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Collaborate with safety to get some truly head-turning results

'Demystify the process'

If occupational health and safety fail to work together as a team, "it is a waste of time and talent," says **Jonelle K. Leach**, BSN, RN, CRRN, CCM, COHN-S, an occupational health nurse and medical services technician at U. S. Pipe and Foundry's North Birmingham (AL) plant. "The free flow of ideas suffers if you aren't able to easily bounce thoughts off a teammate. That is counterproductive."

Robert Emery, DrPH, vice president of safety, health, environment and risk management at The University of Texas Health Science Center at Houston, recently merged safety and occupational health into a single department. He says that the biggest difference he sees between the two roles is that safety is generally focused on acute issues, whereas occupational health's focus is largely on prevention. "That is where the disconnect can come in," he says. Here are several approaches to improve collaboration:

1. Tell safety what you do.

A safety person may not fully appreciate the value of a tetanus shot. On the other side of the fence, occupational health might not comprehend all the risks associated with working in a confined space.

Emery says that for occupational health, 'on a good day, nothing happens. We have to be really good at explaining to other people that there are a whole lot of things going on behind the scenes to make nothing happen," he says. "So the first step is for both groups to explain what they do."

2. Create a spreadsheet for people to view accomplishments of both areas.

Emery developed a set of performance measures and metrics for both

EXECUTIVE SUMMARY

Good communication is key to avoid problems between occupational health and safety, as often there is a lack of understanding between the two roles. To improve relationships:

- Jointly develop a series of measures and metrics that clearly conveys what each program does.
- Team up with safety during health events.
- Give presentations on safety issues such as back injuries.

the occupational health and safety programs, and put them in a spreadsheet for everyone to see. He says that this was enlightening not only for higher-ups, but also safety. "If you ask the average safety person, they wouldn't have a clue as to what immunizations or clinical tests are appropriate for individuals in the various work settings," he says.

The spreadsheet clearly outlines this information. It is also used to clear up misconceptions about who does what during emergencies. "For example, who is responsible for distributing and maintaining the hand sanitizers?" asks Emery. "It allows you to see the whole process, from soup to nuts. By improving understanding, we can minimize overlap and eliminate things that fall between the cracks. "

The spreadsheet articulates to a wide variety of audiences that safety and occupational health "play well together," adds Emery. "It serves to demystify the process by categorizing what type of things people in different settings are typically exposed to." For instance, those in clinical settings have biological exposures whereas office workers don't, thus, they have different testing requirements. On the safety front, the number of injuries is listed along with initiatives underway to drive those down. This data overlaps into occupational health programs.

3. Identify areas of overlapping responsibilities.

Emery says a good example is respiratory protection. "Typically, safety is the one doing the fit testing, but occupational health determines whether the employee is physically able to accommodate respiratory protection," he says.

4. Offer "one stop shopping" for employees.

Emery suggests teaming up with safety to hold health fairs. This way, employees can obtain necessary safety training, and also fulfill occupational health requirements such as tetanus shots and TB tests. "This helps to weave the occupational health and safety roles together," he says. "It also increases productivity because the employee is not having to roller skate around to get all of this done."

5. Volunteer to give talks to employees.

Judy A. Garrett, health services manager at Syngenta Crop Protection in Greensboro, NC, noticed that back injuries were more common on the Occupational Safety and Health Administration log and workers' compensation cases than any other injury. She pointed this out to safety, and volunteered to give a presentation at all plant sites.

"Safety loved it because they are always looking for topics and speakers," says Garrett.

As part of the "Oh, my aching back!" event, employees were given "wellness points" which can be traded in for cash, as part of a company-wide program. "That gave safety something special to offer, and it helped us to promote wellness," says Garrett. "

In addition to healthy lifting demonstrations, occupational health covered other causes of back pain, such as carrying a wallet in your back pocket or shoulder bags. "Many times people like to blame all back issues on their jobs, particularly if they do manual labor," says Garrett. "We included factors outside of the actual lifting, such as a person's weight, flexibility, fitness level, and age."

SOURCES

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What safety should know about occ health role

Employees at U. S. Pipe and Foundry's North Birmingham (AL) plant seem to have a "sense of well-being and security" when they come into the office of **Jonelle K. Leach**, BSN, RN, CRRN, CCM, COHN-S, an occupational health nurse and medical services technician. Leach credits this to close collaboration with safety, as follows:

• She trains safety and as a result, enlists their help.

Leach says her duties are "almost completely blended" with the safety director's. "We are actually set up as our own department and work as a team," she says. "He, of course, doesn't feel very comfortable treating injuries—although he can put a Band-Aid on and hold pressure on a cut until I can get to the patient! He does assist me as needed."

Leach has taught First Aid techniques to the safety director, along with 43 other managers, supervisors and a handful of non-management employees. "They do a really great job helping me to take care of all the workers. They make up our First Responder Team, and are amazingly right on it when someone needs help," she says.

Leach also trains all new Safety Captains on the company's Behavioral-Based Safety Program. "I provide them with a weekly topic information sheet, but often the departments come up with their own topics," says Leach. "I serve as a resource for them if needed."

• She cross-trains on tasks normally done by safety.

While going on site to investigate a workplace injury is normally done by the safety director, Leach does this as needed. "I make sure an incident report is generated, and I follow the report to completion," she says.

Keep safety informed of real-time concerns

Lavonda F. Shires, RN, COHN/CM, an occupational health nurse who also handles environmental health & safety for one of Shaw Power Group's power plant construction sites in Cliffside, NC, says she's fortunate her employer "values the impact worker safety has on the bottom line."

At the beginning of every work week, the entire site workforce of 2,100 employees participates in a mass safety meeting. "Separate, smaller meetings are conducted in different languages so that all employees are kept informed," says Shires. "Each crew begins every single day with a safety meeting. I keep site safety management apprised of real-time issues and concerns so that immediate investigation is initiated."

As a North Carolina Star site, safety management maintains a close working relationship with Occupational Safety and Health (OSHA) representatives.

Internal auditors visit the construction site annually and conduct records audits as well as visual inspections. "As site occupational health nurse, accurate OSHA recordkeeping begins with me," says Shires.

• Successes are celebrated jointly.

Every month without a recordable injury means a celebration dinner is held for employees. "We serve them a meal that is cooked by our manager of engineering and maintenance," says Leach. "It's a real family affair, in that our plant manager joins right in with us. He helps to serve and encourage the guys as well."

Also, each department that has a perfect score on their audits and turns in all their data by the deadline each month gets a special lunch ordered and delivered to them.

Quarterly, the injury rate is also celebrated. A Total Recordable Injury Rate scorecard is used, which is the number of injuries times 200,000, divided by the number of hours worked. This rate is factored in, along with departmental audits and training documents to determine if everyone qualifies. If so, every employee in the plant is awarded a gift card to Wal-Mart in varying amounts, depending on the score.

• New projects are tackled together.

If the safety director is asked to improve compliance for a particular Occupational Safety and Health Administration standard, Leach also gets involved. "We put our heads together and brain-

storm and work up the plan together. Then, when it is ready to put into place we each take a part in completing it," says Leach.

Recently, the corporate office asked all plants to come up with a Severe Incident Prevention Plan. This involved assessing their particular hazards, determining the severity of each hazard, deciding if the safety measure in place was adequate and then if not coming up with a plan to increase the safety measures for the hazard.

"All employees were involved in doing this and we acted as facilitators. My role was to provide information and support to the safety captains and supervisors," says Leach. ■

Be the "go to" person to keep all in compliance

Who do company leaders expect to keep...

Who do company leaders expect to keep them in the loop about changes in regulations that impact your workplace? You—the occupational health professional.

This means you need to stay abreast of changes in requirements from the Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), the Environmental Protection Division, the Food and Drug Administration and the United States Department of Agriculture, among others.

Here are ways to make yourself the "go-to" person for compliance:

1. Provide a monthly or quarterly update on items which affect your specific industry.

"Compare your company's compliance record with the industry standards," says **Diane DeGaetano**, RN, BSN, COHN-S, COHC, president of the Atlanta, GA chapter of the American Association of Occupational Health Nurses (AAOHN). For example, for fleet safety, they may want to know what the industry standards are for accident rates per million miles driven, compared with your own workplace. Also offer comparison figures, such as stating that, 'For the Pharmaceutical Industry, the accidents per million miles in 2008 was 12.7."

2. Offer best practice ideas that go beyond compliance.

"These ideas require research and creativity," says DeGaetano. She recommends networking with experts in the fields related to occupational health and safety, such as the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, AAOHN, the National Safety Council, the American Society for Safety Engineers (ASSE), and the National Institutes of Health.

3. Rely on professional organizations to keep you informed.

Being a member of ASSE or the American Association of Occupational & Environmental Health Nurses is one way to keep up with the updates from OSHA and EPA, for example.

"Both organizations have partnership with most federal organizations," says DeGaetano. "The information in provided in a variety of formats including webinars, teleconferences, regional professional development meetings and national conferences." ■

EXECUTIVE SUMMARY

As an occupational health professional, you need to provide ongoing updates on regulatory changes which impact the workplace. To keep informed:

- Compare your company's compliance record with others.
- Join organizations which provide information on federal regulations.
- Identify best practices by networking with experts.

SOURCES

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Workers' comp costs are closely linked to depression

Depression screening is cost effective

Three factors: depression, stress and obesity, together account for about half of the variance in the average workers' compensation cost per case at PPG Industries. That is based on data from Health Risk Assessments completed by several thousand of the company's employees, and analysis of five years of workers' compensation claims at 35 worksites, according to **Alberto M. Colombi**, MD, MPH, medical director.

"Depression screening is the most important tool that can be promoted in the realm of mental

Single out high-risk workers for screening

Mental health screening should be part of your overall plan to assess risk, implement interventions, and establish outcomes measurement strategies, says **Nancy W. Spangler**, MS, OTR/L, a consultant to the Partnership for Workplace Mental Health and president of Leawood, KS-based Spangler Associates Inc. She suggests the following approaches:

1. Add questions about mental health and stress to health risk appraisals.

"This is a valuable and low-cost way to increase awareness," says Spangler. She advises using validated tools, including the World Health Organization Health and Work Performance Questionnaire or the Work Limitations Questionnaire.

2. Screen high-risk groups.

These include employees with other medical conditions, people who access employee assistance programs, those who are frequently absent from work, and employees in particularly high-stress positions.

Also screen any employee who has been off work for five days or more with an occupational injury or accident. For these cases, Spangler suggests using a nine-item depression scale, called the Patient Health Questionnaire.

"This tool may be helpful for both screening and monitoring progress," she says. Spangler points to one study that found a high prevalence of depressive symptoms at one month (43%) and six months (27%) post-workplace injury. In addition, the researchers found that few of the injured employees were receiving any treatment for depression(13% and 24%, respectively).[1]

3. Collaborate with others in your organization who may be able to influence mental health awareness.

Enlist the help of human resources, leadership, employee assistance, safety, and communications.

4. Communicate with referral clinicians.

Inform independent medical examiners, rehabilitation, and disability vendors that your organization values a comprehensive biopsychosocial approach to functional capacity examinations, work accommodations, and return-to-work strategies.

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EXECUTIVE SUMMARY

Depression, stress and obesity are three factors which increase the average worker's compensation case, according to data from Health Risk Assessments done at PPG Industries in Pittsburgh, PA. To reduce these costs:

- Add a mental health screening questionnaire to your online Health Risk Assessment.
- Include depression screening in your existing wellness programs.
- Screen workers out five or more days due to a workplace injury.

well-being," says Colombi. "It has direct bearings on occupational health and productivity. We found that the percentage of people that screen positive for depression, together with other factors, has an important impact on overall worker's compensation costs."

The findings indicate that depression is a contributing factor in a multi-factorial process, not the sole factor affecting worker's compensation. "Treating depression as a linear and isolated factor is a serious mistake, in my opinion," says Colombi.

When depression, obesity and stress are all set at their median level, the average payment for a worker's compensation case was found to be $4612. However, if obesity prevalence at that worksite increases from its median of 0.34 to .05, the cost increases 84% to $8519.

Conversely, if the proportion of workers reporting a neutral stress and satisfaction score improved from the median of .33 to .45, the average cost per case would decrease by 63%, to $2918. Finally, if all other factors remained unchanged, and the percentage of workers screened for depression at a worksite was increased from its medial level of 0.25 to 0.45, that would decrease the average payment to $2425, or 53%.

In order to determine your own return on investment from depression screening, Colombi says you need to understand three things. First, you need to know the relationship between depression and workers' compensation costs at your workplace. Secondly, you need to determine the investment required to prevent or treat depression. Lastly, compute the relationship between the financial investment and the benefits resulting from it.

"How much does it cost to increase depression screening from a quarter to half of the worksite population?" asks Colombi. "There are direct costs and indirect costs involved in this."

The direct costs are due to adding a Patient Health Questionnaire including depression to an online Health Risk Assessment, which Colombi

says involved a one-time programming fee of $5,000. The indirect costs involved adding depression screening to the wellness programs already in place at each worksite. That cost, for PPG, was $25 per employee per year.

Thus, Colombi estimates that to reduce the average worker's compensation cost per employee by 50%, "you would need to invest $25 per employee to have a worker's compensation payment per employee saving of $500." *(See sidebar on effective ways to screen employees, p. 41.)* ■

SOURCES

For more information on the benefits of mental health screening in the workplace, contact:

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Don't ignore the powerful influence of peer pressure

Identify your local champions

Often, getting results from wellness programs requires a lot of money and time—sometimes more than you have to give. Why not capitalize on a resource that is completely free—that of positive peer pressure from co-workers? Some approaches:

1. Find some local champions.

"Ideally, these are people who have achieved a major wellness goal, and they're proud of it," says **Jodi Prohofsky**, PhD, LMFT, senior vice president of health management operations at CIGNA. "You just need one to get started!"

First, tell the person about the positive impact their story can have on others. "Once they tell their story, others will want to share theirs, too," says Prohofsky. "One way to find that first champion is to have an essay contest." Publish the winning essays, and then ask the winners to judge the next contest you hold. Once you get the go-ahead from an employee, publicize their success story through the Intranet, brown bag lunch gatherings, and team meetings.

2. Ask employees to form teams with others.

Prohofsky is executive sponsor of CIGNA's Healthy Life Team Challenge, a 10-week enterprise-wide weight loss and physical activity competition that encourages employees to manage their weight safely or embrace an active lifestyle. "I sent a message to all employees asking them to consider forming teams with their friends and co-workers," she says. "When people saw teams forming, it prompted them to join one or form their own. The response has been fantastic. I expect this to a very successful, low-cost wellness initiative."

3. Solicit stories during wellness events.

During a diabetes education class at Alexandria, LA-based RoyOMartin Lumber Company, a 32-year-old employee shared with the group that he and his wife had recently lost a significant amount of weight. "He lost 35 pounds and she lost 20 pounds. They took a simple approach of exercising together daily and preparing and eating healthy choices together," says **Collene Van Mol**, BSN, RN, COHN-S/CM, the company's occupational health manager. "He is now off his oral medication for diabetes. His next goal is to be taken off blood pressure medication as he continues to lose weight, exercise and eat a healthier diet."

The couple was featured in the company-wide employee newsletter, as an example of success resulting from taking personal responsibility for healthy changes.

4. Enlist company leaders and managers.

These individuals can serve as role models. They also have the clout to encourage employees to participate in wellness programs while at work. "Our Health Culture Survey showed that supervisors, the health and safety team, and our company leaders are well trusted by employees, with the supervisor trust rating right up there with family members. That is powerful!" says Van Mol. ■

EXECUTIVE SUMMARY

Positive peer pressure from co-workers can improve participation in wellness programs, and costs nothing. To maximize this:

• Hold an essay contest, with the winning stories published.

• Ask employees to form teams with co-workers.

• Get company leaders and supervisors to act as role models

OSHA may track MSDs, warns of inspections

Is ergonomics reg on the horizon?

Keeping track of work-related musculoskeletal disorders (MSDs) would be a new priority under a proposed record-keeping rule, evidence of a new direction for the U.S. Occupational Safety and Health Administration.

OSHA moved swiftly to reinstate a requirement to record MSDs on the OSHA 300 log in a proposal that was published in the Federal Register on Jan. 29. In an expedited timeline, the agency requested comments by March 15 and scheduled a public hearing for March 9. OSHA said it wants the revised OSHA 300 log to be in place by Jan 1, 2011.

"It's clear that they want to get this in effect as soon as possible," says **Brad Hammock**, Esq., workplace safety compliance practice group leader at Jackson Lewis LLP in the Washington, DC, region office.

Meanwhile, OSHA also has shifted some positions from voluntary compliance efforts to enforcement. The agency added 100 inspectors in the fiscal year 2010 budget and would have another 60 inspectors in the proposed 2011 budget.

In a live, online "chat" on the proposed budget, OSHA administrator **David Michaels**, PhD, MPH, said the additional inspectors would enable the agency to conduct more targeted inspections and National and Local Emphasis Programs, which involve inspections that are focused on specific standards or concerns, such as bloodborne pathogens.

U.S. Labor Secretary Hilda Solis said the budget showed "this administration's strong commitment to vigorous enforcement. . . . [W]e are sending a strong message throughout industry that we will not tolerate the endangerment of workers. We will continue those efforts with a number of new and innovative enforcement initiatives in the coming year."

OSHA defines work-related MSDs

As OSHA notes in its record-keeping proposal, the new reporting requirement doesn't call for employers to respond to the new data they will collect. In fact, it predicts that the proposed rule would create little burden on employers.

"OSHA stresses that the purpose of this rulemaking is solely to improve data gathering regarding work-related MSDs. The proposed rule does not require employers to take any action other than to check the MSD column on the OSHA 300 log if a work-related MSD case occurs that meets the general recording requirements of the record-keeping regulation," the agency said in the Federal Register notice.

Yet even the act of recording MSDs brings up past controversies. A far-reaching ergonomics rule was rescinded by Congress in 2001. "A number of people in the employer community will believe this is the very first step towards re-regulating ergonomics," says Hammock.

Under the Bush administration in 2003, OSHA eliminated the MSD record-keeping provision, asserting that it was too difficult to define work-related MSDs — an argument that echoed the controversy over the ergonomics rule. "OSHA found that no single definition of 'ergonomic injury' was appropriate for all contexts," the agency said when it suspended the MSD reporting requirement.

Yet OSHA now notes that MSD definitions are being used by the Bureau of Labor Statistics, the National Institute for Occupational Safety and Health, the U.S. Navy, and the American National Standards Institute. The proposed OSHA definition would provide both examples and exclusions: "MSDs are disorders of the muscles, nerves, tendons, ligaments, joints, cartilage, and spinal discs. MSDs DO NOT include disorders caused by slips, trips, falls, motor vehicle accidents, or other similar accidents. Examples of MSDs include: carpal tunnel syndrome, rotator cuff syndrome, De Quervain's disease, trigger finger, tarsal tunnel syndrome, sciatica, epicondylitis, tendinitis, Raynaud's phenomenon, carpet layers knee, herniated spinal disc, and low back pain."

MSDs would be treated no differently than other occupational illnesses and injuries in terms of the criteria for reporting, OSHA says. An employer would record the MSD on the OSHA 300 log only if all of four criteria are met: "The employee experiences 'pain, tingling, burning, numbness or any other subjective symptom of an MSD'; the symptoms are work-related; new; and meet the general recording criteria in the record-keeping regulation" (that is, they involve restricted work, job transfer, days away from work, or medical treatment beyond first aid).

Underreporting remains a problem

The proposed rule was welcome news to safe

patient handling experts, who said it would shed more light on the problem. Critics also have asserted that occupational injuries and illnesses are greatly undercounted. While the proposed rule does not address the fundamental reason for undercounting — that is, a system based solely on employer reports — it would provide important new information, says **Kenneth D. Rosenman**, MD, chief of the Division of Occupational and Environmental Medicine at Michigan State University in East Lansing and an expert on occupational injury and illness reporting.

"I think it's important because it's the only way we can get a [handle on] the number of musculoskeletal injuries," he says. Hospitals could use the MSD information to measure the effectiveness of injury prevention efforts, although comparisons to the national rate or to other hospitals would be problematic because of differences in reporting, he says.

For its part, OSHA says the new MSD information would help with policy setting: "Having the total number of MSDs would provide BLS with more complete data for analyzing the magnitude of the MSD problem and trends over time in the country as a whole, as well as in specific industries. Having more complete MSD data would assist OSHA and other safety and health policymakers in understanding MSDs and making informed decisions on policies concerning workplace MSDs." ■

As pandemic eases, EHPs look to the next one

Lessons learned: Stockpile and communicate

The collective sigh of relief was almost audible at the approach of the one-year anniversary of the start of the pandemic of novel H1N1 influenza. Hospitals had dodged a bullet.

Despite shortages of respirators, delays in delivery of vaccine, and difficulties identifying and isolating patients swiftly, hospitals found that employees were able and willing to continue to report for work and care for patients.

Still, it isn't too soon for employee health professionals to begin reviewing what worked and what didn't — and preparing for the inevitable advent of the next pandemic.

"This pandemic isn't over yet . . . we're still responding," **Anne Schuchat**, MD, director of the Centers for Disease Control and Prevention's National Center for Immunization and Respiratory Diseases, said at a recent press briefing at which she announced that there was no widespread influenza in any of the 50 states. But she noted that CDC is already looking ahead. "If we have the next pandemic, with an influenza virus like the [more virulent] H5N1 bird flu strain, we need to do a lot more than what we've done this year," she said.

Health care workers were not fearful of this H1N1 influenza strain, which was viewed as similar in severity to seasonal flu. But some weaknesses in the hospital response could cause problems in the future, such as a lack of adequate training of hospital employees and sick leave policies that don't reinforce the important message that employees should stay home when they're ill, says **Robyn Gershon**, DrPH, professor of sociomedical sciences and associate dean for research resources at the Mailman School of Public Health at Columbia University in New York City. In an often-cited study from 2005, Gershon and colleagues found that less than half of health care workers (48%) would be willing to report to care for patients in an outbreak of severe respiratory distress syndrome (SARS).[1]

Gershon notes that health care workers are "very devoted workers, but even they have limits. This pandemic was fortunately very mild, but future pandemics might not be." Hospitals need to examine the recent experience — from the effectiveness of communications to the availability of protective equipment, she suggests.

"This pandemic helped us to identify ways we could effectively mobilize and respond to any severe respiratory-borne infectious disease threat; it also helped identify gaps that need to be addressed so that we meet the health care needs of patients, while providing the highest degree of protection for our health care employees," Gershon says.

Lesson one: Stockpiling matters

Some hospitals and health systems had used federal pandemic preparedness funds that were available from the Health Resources and Service Administration, along with other resources, to maintain a stockpile of protective equipment and antiviral medications. For example, the Veterans Health Administration created stockpiles at individual medical centers as well as a national

stockpile.

"It affirmed my belief that it's very important to prepare ahead of time," says **Lewis J. Radonovich**, MD, and director of Biosecurity Programs for the Office of Program Development at the North Florida/South Georgia Veterans Health System in Gainesville. "The VA did not run out [of supplies]. In fact, we have a substantial national stockpile that remains."

Hospitals facing supply shortages used surgical masks rather than the recommended N95 respirators for routine care. But as they scrambled to find respirators to fit employees who needed protection in the more risky aerosol-generating procedures, they often had to refit-test using models that were not the preferred brand or style.

Yale-New Haven (CT) Hospital had made a substantial investment in pandemic preparedness and went through half of its stockpile of 200,000 N95s.

"It got us through the spring and the second wave," says **Mark Russi,** MD, the hospital's director of occupational health and associate professor of medicine and public health at Yale University. Even so, the hospital ran out of the small size and needed to substitute a different model for some employees. The hospital is now replenishing its stockpile with a respirator, the 3M 1870, that comes in one size and has good fit characteristics, he says. "We will find money to replenish the stockpile because we all understand that it's important," Russi adds.

Until a novel virus is well characterized, hospitals need to err on the side of protecting workers, he says. "The challenge, of course, is to decide whether and when there is adequate knowledge of transmission characteristics and virulence to adjust PPE recommendations," he says.

Lesson two: Mask patients

Once patients were identified as having novel H1N1, hospitals sprang into action to cohort them with other H1N1 patients and to protect workers. But how many people did they expose before that happened? One hospital found that some patients would complain of asthma — and later would discover they actually had H1N1 influenza, says **Gina Pugliese**, RN, MS, vice president of the Premier Safety Institute, part of the Charlotte, NC-based Premier Inc. health care alliance.

At the height of the H1N1 outbreak, Yale-New Haven (CT) Hospital began asking all patients and family members who came to the emergency department to wear masks — regardless of whether they had respiratory symptoms.

"[Previously], we weren't very good at determining which people needed masks, and people weren't good at identifying themselves either," says Russi. "We were concerned that people wouldn't like it. Actually, they loved it because they felt safe themselves — they felt protected from others around them who might have had flu."

Health care workers were safer, also, as they evaluated which patients needed greater infection control precautions. Emergency department employees wore N95 respirators if they cared for patients with respiratory symptoms, and if they were unprotected and spent at least five minutes in the room with a patient who later was identified as having H1N1, they received antiviral prophylaxis, he says.

The policy on masking patients as they arrived reduced the incidents of unprotected exposures, he says. "The real danger is the unidentified patient in which no personal protective equipment is used," he says.

Some hospitals set up tents (indoors or outdoors) to triage patients. Stanford Hospital in Palo Alto, CA, tested a drive-through triage in a simulation and declared it a promising strategy for future pandemics. The patients first stopped at a registration station, then moved on to a station where an emergency department nurse measured their vital signs. At the third station, the patients left their vehicles and sat on a cot in a screened and heated area, where they were evaluated by an emergency physician.

Finally, they stopped at a discharge station, where they received prescriptions or other discharge instructions. "In essence, the patient's vehicle provided a moving examination room that alleviates the delay inherent in turning over a fixed number of rooms and spaces," concluded lead author **Eric A. Weiss**, MD, an emergency physician and medical director of Stanford Hospital's Office of Service Continuity and Disaster Planning. The drive-through strategy also would minimize the risk of transmission of infectious diseases, he said.[2]

Lesson three: Evaluate policies

Now is the time not only to review and revise policies and procedures for pandemic response, but to record the lessons and observations from this novel H1N1 pandemic, says Pugliese. After all, the next pandemic could be rapidly upon us —

or it could be a decade or more away.

"In the middle of taking action, it's often difficult to capture everything you want to do differently next time," says Pugliese. "It's important to [analyze] what you did and what you learned for the next generation [of health care workers]."

Hospitals need to consider everything from just-in-time fit-testing and training on new safety devices to human resources policies, she says. For example, some hospitals combine sick leave and vacation time into an annual bank of "paid time off" for employees. Employees may begin to count on the days as vacation leave — and may be more likely to go to work sick to avoid using up their time, she says.

Communication is another important component of the pandemic response. Hospitals should have a single source for updated information to help avoid confusion or mixed messages, she says.

REFERENCES

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2. Weiss EA, Ngo J, Gilbert GH, et al. Drive-through medicine: A novel proposal for rapid evaluation of patients during an influenza pandemic. *Ann Emerg Med* 2010. Jan. 15, 2010. Available online on www.annemergmed.com. ■

Cal-OSHA: RN death not fully probed

Hospital cited in H1N1 investigation

The death of a nurse from the novel H1N1 and methicillin-resistant *Staphylococcus aureus* (MRSA) should have been more thoroughly investigated for a work-related link, according to the California Division of Occupational Safety and Health (Cal-OSHA).

California nurse **Karen Ann Hays**, RN, 51, a previously healthy triathlete, marathon runner and skydiver, came to the emergency department with severe respiratory symptoms on July 9, 2009. Less than two weeks later, on July 17, she became the first known health care worker to die of complications of H1N1. The death certificate also noted methicillin-resistant *S. aureus* (MRSA) infection as a contributing factor. Cal-OSHA cited Mercy San Juan Medical Center in Carmichael, CA, for failing to screen its employee sick calls to determine if the nurse may have had exposure from people other than immediate co-workers, such as environmental services workers, physicians, students or volunteers.

The hospital also looked only for cases of H1N1 among the nurse's patients and failed to look into H1N1 cases in her unit or in the hospital generally.

"They looked at patients to whom the nurse was clearly exposed, but they didn't look at all the potential sources of occupational H1N1 infection," says **Deborah Gold**, MPH, CIH, senior safety engineer in the research and standards health unit at Cal-OSHA in Oakland.

At the time, the H1N1 outbreak still was evolving in the community. The citation pertained to a California standard requiring employers to maintain an effective Injury and Illness Prevention Program. The Cal-OSHA citation also notes that the hospital did not investigate a potential occupational link for the nurse's MRSA and the hospital's MRSA program did not include a procedure to investigate occupational exposures.

"Because [hospitals are] a higher risk environment for MRSA, we do think that when employees have MRSA infections, health care employers should look at that as a potentially occupational infection," says Gold.

In a statement, **Belva Snyder**, RN, chief nurse executive of Mercy San Juan Medical Center, took issue with Cal-OSHA's conclusions and said the hospital will appeal the citation:

"The unfortunate death of one of our employees due to H1N1 was extremely unusual and devastating for the staff and physicians at Mercy San Juan Medical Center. Upon her sudden and serious illness, a physician specializing in infectious diseases

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and infection control nurses immediately launched a thorough investigation into the employee's work history to ensure there was no hospital-based or occupational hazard that caused an exposure to H1N1. We are confident in the findings of our investigation that our employee's H1N1 illness was not the result of workplace exposure to the virus."

Meanwhile, the National Institute for Occupational Safety and Health (NIOSH) decided not to probe the California case as it sought to investigate cases that were clearly occupationally linked. NIOSH has been working with state health departments to gauge the occupational link to novel H1N1 cases in health care that caused fatality or severe illness.

"We looked at a number of different cases that have been presented to us, but we haven't moved forward to a field investigation," says **John Halpin**, MD, MPH, medical officer in the NIOSH Emergency Preparedness and Response Office in Atlanta. ■

TN hospital: No jobs for smokers

Policy promotes 'healthy behaviors'

Smokers need not apply. That is the new policy of Memorial Health Care System in Chattanooga, TN.

Everyone who applies for a job at Memorial Health Care will be tested for nicotine, and employment offers will be rescinded for those who test positive. The policy mirrors that of several other health systems, including the Cleveland Clinic and Akron Children's Hospital in Ohio and Phoebe Putney Memorial Hospital in Albany, GA.

It is the natural next step after implementing a tobacco-free campus, Brad Pope, vice president of human resources, explained in emailed comments.

"As a hospital, our work force and the communities we serve should expect us to set the example for improving healthy behaviors and lifestyles," he said. "We realize this will not happen overnight and there will be difficult decisions to make, but that should not stop us from making the decisions that will keep us on our journey to creating healthier communities."

The hospital also offers programs for current employees who are smokers, including Freedom from Smoking, the cessation program proven successful by the American Lung Association. "Smoking doubles a person's risk for stroke and heart disease; it increases by 10 times your risk of dying from chronic obstructive lung disease, and it drives up the cost of health care," a Memorial employee newsletter reminds.

In a related development in the nation's biggest tobacco-producing state, no one can smoke or use tobacco on any campus of North Carolina's 125 acute care hospitals. North Carolina is the first state in the country to be 100% tobacco-free in its nonfederal hospitals. Employees at state hospitals who smoke also pay more for insurance premiums. It is a sign of things to come as more and more hospitals remove smoking — and other tobacco use — from their campuses, not just their buildings.

"We are still the number one tobacco-producing state, and we have a tremendous number of health problems as a result of that," says **Melva Fager Okun**, DrPH, senior program manager for NC Prevention Partners in Chapel Hill, a nonprofit organization that seeks to reduce preventable illness and early death. "For us to have achieved this is remarkable. It's exceptional." ■

CNE OBJECTIVES / INSTRUCTIONS

The CNE objectives for Occupational Health Management are to help nurses and other occupational health professionals to:

- Develop employee wellness and prevention programs to improve employee health and productivity.
- Identify employee health trends and issues.
- Comply with OSHA and other federal regulations regarding employee health and safety.

Nurses and other professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this semester's activity, you must complete the evaluation form provided in the June issue and return it in the reply envelope provided in order to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you.

CNE QUESTIONS

13. Which is recommended regarding collaboration between occupational health and safety?
A. Never combine data on the two areas in a single spreadsheet.
B. Avoid putting information on who does what during emergencies in writing.
C. Ensure that areas such as respiratory protection are handled either by safety or occupational health, with no overlapping responsibilities.
D. Offer safety training, necessary clinical tests and immunizations at health events.

14. Which approach is recommended regarding the safety and occupational health roles?
A. Ensure that safety is solely responsible for site visits done to investigate workplace injuries.
B. Offer to go on site to investigate a workplace injury as needed.
C. Avoid teaching First Aid techniques to safety, in order to reduce liability risks.
D. Never enlist the help of non-management employees as part of the efforts to improve the company's response to injured workers.

15. Which is true regarding the average worker's compensation cost per case, according to research done at PPG Industries?
A. Depression had no impact on the cost of workers' compensation cases.
B. Only obesity, not depression, resulted in increased worker's compensation costs.
C. Of all the data from the Health Risk Assessments, depression was the sole factor affecting worker's compensation costs.
D. Obesity, stress and depression all increased the average cost per case.

16. Which is recommended for mental health screening in the workplace?
A. Questions about mental health and stress should be included in health risk appraisals.
B. Health risk appraisals should focus solely on the employee's clinical risks, with mental health issues addressed separately.
C. Employees with other medical conditions should not be singled out for screening.
D. Occupational health should not work with human resources or communications on implementing mental health screening in the organization.

Answers: 13. D; 14. B; 15. D; 16. A.