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Health care becomes first target of OSHA ergo plan

Tough talk: OSHA warns 'bad actors' to beware

Health care will be the first industry targeted as part of the U.S. Occupational Safety and Health Administration's (OSHA) new "comprehensive plan" to reduce musculoskeletal disorder (MSDs) injuries, which relies on voluntary, industry-specific guidelines and selected enforcement action.

Days after releasing its new strategy for ergonomics, Labor Secretary **Elaine L. Chao** announced that safe patient handling in nursing homes would be the topic of the first draft guideline. Nursing homes also provide a model for enforcement, as OSHA cited the Beverly Enterprises case involving the nation's largest nursing home chain as an example of successful enforcement of ergonomic hazards.

Both the guidelines and the Beverly model of "general duty clause" enforcement could easily be adapted to hospitals, employee health experts say. The Occupational Safety and Health Act states that employers have a "general duty" to maintain a workplace free of recognized, serious hazards.

"There's now a de facto standard for patient handling and movement. It's [the] Beverly [Enterprises case]," says **Geoff Kelafant**, MD, MSPH, FACOEM, chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine (ACOEM) in Arlington Heights, IL, and medical director of the occupational health department at the Sarah Bush Lincoln Health Center in Mattoon, IL. **(For more information on the Beverly case, see *Hospital Employee Health*, March 2002, p. 29, and May 2002, p. 51.)**

OSHA is hiring 17 additional solicitors, and the

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***Sentinel Event Alerts* to remain 'consultative'**

Sentinel Event Alerts, such as a recent one on needle safety, will remain consultative unless the alert relates to one of six National Patient Safety Goals set by an expert panel, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, announced. That means hospitals won't be scored on the alerts during surveys. The action represents a tightening of focus for the Joint Commission, which placed a moratorium on scoring related to the alerts in January. 66

HIPAA doesn't protect employee health records

The Health Insurance Portability and Accountability Act (HIPAA), which became effective April 14, 2001, was created to give patients greater control over their personal health information. However, it won't apply to most employee health records because they don't involve electronic claims transactions. Deborah V. DiBenedetto, MBA, RN, COHN-S/CM, ABDA, an occupational health consultant based in Yonkers, NY, and president of the American Association of Occupational Health Nurses (AAOHN), analyzed the rule and shared her perspective with *HEH*. 68

Transitional work keeps injured workers on the job

Transitional work programs keep injured employees productive and helps reduce lost workdays. Support from leadership is key to the program, which enables employees to work in modified jobs in their same or a different department, employee health experts say. Transitional work also has a time limit, usually 90 days 69

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COMING IN FUTURE ISSUES

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- Aftermath of a needlestick: In a split second, a nurse's life changed
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- Have hospitals done enough on latex?

lawyers will be working as a team with inspectors to design an effective enforcement strategy, Chao told senators at an oversight committee hearing.

"The writing is on the wall now for hospitals to be on notice," says **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union (SEIU). "At this point, it's just a matter of a worker calling OSHA and saying, 'We want you to come in and cite our employer for not having an adequate ergonomics program.'"

Still, Borwegen and other advocates for health care workers questioned just what OSHA would consider an adequate ergonomics program. OSHA has said employers won't be cited for failing to follow the guidelines. OSHA has abandoned the idea of creating a regulatory standard and instead is emphasizing voluntary compliance.

OSHA chief **John L. Henshaw** geared his tough talk toward employers who ignore ergonomic hazards. The agency announced it has "a legal strategy designed for successful prosecution" that will "crack down on bad actors" who fail to protect workers from possible injury.

Advocates for health care workers renewed their push for a standard that would outline employers' obligations. Within days of OSHA's announcement, U.S. Sen. John Breaux (D-LA) introduced a bill co-sponsored by Sen. Arlen Spector (R-PA) that would force OSHA to issue a new ergonomics standard within two years.

"As far as we're concerned, there was no meat in that plan," says **Karen Worthington**, MS, RN, COHN-S, occupational safety and health specialist for the American Nurses Association in Washington, DC. "Now more than ever, this Breaux bill is needed to force OSHA to work on a serious standard that will make a difference."

Occupational health organizations reiterated their support for a standard as well. Although ACOEM opposed OSHA's earlier effort at ergonomics regulation as "fatally flawed," the organization expressed disappointment at the weak OSHA action. The Association of Occupational Health Professionals in Health Care (AOHP) in Pittsburgh still supports a standard, but reacted favorably to the preventive approach and enforcement strategy that OSHA announced.

"I'm glad they haven't completely put it on the sidelines," says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, AOHP executive president and employee health nurse practitioner with Western Pennsylvania Hospital in Pittsburgh.

"They are going to try to address [ergonomics, although] certainly not in as broad an effort as in a standard. If they create some guidelines and continue research on ergonomics, that will ultimately help us," she says.

RNs, aides face high ergo risk

Beyond political pressure, OSHA faces some undeniable statistics: One in three injuries requiring time away from work involve MSDs. More than 577,000 work-related MSDs were reported in 2000. Some 44,000 of those were among nursing aides, orderlies, and attendants; 12,000 occurred among registered nurses, according to recent Bureau of Labor Statistics data.

Nurses once again were in the top 10 of occupations with the highest lost time due to MSD injuries, with 24.5 injuries per 1,000 full-time equivalent workers. Nursing aides ranked third, with 74.2 lost-time MSD injuries per 1,000 workers.

Those facts add up to greater OSHA scrutiny. Nursing homes will face OSHA inspections as part of a "National Emphasis Program," and hospitals are part of OSHA's targeted inspection program. **(See related article, p. 65.)** Kelafant predicts

Chronology of OSHA Ergonomics

1979 The Occupational Safety and Health Administration (OSHA) hires its first ergonomist.

1986 OSHA begins a pilot program on reducing back injuries through analyzing injury records, training, and job redesign. Six months later, OSHA requests information from general industry on reducing back injuries resulting from manual lifting.

1987 OSHA cites automobile plants for ergonomic hazards.

1990 Labor Secretary Elizabeth Dole promises action on ergonomics and stresses the need to eliminate musculoskeletal disorder (MSD) hazards. OSHA creates an Office of Ergonomics Support. OSHA also publishes ergonomics guidelines for the meatpacking industry.

1991 OSHA cites five Beverly Enterprises nursing homes in Pennsylvania. Beverly appeals the citations.

1992 OSHA issues an Advance Notice of Proposed Rulemaking and requests comments.

1994 An administrative law judge rules that OSHA had not identified a "recognized hazard" when it cited Beverly Enterprises.

1995 OSHA begins drafting an ergonomics standard. Congress prohibits use of FY 1995 and 1996 funds to issue a proposed or final ergonomics standard or guidelines.

1997 Congress allows OSHA to work on ergonomics in FY 1998 but prohibits issuance of any proposed or final standard or guidelines. A House Conference Report states this will be the last time OSHA's work on an ergonomics standard is restricted.

1998 OSHA holds "stakeholder" meetings on ergonomics rulemaking.

1999 OSHA publishes its proposed ergonomics standard in the *Federal Register*.

2000 OSHA holds five sets of public hearings on the proposed standard. President Clinton vows to veto an appropriations bill that contains language barring OSHA from spending funds to complete or implement an ergonomics standard. A review commission rules that lifting does represent a hazard that requires abatement under the general duty clause. A final standard is released on Nov. 14. Opponents of the standard immediately file lawsuits to overturn it.

2001 A National Academy of Sciences panel issues a report citing scientific evidence for certain types of work-related MSDs and positive outcomes from ergonomic interventions. The ergonomics standard becomes effective on Jan. 16, two days before Clinton leaves office. In March, the House and Senate approve a Joint Resolution of Disapproval that overturns the standard. In April, Labor Secretary Elaine L. Chao promises a "comprehensive approach" to ergonomics, and in July, OSHA holds forums on key questions about ergonomics.

2002 In January, OSHA announces its settlement with Beverly Enterprises, including oversight of a program that implements lifts and transfer devices in 240 nursing homes. In April, OSHA announces its new ergonomics strategy, relying on a four-pronged approach of voluntary guidelines, selected enforcement, outreach, and research. Enforcement will fall under the general duty clause that requires employers to maintain a workplace free of recognized, serious hazards.

OSHA Announces Regional Ergonomics Coordinators

As part of its outreach in its new ergonomics strategy, the Occupational Safety and Health Administration (OSHA) in Washington, DC, has designated ergonomics coordinators in each of its 10 regions. These coordinators will provide guidance to compliance officers and will be involved in education and outreach. They also are available to employers and employees with questions about ergonomics and OSHA guidelines. The coordinators are:

Region	City	Coordinator	Telephone
Region I	Boston	Fred Malaby	(617) 565-9860
Region II	New York City	Paul Cherasard	(212) 337-2378
Region III	Philadelphia	Jim Johnston	(215) 861-4900
Region IV	Atlanta	Jim Drake	(404) 562-2300
Region V	Chicago	Dana Root	(312) 353-2220
Region VI	Dallas	Susan Monroe	(214) 767-4731
Region VII	Kansas City, MO	JoBeth Cholmondeley	(816) 426-5861
Region VIII	Denver	Terry Mitton Terry	(303) 844-1600
Region IX	San Francisco	Barbara Goto	(415) 975-4310
Region X	Seattle	Steve Gossman	(206) 553-5930

that OSHA will seek to set an example of a hospital or nursing home to show the agency's intent to uphold the general duty clause enforcement. "They're going to go after somebody," he says. "I think it's not a matter of if, it's a matter of when."

The new ergonomics plan takes a four-pronged approach of guidelines, enforcement, outreach, and continued research — a combination that Henshaw and Chao insisted would lead to the swiftest impact. "Our goal is to help workers by reducing ergonomic injuries in the shortest possible time frame," Chao said in a statement. "This plan is a major improvement over the rejected old rule because it will prevent ergonomics injuries before they occur and reach a much larger number of at-risk workers."

It has been about 12 years since then-Labor Secretary Elizabeth Dole promised action on ergonomics. OSHA began drafting a standard in 1995, but faced delays when Congress prohibited the agency from issuing a proposed or final guideline or standard. In November 2000, OSHA released its final standard, which drew sharp opposition, particularly to provisions that provided pay and benefit guarantees for employees with work restrictions. **(See complete chronology, p. 63.)**

The ACOEM withdrew support for the final rule when it failed to require a medical diagnosis of work-related MSDs. Instead, the rule provided a checklist for employers to determine if an MSD was work-related.

Amid the controversy over the standard, Congress voted to rescind the rule in March 2001, an action supported by President George W. Bush.

In this latest OSHA action, Henshaw sought to win over skeptical labor union representatives. Shortly after issuing the "comprehensive plan," he met with them and assured them that OSHA would be serious about enforcement. In its released statements, the agency presented the approach as its best effort yet:

"For the first time, OSHA will have an enforcement plan designed from the start to target prosecutable ergonomic violations. Also for the first time, inspections will be coordinated with a legal strategy developed by Department of Labor (DOL) attorneys that is based on prior successful ergonomics cases and is designed to maximize successful prosecutions. And OSHA will have special ergonomics inspection teams that will, from the earliest stages, work closely with DOL attorneys and experts to successfully bring prosecutions under the general duty clause."

Guidelines tailored for patient handling

OSHA can make quick progress on patient-handling guidelines because such guidelines already exist. The Veterans Health Administration released a safe patient-handling guide earlier this year that has been lauded by many ergonomics experts. **(For more information, see *HEH*, May 2002, p. 49.)**

"The fact that OSHA is going to embrace [the

OSHA inspections are honing in on health care

Nursing homes receive special emphasis

Seventy-three hospitals and 2,514 nursing homes have been notified that they are on a list for possible inspection because they have above-average lost-workday injury and illness rates. The health care industry, and particularly the nursing home industry, has been receiving increasing scrutiny from the Occupational Safety and Health Administration (OSHA). The agency announced a new National Emphasis Program for nursing homes that will result in unannounced, wall-to-wall inspections of 1,000 of those 2,514 high-injury facilities.

For the first time, OSHA also will include low-injury and -illness workplaces in its "site-specific targeting" inspection program as a way to gauge compliance with regulations. However, none of the 200 low-injury workplaces will be hospitals because the industry as a whole does not have a rate of eight or more lost-workday injuries and illnesses per 100 full-time equivalent workers.

The national lost-workday injury rate is three; hospitals have an average rate of 4.1. Nursing homes and personal care facilities have a rate of 7.9.

"When we visit a nursing home, we're going to zero in on just the potential problem areas that result in the majority of injuries and illnesses among nursing home staff, such as ergonomics; bloodborne pathogens and tuberculosis; hazard communication; and slips, trips, and falls," **John L. Henshaw**, director for OSHA, said at the Applied Ergonomics Conference held in Baltimore in March.

The National Emphasis Program reflects a growing scrutiny of nursing homes, which have among the nation's highest injury rates. "We're encouraged that now OSHA inspectors will actually be going into nursing homes and looking at some of the more significant hazards in these facilities," says **Bill Borwegen**, MPH, occupational health and safety director of the Service Employees International Union. Each year, OSHA reviews the lost-workday injury rates of about 1,000 hospitals, and keeps on its list those hospitals previously surveyed that had a rate of seven or higher. Hospitals with rates of 14 or higher will receive a wall-to-wall inspection, while hospitals with rates from eight to 14 receive warning letters and are placed on a secondary list for possible inspection.

OSHA determines its list of high-injury workplaces from a survey of 80,000 workplaces in selected industries. About 3,000 workplaces with injury rates of 14 or higher will receive the targeted inspections this year. ■

guidelines] means they'll get wider dissemination. People are going to pay attention," Borwegen says.

Guidelines also allow OSHA to tailor its ergonomics interventions, rather than trying to create a one-size-fits-all rule, says ergonomics expert **Guy Fragala**, PhD, PE, CSP, director of environmental health and safety at the University of Massachusetts Medical Center in Worcester.

"If this [voluntary] approach is not effective in addressing some of the problems and making improvements, then we'll have to look to other approaches," he says. "I'm not discouraged in any way by this [announcement]. I think it's a step forward that a release has been made and that we are going to see activity in the area of ergonomics to improve working conditions."

Henshaw has asked the SEIU and nursing home industry to assist with the development of the guidelines. But despite that collaboration, political efforts continue for greater regulation.

"There will be an effort to look at states that want to deal with the epidemic of ergonomic injuries among their citizens," Borwegen says.

Meanwhile, OSHA immediately began its outreach program by announcing the 10 regional coordinators for ergonomics. **(See list, p. 64.)** OSHA said it would provide courses and target training funds on ergonomics. The agency also said it will create a national advisory committee to "identify gaps in research related to the application of ergonomics and ergonomic principles to the workplace." OSHA would work with the National Institute for Occupational Safety and Health to increase research in those areas.

While many questions remained about how OSHA would implement its new ergonomics strategy, Fragala was at least encouraged by the activity. "As long as we keep moving forward, we are making progress," he says. ■

E-answers: OSHA's advice right at your fingertips

Internet tool offers overview of hazards

What are the dangers in a wheelchair-bound patient's room? Click. Ergonomics. Wheelchairs with removable arms allow for easier lateral transfers. What often leads to slips, trips and falls in central supply? Click. Employee exposure to slippery floors from steam and washing processes.

With the Hospital e-Tool feature now available on the web site of the Occupational Safety and Health Administration (OSHA), answers to common employee health questions are just a click away.

Far from the dry, technical language of guidelines, standards, and bulletins, the new e-Tools feature offers quick educational links designed for both employees and employers. They are very visual, allowing the user to click on different units of the hospital and then on items within a room. The accompanying text includes links to more detailed OSHA documents.

OSHA is promoting the e-Tools as part of its new ergonomics approach. **(See cover story.)** Information on the e-Tools can be used as a part of safety and health training.

"This is a good example of the kind of outreach materials we can use," says **Elise Handelman**, RN, MEd, COHN-S, director of OSHA's office of occupational health nursing. "The visual aspect helps some of the workers who may not relate to formal bureaucratic language."

The site also makes it easy to access information on a range of hazards, says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, AOHP executive president and employee health nurse practitioner with Western Pennsylvania Hospital in Pittsburgh.

"This is a great resource with numerous links not only to OSHA standards but to other resources," she says. "I would encourage anyone in occupational health in health care to take a few minutes and explore this site."

Use it as an overview

The tool could be used as an overview for employers "to get a sense of the breadth and scope of what their [health and safety] program should cover," Handelman notes. But it's not comprehensive, she acknowledges.

For example, in the laboratory area, OSHA mentions exposure to tuberculosis, bloodborne pathogens, formaldehyde, and other chemicals such as Toulene and Xylene. But the recent caution from the Centers for Disease Control and Prevention in Atlanta on working with meningococcal strains is not mentioned.

Such items could be added, with links to the appropriate documents of other agencies, Handelman says.

Each e-Tools site has an editor and an editorial advisory board who review it periodically for updates, she says.

While e-Tools can be useful for those who are reviewing their programs or providing orientation for workers, it is not directly related to OSHA enforcement. The items on the e-Tools site can't be used as a checklist to determine if you're in compliance with OSHA standards.

"It's an outreach tool, it's not an audit tool," says Handelman. "It's not intended to replace an OSHA inspection."

Certainly, e-Tools won't answer every possible question about hospital health hazards.

"There's no way this can be all encompassing," she says. "If [employee health professionals] get on here and they don't find what they need or they want more depth than they can find on the web site, then they can call their local OSHA office."

(Editor's note: The Hospital e-Tools can be accessed through the OSHA home page at www.osha.gov.) ■

Moratorium is extended on JCAHO's alert scoring

Panel will select national goals for compliance

Hospitals undergoing accreditation won't be scored on *Sentinel Event Alerts* such as a recent one on needle safety, unless the alert relates to one of six National Patient Safety Goals set by an expert panel, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, announced.

The action represents a tightening of focus for the Joint Commission, which placed a moratorium on scoring related to the alerts in January. While hospitals are still expected to respond to the alerts, surveyor comments will be consultative only.

Has JCAHO 'reneged' on its obligation?

The announcement came as a surprise to some who had hoped the Joint Commission would have a major impact on implementation of safer sharps devices in the nation's hospitals by monitoring compliance with the needle safety alert.

"We would have saved the lives of a number of health care workers," says **Bill Borwegen**, MPH, occupational safety and health director of the Service Employees International Union (SEIU).

Sentinel Event Alert moratorium announced

Published for Joint Commission on Accreditation of Healthcare Organizations-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future.

At this time, the Joint Commission has placed a moratorium on using the organization's response to *Sentinel Event Alert* recommendations as the basis for scoring standards.

During the on-site survey of accredited organizations, Joint Commission surveyors assess, for consultative purposes, the organization's familiarity with and use of *Sentinel Event Alert* information. Accredited organizations are expected to:

- ✔ Review and consider relevant information, if appropriate to the organization's services, from each *Sentinel Event Alert*.
- ✔ Consider information in an alert when designing or redesigning relevant processes.
- ✔ Evaluate systems in light of information in an alert.
- ✔ Consider standard-specific concerns.
- ✔ Implement relevant suggestions or reasonable alternatives or provide a reasonable explanation for not implementing relevant changes. ■

"But JCAHO reneged on [its] responsibility to make the workplace safer for health care workers."

The patient safety goals will be chosen based on past issues of *Sentinel Event Alert* by a panel of physicians, nurses, risk managers, and "other health care experts," the Joint Commission said. The first goals will be released this July and, as of Jan. 1, 2003, surveyors will check for compliance with the recommendations or "implementation of an acceptable alternative."

Hospitals can receive a Type I recommendation if they are not in compliance with those goals.

"These six goals are essentially going to replace the survey compliance for all of the *Sentinel Event Alerts*," says **Janet McIntyre**, Joint Commission spokeswoman.

In a statement, **Dennis O'Leary**, MD, president for the Joint Commission, said the goals are part of "intensive efforts to reduce errors in health care. . . . Great strides are being made in improving patient safety, but we want organizations to concentrate on widely recognized vulnerabilities in the way care is provided."

Needle alert was first ever for HCWs

The Joint Commission has a longstanding partnership with the Occupational Safety and Health Administration (OSHA), and its surveyors often ask about needle safety devices or bloodborne pathogen exposures.

But the alert issued in September 2001, the first ever that related to worker safety, placed greater emphasis on needlestick prevention. In that alert, the Joint Commission said its surveyors would assess compliance with the Needlestick Prevention and Safety Act of 2000, including requirements for detailed needlestick logs and involvement of frontline workers in device evaluation.

When the Joint Commission announced a moratorium on scoring related to the alerts, JCAHO officials insisted that they never intended to become surrogate OSHA inspectors. "Our whole accreditation process is as much consultation as it is compliance," said **Richard J. Croteau**, MD, executive director for strategic initiatives.

"It's an improvement process, not a regulatory process," he said.

While surveyors won't score based on compliance with the act, the accrediting body still requires hospitals to comply with "applicable laws and regulations." Surveyors are likely to still ask for documentation related to bloodborne pathogen exposures and efforts to reduce them.

Hospitals had complained about the burden of responding to monthly *Sentinel Event Alerts* and questioned whether they were evidence-based. The new *Sentinel Event Alert* advisory panel will "assess the evidence for and validity of past and future *Sentinel Event Alert* recommendations, as well as the practicalities of implementation," the Joint Commission said. Each July, the next year's goals will be announced, with some goals continuing and others replaced with higher priorities, the agency said.

Amid the Joint Commission's announcement, some wondered whether OSHA would step up compliance activity related to the revised bloodborne pathogen standard.

"What remains to be seen is how aggressive OSHA is," says **Geoff Kelafant**, MD, MSPH, FACOEM, medical director of the occupational

health department at the Sarah Bush Lincoln Health Center in Mattoon, IL, and chairman of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine in Arlington Heights, IL.

OSHA has announced that it would step up inspections of employers with above-average injury rates, which includes the hospital sector. ■

HIPAA privacy reg mostly bypasses employee health

Electronic transactions are key to coverage

The Health Insurance Portability and Accountability Act (HIPAA), which became effective April 14, 2001, was created to give patients greater control over their personal health information. Health plans and health care providers who conduct certain financial and administrative transactions electronically must comply with its provisions by April 14, 2003.

In response to concerns about some aspects of the privacy rule, the Department of Health and Human Services (HHS) published some proposed modifications in March.

Deborah V. DiBenedetto, MBA, RN, COHN-S/CM, ABDA, an occupational health consultant based in Yonkers, NY, and president of the American Association of Occupational Health Nurses (AAOHN), analyzed the rule and shared her perspective with *Hospital Employee Health* on how the rule will impact employee health professionals. DiBenedetto will be leading HIPAA workshops sponsored by AAOHN.

Question: *Does HIPAA specifically mention employee health and employers' access to health information? Does it bolster safeguards to prevent unauthorized viewing of employee health records by supervisors and others?*

Answer: HIPAA does not regulate employers, only health care plans, clearinghouses, and health care providers who transmit any health information in any electronic form in connection with transactions and those who receive, maintain, or disclose individual identifiable health information in any form or medium.

This includes oral, written, and electronic communications. It does provide safeguards for employees in that their personal health information (PHI) only can be released with their authorization. However, HIPAA's preamble states that HHS has no problem, per se, with self-insured employers requiring, as a condition of employment, a signed authorization from the applicant/employee allowing the release of protected PHI for specific, stated purposes. For example, the authorization might include release of information for return-to-work planning, case management, health promotion activities, and referral to an outside provider.

The PHI must not be used for the purpose of hiring, promotion, etc. The PHI must not be misused or disclosed inappropriately.

Question: *Are occupational health physicians and nurse practitioners defined as providers under HIPAA? Do they need to create new privacy notices for all employees to sign?*

Answer: HIPAA does not regulate employers — although employers who are self-insured and sponsor group health plans are required to comply with HIPAA. Occupational health providers who work directly for these employers are health care providers, but they generally do not perform any of the covered transactions. Therefore, they are not health care providers under HIPAA's definition of covered entities.

HIPAA transactions include:

- health claims or equivalent encounter data;
- enrollment/disenrollment;
- eligibility for a health plan;
- health claim payment and remittance advice;
- health plan premium payments;
- health claim status;
- referral certification and authorization;
- coordination of benefits.

In-house professionals are probably not covered under HIPAA unless they perform one of the covered transactions.

Workers' comp excluded from HIPAA

Now, under the original rule, an additional covered transaction included "first reports of injury" (FROI). Workers' compensation is excluded from HIPAA, but the FROI is generally issued prior to the claim being established by the workers' compensation carrier.

HHS has stated that it will not be making further rulemaking on FROI as a covered transaction under HIPAA. State laws may have requirements in place that are more stringent than HIPAA,

which must be reviewed for impact on the delivery of occupational health services and other health information. OSHA also regulates privacy of and access to occupational health records.

Question: *Is there a distinction between records related to a specific occupational injury and those related to other employee complaints that may or may not be work-related, such as stress-related symptoms, headaches, or high blood pressure?*

Answer: At this time, occupational records (workers' compensation, OSHA-mandated surveillance, Department of Transportation fitness, and public health records such as communicable diseases) are not impacted by HIPAA.

Occupational health records maintained by employee health services/occupational health services also are excluded, unless, there is a HIPAA-covered transaction involved in the care. For example, if billing for these services is made to commercial plans, employer-sponsored health care plans, Medicaid, etc., the records are covered.

Question: *Will HIPAA place new limits on how much information employee health practitioners can share internally about individual cases or congregated data?*

Answer: We always have used consents and releases for sharing relevant health care information as necessary. HIPAA-covered transactions at this time require an initial consent for treatment, payment, and operations (TPO).

There is a notice of proposed rulemaking that would change this to require only information being given to the patient about the covered entity's privacy policies.

An authorization would still be required for additional disclosures outside of TPO. ■

Changes are coming for *Bioterrorism Watch*

We hope you have enjoyed receiving complimentary issues of *Bioterrorism Watch* with your subscription to *Hospital Employee Health*.

Beginning in July, *Bioterrorism Watch* will become an eight-page bimonthly newsletter, which will offer both CE and CME credits. The six yearly issues combined will offer six hours of CE and CME. As a subscriber to *HEH*, you will continue to receive the publication free, but now on a bimonthly basis.

If you have any questions about your subscription, please call our customer service department at (800) 688-2421 or visit us on-line at www.ahcpub.com. ■

Transitional work keeps employees on the job

Create policy, job bank for injured workers

The longer your employees are out of work due to injury, the less likely they are to ever return. That is a maxim that has led hospitals to embrace transitional work programs, which enable employees to continue working with physical restrictions.

Transitional work means more than sending a nurse to a desk job or telling him or her to limit tasks. It's a formalized program that involves senior management support, supervisor involvement, and employee education, points out **Livia Pontani Bailey**, RN, BS, MA, COHN-S, risk control supervisor for PMA Insurance Group, a workers' compensation insurer based in Blue Bell, PA.

"The whole purpose of this [program] is to transition employees back to their full capacity," Bailey says.

At El Camino Hospital in Mountainview, CA, the transitional work program has contributed to a steady decline in lost workdays, from 36 in the first quarter of 1999 to 17 in the last quarter of 2001, says **John Deex**, RN, MS, OHNP, COHN, the hospital's director of employee health and safety.

"We have opportunities for people to do transitional work as opposed to losing days," says Deex, who notes that the labor shortage in health care makes such programs even more valuable.

But it also has a direct benefit to the employees, he says. "By keeping people productive within their professional environment, they get better."

Program's structure is key to success

How you structure your transitional work program may be critical to its success, Bailey and Deex say.

Some major components for a transitional work program include:

• **Gain buy-in from senior management.**

As with many other health and safety initiatives, the full support of senior management can make the difference between success and failure. After all, the supervisors need to identify appropriate placements for injured workers, and the employees need to have a positive feeling about the program.

"You've got to have the commitment from senior management that all the departments are going to cooperate with you to come up with a bank of positions that you can place people in," Bailey says. "This gives you the control you need [to develop transitional work]."

• **Create a formal, written policy.**

Managers may informally arrange for workers to perform lighter tasks when they return after work-related injuries. But a transitional work program involves definitions, protocols, and limitations.

Set a time limit on the transitional job

Transitional work programs typically set a time limit of 90 days in which the employee can remain in the transitional job.

"The philosophy is progress [toward recovery] within the scope of work," Deex says. "If you're not making progress within 90 days, then [perhaps] something we're doing is putting a barrier in front of you getting better."

By placing a cap on the duration of transitional work, employers avoid creating new, permanent jobs. "Under the Americans with Disabilities Act, you have to be very careful about modifying work," Deex says.

"If you let it go on for a period of time, you have established a sense of permanence. That could be perceived as creating an [permanent work] accommodation," he says.

Who will be eligible?

The policy would state who is eligible for transitional work. For example, some hospitals might include nonoccupational injuries as part of an integrated disability management program, Bailey notes.

It defines transitional work: Temporarily modifying the current position to meet the restrictions; placing the employee in a transitional duty position in the same department or another department; temporarily altering the number of hours an employee may work, or placing the employee

CE questions

Please use the enclosed Scantron to submit your answers for the January-June 2002 CE test and return the Scantron and CE.Survey in the envelope that's provided.

21. How will OSHA handle enforcement in its comprehensive plan for ergonomics?
    A. There is no enforcement, because the guidelines are voluntary.
    B. Inspectors will use the guidelines as a basis for enforcement.
    C. OSHA will use the general duty clause to cite employers who aren't acting on ergonomics.
    D. OSHA will announce enforcement strategy at a later date.

22. What is the purpose of the National Patient Safety Goals set by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL?
    A. They will replace the survey compliance for all of the *Sentinel Event Alerts*.
    B. They will be a part of surveys along with all *Sentinel Event Alerts*.
    C. They will guide future standard-setting by the Joint Commission.
    D. They will be topics for guidelines and educational sessions.

23. The Health Insurance Portability and Accountability Act (HIPAA) does not cover occupational health physicians and nurses unless:
    A. The encounter involves workers' comp.
    B. The employee's condition is considered nonwork-related.
    C. The encounter involves a covered transaction, such as a health claim.
    D. HIPAA specifically excludes occupational health transactions.

24. A key aspect of transitional work involves setting a time limit on the temporary work assignment. According to Livia Pontani Bailey, risk control supervisor for PMA Insurance Group, a workers' compensation insurer based in Blue Bell, PA, what is a reasonable limit?
    A. 30 days
    B. 60 days
    C. 90 days
    D. 120 days

in another division or business unit, she says.

The policy also outlines what steps employees and managers should take after a work-related injury, and states what accountability and responsibility each party has. Employees generally are paid their regular rate of pay while on transitional duty.

In some states, workers' compensation laws may dictate how much they can earn per week. For example, in California, the maximum workers' compensation benefit is $490 per week, Deex says. "If you made $20 an hour, you would work 24.5 hours a week to get to that $490."

• Find jobs that fit the restrictions.

Who will decide what transitional work an injured employee should perform? That is the duty of a team made up of the employee, supervisor, and transitional work program coordinator.

The physician who examines an injured employee should have a copy of the employee's job description so they have an idea of what types of restrictions might be necessary.

"Sometimes their work restrictions may meet the job description and there's no need to put them in transitional duty," Bailey notes. You want the treating physician or clinician to be as specific as possible, she says.

A physical capabilities form can enable the physician to identify what tasks, such as repetitive motion, must be curtailed and what can still be performed. **(See sample form, inserted in this issue.)**

Set up a job bank

When you set up your transitional work program, you may want to designate a "bank" of possible jobs. These will not be charged to a department's budget, but will be part of a separate transitional work program budget, Bailey notes.

Otherwise, managers may have a disincentive to create transitional work positions, she explains.

"When a physician assigns restrictions, then there is dialogue between the manager, employee, and nurse practitioner who handles the case, to try to determine if there are accommodations that can be made within the usual and customary work," Deex says.

"If that is possible, that is the ideal situation. If that is not possible, then we look at other work alternatives, with the home department being the preference," he adds.

"If their manager does not have anything, then we would utilize their skills elsewhere in the facility or hospital, depending on the need from managers who have called employee health," Deex says.

Match duty to employees' skills

The jobs should conform to the expertise of the injured employee, Bailey says. "You want to make sure the employee is being utilized to the fullest capacity in that position, and you want to make sure it's meaningful work.

"The goal is to transition them back to their position. You want them to have maximum potential," she says.

• Monitor the program.

The transitional work program coordinator should follow up with the employee periodically while he or she is in the program. After all, you

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don't want employees to violate their restrictions and impede their healing process, Bailey notes.

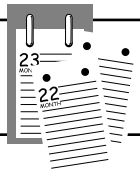
At El Camino, employee health nurse practitioners treat patients in-house and function as case managers. "They understand the work environment and how that relates to the recovery and treating process," Deex says.

Hospitals can compare their lost workdays before and after the implementation of transitional work to show the cost impact of the program. But there are other, less tangible benefits of employee loyalty and retention, he says.

While the transitional work program seeks to rehabilitate injured workers, employee health also should analyze the causes of the injuries, Deex says.

Beyond responding to injuries, employee health professionals should consider, "How do we promote prevention and the reduction of injuries in general?" he adds. ■

CALENDAR



• **Association of Professionals in Infection Control, Virginia** — Sept. 18-20, Fairfax, VA. "Focus on the future: Where do we go from here?" Annual educational conference highlighting emerging trends in infection control and new regulatory standards.

Contact Dorothy Seibert, Fauquier Hospital, 500 Hospital Drive, Warrenton, VA 20186. Telephone: (540) 341-0826. Fax: (540) 349-5506. E-mail: seibertd@fauquierhospital.org.

• **Association of Occupational Health Professionals in Healthcare** — Oct. 17-19, St. Louis. "Meet me in St. Louis: Unlock the Gateway to Success," annual conference highlighting occupational health success stories.

For more information, contact AOHP, 500 Commonwealth Drive, Warrendale, PA 15086. Telephone: (800) 362-4347. Fax: (724) 772-8349. Web site: www.aohp.org/aohp/. ■

CE objectives

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

• identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;

• describe how those issues affect health care workers, hospitals, or the health care industry in general;

• cite practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■

Return-To-Work Physical Capabilities

RETURN TO WORK PHYSICAL CAPABILITIES

PHYSICIAN: _____ INJURED WORKER: _____
EMPLOYER: _____ CLAIM #: _____

In an 8 hour workday, the worker can:

	No Restrictions	3-5 Hours	1-3 Hours	Not At This Time
1. Stand/Walk:				
2. Sit:				
3. Drive:				

	No Restrictions (67%-100%)	Frequently (34%-66%)	Occasionally (1%-33%)	Not At This Time
4. Lift:				
0-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
101 + lbs.				
Carry:				
0-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
101 + lbs.				

5. In an 8 hour workday, the worker is able to:

(a) Bend				
(b) Squat				
(c) Climb				
(d) Kneel				
(e) Push/Pull				
(f) Reach				
(g) Crawl				

6. Worker can use hands for (a) Gross grasping: _____Yes _____No
(b) Fine manipulations: _____Yes _____No

7. Worker can use feet for operation of foot controls: _____Yes _____No

8. _____SEDENTARY WORK: Lifting 10 lbs maximum and occasionally lifting and/or carrying.
_____LIGHT WORK: Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs.
_____MEDIUM WORK: Lifting 50 lbs. maximum with frequent lifting and/or carrying objects up to 50 lbs.
_____HEAVY WORK: Lifting 100 lb. Maximum with frequent lifting and/or carrying objects.
_____VERY HEAVY WORK: Lifting objects in excess of 100 lbs. with frequent lifting and/or carrying objects weighing 50 lbs. or more.

9. Comments: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Agency name

Please complete this form at the time of the employee's office visit and fax to _____

Consultant Referral/Treatment Record

M. D. Name: _____ Fax Number: _____

Employee Name: _____ Date of Service: _____

Diagnosis: _____

Treatment Plan: _____

_____

_____

Medications: _____

Work Status: ☐ **Regular Duty/No restrictions**		**Client can work:** ☐ **Full Time** ☐ **Part Time** ____ **Hours/Days**		
☐ **Return to work with the following restrictions: (Place a check in the appropriate box)**				
Client Can:	**6-12 Hours**	**3-6 Hours**	**1-3 Hours**	**Never**
Sit				
Stand				
Walk				
Drive				
Client Can Lift:	**6-12 Hours**	**3-6 Hours**	**1-3 Hours**	**Never**
1-10 lbs.				
10-20 lbs.				
25-50 lbs.				
50-100lbs.				
Client Can Carry:	**6-12 Hours**	**3-6 Hours**	**1-3 Hours**	**Never**
1-10 lbs.				
10-20 lbs.				
25-50 lbs.				
50-100lbs.				
Client is Able to:	**6-12 Hours**	**3-6 Hours**	**1-3 Hours**	**Never**
Push/Pull ____ lbs				
Climb/Balance				
Stoop/Squat				
Kneel/Bend/Crawl				
Reach above Shoulder				
Grasp Objects				
Manipulate Objects				
Environmental Restrictions	**6-12 Hours**	**3-6 Hours**	**1-3 Hours**	**Never**
Unprotected Heights				
Temperature Changes				
Dust, Fumes, Gases				
Client can use hands in repetitive movements (same motion every few seconds for 2 hours or more)			**Left Side** ☐Yes ☐ No	**Right Side** ☐Yes ☐ No
Client can use feet in repetitive movements (same motion every few seconds for 2 hours or more)			**Left Side** ☐Yes ☐ No	**Right Side** ☐Yes ☐ No
These restrictions are in effect until:				

Next Follow Up Appointment: _____

Physicians Signature: _____ Date: _____

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BIOTERRORISM WATCH
Preparing for and responding to biological, chemical and nuclear disasters

They don't call it bio*terror* for nothing: Fear is the foe when anthrax spores are found within hospital walls

'We feel we were able to ward off a panic . . .'

Clinicians nationwide were beset with hoax powder scares last year at the height of the anthrax attacks, but at one hospital, the threat turned out to be real. Positive cultures for *Bacillus anthracis* were found within hospital walls, setting off a wave of anxiety that threatened to descend into panic.

"There was a mounting level of anxiety among our health care workers," said **Maureen Schultz**, RN, infection control coordinator at Veterans Affairs (VA) Medical Center in Washington, DC. "It had to be dealt with before we could work out any other aspect of the situation."

The events began to unfold last October, when it was discovered that the anthrax letter sent to Sen. Tom Daschle (D-SD) might have contaminated other federal buildings through cross-contamination of mail processed at the Brentwood postal building in Washington, DC.

"It was several days before the contamination was discovered, and by that time, several downstream facilities, including our VA hospital, were contaminated," she said recently in Salt Lake City at the annual meeting of the Society for Healthcare Epidemiology of America (SHEA).[1] In light of the situation, it was recommended that mailrooms in federal buildings be cultured for anthrax.

"One of the things we found frustrating was that we were not given any guidance as to how we should screen the mail," Schultz said. "So we [took] cotton swabs and ran each swab over an approximately 10 to 50 square inch area."

Four of 34 environmental swabs taken in the hospital mailroom grew *B. anthracis*, with colony counts varying from one to 11. The anthrax was found on a canvas mail tote, a cardboard box that had been mailed, on the top of a mailroom speaker, and on a canvas mail cart.

The fear factor

"Even before the contamination was discovered, [we] decided to take some action because of the growing concern among our employees," she said. "So [we] convened a group from the emergency response team, infection control, safety, and public affairs."

The focus of the response was to determine risk level, provide prophylaxis as needed, decontaminate the environment, and get accurate information to all 1,700 health care workers, patients, and visitors, Schultz said. In order to reduce the high level of anxiety, a series of educational sessions were held, information was posted on the hospital web page, press releases were distributed, and printed materials were given to staff, patients, and families. In addition, a series of "town-hall" meetings was held to fully air the concerns of employees.

"These were informal sessions that we had in our auditorium where many health care workers could come and interact on an informal basis," Schultz said.

The risk to hospital workers was determined to

This supplement was written by Gary Evans, editor of *Hospital Infection Control.* Telephone: (706) 742-2515. E-mail: gary.evans@ahcpub.com.

be low, and only eight staff members were started on prophylactic antibiotics. Those included five mailroom employees who were encouraged to take full 60-day regimens. Another three workers, considered at lower risk, were given 10-day regimens due to possible contact with contaminated mail. The mailroom and surrounding area were decontaminated by an outside contractor.

Overall, some 500 health care workers attended the education sessions, and each town-hall meeting drew more than 200 staff members. With the colony counts low and the contamination limited, the decision was made to limit prophylaxis to only the eight aforementioned employees. That approach was not well received by other health care workers who feared they could have been unknowingly exposed.

"We refused treatment to all other employees, and initially, this created a lot of anxiety among the health care workers, particularly in these large town-hall meetings," Schultz said. "They were demanding ciprofloxacin or doxycycline in case they had come in contact with something contaminated. But we did hold firm on this, and we did not provide prophylaxis to any other employees."

Still, at the SHEA meeting, the Centers for Disease Control and Prevention (CDC) conceded that many of its initial assumptions about anthrax turned out to be false, including the perception that mail handlers were not at risk for inhalational anthrax. Given that acknowledgment, *Bioterrorism Watch* asked Schultz if she would now reconsider the decision to limit antibiotic prophylaxis to a few workers. "Based on the information we have now, no. I don't think we would change that decision." There really was no evidence that any widespread contamination had occurred, she added.

A total of 34 workers reported to the occupational health service for clinical evaluation, but there were no reports of staff refusing to work, and patient care was not interrupted. The initial level of fear and anxiety among many of the workers eased off under the continuous education and communication effort.

"We feel we were able to ward off a panic situation by the actions that we took," she said.

NYC hospital faces similar situation

A similar contamination incident was feared at Memorial Sloan Kettering Institute, a 431-bed cancer center in New York City. Some 1,200 health care workers at Sloan Kettering work in the same building as Gov. George Pataki's Manhattan office, which was reported to be the target of anthrax mailing. On Oct. 17, possible anthrax (positive by polymerase chain reaction test) was discovered in the governor's office. Pataki and staff vacated their part of the building, and infection control staff and hospital administration at Sloan Kettering developed a response plan to protect their workers.

The hospital employees worked on 10 floors of the 40-story building, including three floors that shared an air-ventilation system with the governor's offices. The response was honed to focus on mailroom staff and some 250 employees who worked on the three floors with shared air. With incomplete information on the scope of potential contamination of Pataki's offices, hospital clinicians decided to perform nasal cultures on the employees on the three floors, **Janet Eagan**, RN, an infection control professional at Sloan Kettering reported at the SHEA conference.[2] All of the 245 cultures taken were negative.

"I think the nasal swabs were more to allay fear," she said. "We wanted to do something that was proactive."

Public health investigators first used the nasal swab approach after the first anthrax case in Florida, but the CDC would later advise against routine use of the practice. The reliability of the swabs came into question, in part, because even those exposed may test negative as the nose clears of spores. At a Nov. 1, 2002, press briefing, the CDC advised against using nasal swabs "as a nonspecific probe to determine whether anthrax has ever been present in an environment."

Of course, clinicians at Sloan Kettering were dealing with a situation before that clarification was issued, but even then there were doubts about the wisdom of swabbing the workers.

"By the time we agreed to do the nasal swabs, I was kicking myself, thinking what on earth are we going to do with this information," **Ken Sepkowitz**, MD, epidemiologist at the hospital told SHEA attendees. "The nasal swabs was a screw-up, but with the information we had . . ."

With all the swabs negative, no antibiotics were administered. Additional efforts were needed to reassure the "worried well" that they were not at risk. Personnel from infection control, safety, security, and social work all met with the staff. Building management conducted an independent environmental survey of the building.

"E-mails went to all staff that all 245 employees tested had negative results," Eagan said.

"Communication is key. We believe that by having a hands-on approach — actually being there meeting with staff — prevented panic in employees that were very vulnerable."

Then word came that the original specimen from the governor's office had been found culture negative on retesting. The hospital had been through an intense false alarm drill, but overall had met the challenge, Eagan said.

"Decisions were made using incomplete information at a time-sensitive pace," she said. "Staff responded in a positive manner to the high visibility of administrative leadership, infectious disease, and infection control in numerous educational sessions and e-mail alerts."

References

1. Gordin F, Schultz M, Benator D, et al. A coordinated response to contamination of the hospital environment with *Bacillus anthracis* spores. Abstract 129. Presented at the annual conference for the Society for Health Care Epidemiology of America. Salt Lake City; April 6-9, 2002.
2. Eagan J, Martin K, Prager L, et al. Infection control response to potential anthrax contamination of building with hospital workers. Abstract 130. Presented at the annual conference for the Society for Health Care Epidemiology of America. Salt Lake City; April 6-9, 2002. ■

APIC: Smallpox plan uses outdated infection control

Designating patient facilities a mistake

The Centers for Disease Control and Prevention (CDC) has based its smallpox bioterrorism response plan on "outdated concepts," and entire sections need to be revised to reflect current epidemiologic strategies, the nation's leading group of infection control experts warned.

The Association for Professionals in Infection Control and Epidemiology (APIC) commented on the *CDC Interim Smallpox Response Plan and Guidelines*, which has been released as something of a work in progress.

"In general, we are concerned that the draft guidelines appear to be based on outdated strategies used to control this disease decades ago and do not appropriately integrate those infection control strategies and environmental controls utilized in our hospitals today," the APIC letter stated.

The CDC response plan calls for investigators to rapidly immunize a "ring" around the first cases. The ring concept uses isolation of confirmed and suspected smallpox cases followed by contact tracing, vaccination, and close surveillance of contacts. The ring approach was used to successfully eradicate smallpox from the world in 1980. But the ring concept was effective when the demographics of smallpox were very different, when few were infected, and the vast majority of people already were immune.

As part of the ring response, vaccine would be administered to people involved in the direct medical care, public health evaluation, or transportation of confirmed or suspected smallpox patients.

"Vaccination, like any preventive strategy, is more effective if given prior to exposure," APIC argued. "If health care workers are not immunized prior to case identification, these individuals [especially emergency department staff, direct caregivers, and laundry personnel] should be vaccinated immediately upon documentation of a case in their community. It is crucial that we not wait for a case to present in the facility before taking preventative action."

In addition, it may not be possible to distinguish between febrile response to vaccine or actual exposure in health care workers, APIC warned.

"Approximately 20% of vaccinated employees will develop fever and not be able to work if vaccine is given in response to a suspect or confirmed case," the association stated. "We need to develop strategies for dealing with staffing shortages whether they are due to febrile reaction to vaccination, true infection / disease, or refusal to care for patients in a smallpox emergency."

'Misuse of resources'

APIC also questioned the CDC concept of a "Type C isolation facility" for smallpox patients. As proposed, the sites would be facilities that are at least 100 yards from any other occupied building, or those that have nonshared air-ventilation systems with filtered exhaust.

"We believe it would be a misuse of resources to design, build / retrofit, and maintain a designated facility that is not integrated with the existing health care system," APIC stated. "Using alternative structures rather than enhancing the current infrastructure is not a wise use of our limited resources."

Instead, existing facilities could substantially

benefit from dedicating resources to ensuring appropriate air handling and ventilation systems for existing clinics, emergency departments, and isolation rooms. "This would provide the added benefit of controlling more likely exposures to infectious droplet nuclei [tuberculosis, disseminated zoster, chicken pox, measles, etc.] in addition to minimizing or eliminating the likelihood of intrafacility transmission of smallpox," APIC stated.

The association expressed concern that health care delivery might be compromised in separate Type C facilities, particularly if they are not designed to provide services such as intensive care, ventilator support, dialysis, and laboratory resources. Rather then designate facilities for smallpox patients, each hospital should be prepared in advance to activate its program when the first case is identified, APIC argued.

"There needs to be a predetermined area [building or wing, etc.] that meets the 'Type C' facility requirements for isolation," APIC noted. "Part of a facility's planning would include a determination regarding the number of patients that could be housed in the designated area."

Some of the cleaning and disinfection recommendations in the document are out of date with current sterilization principles and practices. That includes "fogging" rooms to disinfect environmental surfaces, the association charged.

"CDC has not recommended the fogging of rooms for many years," APIC stated. "We strongly suggest the deletion of any archaic references to fogging." ■

Stanford sets the standard for bioterrorism planning

A separate piece: Stand-alone plan advised

It's not enough merely to update the bioterrorism component of your current disaster preparedness plan, experts say; you must create a detailed bioterrorism response plan that stands on its own.

That's precisely the philosophy behind the Stanford (CA) Hospital and Clinics (SHC) & Lucile Packard Children's Hospital (LPCH) Bioterrorism Response Preparedness Plan, which is gaining widespread recognition as a model for such plans. In fact, several Kaiser Permanente facilities in California already have adopted the plan.

"You need a separate [bioterrorism] plan," asserts **Eric A. Weiss**, MD, assistant professor of emergency medicine at Stanford, associate director of trauma at Stanford Hospital, and chairman of the disaster committee and bioterrorism task force. "During most disasters, for instance, you don't rely on the microbiology lab to identify pathogens. Also, infectious disease and infection control staff take on a major, heightened role."

In disasters such as an earthquake, Weiss notes, you generally don't have to worry about the quarantine of patients or the spread of infectious agents. Similarly, you may not have to put on protective clothing or worry about cross-contamination of existing patients who may be immunosuppressed.

A bioterrorism plan had been in place prior to 2001, Weiss says, "but it was really just a skeleton plan — not very comprehensive. It was part of a larger disaster preparedness plan, but a plan to deal with mass casualties from bioterrorism is very different."

When you have a major disaster such as the collapse of the World Trade Center, Weiss notes, local health care providers are likely to come to the hospital and offer to chip in and help wherever they can.

"But what happens when the word goes out that patients are walking around with smallpox?" he asks. "Are providers going to want to stream down to the hospital and potentially infect themselves and their families? You need a response plan to address the safety of health care providers, so they will feel comfortable and want to show up for work."

To create such a plan, the Bioterrorism Planning Task Force was formed, incorporating personnel from 30 or more different departments at both facilities. Those departments include infectious diseases, infection control, emergency medicine, pediatrics, critical care, intensive care units, nursing and hospital administration, dermatology, psychology, social services, and environmental health and safety.

"We began putting the plan together when we identified the fact that the current plan was not adequate," notes Weiss. "We accelerated our activities after Sept. 11. After Sept. 11, *everybody* wanted to be part of it."

[Editor's note: The bioterrorism plan is available on the Stanford web site at www.stanfordhospital.com.] ■