AMERICAN HEALTH CONSULTANTS®

Occupational Health Management™

A monthly advisory for occupational health programs

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To merge, or not to merge: Pondering the tradeoffs of affiliation
They've become known as the industry's Big Three: Mega-firms that have grown over the past 10 years through the acquisition of other organizations. Affiliation with these firms offers significant potential benefits to independent occ-med organizations, particularly in the areas of marketing and information services. On the other hand, such arrangements often mean loss of control for individuals who are used to controlling all aspects of day-to-day operations . . . . . cover

Outcomes are key determining factor in awards program
Awards programs may be as plentiful as mushrooms after rain, but that doesn't mean they're all created equal. The Corporate Health Achievement Award, cosponsored by the American College of Occupational and Environmental Medicine (ACOEM) and GlaxoSmithKline, recognizes winners not only for well-designed employee health programs, but for demonstrating positive outcomes. In an exclusive *OHM* interview with the ACOEM staffer in charge of this year's program, we offer an insider's view of what makes an award-winning occ-health program. 52

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MAY 2002
VOL. 12, NO. 5 (pages 49-60)
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Merger, joint venture with firm makes growth easier

Tradeoffs in culture, control may be necessary

To affiliate, or not to affiliate — that is a tough question. With the Big Three of Concentra Inc., Occupational Health and Rehabilitation, and U.S. HealthWorks firmly entrenched as dominant forces in the occupational health industry, small- and medium-sized providers have come to recognize that affiliation with one of these large organizations can be their ticket to growth and greater financial success.

That success does not come without a price, however. Entrepreneurial individuals used to calling their own shots must consider relinquishing some or all of that control, and there can be significant differences in corporate culture or even in delivery of services.

Still, a large number of firms have chosen the route of affiliation, through one of several possible routes. "There are lots of different types of affiliation," explains **William B. Patterson**, MD, FACOEM, MPH, medical director of Wilmington, MA-based Occupational Health and Rehabilitation. "Some choose a kind of joint venture, while others opt for outright acquisition. The benefit of a joint venture is that a smaller organization may retain some control over and have some say in the operation of the business, and obviously over what percentage of the business they still own. And, they have the opportunity to participate in future profitability."

Of course, he adds, if you turn over 100% of the ownership to a larger partner you lose control, but you also get rid of a lot of the headaches of running a business. "So you have to consider which of these you prefer," Patterson says.

When an occupational health organization

Continued from cover

Ergonomic equipment is great, but do workers know how to use it?
You can invest all the money you want in ergonomic chairs, keyboards, and mice, but if you don't teach your employees how to use them you won't realize the full benefits of your investment. This was among the key findings of a study of several hundred State of New Jersey office workers. They achieved about a 40% reduction in overall complaints after switching to ergonomically designed equipment, but the researchers made it clear that the training program that accompanied the new equipment was an equally important factor in the gains made in employee health 55

AEDs recommended for health and fitness facilities
Attention fitness center managers: The chances that one of your members will have a heart attack while working out is growing steadily. That's the disturbing trend cited in a joint statement issued by the American Heart Association and the American College of Sports Medicine. The aging population and the presence of more unfit individuals in fitness centers make it more likely that someone with undiagnosed cardiovascular disease will suffer a myocardial infarction, leading to the recommendation that automated external defibrillators be placed in all such facilities. 57

Program designed to protect health of WTC workers
In recognition of the unique set of potential health risks facing rescue workers at Ground Zero, the Occupational Health & Safety Administration and a coalition of labor, management and local government agencies has come together to outline additional steps to protect them, including the establishment of a safety committee, which meets weekly to assess new and ongoing challenges, and orientation programs for all workers on the site 58

COMING IN FUTURE ISSUES

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reaches a certain size, or faces certain business challenges, management might begin to consider affiliation, says **Jim Greenwood**, executive vice president of corporate development for Concentra Inc., in Addison, TX.

"As you look at your business, are you feeling competitive pressures? Are your customers asking for something you can't deliver? In many cases, that could be related to information systems," Greenwood notes. "We spent over $20 million to develop information systems to manage our business and to report income to employers and payers. As they begin to see these report cards, they might start to ask independent providers where *their* report cards are. This could put those businesses at risk."

Patterson adds, "I've observed that when an organization reaches $1.5 million to $2 million in annual revenue, it's big enough to benefit from a higher level of support — especially in sales and marketing and IT services. Those are the areas where you can see significant benefits from joining a larger organization."

Small organizations typically do not have the professional experience in hiring and managing a sales team, notes Patterson. "But if you want to grow, this is essential. My experience is that, for example, in the hospital that employs a sales staff of one or two people they just don't know how to manage productivity, to teach others how to close a sale, and things like that."

Hospitals: A breed apart

Hospitals are a particularly challenging situation, notes Patterson. "Typically, they like to have their name on the door and they like the relationships they've developed with area employers, but they are just as typically not very good at managing," he asserts. "The occ-med program usually represents a very small piece of the total hospital budget, so it attracts very little management attention."

Hospitals, he notes, tend to be cumbersome organizations with entrenched turf guarding, making it hard for an entrepreneurial, customer-oriented program to thrive in such an atmosphere. "Affiliating with a larger partner allows the hospital to bring in outside management expertise while retaining some of the benefits of a close relationship with the occ-health program," says Patterson.

Because of these factors, adds Greenwood, most hospitals choose the joint venture route. "Generally, joint ventures are completed with hospital programs; they want to be able to have

a say in the market," he explains. "If you are a big hospital organization in a major city, you have great name recognition and good relationships with employers. But some of our savviest hospital partners have come to realize that if we can help them have the best occupational medicine business in the market, they will gain market share."

Expanding horizons

Affiliation can, of course, help expand the reach and leverage the resources of an occupational health program. "If you have a big, installed base of offices you can deliver services more cost effectively," says Patterson. "We just looked at a program that had IT [information technology] costs that represented almost 10% of their annual revenue, whereas our percentage companywide is much lower than that. Through affiliation, you leverage your installed base for per-unit costs."

On the other hand, he notes, occupational medicine can be quite isolating. "If you are the only provider in one or two offices owned by a hospital, you may find that isolating, depending on whether or not you are effectively connected to the hospital," Patterson says.

Speaking of isolation, national relationships with both large employers and payers are only possible through affiliation, says Greenwood. "Even when we had 30, 40, or 50 clinics we really didn't have national relationships," he recalls. "As we've grown over the last 10 years, we've reached the point where we truly can sit down with the national risk manager for Home Depot, or Target, or AIG and make an impact on their outcome. A hospital program in Indianapolis or a doctor who owns a clinic in San Diego does not have that marketing opportunity."

Weighing the options

Despite the obvious advantages, affiliation is a major decision that must be weighed carefully. "If you sell to one of these organizations, for the most part there will be a relative lack of control or autonomy in dealing with clients you've been working with," notes **Charles Prezzia**, MD, MPH, FRSM, general manager, health services and medical director at USX/US Steel Group in Pittsburgh. "You give that up, and in return you are essentially promised a certain degree of stability in your income in addition to a larger organization to help you with marketing and IS."

Prezzia, who was formerly in private practice, has some personal experience dealing with larger occ-health providers, and has also spoken with a number of colleagues who have affiliated.

"What I have heard from a lot of people — although some are very happy — is that they find they are being assessed by productivity measures some of them regard as unethical."

In some cases, Prezzia notes, physicians are asked how many physical therapy or radiology referrals they make. "Some people I consider to be ethical practitioners have become disgruntled," he notes. "For some of them there were incentive clauses for [physical therapy] and radiology referrals, as well as strong incentives to see a certain volume of patients. Obviously, some of that is needed, but in some cases it can affect quality issues."

He is quick to note this is not a universal practice. "We negotiated with one provider who had a fairly ethical approach," he says. "The question is: Is that an issue for you to begin with? At my old practice we felt we had to have a [physical therapy] component to compete, but we used an ethical approach. When you start incentivizing, you are bound to get physicians who will make referrals just to get the money."

Of course, if you don't like how an organization operates you should not link up with them, says Prezzia. "If you decide you can exist with an organization that does this stuff then you make the deal. If you have issues and they won't compromise, then continue the way you are or go with someone else."

As with any industry, corporate cultures vary. **Richard J. Reichert**, MD, MPH, who sold a private practice in Canton, OH, to U.S. HealthWorks, saw none of the concerns put forth by Prezzia. "I had started in private practice in 1989 and had grown to two sites, the other in Wooster [OH]," he recalls. "In March 1998, I sold the Canton office; Wooster was just a start-up. We had started to see large employers make decisions in corporate offices and take the decisions out of the local offices or plants. We began to see people having national contracts."

Reichert says his experience has been good. "I function now as medical director for my facility and regional medical director for U.S. HealthWorks," he says.

He recognizes that physicians are often concerned about how much their new partners will tell them about how to practice medicine. "I have not had that concern," he says. "I was never given any quota. From the corporate point of view, they recognize that each location has its

own individual character." In short, he says, "Given the same choice, I would do it again."

Think ahead

A bit of planning and the careful consideration of options can help avoid disappointment in the future, says Prezzia.

"First, consider the willingness of existing program management to share control and responsibility," he advises. "Second, find a good match between the cultures of the two organizations. The program that is affiliating needs to feel comfortable with the corporate culture of the occ-med company with which it is affiliating. And finally, consider the local marketplace — there may or not be business benefits to the affiliation. You could have the first two elements, but there may just not be any reason in the local marketplace to do the deal."

Finally, says Reichert, do your homework thoroughly. "Get a feel for the management team and talk with doctors who are currently in the organization," he recommends.

Greenwood says that occupational health managers will continue to have both options of affiliation or independence open to them. "I don't see anyone else out there today that will join the Big Three [and reduce options]," he observes. "These three have had a nice head start. When they started to consolidate, many markets had large independent firms they could acquire. Now, pedestal acquisitions are hard to come by."

He does not foresee fewer independent operations in the future. "I would say they might decline slightly, but in any given year we probably see as many startups as buyouts; we've probably leveled off."

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Award program puts focus on outcomes

ACOEM recognizes exemplary practices

Awards and award programs have become so prevalent in the United States that at times they take on a sameness that overshadows the reason they were created in the first place. That's unfortunate, for many awards programs in the health care industry do more than just recognize outstanding performance; they help identify best practices that can be emulated by others.

That's certainly the case with the Corporate Health Achievement Award (CHAA), which is cosponsored by the American College of Occupational and Environmental Medicine (ACOEM), of Arlington Heights, IL, and GlaxoSmithKline. Designed to recognize organizations "with exemplary employee health and occupational and environmental medicine practices," the CHAA focuses on four key categories:

- Healthy People;
- Healthy Environment;
- Healthy Company;
- Management and Leadership.

Those four categories are detailed in a four-page worksheet called the CHAA Excellence Checklist. **(See "Healthy People" and "Healthy Company checklists on pp. 53-54.)** But the selection process itself also illustrates the uniqueness and value of the CHAA.

"In addition to recognizing exemplary programs conducted in a corporate setting, the role of CHAA is also to identify model practices corporations have that could be emulated," explains **Doris Konicki**, MHS, director of research and development at ACOEM and the staffer in charge of this year's award program. "We are really looking for outcomes; is this being implemented? What is the effect, and if the program has not taken off as anticipated, how was it modified to make it acceptable?"

Konicki worked in concert with a committee of physicians. This year's winners were announced mid-April and posted on the web site.

To further explain the process, Konicki gave this hypothetical example. "If you identified a number of injuries in a particular area and wanted to decrease that number, we would look at what kind of program you put in place, any positive results you achieved, such as a decrease in disability or

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ACOEM Corporate Health Achievement Award

Corporate Health Excellence Checklist

Indicated by checking the boxes provided in each category the 1) level of service, 2) dissemination to appropriate employee populations, and 3) quality assurance of program. Programs are comprehensive complete and possibly excellent if all three boxes are checked in each category.

1.0 Healthy People

		Implemented	Well deployed	Measured and showing Trends	Implemented	Deployed	Measured (Trends)
1.1	Health evaluation of employees	☐	☐	☐	Programs exist to assess hazards, risks, and monitor exposures	Assessments are preventive and reactive across a defined population	Safety and compliance issues are directly effected by these programs
1.2	Diagnosis and treatment of occupational and environmental injuries or illness, including rehabilitation	☐	☐	☐	There are an ongoing assessments and investigations of activities, jobs and exposure issues	Identifies past and emerging issues with a systematic process to track improvements	Tracks reductions in accidents, injuries and disability related to program design
1.3	Assistance in rehabilitation of alcohol and drug-dependent employees or those with emotional disorders	☐	☐	☐	Programs offer prevention, early intervention and treatment services	Coverage for substance abuse issues has parity to other health treatments	Mental health, alcohol and substance abuse metric programs demonstrate reductions in risks
1.4	Emergency treatment of non-occupational injury or illness, and palliative treatment of disorders	☐	☐	☐	Services are assessable and reactive to employee's urgent and non-urgent issues	Services are equally dispersed to all shifts, locations and populations	Productivity, loss days, return to work are direct outcomes of the program
1.5	Immunization against maximum occupational infections and other infectious diseases	☐	☐	☐	Programs assess risks to travelers and other susceptible populations	Services cover all at risk populations (travelers and at risk populations)	Immunizations rates and outcomes metrics attest to program effectiveness
1.6	Collaborative treatment of non-occupational conditions	☐	☐	☐	Programs and services actively invite business and community team work	Employees, managers and local medical community are involved in programs	Outcomes are assesses for quality and impact on locations and community

Source: American College of Occupational and Environmental Medicine, Arlington Heights, IL.

ACOEM Corporate Health Achievement Award

Corporate Health Excellence Checklist

Indicated by checking the boxes provided in each category the 1) level of service, 2) dissemination to appropriate employee populations, and 3) quality assurance of program. Programs are comprehensive complete and possibly excellent if all three boxes are checked in each category.

3.0 Healthy Company

		Implemented	Well deployed	Measured and showing Trends	Implemented	Deployed	Measured (Trends)
3.1	Health education and counseling	☐	☐	☐	Programs exist to address non-occupational health risks and wellness concerns	Risk communication and programs include general and targeted populations at risk	Assessments document education effectiveness and risk reductions
3.2	Assistance in control of illness-related absence from job	☐	☐	☐	Policy, guidelines and best practices promote early return to work, disability and risk reductions	All covered members have access to programs and input into benefits	Reductions in lost days and disability demonstrated program effectiveness
3.3	Participation in planning, providing and assessing the quality of employee health benefits	☐	☐	☐	Quality health care and benefits are evaluated by qualified professionals and offered to employees and families	Covered members have ready access to cost effective and quality health services	Health, wellness, costs, and quality metrics show continuous improvement
3.4	Assistance in evaluation of personal health care	☐	☐	☐	Covered populations have impact and access to information concerning health, safety and programs	Communications if health and safety is assured	Populations showing understanding and interest in personal health care
3.5	Medical interpretation/participation in development of governmental Health and Safety regulations (**Optional to smaller employers**)	☐	☐	☐	The business is active in committees, community, and regulatory rules and statute development that promote Health and Safety	Assures the protection of employees and company risks through appropriate lobbying and committee work	Staff and line management have goals that show interactions and outcomes of success
3.6	Termination and retirement administration	☐	☐	☐	Health status is evaluated and documented for at-risk employees leaving the organization	Records policy retention schedules and communication processes exist all employees	Continuous improvement plans demonstrate appropriate retention and communication

Source: American College of Occupational and Environmental Medicine, Arlington Heights, IL.

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days off work, and how it led to the overall improvement in the health, wellness, and productivity of the employees."

What makes a winner?

While Konicki could not disclose the names of this year's winners, she did cite elements that all winning programs had in common. "First, there was the commitment from top management, which is very important. If you don't have that, and you don't have the necessary resources, whether the issue is safety, decreasing injuries or addressing chronic illness, your changes of success are not nearly as high."

Second, she says, is the successful integration of several different departments within the corporations — which she sees as linked to leadership as well. "The support and interaction of the safety officer and environmental folks was one example," she observes. "Those individuals traditionally may not work together on any other issue, and if senior management was not committed to bettering the health and safety of the workers they wouldn't have had the interaction and the willingness to do it in these companies. Having been in a large corporation myself, I know that cross-pollination like this does not usually happen. This is one way you can get mid-level managers talking across the organization."

If a plant manager is dealing with a specific safety issue, he might not normally care what the health department thinks about chronic asthma or hypertension, notes Konicki. "But when leadership shows them it has an impact on the effectiveness of their own employees, or on absenteeism, they are more willing to work at issues that affect the overall health of employees," she explains.

Different approaches seen

While there were certain approaches the winning programs had in common, each of them also had something unique that made them stand out, Konicki says. "First of all, they were not in the same areas; this year's cadre focused on different program targets," she offers.

Each program focused on what was of greatest importance to their company, she adds. "The wellness programs were absolutely outstanding — they showed the outcomes and the impact on employee health, noting the level of illness, days off, short- or long-term disability prior to and after program implementation. In some instances, where the focus was on specific diseases, they noted when those diseases were caught in the early stages."

In safety programs, the winners look at where the greatest number of injuries were being reported, and through program implementation tracked the impact on the number of days of lost work due to that particular type of injury.

"Not having been involved in this aspect of occupational health before, I was quite amazed and very happy to see the level of commitment among major corporations and institutions in this company in terms of looking at the health and wellness of employees," Konicki concludes.

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Editor's note: A list of winners and the four-part CHAA Excellence Checklist can be found at www.chaa.org.] ■

Equipment alone won't solve ergo problems

Training also key element in injury reduction

While ergonomically designed office equipment such as seating and keyboards can help reduce employee injuries and physical complaints, a strong training program is essential to optimizing the effects of an ergonomics program.

This opinion is shared by two of the primary researchers in a recent study of 356 State of New Jersey office workers. The workers, who were provided with negative-slope keyboards with upper mouse trays and ergonomic chairs, showed an overall reduction in the prevalence of musculoskeletal symptoms by an average of 40%. The results of the study were presented at the Proceedings of the Human Factors and Ergonomics Society 45th Annual Meeting.

"You really can't have one without the other," asserts **Alan Hedge**, PhD, a professor of ergonomics at Cornell University in Ithaca, NY. "Yes, you will get some benefit from the product, but without training the benefits won't persist. It's like getting a new software program without

looking at the manual; you'll only get a fraction of the benefit."

Mary Rudakewych, MS, health and safety manager for the State of New Jersey department of personnel, agrees wholeheartedly. "You can give employees equipment without training and not receive the full benefits of the retrofit," she asserts. "If you combine the two, that's when you really get to see the results."

Don't assume too much

By simply giving employees ergonomically correct equipment without training, one assumes many things that are probably not true, says Rudakewych. "You can't assume employees know what postures are best for them simply because they've got new equipment," she notes. "They will still continue to do wrong things."

In addition, she insists, the training must be provided by knowledgeable professionals. "You can't train the trainer or put the information out on computer modules," she explains.

In this program, training was conducted with 30-40 employees at a time in a classroom setting. An ergonomist spoke with the workers about the biophysiological causes of injuries. Rudakewych was the other instructor.

"The overall training program included a piece about physiology, demonstration of the new equipment and how it relates to good and bad posture," she adds. "We showed the employees how you can use good equipment either badly or properly, and how to tell the difference. That's why the effects were so positive; it was a combination of the quality of training and the quality of the products as well."

Equipment carefully chosen

The equipment was chosen because earlier research had indicated this type of product can help reduce injuries, notes Hedge.

"The negative-slope keyboard with the upper mouse platform has been tested in various guises for over decade," notes Hedge. He explains that with this device the keyboard tray tilts downward instead of upward. The mouse sits to the right of the keyboard on an adjustable platform, so the worker can pull it over any number of keys. "This way, you don't have to reach across the body," Hedge explains. "This works better for your wrist position, and also helps the elbows, shoulders, neck and back."

This is borne out by some of the specific effects of the ergonomics intervention of symptoms. The following areas showed the greatest impact:

- Back — 49.1% reduction;
- Elbow — 47.3% reduction;
- Upper arm — 45.5% reduction;
- Eyes — 44.5% reduction;
- Shoulder — 42.5% reduction;
- Forearm — 42% reduction;
- Wrist — 40% reduction.

Still, says Hedge, there was a value-added element provided by the training. "Clearly, the equipment would have had some effect even without the training," he concedes. "And I would say that the products without training are of more value than the training without products. Training without technology gives you at best a 10% improvement. Technology without training would give you about a 25%-50% improvement. Put the two together, and you really have a great package."

Other findings significant

Hedge notes the study offers other take-home messages for occupational health professionals.

"One of the things that was interesting to us but was not included in the paper concerned visits to the physician for physical problems," he says. "What seemed to emerge from that was the fact that a lot of times people will go to the doctor for symptoms without realizing those symptoms are related to the workplace. The doctor will treat the symptoms without knowing they are work-related. So, for example, they may see a doctor for back pain, get an X-ray or MRI, and be referred to a therapist, an orthopod, or a chiropractor. If the real source of the problem is sitting hunched over a computer for six to seven hours a day, they won't see any benefits from therapy unless they change what they do at work. Some of our participants were followed up with a year later and we found their ongoing therapy had now become effective."

Finally, says Hedge, occupational health professionals should not wait until there are a significant number of symptoms and injuries before instituting an ergonomics program. "Ergonomics is really a preventive approach," he insists. "If you are a smoker and wait until you have lung cancer, it's too late. Ergonomics does *not* apply just to people who are injured."

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Fitness facilities need AEDs, say AHA, ACSM

Undiagnosed heart disease a growing threat

The growing number of Americans, including senior citizens, exercising in fitness facilities has increased concerns that more individuals with undiagnosed heart disease will suffer cardiac arrests during exercise. This concern has led the American Heart Association (AHA) in Dallas, and the American College of Sports Medicine (ACSM) in Indianapolis, to issue a joint statement urging fitness facilities to install automated external defibrillators (AEDs) and train staff to use them.

While occupational health professionals may be well aware of the potential risks of strenuous exercise, the joint AHA/ACSM statement holds valuable messages for them as well, especially for those who operate clinics in private industry and do not have the access to defibrillators that their colleagues in hospital settings do.

"Coronary artery disease can be asymptomatic in 25% of all myocardial infarctions that occur, and it's estimated that 10% of heart attacks are totally silent," says **Gary Balady**, MD, professor of medicine at Boston University School of Medicine, director of preventive cardiology at Boston Medical Center and chair of the joint writing group that drafted the statement.

The statement, published in a March edition of *Circulation,* the AHA journal, noted that the demographics of the more than 30 million individuals who exercise at health and fitness facilities demonstrates a steady increase in the number of members who are older than 35. "It is reasonable to assume that the number of members with cardiovascular disease [and other comorbidities] is rising as well,"[1] wrote the authors.

They go on to note a database of more than 2.9 million members of a large fitness chain showed the highest death rate to be among those members who exercised less frequently; nearly half of the exercise-related deaths occurred in individuals who exercised less than once a week.

Even in occupational health programs where health risk appraisals) are regularly given, you have to ask the right questions to help prevent such incidents, notes Balady. "If you ask orthopedic or neurologic questions, which is usually the case, you may not [uncover at-risk individuals]."

PADs recommended

The AHA/ACSM statement recommends that health and fitness facilities establish a Public Access to Defibrillation (PAD) plan. It should include the following:

• Written emergency policies that are practiced at least every thee months;

• Designated staff members trained in CPR who function as first responders during all hours of operation;

• Training staff to recognize cardiac arrest;

• Activating EMS — assigning staff to meet the emergency response team at the entrance of the facility;

• Providing CPR;

• Attaching/operating AED;

• Instructions on use of AEDs in infants and

Key points of the joint AHA/ACSM statement

The Cardiac Arrest Survival Act and the Rural Access to Emergency Devices Act, as components of the federal Public Health Improvement Act of 2000, as well as Good Samaritan laws passed in 47 states, expand Good Samaritan legal protections to users of AEDs throughout the nation.

The placement of AEDs in selected locations for immediate use by trained laypersons may be the key intervention to significantly increase survival from an out-of-hospital cardiac arrest.

The chain of survival includes a series of actions designed to reduce mortality associated with cardiac arrest and includes the following links: a) early recognition of cardiopulmonary arrest; b) early CPR; c) early defibrillation when indicated; and d) early advanced cardiac life support care.

Well-trained health/fitness facility staff members are essential to maintain strong links in the chain of survival for their clients.

Effective placement and use of AEDs at all health/fitness facilities is encouraged, as permitted by law, to achieve the goal of minimizing the time between recognition of cardiac arrest and successful defibrillation. Until further definitive data are available, AED placement is strongly encouraged in those health/ fitness facilities with a large number of members (i.e., membership less than 2,500); those that offer special programs to clinical populations (i.e., programs for the elderly or those with medical conditions); and those health/ fitness facilities in which the time from the recognition of cardiac arrest until the first shock is delivered by emergency medical services is anticipated to be greater than five minutes. In unsupervised exercise rooms, such as those that might be located in hotels, apartment complexes or office buildings, the AED should be part of the overall PAD plan for the host facility.

Health/fitness facilities should coordinate their PAD program with the local EMS. Emergency drills should be practiced at least once every three months or more often when staff changes occur. PAD programs must comply with local or regional regulation and legislation. ■

children younger than 8 years of age (note: use is not recommended).

Of course, a number of these would be redundant in the hospital setting. "With a hospital-based clinic, they all have a code team and access to defibrillators," notes Balady. "So while it may take one or two minutes to first shock, it's not what it takes when you have to wait for [emergency medical technicians] or paramedics [at a corporate facility]. And of course, in cardiac rehab programs, they actually have to have a defibrillator at the site."

Is the AHA/ACSM statement important for occupational health facilities outside the hospital setting? "I think so," Balady offers, noting that the AHA considers any location where individuals go to improve their fitness levels to be an "exercise" facility.

"Even if you're a hospital satellite facility, or you're not attached to the main building, it would probably be prudent to have one," he says.

AEDs cost between $3,000 and $4,500 per unit, and Balady says one is really all you need. "Fitness facilities are not like airports, where they need to be placed frequently," he says. "We would be happy if all facilities screened their clients, had a plan in place, practiced it and had an AED — that would be the goal," he concludes.

*[A reprint of the AHA/ACSM statement is available by calling (800) 242-8721 or writing the American Heart Association, Public Information, 7272 Greenville Ave., Dallas, TX 75231-4596. Ask for reprint number 71-0222. You can contact **Gary Balady**, MD, at (617) 638-8968.]*

Reference

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Group guards health, safety of WTC workers

Government, labor, and management join forces

A coalition of government agencies, organizations, employers, and employees has been established to help protect the safety and health of the thousands of workers at the World Trade

Center disaster site.

Formalized under the WTC Emergency Partnership Agreement, the partnership was announced recently by the U.S. Department of Labor. Its members include the Occupational Health and Safety Administration (OSHA); the New York City Department of Design and Construction and the Fire Department of New York (co-incident commanders); the Building and Construction Trades Council of Greater New York; the Building Trades Employers' Association; the Contractors Association of Greater New York; the General Contractors Association; and the four prime contractors at the WTC site: AMEC Construction Management Inc.; Bovis Lend Lease LMB Inc.; Tully Construction Co. Inc.; and Turner/Plaza Construction Joint Venture.

The partnership agreement outlines a cooperative effort to ensure a safe work environment, including new safety and health initiatives and the establishment of a safety committee.

Many of these groups had already been working well together, but it was felt that formalizing the working relationship in a document was important, says **Patricia K. Clark,** regional administrator for the OSHA's New York Region.

"Basically, we had been working with all of these groups — agencies, employer and employee associations and contractors," She says. "We are committed not only to working together, but also to the same goals."

OSHA also felt it was important to have a very visible manifestation of participation from top players. "That's why the signatories decided to go with the [Fire Department of New York] and the New York City Department of Design & Construction as co-incident commanders," she explains.

Site health emphasized

In terms of the environmental safety and health initiatives, there has been significant labor/management involvement in site health, says Clark. "Every week we have safety meetings, which include operations and safety people, OSHA and the co-incident commanders," she says.

These meetings deal with health and safety issues that have come up onsite. "It's handled the way good site health in any industry or construction work should be handled," Clark notes. "Labor and management sit down and hash out issues." Once a month there is a leadership meeting, which involves the signatories. "There, we decide on big issues — major areas of concern," she observes.

An ongoing process

Because new issues arise as the nature of the work changes, the safety committee must be flexible and able to react to these changes. For example, it was found that the core drilling created a good bit of dust and silica, so the workers' respiratory protection was modified accordingly.

"As the workers went below grade, fall hazards became an issue," Clark recalls. "This process calls for continued vigilance, and that plays into these safety meetings."

For example, she notes, while exposure assessments have not revealed any serious air quality

Occupational Health Management™ (ISSN# 1082-5339) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Occupational Health Management**™, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $435. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $348 per year; 10 to 20 additional copies, $261 per year. For more than 20 copies, call customer service for special arrangements. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $73 each. (GST registration number R128870672.)

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issues so far, samples continue to be taken around the clock and discussed every week.

Safety monitoring goes on 24-7 throughout the site, and the orientation program is in full swing. "All of the people who go on site have to have the orientation," says Clark. Here, too, additional training is added as needed, such as a confined space entry program, for PATH (Port Authority Trans-Hudson) and subway tunnels.

In fact, the entire safety and health program is constantly being re-evaluated and strengthened. "When the first one was written, no one was working below grade," Clark points out, "So we are now modifying procedures for those operations. Groups working on tunnels and utilities have also suggested modifications to reflect the changing nature of the site."

Clark says the results to date speak to the success of the program. "Overall, no other lives have been lost on the site, and we have had no serious injuries through the recovery operation," she reports.

[For more information, contact:

*• **U.S. Department of Labor**, OSHA, 201 Varick St., Room 670, New York, NY 10014. Telephone: (212) 337-2378. OSHA web site: www.osha.gov.]* ■

World Trade Center Emergency Project Environmental, Safety, and Health Plan

The World Trade Center Emergency Project Environmental, Safety and Health Plan provides the framework for a cooperative, focused effort to ensure a safe and healthful work environment. The plan includes several provisions that exceed Occupational Safety and Health Administration standards. These include:

Increased coordination and communication

A joint labor/management environmental, safety, and health committee for the entire site to discuss safety and health issues concerning all prime and subcontractor employees, identify hazards and recommend corrective actions, and increase coordination between all agencies, prime contractors and their subcontractors.

Daily environmental, safety, and health meetings by prime and subcontractors before the start of each work shift or when employees arrive for work. Regular forums for all parties involved to exchange environmental, safety, and health-related information on a site-wide basis and to discuss and resolve existing or potential problems.

Increased oversight and reporting

Assignment of a full-time environmental safety and health manager by each prime contractor to implement the plan and focus on environmental, safety, and health issues. Weekly environmental, safety, and health reports that track, among other things, OSHA recordable injuries and illnesses, restricted-work cases, and weekly sampling reports. First-aid logs maintained at the site for all first-aid rendered, with results reported to the Department of Health.

Increased worker safety and health protections

Safety orientation training for all new workers at the site. Enhanced personal and bulk sampling for hazardous substances such as dusts, metals and volatile organic compounds, as well as heat and cold stress. ■