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IN THIS ISSUE

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Is injury recordable? Take a strong stance, or risk OSHA violations

Pressure may be strong to under-report

Editor's Note: This is a two-part series on occupational health's role in preventing recordkeeping violations. This month, we cover strategies to identify and prevent violations, and what OSHA's new enforcement emphasis means for your workplace. Next month, we'll report on common recordkeeping violations being found in workplaces.

An employee who was injured because of a safety rule violation may not want management to know that an injury occurred because of the possible consequences. On the other hand, if management takes great pride in a low injury rate, supervisors might have a lot of explaining to do for a recordable injury.

Either way, an injury that is not recorded appropriately risks a record-keeping violation from the Occupational Safety and Health Administration (OSHA). (*See related story, p. 135.*)

"Recordkeeping is a huge problem," says **Michelle L. McCarthy**, RN, COHN, on-site medical case manager for Genex Services in Norcross, GA. "Many places don't realize just how much detail is required for OSHA."

Thomas Slavin, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines, says, "These days, OSHA is really looking at recordkeeping issues. Knowing what the rules and nuances are, is really critical."

Push back

A strong stance may be needed to resist pressure from others who want

EXECUTIVE SUMMARY

Recordkeeping violations are increasing, due to the Occupational Safety and Health Administration (OSHA)'s new emphasis on enforcement, but others may try to convince occupational health that an injury should not be recorded. To take a lead role:

- Assist safety or human resources with monitoring the OSHA log.
- Resist pressure from others to make changes in recordkeeping.
- Avoid tying performance measurement or financial bonuses to OSHA injury rates.

you to make changes in recordkeeping. "Pressure can come from many directions," says Slavin. "Know the rules and don't fall to the temptation to make changes."

Some workplaces have incentives for reaching certain injury-free milestones, such as one million hours without a recordable injury. It's easy to see why everyone will want the treatment to be recorded as First Aid only.

"There are people who don't want a case to be recordable, or a prescription to be given," says Slavin. "The important thing is, do the right thing for the injury. Remember that you are the professional, if you will, and should push back at times."

The facts and good medical judgment are your best allies. "Understand that people may be disappointed. Some may try to blame the messenger, but recording is not an option," says Slavin. "Good medical practice dictates proper treatment, and regulations dictate what is recordable. "

One challenge is that many times, OSHA numbers are the easiest performance indicators available. Part of a supervisor's or manager's evaluation may be based on those numbers.

The problem is that most companies use OSHA recordkeeping statistics, on the number of recordable incidents or lost time cases, as a way to measure performance, says **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH.

"Managers, including senior managers, may have their financial bonuses impacted by the OSHA injury rates," she explains. "This drives the pressure to keep cases from being recordable, or to keep an injury from being a lost time case."

While many people use the OSHA injury numbers for performance measurement, they are really intended for statistical control, notes Slavin. "It's hard for people to understand that a particular case was recordable, even though management was not at fault and could not have foreseen or prevented the injury," he says.

If someone injures themselves with a knitting needle while on lunch break in the company cafeteria, the case may be recordable but may not really indicate a defect in the safety program.

"It is much better to use 'leading' performance indicators instead of 'trailing' or after-the-fact performance indicators, such as injury rates," says Slavin. "Supervisors cannot do much to control trailing indicators, but they can control leading indicators." These may be audit scores, the percentage of people trained or tested, employee survey results, the reduction in the number of noisy machines, or other activity-based metrics. "When someone complains about a recordability decision, you could take the opportunity to suggest a better set of performance metrics," advises Slavin.

Step into role

An occupational health nurse or physician may have total responsibility for OSHA recordkeeping, or be responsible for providing information to the person who is in charge of this area. "In either case, it is vital that the occupational health professional is knowledgeable about recordkeeping requirements," says Strasser.

McCarthy recommends offering to assist safety

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OSHA targets records in employer inspections

Emphasis program boosts inspections, fines

Violations involving recordkeeping are becoming more likely, as a result of the Occupational Safety and Health Administration (OSHA)'s National Emphasis Program (NEP), launched in October 2009, to assess the accuracy of injury and illness recordkeeping by employers.

"Studies purportedly showed a gap between reported injuries versus the numbers drawn from other sources, such as hospital and workers' compensation records," explains Eric J. Conn, a partner based in the Washington, DC office of McDermott Will & Emery. Conn's practice focuses on occupational safety and health law.

"A year into the NEP, OSHA has initiated nearly 200 inspections," says Conn. "The inspections found OSHA violations at 70% of the establishments, and recordkeeping violations at more than half."

OSHA recently tipped its hand about the industries that most need to be on guard for an inspection under the Recordkeeping NEP, notes Conn. In September 2010, OSHA announced an adjustment to the targeting criteria for new inspections, to focus on manufacturing, larger worksites and employers with higher injury rates.

Bigger penalties

"Inspections and the size of enforcement actions are increasing under the Obama administration," says Conn. "OSHA has not only increased the size of its enforcement team, but has also greatly increased the size of its enforcement actions."

In the last year, OSHA has nearly tripled the number of significant cases — those with citations including fines of $100,000 or more. A "Severe Violator Enforcement Program" will generally increase the size of civil penalties, expand the time frame for considering an employer's violation history for repeat violations, and more consistently result in follow-up inspections. These will include inspections of other worksites of the same employer.

"There is no question about it," he says. "Employers should expect to see, and indeed are already seeing, increased fines and an increased focus by OSHA on recordkeeping issues."

While for years, employers have been required to maintain their OSHA 300 logs at the workplace, OSHA is laying the groundwork now for a requirement that employees electronically submit their OSHA logs. "This will help OSHA identify patterns of under-recording, and target employers for recordkeeping inspections," he says.

Employees responsible for safety and health should verify that their OSHA 300 logs are up to date and accurately reflect all reportable injuries and illnesses. "Cross-check the logs against other injury and illness records, such as incident reports, First Aid records, medical records and workers' compensation claims," he recommends. "Most importantly, review OSHA's recordkeeping standards and interpretations."

SOURCE

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or human resources with monitoring the OSHA log. "This is a great way to help out," she says.

An occupational health nurse or physician will have treated an employee for occupational illness or injury, and should have access to the initial and on-going medical information if care is delivered by an external provider.

"The medical information is the basis for determining whether a case meets recording criteria or not, such as restricted work activity, medical treatment beyond First Aid, or loss of consciousness," says Strasser.

As you continue to monitor the employee's care, be aware of any changes that signal a need to update the OSHA log. "A case may initially be 'medical treatment only,' but later result in the need for work limitations or days away from work," says Strasser.

SOURCES

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Is employee being less than truthful?

Story may contradict the facts

You probably get the feeling, more often than you'd like, that there is more to the story than what a worker is telling you about an injury. There are several possible reasons for the facts not adding up.

"We are trying to make everyone more mindful of the mechanism of injury," reports **Laurie Heagy,** RN, COHN-S, president of the Berks County Pennsylvania Association of Occupational Health Nurses. "We are trying to look more critically at that issue right up front when seeing a new injury."

An employee once told Heagy that he had injured his hand at work. When the X-ray revealed a boxer's fracture, it did not fit the "mechanism of injury" that he had reported. "After digging some more and talking to the employee, he finally admitted that he had punched his locker and that was how he was hurt," says Heagy.

Another employee presented with a bump on his leg, and immediately went to the hospital. He was diagnosed with a cellulitis and infection, and was admitted to the hospital within only a few hours of the injury. "The mechanism did not fit that scenario in the time frame he reported," says Heagy.

Studies ordered for employees may reveal inconsistencies. If the results show that there is a full thickness rotator cuff tear, for example, you need to determine if that result fits the reported body movement that was the mechanism of injury, says Heagy.

It may be that the employee has a triangular fibrocartilage complex tear in one hand and is treated for hand pain with no acute injury. This may be a degenerative tear, and may call for studies to be done on the other hand to see if the tears are bilateral, says Heagy. "The employee may have been in a motor vehicle accident in the past, and braced themselves on the dashboard. That may have been the cause," she says.

Go look at the job

Workers may not want to admit that they got hurt by doing something unsafe. One left-handed worker claimed that he lacerated his right forearm by cutting strapping from a stack of boxes. "He was, in fact, cutting. However, he was reaching way over his head with a box cutter in his hand, which is unsafe practice, " says **Susan L. Zarzycki,** RN,COHN,CM, an occupational health manager at Finch Paper LLC in Glens Falls, NY.

How did Zarzycki find out the truth in this situation? By going to the job site and asking the same questions over and over.

"I don't understand, so can you show me? How did it happen? Can you please show me what you were doing so I can understand the injury?" are some of things she asked.

If an employee presents with repetitive strains or sprains, Zarzycki always looks at their job and asks what they do outside of work for recreation. "People may bowl, fish, or hunt. They sometimes don't realize that what they do for fun might have an impact on their body," she says.

If the injury doesn't match the job, then Zarzycki documents "The employee states that the incident occurred …."

To catch inconsistencies, however, you need to have a solid understanding of the job someone does. "I work in a paper mill and I don't have to know how to make paper, but I do need to know if the injury matches the job they are doing," says Zarzycki. "If someone is complaining of right shoulder pain and their job does not involve the upper body, this is important to note."

Misplaced anger

A right-handed employee may tell you that he has carpal tunnel in both wrists, with the right wrist being much worse. He then goes on to say that he bowls three nights a week. Do you have an obligation to tell the employer?

When it comes to a work-related injury, the employer has a right to information about what happened, says Zarzycki. "If the stories don't match up, eventually somebody has to question the employee a bit further" she says. *(See related story, p. 137, on how to handle various scenarios.)*

EXECUTIVE SUMMARY

Workers may be untruthful about an injury for a variety of reasons, including concern about disciplinary action and being denied for workers' compensation. To elicit the facts:
- Determine if the mechanism of injury fits the scenario.
- Go out to the job and ask the employee to demonstrate what happened.
- Document inconsistencies that you identify.

Did a worker admit something to you?

It's a tough situation to be in

Who knew what when? At times, you can be put in a tough position because of what a worker tells you. "We are not safety and we can't discipline, so employees tend to tell us more than they would tell others," says **Susan L. Zarzycki**, RN,COHN,CM, an occupational health manager at Finch Paper LLC in Glens Falls, NY. Here are some common scenarios and how to deal with each:

1. **An employee's story changes.**

An employee may tell you he was horse playing with his buddy and slipped and injured his ankle, but tells somebody else that he tripped on a floor drain. "The truth is eventually going to come out," says Zarzycki. "First and foremost, I tell them, 'Let's get you treated and we'll figure out the rest later.'"

Zarzycki usually repeats what she is told, and advises the employee of what she will be passing on to safety and management.

2. **An employee comes to you with a cut finger, and reports they were wearing their gloves, but you notice they are the wrong ones.**

It's not part of your role to challenge the employee. "However, the information stated or observed gets passed along to safety. They will do a more thorough investigation," says Zarzycki. Their findings will then be reported to the manager and human resources.

3. **An employee tells you he or she has a substance abuse problem.**

A distraught employee admitted he had a problem to Zarzycki. The first thing she did was to facilitate his getting help at a facility, but he then wanted to return to work before his treatment was completed.

"He worked in a dangerous area, and I had to tell him that knowing the dangers of his job, I couldn't allow him to come back to work," she says. 'I told him, 'It's not only for your protection, it's for your coworkers. We don't want anyone at risk.'"

4. **An employee tells you medical information that suggests an injury may not be 100% work-related.**

A worker may tell you that his right arm was broken in a car accident years ago and he has had problems ever since, but later claim that it's only hurting now because of his job.

This puts you in a sticky situation with documentation. "When given this kind of information, we can't tell anybody what the other issues are. All we can say is that the patient has other contributing medical issues," says Zarzycki. "We have to separate personal private information with the actual injury and work-related information. We are always juggling, and some days, it's a tough balance." ■

At times, the inconsistency in the employee's story may result in denial of workers' compensation or disciplinary action. "They may not be happy with the outcome, and may be angry at you," says Zarzycki. "They will, most times, understand, if it is explained that the facts need to be documented and consistent."

Zarzycki tells workers, "You stated …, I will be documenting…. Others can learn from this incident. We may be able to prevent a more serious injury by understanding exactly what happened."

The bottom line, though, she says, is that people are working adults responsible for their actions. In order to gather all of the information about an incident, sometimes hard questions have to be asked.

"Demonstrate that you are fair and consistent by asking the same questions after any injury occurs. Everyone appreciates this," says Zarzycki.

SOURCES

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Use hand cleansers to decrease absenteeism

Get workers thinking about it

Use of alcohol-based hand cleansers significantly reduced several common infections and

reduced absenteeism in a study of 129 white-collar workers in 2005 to 2006, according to research from the Institute of Hygiene and Environmental Medicine in Greifswald, Germany.[1]

Participants were told to wet their hands fully with the rubs at least five times a day, especially after visiting the restroom, blowing their noses, before eating, and after touching other people or papers. No hand-hygiene behaviors were suggested to the control group.

Putting disinfectants on employees' desks helped reduce absenteeism as well, with workdays lost because of diarrhea cut dramatically.

"Hand cleansers are an important component of an overall approach to creating a culture of health at a business location," says **Brent Pawlecki**, MD, corporate medical director at Stamford, CT-based Pitney Bowes. "Hand hygiene is something that we want our employees thinking about at all times."

Because the hand sanitizing stations are so noticeable, their strategic placement can set a tone for the workplace. "This has symbolic value, by encouraging hand hygiene even when the employees are not passing by the station itself," says Pawlecki.

At Pitney Bowes' headquarters, the first sanitizing station that visitors and employees who use the main entrance see is right in the lobby. In addition, sanitizers were installed in high-traffic locations: The entrances to the main cafeteria, fitness center, and the on-site clinic.

Restroom reminders

Every single restroom in the company's facilities has signage with tips on how to wash hands effectively, and instructions on how to leave the restroom in a hand-healthy manner. That means drying your hands with a clean paper towel, and using that same towel to turn off the water at the sink and open the door when leaving.

"We provide a wastebasket next to the outer door of every restroom for convenient disposal of used paper towels," says Pawlecki.

Pawlecki says that he believes that accessibility of hand cleansers does have an impact on absenteeism.

"It certainly helps, although we have not undertaken a comprehensive study to prove the degree to which it helps," he says. "There are many factors that influence absenteeism, but having a comprehensive and aggressive healthy-hands program can be a meaningful contributor to overall employee health, well-being, and productivity."

EXECUTIVE SUMMARY

Use of alcohol-based hand cleansers significantly reduced several common infections and reduced absenteeism, says a recent study. To make hand hygiene easier:

- Make hand sanitizing stations noticeable.
- Put a sanitizing station in the lobby and high-traffic locations.
- Post signs in restrooms with instructions.

REFERENCE

1. Hubner, NO, Hubner C, Wodny M, et al. Effectiveness of alcohol-based hand disinfectants in a public administration: Impact on health and work performance related to acute respiratory symptoms and diarrhea. *BMC Infect Dis* 2010; 10:250; doi:10.1186/1471-2334-10-250. ■

Employers missing out on wellness benefits

Explain reasons for wellness programs

Despite the tremendous amount of buzz about the cost savings from wellness initiatives, the vast majority of employers are missing out on the big picture. Few firms implement comprehensive programs likely to make a meaningful difference in employees' health, according to a new study conducted by the Center for Studying Health System Change (HSC).[1]

After conducting 45 interviews with wellness industry experts, researchers learned that most felt that in order to make a real difference, a comprehensive program must be strongly linked to a firm's business strategy and championed by senior leadership and managers throughout the company.

Ha T. Tu, MPA, a senior HSC health researcher, says, "It was somewhat surprising to us, that given all the buzz about employee wellness as a solution to rising health care costs, that so few programs have the kind of comprehensive, integrated, program elements that are likely to make a big difference."

Many employers are implementing wellness in a "sort of superficial way," says Tu, such as offering online health risk assessments with incentives of small cash rewards.

"Especially in a recession environment, they are just dipping their toes in Most experts are saying, pretty much universally, that is not likely to have much of an impact in itself," says Tu.

Employers may purchase behavior modification programs for tobacco cessation and weight management, but doing these things in isolation doesn't give lasting results. "Often with those

programs, especially with strong financial incentives to participate, people will quit smoking or lose weight," says Tu. "But if you follow those participants over time, they tend to bounce back to their previous behavior."

The kind of comprehensive work programs which change the work environment to promote healthy behaviors are actually very rare. "It is not terribly surprising in some ways. It requires an investment — not only a financial investment, but a commitment from senior leaders down through the company," says Tu. "Very few companies are taking a meaningful approach to wellness."

New role for occ health?

Tu notes that one large employer shared insights regarding their progression from having an onsite clinic for occupational health, to providing wellness and primary care to their workforce. "They found that the qualities they look for in health professionals can be quite different for those two roles," notes Tu.

In the occupational health environment, the focus is on treating particular injuries and getting the person back in the workforce as efficiently as possible. "With a wellness program, you are looking for someone who takes a holistic approach," says Tu. "This employer was saying that some occupational health professionals are able to make that transition and do it really well. For others, it's been a struggle."

If companies have had adversarial relationships with their workforce, implementation of wellness programs is often received with mistrust. "The workforce might question the motive of management," says Tu. "Unless you can transition successfully to that trusted provider role, the wellness program doesn't tend to have much of an impact."

Employers need to be honest and candid with their employees about why they are implementing wellness programs, and how this is related to the core business strategy.

"Sometimes, wellness programs are imposed on employees without that kind of candor," says Tu. "Then the implication for the health professionals who are delivering the wellness services is that it doesn't tend to be a very satisfying and meaningful relationship."

In some cases, the occupational health clinic was regarded as a place that tried to push people back to work before they were ready to do so from a health standpoint. "When the employer tries to put on an overlay of wellness, it is not well-received," says Tu. "This is the larger issue of corporate culture. The attitude is, 'Why did they even bother?'"

REFERENCE

1. Tu HA, Mayrell RC. Employer wellness initiatives grow, but effectiveness varies widely. National Institute for Health Care Reform Research Brief. July 2010.

SOURCE

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HHS looks to OH on flu shot issue

'We are the interface between the policy and practice'

A proposed federal action plan is targeting influenza vaccination of health care workers, and occupational health physicians will be represented on the working group that is considering new recommendations — including possible mandates.

The American College of Occupational and Environmental Medicine (ACOEM) is a key stakeholder as the U.S. Department of Health and Human Services' inter-agency working group considers new strategies to increase immunization rates.

After all, occupational health physicians and employee health nurses are often the ones who coordinate the flu vaccination campaigns, notes **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN, and vice chair of ACOEM's Medical Center Occupational Health section.

"You need that experience at the table. We are the interface between the policy and practice," says Swift, who may be representing ACOEM as a liaison member. "We see firsthand the impact of policies like this on workers. To exclude us from that conversation would be to miss an incredibly vital piece of the picture."

ACOEM's position differs from that of the

infection control organizations mentioned in the action plan. (The action plan is available at www.hhs.gov/ash/initiatives/hai/tier2_flu.)

In a 2008 position statement, ACOEM advocated using "a comprehensive approach...encompassing education, vaccination, and infection control practices" to improve influenza vaccination of health care workers. However, ACOEM did not endorse a mandatory approach that would lead to punitive consequences:

"Education and adherence to infection control practices should be mandatory. Immunization is safe but variably effective and is not a panacea for respiratory virus transmission in the health care setting...Current evidence regarding the benefit of influenza vaccination in HCW as a tool to protect patients is inadequate to override the worker's autonomy to refuse vaccination." (The guidance is available at www.acoem.org.)

HHS will likely also solicit input through a stakeholders meeting in the spring, says **Ray Strikas**, MD, medical officer and seasonal influenza coordinator for the National Vaccine Program Office and co-chair of the inter-agency working group. "We'll make recommendations in concert with the many partners in organized health care," he says.

Will Joint Commission up the ante?

The greatest impact of the HHS action plan may come from the Center for Medicare & Medicaid Services (CMS) or The Joint Commission accrediting body.

A Joint Commission standard requires hospitals to offer influenza vaccination on-site and to educate staff and affiliated "licensed independent practitioners." They also must monitor their vaccination rates and seek to improve them.

The draft HHS action plan suggests encouraging The Joint Commission to create a performance measure based on the percentage of health care personnel who are vaccinated against influenza and to establish a specific vaccination goal. Healthy People 2010 set a goal of vaccinating 60% of health care workers; the proposed 2020 goal is 90%.

According to a survey sponsored by the Centers for Disease Control and Prevention and conducted by the RAND Corp., in the 2009-2010 flu season, about 74% of hospital-based health care workers received either the seasonal or H1N1 flu vaccine (or both). Vaccination rates were lower in other health care settings. Nurses and physicians were the most likely to be vaccinated, and non-clinical support staff were the least likely to receive the vaccine.

"The Joint Commission views the vaccination of health care workers as a very important issue and we are currently in the discussion stage about the issues [in the action plan]," **Ken Powers**, spokesperson for The Joint Commission, told HEH in an e-mail response.

Does HCW vaccination save lives?

The first stage of the action plan involves reviewing existing evidence on influenza immunization, identifying current state statutes and developing model policies or statutes, Strikas says.

Alexandra Stewart, JD, an assistant research professor in the Department of Health Policy at the George Washington University School of Public Health and Health Services in Washington, DC, will research the pros and cons of an immunization mandate, Strikas says.

Stewart published a commentary in the *New England Journal of Medicine* in November 2009 stating that a New York rule mandating influenza immunization of health care workers would likely be ruled constitutional. (The rule was suspended when there was a delay in vaccine supply during the H1N1 pandemic.)

"I believe that the state's right to compel health care workers to receive vaccinations will supersede their individual rights because of the state's substantial relation to protection of the public health and safety," Stewart wrote.[1]

However, a recent Cochrane Review raised questions about whether the research really shows a patient safety benefit from influenza immunization of health care workers. A review of five studies found all were "at high risk of bias."[2]

Even so, the studies did not show an effect for influenza immunization of health care workers on laboratory-confirmed influenza, pneumonia (a possible complication of influenza), or deaths from pneumonia among people who were 60 or older and living in long-term care facilities.

There was some association between immunization and influenza-like illness or mortality from all causes among elderly long-term care residents, but the authors questioned the significance of that finding. "These non-specific outcomes are difficult to interpret because influ-

enza-like illness includes many pathogens, and winter influenza contributes less than 10% to all-cause mortality in individuals 60 or older," the authors stated.

"We conclude there is no evidence that vaccinating health care workers prevents influenza in elderly residents in long-term care facilities," they stated.

The authors suggested future research should use high-quality, randomized control trials, and should test combinations of interventions, including hand-washing, masks, early detection of influenza, anti-viral prophylaxis, isolation of patients, restrictions on visitors and policies to discourage health care workers with influenza-like symptoms from coming to work.

Common metrics needed

Demonstrating an actual benefit to patients is important before subjecting employees to a mandate that requires not one-time but annual vaccination, says Swift. Hospitals that implement mandatory policies also should collect data on nosocomial flu before and after the policy change to gauge the impact, she says.

"It's very important that we not lose sight of the intent of these policies and ensure we have metrics in place to evaluate their success and failure — namely, nosocomial flu rates," she says.

While it's not yet clear whether HHS will recommend flu vaccine mandates for health care workers, Strikas says other measures still will be emphasized, such as education of health care workers about influenza. "Multiple approaches are necessary to get this done," he says.

Meanwhile, health care facilities need a more standardized approach to measuring influenza vaccination, including a common definition of health care personnel and method of measuring rates, he says.

In 2010-2011, about 160 million doses of flu vaccine will be available. "We have the opportunity with relatively abundant vaccine this year and [many strategies] to do a much better job of getting people vaccinated," he says.

REFERENCES

1. Stewart AM. Mandatory vaccination of health care workers. *N Engl J Med* 2009;361:2015-2017. Available online at www.nejm.org/doi/full/10.1056/NEJMp0910151.

2. Thomas RE, Jefferson T, and Lasserson TJ. Influenza vaccination for healthcare workers who work with the elderly: Systematic review. *Cochrane Database of Systematic Reviews* 2010;doi:10.1016/j.vaccine.2010.09.085. Available online at www2.cochrane.org/reviews/en/ab005187.html. Accessed on October 13, 2010. ■

Injured nurses struggle with financial loss

'Workers' compensation fails the nurse'

"I was injured at work almost seven years ago. I am still going through financial difficulties. I can never return to nursing. I am left with a lot of nerve damage to my legs and continuous back pain. I receive about $400 biweekly from worker's comp. This is nowhere near my pre-injury pay. Learning to live with pain and limited mobility and chronic money problems has been the worst of it all. — Nurse's post on an online forum of Work Injured Nurses' Group (WINGUSA)."

In 2008, 16,560 hospital employees injured their backs at work badly enough to require days away from work — more such injuries than workers in any other industry, according to the U.S. Bureau of Labor Statistics. In addition to pain and lost work time, those health care workers also suffer significant financial losses, says **Anne Hudson**, RN, a back-injured nurse from Coos Bay, OR, who founded WING USA (Work Injured Nurses' Group USA).

Hudson and occupational health consultant **William Charney**, DOH, of Newfane, VT, are now asking the American Nurses' Association and other unions to step up to help their injured colleagues by creating a special fund.

"Workers compensation at best is inadequate to meet the needs of injured workers," says Hudson, who co-authored a book with Charney (*Back Injury Among Healthcare Workers: Causes, Solutions, and Impacts*, Lewis Publishers, 2004) and donates all royalties to help back-injured nurses. "It's slow. People are denied care...and [provided] incomplete and inadequate care. They're never made whole."

Workers' compensation laws vary widely across the nation and often tie benefits to the statewide average weekly wage. That means higher paid workers, such as nurses, will feel a greater income loss from their injury, says **Carol Telles**, JD, senior

analyst with the Workers Compensation Research Institute in Cambridge, MA.

For example, Iowa provides a maximum of $1,366 weekly for permanent total disability, while Arizona provides a maximum of $461.60 weekly, according to a 2009 survey by the research institute. "It's not the goal of workers compensation to make workers whole in terms of income benefits," says Telles. "It's to replace a certain portion of those benefits and that portion varies by state."

The definition of a permanent disability also may be restrictive, Telles says. The workers' compensation system is designed to respond to the accidents of the industrial age, such as when workers were at risk of amputation, she says.

Losing the safety net

For nurses, the greatest risk of long-term occupational injury is from work-related musculoskeletal disorders. Hudson herself suffered a back injury as a bedside nurse. She struggled to win workers' compensation benefits but was unable to return to the hospital because of a lack of accommodations for her lifting restriction. Hudson currently works as a public health nurse, which makes hers a re-employment success story (although her wages are far lower than they were as a bedside nurse).

She says she fields frequent calls and emails from other back-injured nurses who are having trouble making ends meet, whether or not they receive workers' compensation benefits.

"[Employers] may cover a muscle strain but deny the spine injury, which is the disabling portion of the claim," she says. "That's just one example of the way workers compensation fails the nurse."

Back-injured nurses may lose their jobs, their health insurance, and their safety net, says Charney. "They lose all their capability of monetary support," he says.

The American Nurses Association advised Hudson and her fellow nurses to bring up the issue through the House of Delegates, a governing body of nurse representatives from each state.

Nancy Hughes, MS, RN, director of ANA's Center for Occupational and Environmental Health, says she has heard from some injured nurses and encouraged them to work through their "constituent member associations," or the affiliated state nursing associations.

Bill Borwegen, MPH, health and safety director of the Service Employees International Union (SEIU), stresses that a bigger fix needs to occur through the workers' compensation system.

"Every study shows workers comp only provides a very small percentage of income replacement and coverage for medical related costs," he says. "The bulk of the payment comes out of the Social Security system when nurses become injured and apply for disability benefits." That means individual employers do not face the full burden of compensating injured workers, he says.

"I'm not suggesting ANA or anyone can create a fund that's going to make you whole," says Hudson. "That's not realistic. But certainly there could be something to [help injured nurses] meet immediate needs. There should be some place nurses can turn for help."

Others try to help nurses

Meanwhile, there are some other efforts to help injured nurses. Nurses House, established in 1922 as a Long Island, NY, respite for weary nurses, now provides a fund to assist nurses in need. However, the organization says it can only help about half of those who apply.

"Over the past three years, we've helped nearly 300 nurses, with grants totaling almost $300,000. That's an admirable record, but the truth is, we can't keep pace with the ever-increasing demand," Nurses House says on its website. "In fact, with current levels of charitable giving, we can only assist about half of those seeking our help. While many nurses face truly dire circumstances, there are simply not enough funds in reserve to help them all."

The Minnesota Nurses Association has addressed one potential gap in workers' com-

pensation by placing language in contracts assuring continued health insurance for injured nurses for 24 months. The California Nurses Association has targeted the issue of work-relatedness of injuries. A bill in the 2009 California legislature would have created a presumption that certain injuries or illnesses, including neck or back injuries, are work-related unless the employer proves otherwise.

The California Chamber of Commerce opposed the bill, saying that hospital workers should not be given special legal status. "The fact that hospital employees face specific types of risks in the workplace is not a justification for altering the legal standard for determining what is or is not an industrial injury," the chamber argued. ■

New rapid test identifies active TB

Test may improve early detection

A new rapid tuberculosis test promises to help reduce health care worker exposures through early identification of patients.

The test, called Xpert MTB/RIF, can be performed in less than two hours. In a study involving 1,462 patients with suspected TB, the test correctly identified 98% of those with culture-confirmed tuberculosis and 98% of those with drug-resistant tuberculosis. It also correctly ruled-out tuberculosis in 99% of the patients who did not have TB.

The test isn't available yet in the United States — it isn't approved by the Food and Drug Administration — but already TB experts are touting its prospects.

"The goal right now is to recognize the people who have the symptoms of tuberculosis and to make a presumptive diagnosis and put them in isolation. In the United States, I think they're doing a pretty good job [of doing that]," says **Gerald Mazurek**, MD, captain in the U.S. Public Health Service and medical officer and epidemiologist in CDC's Division of TB Elimination.

However, there's always a risk that the symptoms of TB will be misconstrued for another respiratory illness and that other patients and health care workers could be exposed before the patient is placed in isolation, he says.

The Xpert MTB/RIF amplifies the nucleic acid in a sputum sample and can identify sensitivity to rifampin, an anti-viral. The test can therefore indicate not only whether a patient has TB, but whether he has a drug-resistant strain.

The testing procedure is simple and involves mixing a reagent with the sputum sample in a cartridge, shaking it and incubating it at room temperature for 15 minutes, and inserting the cartridge into the testing instrument. The remaining steps are automated. "It is definitely user-friendly," says Mazurek.

The test can be used to diagnose active TB but cannot detect latent infection, says Mazurek. ■

CNE ANSWERS

ANSWERS: 20. D; 21. B; 22. C; 23. A.

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 **December** 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

20. Which practice is recommended regarding compliance with the Occupational Safety and Health Administration (OSHA)'s recordkeeping standards?
A. There is no need to update the OSHA log if a case is initially "medical treatment only" and later results in the need for work limitations or days away from work.
B. OSHA recordkeeping statistics, on the number of recordable incidents or the number of lost time cases, are the best way to measure performance.
C. Tying financial bonuses of senior managers to OSHA injury rates will result in a safer workplace.
D. It is better to use "leading" performance indicators, such as audit scores or survey results, to measure performance than injury rates.

21. Which is true regarding the occupational health response when employees are being untruthful about their injury?
A. It is not a good practice to document inconsistencies in the employee's story.
B. If the injury doesn't match the job, this information should be documented.
C. It is not advisable to share information about an employee's incorrect use of personal protective equipment with safety.
D. Information about the specific medical conditions contributing to an employee's injury can and should be shared with supervisors.

22. Which is true regarding hand hygiene and absenteeism, according to a recent study?
A. Use of alcohol-based hand cleansers did not reduce any common infections.
B. Use of alcohol-based hand cleansers had no impact on absenteeism.
C. Use of alcohol-based hand cleansers significantly reduced several common infections and reduced absenteeism.
D. Putting disinfectants on employees' desks had no impact on lost workdays.

23. Which is true regarding employee wellness programs, according to a new study?
A. Few firms implement comprehensive programs likely to make a meaningful difference in employees' health.
B. Online health risk assessments with incentives of small cash rewards are even more effective than comprehensive programs.
C. Purchasing behavior modification programs for tobacco cessation and weight management has been shown to get lasting results.
D. Individual behavior modification programs typically get better results than comprehensive programs at less cost.

Occupational Health Management™

A monthly advisory for occupational health programs

OHM120110TM

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

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CNE Evaluation: Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your letter of credit**.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⚑

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
2. Develop employee wellness and prevention programs to improve employee health and productivity.	○	○	○	○	○	○
3. Identify employee health trends and issues.	○	○	○	○	○	○
4. Comply with OSHA and other federal regulations regarding employee health and safety.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I detected no commercial bias in this activity.	○	○	○	○	○	○
7. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
8. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

9. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

10. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

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