environmental medicine. Founded in 1916, the College is composed of 31 societies in the U.S., Canada, and Mexico.
  National office: ACOEM, 1114 N. Arlington Heights Road, Arlington Heights, IL 60004. Telephone: (847) 818-1800. Fax: (847) 818-9266. World Wide Web: www.acoem.org.

- **Association of Occupational Health Professionals in Healthcare** (AOHP)
  Philosophy: AOHP is dedicated to promoting educational and professional growth opportunities for its members and advocating the protection and well-being of health care workers in a cost-effective manner.
  Membership: Membership directory includes more than 1,400 members in the U.S. and other countries. Members include: RNs/LPNs who specialize in occupational/employee health, human resources personnel, infection control practitioners, attorneys and paralegals, workers' compensation coordinators; medical case managers, rehabilitation case managers, safety and industrial hygiene personnel, and risk managers.
  National office: AOHP, 11250 Roger Bacon Drive, Suite 8, Reston, VA 20190-5202. Telephone: (800) 362-4347. Fax: (703) 435-4390. World Wide Web: www.podi.com/aohp.

- **Case Management Society of America** (CMSA)
  Philosophy: To influence the future development of case management as a profession. Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communications and available resources to promote quality, cost-effective outcomes.
  Membership: CMSA has more than 100 affiliated and pending chapters; membership exceeds 7,500 individuals. Case manager members must have a health professional degree, current license, or national certification in the health or human services profession. Associate members include individuals actively providing case management related services and not qualified as a case manager member.
  National office: Case Management Society of America, 8201 Cantrell Road, Suite 230, Little Rock, AR 72227. Telephone: (501) 225-2229. Fax: (501) 221-9068. World Wide Web: www.cmsa.org.

very recently," adds Gruden. "As AAOHN president, [DiBenedetto] is very interested in collaborations that are either occupational health-related or affiliated, like case management. We are both primarily occupational health nurses, so our members have a lot of similar needs and concerns: membership, education, competency, keeping abreast of current legislative issues."

Both associations responded to the latest call for comments for the National Forums on Ergonomics. "Even though we didn't do a joint presentation, we were able to work with Kae Livsey and collaborate on ideas and thoughts, we shared position papers with one another, and saw our similar outlooks and philosophy on positions that should be taken," says Gruden.

Working together with AAOHN in Washington, DC, has benefited Barranco as well. "It provides increased information, an exchange of ideas, and a united front on Capitol Hill or with regulatory agencies," he notes. "We've done joint press releases and shared comments on issues like ergonomics."

"It gives us a single voice on things like position papers," DiBenedetto explains. "There might be common lobbying issues, like the [Occupational Safety and Health Administration's] ergonomics standards. We knew what its issues were, and we could refer to our mutual understandings. In the courts, we have developed *amicus* briefs for other organizations."

Safety in numbers?

In many cases, associations will have numerous partners. For example, Gruden's organization collaborated with the Association for Professionals in Infection Control and Epidemiology, as well as with the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Disease Control and Prevention, and OSHA.

"In areas like infection control, there is power in numbers and a lot of opportunities," she explains. "The same is true with our education programs. This year in San Francisco, members of our Northern California chapter presented a specialty workshop on getting started in occupational health care at the AOHC."

Gruden says she's also looking to develop a task force with members from AAOHN and AOHP to address the growing nursing shortage.

AAOHN co-sponsors and endorses other conferences that benefit its members. "For example, we cosponsor CMSA's conference," she says, "and I attended last year as AAOHN president. We speak at each others' conferences in an official capacity, sharing information and just trying to get us all out of our 'silos.'"

AAOHN also has worked quite a bit with the American Nurses Association, says DiBenedetto, as well as OSHA's Office of Occupational Health Nursing. "Just to be there and to have the same voice on issues like health and safety in the workplace is really important," she says.

Sometimes the collaborations go surprisingly far afield. For example, AAOHN is seeking to invite members of the Society of Human Resources Management to a local program it is sponsoring on telemedicine, and discussing with the National Safety Council the role of the occupational health nurse in managing lost time and disability. **(To find out how one health care organization has collaborated with more than 50 partners, see article, p. 101.)**

Barranco says ACOEM also partners with the American College of Preventive Medicine (ACPM). "We review each other's comments before turning them in. In the summer of 2000, we co-signed a comment paper, and we have done that before. Where we couldn't agree on joint statements or comments, we have cited specific pieces of each other's documents in our comments and vice versa. For example, we might say, 'We agree with ACPM in its position that such and such is or is not a good thing.'"

Of course, no two organizations can agree on everything. "We're still very different organizations with different missions and visions," says DiBenedetto. "Still, if we are going to the same shore, we can take different boats. In recognition of these new market realities, AAOHN recently changed course, adopting a new approach to strategic planning and issuing a new vision statement. **(See article, p. 102.)**

"There definitely are issues where we don't see eye to eye with AAOHN, like scope of practice," notes Barranco. "We have clashed in the past, but that does not stop us from getting together. We both know where our lines are drawn in the sand, and we stay away from them."

Benefits outweigh drawbacks

Despite the potential risks and occasional pitfalls, collaboration is well worth the effort, says Boling. "What happens on a organizational basis is just remarkable, because rather than competing for member loyalty — which is the traditional

way of looking at things — it makes *both* organizations much stronger, and the members get even more benefits," she declares. "For instance, AAOHN members may be able to access benefits of CMSA members for a negotiated fee, and vice versa. If we can do that, then AAOHN doesn't have to pay for the development of those resources. The member can choose whether or not to take advantage of the opportunity; it's a dynamite concept."

DiBenedetto agrees. "We need to look outside ourselves at many groups that may have been seen as competing organizations," she says.

Will this trend continue, or is it just a fad? it depends on the issues of the day, Barranco says. "It's increased since I've come on board, so I imagine it will continue, but it can come in waves also," he says. "Ergonomics will not always be our No. 1 priority, nor will privacy."

Boling, on the other hand, predicts "an explosion" of collaborations as associations begin to grasp the benefits of partnering instead of competing. "Some people are so protective, and it really depends on a relationship of trust being developed," she says.

"At the executive and board levels of most organizations, they are so accustomed to competing and being careful when other organizations form that they tend to be cautious about similar, closely related organizations," Boling says. "But there is a way to address it in a very positive manner. Boards and staffs have to grasp that and be able to establish relationships of trust, and that takes time."

Of course, she adds, it depends on your partner. "AAOHN has been incredibly easy to work with because it has leadership that grasps the concept while still being quite protective of its turf — and it has to be," Boling asserts. "It's a very delicate balance; you have to know what will work for your members and theirs, and watch where the money will flow and know you will build loyalty in your members. AAOHN is not interested in losing any members to us; we are not interested in stealing them, because we recognize their loyalty will be to the organization they feel closest to."

DiBenedetto says that if associations want to continue to succeed and grow, they must consider collaboration as an important strategy.

"If I have something that would help another organization, I don't mind sharing," she says. "We don't mind rocking the boat; we are very willing to take risks now. The times demand it."

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Not all partners are created equal

Variety, they say, is the spice of life. But when you have ongoing collaborations with approximately 50 different health care organizations, isn't that taking things a bit too far?

Not at all, insists **Jeanne Boling,** MSN, CRRN, CDMS, CCM, executive director of Little Rock, AR-based Case Management Society of America (CMSA). "I have five different levels of collaborations going on," she explains. "Within all of those five we have relationships with a number of different entities on each level."

Those relationships include associations dealing with occupational health, rehabilitation, chronic disease, various professional disciplines, governmental agencies, the military, credentialing organizations, for-profit and not-for-profit health care providers, technology development

organizations, and health care consulting firms.

The first level, Boling explains, may involve sharing mailing lists in order to promote conferences. "So, for example, CMSA gives [the American Association of Occupational Health Nurses] its list, or promotes an AAOHN conference; we trade in an area where there is equivalent value. It saves everybody some costs and benefits the members. It also provides an opportunity to make your members aware of other conferences," she says. This level might involve the "trading" of booths, where each organization gets a free booth at the other's conference, or a trading of speakers. "That's reasonably common, and we do it from time to time with various associations," says Boling.

The second level takes the collaboration a step further. "This is where we recognize expertise and value," she notes. "For instance, AAOHN might have some members interested in case management. Likewise, we may have some members interested in occupational health or disability management. So, from AAOHN's perspective it may want to develop resources in case management; we might be able to add value for their members by allowing them access to our case management resources: on the web, at conferences, and so on. AAOHN can do something similar for us. That becomes really cool because it provides additional benefits to members while keeping those members in their primary association."

The third level involves more "solid," organized coalitions. "For us, that means health policy and international issues," she says. "The international community is really expensive to serve, so it's a good idea to look for a partner."

The fourth level extends to offering cobranded products or educational programs, or a shared data bank. "These could be for salaries, outcomes, or anything that could be of value to one or more organization," Boling explains.

The fifth level involves actual representation on boards of other organizations. ■

Ongoing strategic plan 'creates future path'

AAOHN treats planning as continuous process

Recognizing the rapid pace at which change is occurring in occupational health, the Atlanta-based American Association of Occupational Health Nurses (AAOHN) is seeking to ensure its long-term success through a dramatic new approach to strategic planning. While AAOHN has used strategic planning since the mid-1980s, the association has taken an entirely different approach to the process.

"Recognizing that the association operates in a dynamic and demanding environment that needs to remain relevant as a business and competitive as a profession, strategic planning is now viewed as an ongoing process,"[1] wrote **Anne R. Cox**, CAE, AAOHN executive director, in the June 2001 issue of the *AAOHN Journal.* One of the highest priorities in this new approach, Cox wrote, is "environmental scanning" — a continual monitoring of both the profession of occupational health nursing and the trends affecting all associations.

"Fifteen years ago, 80% of our membership was company-based," notes **Deborah V. DiBenedetto**, AAOHN president. "Now, that figure is closer to 15% to 20%. Through downsizing and outsourcing, a lot of members have lost their positions, but other kinds of work are now available: third-party contractor, entrepreneur, employee health aide. The tried and true vision of nursing 'within four walls' is changing."

It is precisely because of those changes, Cox said, that AAOHN must now think outside the box. In September 1999, AAOHN began its fourth strategic planning process, to address these issues:

- the association's current mission, goals, and objectives;
- internal and external organizational assessment;
- trend analysis;
- an analysis of AAOHN's position in the marketplace.

"Major questions were posed throughout the entire process to encourage out-of-the-box thinking in crafting the next strategic direction for AAOHN," Cox wrote. "As a business, changes were needed to allow AAOHN to seize opportunities more quickly to create increased value for members and customers."[1]

The common expectations of the strategic planning team addressed five major issues:

1. the changing role of occupational and environmental health nurses;

2. the incorporation of technological solutions in the visioning process;

3. the influence of the association's responsiveness, fiscal responsibility, and integration with other organizations on attraction, recruitment, and retention of members;

AAOHN Vision, Core Values, and Envisioned Future

VISION
Advance the profession of occupational and environmental health nursing as the authority on health, safety, productivity, and disability management for worker populations.

CORE VALUES
- ✔ **Dynamic:** Energetic, forceful, yet flexible in a changing environment.
- ✔ **Accountable:** Responsible for one's actions and destiny.
- ✔ **Responsive:** Respond with a sense of urgency.
- ✔ **Excellence:** Striving to be "best in class."

ENVISIONED FUTURE
AAOHN will be universally recognized as the authority and resource for the health of the world's work force.

Source: Cox AR. The art of strategic planning — creating the future path. *AAOHN Journal* 2001; 49(6):280-285.

4. communicating AAOHN's role to foster greater public awareness, collaboration with other organizations, and input in legislative matters;

5. developing research and resources to help design new delivery models, increase return on investment models, and promote advances in the field of occupational and environmental health.

The planning group further developed 15 "High Level Issue Expectations," which fell under three broad categories: organizational structure, service and service delivery, and partnership and external influences. Business, health care, economic, demographic, social, technological, political, and occupational and environmental health and safety professional issues and trends were considered," noted Cox. "From the perspective of AAOHN as a business, it was equally important to assess issues and trends, such as competition, that will dramatically influence the environment in which associations operate."[1]

The planning team ultimately identified these five statements, which encapsulate what they want the association to be:

• the proactive primary resource, in all aspects, for occupational and environmental health professionals;

• the universally recognized authority for occupational and environmental health professionals related to standards of practice, business, management, safety and health, and work force productivity;

• a dynamic and evolving association that engages the membership and is receptive and visionary to its members and all occupational and environmental health nurses' and professionals' needs;

• a financially strong and solvent organization;

• a professional organization with a strong voice influencing government legislation; health care policy; and practices to promote, protect, and secure the health and safety of workers.

To achieve this new vision, AAOHN adopted the following strategic goals:

• Business, government, workers, and other key publics recognize the value and contributions of occupational and environmental health nurses.

• New and enhanced strategic alliances advance the profession and the goals of AAOHN.

• The AAOHN shapes legislation, regulations, and public policy that positively impact the profession of occupational and environmental health nursing.

• Through a dynamic organizational structure, AAOHN advances the profession.

• The AAOHN is the recognized authority and resource in occupational and environmental health practice and research.

"The Board and staff continue to participate in a highly collaborative process to identify emerging opportunities and consider possible future scenarios requiring the association to reshape itself responsibly," Cox concludes. "More than ever, AAOHN will need to anticipate the future and take action to position the association well for the 21st century."[1]

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Reference

1. Cox AR. The art of strategic planning — creating the future path. *AAOHN Journal* 2001; 49(6):280-285. ■

Heavy computer use may *not* cause CTS after all

Study seems to indicate no direct linkage

For years, professionals involved in employee health have commonly held the belief that heavy computer use and the attendant repetitive motion are primary contributors to carpal tunnel syndrome (CTS). Now, however, a new study by the Mayo Clinic indicates there may be no direct linkage at all between CTS and extensive use of computers.

The study, published in the June 2001 issue of *Neurology*,[1] was led by **J. Clarke Stevens**, MD, a neurologist with Mayo in Rochester, MN. Stevens formerly served as chair of the department of neurology at the Mayo Clinic in Scottsdale, AZ. Conducted in Scottsdale in 1995, the research included 257 Mayo employees who were heavy computer users.

Although 29.6% of the employees reported hand paresthesias, just 24 (10.5%) met clinical criteria CTS, and in only seven (3.5%) was the syndrome confirmed by nerve conduction studies. **(See chart, below right.)** Bottom line: The frequency of CTS in these computer users was similar to that in the general population. "This suggests that using a computer in the setting studied does not enhance the risk of CTS,"[1] the researchers concluded.

Even researchers surprised

Even the researchers admit to being surprised by the study's findings. "They were unexpected," admits Stevens. "Like everybody else, we thought we'd find a much higher incidence of CTS."

However, as noted in the study, there is not a significant body of literature on the subject. Why, then, is the linkage between computer use and CTS so widely assumed? "I really don't know how that got to be," Stevens concedes. "There's really nothing in the literature. People say it is due to the repetitive motion of typing. But if that's true, CTS should have been epidemic when people were using manual typewriters, which are a lot tougher on the fingers. I wonder if it isn't because people get a lot of other neck and upper extremity discomfort with computer use. We did ask our subjects about symptoms of the neck, arm, shoulder, and wrist, and discomfort was very high, even in those who didn't have CTS. So there is that association, and maybe that's how the perception of a linkage grew."

The researchers did look at the use of typewriters, but found no differences. "You also would expect to see greater discomfort among those workers who used computers longer, or more during the day, or who were older," says Stevens, "But they were identical in nearly all aspects — age, sex, and years of computer use."

The participants also were asked about symptom onset, and many mentioned waking up at night, or feeling symptoms when they drove a car, read the paper, or put their hands up. "They almost never tell me they get symptoms when they use a computer," says Stevens.

If computers are not a major source of CTS, then what causes the condition? "In just under half of them, there is no obvious cause," Stevens observes. "The biggest risk factors seem to be being female, in your 40s and 50s, and being a homemaker. For the remainder, there are a whole host of other causes — wrist fractures, trauma, diabetes, rheumatoid arthritis, and so forth."

Despite the apparent vindication of the computer, CTS is a very real condition and a threat to employee health and productivity. What steps can occupational health professionals take to help prevent the onset of CTS?

"People have suggested the reason our employees are not getting a higher percentage of CTS is that their workstations are set up so well," says

Carpal Tunnel Syndrome (CTS) Criteria

Symptom	Possible CTS (n=17)	Clinical/NCS* Definite CTS (n=9)
Awakened by paresthesia	9 (52.9%)	7 (77.8%)
Hand goes to sleep driving	8 (47.1%)	5 (55.6%)
Hand goes to sleep reading	7 (41.2%)	6 (66.7%)
Relief by shaking hand	11 (64.7%)	7 (77.8%)

***** *NCS = Nerve Condition Studies*

Source: Stevens JC, Witt JC, Smith BE, Weaver AL. The frequency of carpal tunnel syndrome in computer users at a medical facility. *Neurology* 2001; 56:1,568-1,570.

Stevens. "Maybe, we could do a study of people with bad workstations, or with poor positioning, and see if more of them got CTS."

One thing remains clear to Stevens: providing workers with ergonomically correct workstations is still very important. "Ergonomically incorrect workstations cause a lot of other discomforts," he notes. "It would also be interesting to know if having ergonomically correct workstations also help prevent CTS. It would be a great study to do if you could figure it out."

(For more information, contact:

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Reference

1. Stevens JC, Witt JC, Smith BE, Weaver AL. The frequency of carpal tunnel syndrome in computer users at a medical facility. *Neurology* 2001; 56:1,568-1,570. ■

New program helps meet HIPAA security rules

Encryption technology maintains confidentiality

While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has the primary goal of making health insurance portable for thousands of Americans, the act also mandates new security standards and electronic data interchange (EDI) requirements. These requirements, to say the least, are having far-reaching effects on the entire health care industry, including the professionals who manage occupational health clinics.

A new program developed by Dallas-based ZixIt Corporation, called ZixMail, is designed to help ensure compliance with those security regulations. The product, introduced at several beta sites last year, was just formally launched this spring.

"In addition to meeting confidentiality requirements, it is important for us to facilitate efficiencies for cost savings that the increased use of technology affords," notes **Pat Feyen**, director of sales in ZixIt's health care division.

"We are behind the curve compared to many other industries. In addition to developing standards to protect security, confidentiality, and integrity of private information, this was one of the goals of HIPAA," he explains.

HIPAA's security standards address administrative procedures, physical safeguards of information in computer systems, technical security, and technical security mechanisms, notes Feyen, who served as president and CEO for the Texas and Oklahoma region of PacifiCare Health before joining ZixIt. "There have to be policies and procedures in place within the affected entity," he explains. "They have to be approved by the security committee, people must be in place who are accountable for compliance, and you have to track access to 'individually identifiable health information' to desktops and to the database. If there is a way a reader can identify me with related health data, they have to be protected."

Encryption required

Once this information is moved electronically over the Internet, HIPAA requires the information to be encrypted, notes Feyen. "That's the part of the process we bring value to."

The strength of encryption in ZixMail will meet and exceed HIPAA standards and requirements, says Feyen. "Its other aspects as a business tool make it more efficient."

Here's how it works: The program is installed on a desktop computer, which takes between six to eight minutes. "It can be downloaded from our web site (www.zixit.com); if the client is a large company, we can work with the system administrator to push it to each computer," Feyen explains.

The users then create a password, and if they are using Microsoft Outlook or the Lotus Notes e-mail programs, nothing else changes. "ZixMail is integrated with those programs," Feyen says. "You simply create an e-mail, grab all the attachments you need, as usual. Then, instead of clicking the 'send' button, you click a red 'Z' button, type in your pass phrase, and then hit 'send.'"

What happens then is a bit more complicated. In the world of encryption, there are both public and private keys. ZixIt stores and manages all of the public keys on its worldwide signature server in Dallas. "So, when I send you an e-mail and hit the red 'Z,' the message goes to the server, which grabs the recipient's public key and encrypts the message and attachments so they can be sent point to point," Feyen explains.

The private key is inherent in the software when it's downloaded. "The only thing that will open the file is your matching private key," says Feyen.

"That triggers the decryption of the message."

Unlike earlier encryption programs, ZixMail can be used by individuals who have not downloaded the program themselves, Feyen observes.

"You can send your information to anyone. If the receiver has not installed ZixMail, the system knows that. Since the recipient does not have a public key, we use the worldwide signature public key, send it to the sender's desktop, encrypt the message, then send it back to the server and store it for anywhere from one to 21 days. The receiver is notified that he has a secure message waiting for him," he adds. "He opens it, clicks on the hyperlink, and through our secured connection, it will go to the server and he can read or cut and paste and download the attachment. All of this happens instantaneously."

In this manner, says Feyen, the sender complies with HIPAA regulations by securing the message. The reply is encrypted as well. "But you can't initiate a new message unless you have installed ZixMail," he adds.

Addressing challenges

There are no universal standards when it comes to encryption technology, says Feyen, which causes some difficult challenges. "A lot of products are exclusive — that is, you can't talk to another institution if it is not using the same program you are. We've addressed the issues of interoperability and compatibility."

ZixMail also provides a certified receipt. "When I send you a message, I can check a box that says I want certified receipts notifying me of the exact time and date that you opened the message. I get a note back with that information. This is important, because there are time requirements for responding to claims, submitting credentialing information for physicians, and so on."

Feyen notes that ZixMail also is quite affordable. "The charge is only $24 per year per e-mail address."

Of course, since ZixIt's health care initiative with ZixMail was just launched in March, the jury is still out in terms of users. One such user, **Paul Porter,** security architect for United Health Care in Minnetonka, MN, is pleased with the results so far.

"From our standpoint, this one just works," he says, while noting that ZixMail is not yet considered to be an "authorized product" for United Health. "We don't yet have a formal relationship; we're still beta testing," Porter explains.

Porter is testing ZixMail in several different groups, including the security group. "There's a tremendous need for secure messaging." he notes. "There are clearly some tradeoffs one has to take a look at, and that's why we're trying to look at several systems. For example, once messages are encrypted, it's difficult, if not impossible, to discover viruses."

But, he adds, in light of HIPAA, encryption is a must. "This company [ZixIt] has done some nonstandard things, and we have to wrestle with those issues," he says. "However, the other programs are not as automatic and user-friendly."

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Employee survey shows impact of 'presenteeism'

'Just showing up' a threat to productivity

When employees fail to show up to work due to an acute or chronic medical condition, the impact of that absenteeism on productivity and performance is clear. In recent years, however, experts in employee health have been paying closer attention to a phenomenon called "presenteeism," whose impact is not as readily measured but is potentially more harmful than outright absenteeism.

"Presenteeism [occurs] when an employee goes to work sick but cannot work at full capacity."[1] Its impact was graphically demonstrated in a study recently published in the *American Journal of Psychiatry*, the monthly scientific journal of the Washington, DC-based American Psychiatric Association (APA). The study was conducted by the departments of psychiatry and public health at Yale University in New Haven, CT, and the Yale Department of Veterans Affairs Public Health System in West Haven, CT.

The study, drawn from surveys conducted in 1993 and 1995, was designed to measure the effects of depressive symptoms and satisfaction

with health care on work outcomes. Among the key findings:

• The odds of missed work due to health problems in 1995 were twice as high for employees with depressive symptoms in both 1993 and 1995 as for those without depressive symptoms.

• The odds of decreased effectiveness at work in 1995 was seven times as high.

• Among individuals with depressive symptoms in 1993, a report of one or more problems with clinical care in 1993 predicted a 34% increase in the odds of persistent depressive symptoms and 66% increased odds of decreased effectiveness at work in 1995. **(For more on the effects of chronic illness on work place performance, see article, p. 108.)**

Two surveys used

The study involved nearly 15,000 employees of three corporations, about 1,200 of whom met the criteria for depressive symptoms. The first phase, the Employee Health Care Value Survey, involved using a 154-item questionnaire that was filled out by 14,587 employees in 1993. During the second phase, a 116-item survey was mailed in 1995 to 9,294 randomly sampled employees who had responded to the first survey and still were employed by the corporations. It included a 12-item short-form health survey. This was used, in part, to determine clinically significant depressive symptoms.

In the 1995 survey, participants were asked if they had missed one or more days from work because of health problems in the four weeks preceding the survey. They were also asked to rate the impact of their health on effectiveness at work, on a score of zero (unable to accomplish anything because of health) to 100 (no health problems).

Based on these responses, the odds of taking sick days at work in 1995 were 2.17 times as high for respondents with chronic depressive illness as for respondents without depressive symptoms in 1993 or 1995. The odds of reporting decreased effectiveness in the workplace in 1995 were 7.20 times higher.

The study's findings "suggest that depression has a substantial and persistent association with decreased workplace productivity, an impact that may be underestimated when one looks only as days missed from work,"[1] the authors wrote.

"The impact of depression on function at work was substantially higher than its association with missed days at work," they continued. "These findings suggest that previous reports of absenteeism may represent only a fraction of the cost of depression in the workplace."[1]

Presenteeism, they note, has become an increasing concern of employers in recent years. "Presenteeism would be expected to be particularly likely when an employee is reluctant to report an illness or believes the illness would not be regarded as a legitimate reason for missing work," they explain. "The perceived stigma associated with depressive disorders may thus result in a high proportion of hidden costs to employers that are not readily evident from health or disability claims data."[1]

The significance of these findings was not lost on the APA. "The message is clear," notes **Lloyd Sederer**, MD, the APA's director of the division of clinical services. "There is both medical and

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financial value in better detection and effective treatment for depression in the workplace."

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Reference

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NEWS BRIEFS

Chronic illness costs 2.5 billion workdays

A new study in the *Journal of Occupational and Environmental Medicine* estimates that chronic diseases in the workplace account for more than 2.5 million missed workdays or "work cutback" days.

The study, headed by **Ronald C. Kessler**, PhD, of Harvard Medical School in Cambridge, MA, showed that this amounted to an average of 1.5 days per month across all 2,074 respondents, or 6.7 days per month for those reporting any missed work time.

Although other chronic diseases were more common, cancer had the greatest impact on missed work time. Respondents with ulcers, depression, and panic disorder also had high rates of work impairment.

"The enormous magnitude of the work impairment associated with the chronic conditions studied here should be taken into consideration in the current debate on universal health insurance," wrote the authors.

For more information, contact Marianne Dreger at (847) 818-1800, extension 386. E-mail: mdreger@acoem.org. ▼

PTPN, CCN sign national contract

PTPN, a Calabasas, CA-based outpatient rehabilitation network, expanded its relationship with San Diego-based managed care organization CCN to a national contract.

Under the agreement, PTPN will be a preferred provider of outpatient rehabilitation services for physical therapy, occupational therapy, and speech therapy in CCN's group health, workers' compensation, and auto injury management networks nationwide.

"As part of the contract, PTPN will handle the credentialing process for CCN to ensure that all our outpatient rehabilitation practitioners meet our strict quality assurance standards," notes **Jeff DeGrandpre**, director of marketing at PTPN.

PTPN has more than 1,000 provider offices throughout the United States. It contracts with most of the major managed care organizations in the nation, as well as with a broad range of insurers, workers' compensation companies, preferred provider organizations, health maintenance organizations, medical groups, and independent physician associations.

For more information, contact Joy Scott at (818) 610-0270. ■