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Data driven: Using occ health data to lower health care costs

The 'point where health, safety, sustainability meet'

Are rising health care costs a worry at your workplace? Occupational health professionals would be wise to look at the role they can play in getting them under control, according to **Margie Weiss**, PhD, CEO and community health advocate at the Weiss Health Group, a Neenah, WI-based consulting company that works with companies and communities on health and wellness.

"Employers are faced with an aging workforce, bringing an increased incidence of chronic disease," notes Weiss.

A data-driven strategy is one way to successfully lower health care costs, according to a study which identified drivers of health care costs. The researchers included both direct and indirect costs, such as doctor visits, prescription drugs, absenteeism, disability, and productivity.[1] This data can then be used to develop appropriate interventions, prevention programs or case management for employees with specific diseases, they reported.

"Data should drive your decision-making," says Weiss. "Integrate healthcare costs, workers' compensation care costs and sustainability-related metrics."

Healthy workers and their families are likely to incur lower medical costs and be more productive, while those with chronic health conditions generate higher costs in terms of health care use, absenteeism, disability and overall reduced productivity, says Weiss.

"Occupational health is the connecting point where health, safety and sustainability meet," says Weiss, pointing to increasing evidence that health promotion programs are cost-effective.

For example, include data on healthcare costs, Health Risk Assessments, biometrics, presenteeism, workers' compensation costs, incident tracking,

EXECUTIVE SUMMARY

A data-driven strategy should be used to lower health care costs and develop wellness and case management approaches, according to a new study. Use these approaches:
- Include indirect cost drivers.
- Consider employee needs and interest surveys.
- Include workers' compensation costs.

near-miss tracking, absenteeism, ergonomic assessments, employee needs and interest surveys, and worker demographics, she says.

"Workplace injuries and work-related illnesses can be a huge financial burden for employers," says Weiss. "Economic costs of occupational illness and injury match those of cancer, and nearly match those of heart disease."

Make your case

Kathy Dayvault, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN, notes that according to the Centers for Disease Control & Prevention (CDC), there are four causes of chronic disease that are modifiable:

- lack of physical activity
- poor nutrition
- tobacco use
- excessive alcohol consumption.

"These four modifiable factors are responsible for illness, suffering and early death related to chronic disease," she says.

Dayvault also notes that the three leading causes of death in the U.S. are heart disease, cancer and stroke. "Heart disease and stroke are among the most widespread, costly and preventable health problems in the U.S. today," she says.

Dayvault adds that the cost of heart diseases in 2010 was "astronomical," with coronary heart disease at $177.1 billion; hypertensive disease at $76 billion, stroke $73.7 billion and heart failure at 39.2 billion.

"Using the above data, you can successfully make a case for addressing chronic diseases in the workplace," she says.

One tool that can help you do this, says Dayvault, is statistical data from healthcare insurers. Utilize this information about the health of the workforce, she advises, to determine the chronic conditions that are prevalent in the workplace.

"Through insurance data, healthcare costs for specific chronic conditions can be determined," she adds. After you've reviewed this statistical data, Dayvault says that you can then determine specific ways to address worker health through wellness initiatives and disease-specific programs.

"The impact of preventing and controlling hypertension and elevated cholesterol are key to cardiovascular health," says Dayvault. She points to CDC statistics that a 12 to 13 point reduction in systolic blood pressure can reduce heart disease risks by 21%, stroke risks by 37% and risk for death from heart disease or stroke by 25%.

"Another case for workplace wellness programs is addressing diabetes, and diabetes risk indicators," says Dayvault. In 2007, the national economic burden of pre-diabetes and diabetes was $218 billion, she notes, and of that amount, $65 billion was associated with reduced productivity.

This loss of productivity was determined to be a result of higher levels of absenteeism, working at less than capacity and early mortality, she says.

"These examples are strong cases for occupational health," Dayvault adds. "A little homework on the financial impact of disease and disease prevention can catch the attention of the CEO. It can increase their understanding of the ROI which can be realized from instituting wellness programs in the workplace."

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Better tools needed to measure presenteeism

Advocate for positive changes

More reliable tools are needed to measure the costs of presenteeism, which takes an insidious toll on the work place.[1]

"We were struck by the variation in results by other researchers using different self-report tools," reports **Dee W. Edington**, PhD, director of the University of Michigan's Health Management Research Center in Ann Arbor, MI. "That concern led us to examine the sources of the variation."

Edington says that he was surprised to find "disturbing issues" at each level of analyses: measurement, conversion from measurement to a unit of presenteeism, and translation of presenteeism to a financial unit.

"It would benefit researchers and health professionals if there were more transparency, common metrics between instruments, and increased reliability and validity," says Edington.

According to Edington, your best option is to use a company-generated performance scale. "If the company does not have a measure, then I would use any of the current self-reported measurement scales," he says. "However, I would be cautious about quantification, since we don't know the truth at this time."

In general, those individuals with more risk factors or with a disease have more lost time at work, says Edington. "We have also shown that when risk factors change, presenteeism changes in the same direction," he adds.

EXECUTIVE SUMMARY

The results of tools used to measure presenteeism varied widely, according to a new study, so more reliable tools are needed. Use these approaches:

- Use a company-generated performance scale.
- Target programs to specific needs.
- Invest in screening, education, and treatment.

More than medical costs

Presenteeism costs are estimated to be greater than the cost of absenteeism, and represent up to 60% of all costs of mental and physical illnesses, notes **Diane Lack**, RN, MS, CCM, cardiology case manager at the University of Michigan Health System's Cardiovascular Center in Ann Arbor.

"Costs related to presenteeism are greater than the direct health costs for ten of the most costly health conditions studied and accounted for 18 to 60% of all health care costs," says Lack.

Lack says that employers do not fully consider the fact that expenses related to presenteeism losses are, for the most part, greater than actual medical costs.

"Presenteeism impacts individuals and organizations, affecting quality of life and health," says Lack. "It leads to increased health care costs, increases in occupational accidents related to distractibility, and deterioration of service and product quality."

Lack says that there is an opportunity for occupational health nurses to determine the significance of presenteeism, and its effect on the physical and psychosocial well-being of individual workers.

Obtain information through careful measurement of presenteeism using the appropriate tools, she says, and use this to develop interventions. Here are Lack's recommendations:

• Target wellness and disease management programs to the specific needs identified.

Your goal should be "increased health and health maintenance," says Lack.

• Be a strong advocate for positive changes in workplace policies.

"Promote flexibility for workers providing dependent care and for the special needs of aging workers, and provision of appropriate health care," says Lack. Another important goal, she says, is to "strive for mental health destigmatization, and recognition and treatment for mental health disorders and stress reduction."

• Implement a work culture that promotes self-care and rest.

"This minimizes exacerbation of symptoms, and prevents the spread of illness to co-workers," says Lack.

• **Invest in wellness.**

"Declines in productivity related to presenteeism could be offset by small investments in screening, education, and treatment," says Lack. "Studies do show that, globally, the return on investment for wellness programs is increasing." *(See related story on use of data to measure productivity, below.)*

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SOURCES

For more information on measuring presenteeism, contact:

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Use data dashboard to gauge productivity

Take an integrated approach

"Presenteeism is a measure of productivity. It can be gauged in a number of ways," says **Margie Weiss**, PhD, CEO and community health advocate at the Weiss Health Group, a Neenah, WI-based consulting company that works with companies and communities on health and wellness.

The most frequently used metrics, says Weiss, are absenteeism statistics and Health Risk Assessment (HRA) responses. "One of the best mechanisms for occupational health care providers is a data dashboard that can be updated on a regular basis," says Weiss.

Dashboard components should be linked back to HRA results, health care costs, Employee Assistance Program use rates and Occupational Safety and Health Administration (OSHA)-recordable data, says Weiss.

Weiss says that confounding variables are a challenge when it comes to measuring presenteeism. For instance, an absenteeism rate could be the result of policy changes, effective employee health programs, or cleaner indoor air, she says.

"A great example is a decrease in smokers in the workplace, which could be due to 'no smoking' policies, support services such as counseling, or public policy changes," adds Weiss.

Another challenge, says Weiss, is the fact that HRA presenteeism statistics are the result of self-reported information. "One example of more quantitative testing would be biometric screening, such as blood pressure, percentage of body fat, and nicotine levels," notes Weiss.

Triangulated approach

A drop in absenteeism may coincide with the implementation of a new wellness program, but how do you know if the two events are linked? "It is sometimes hard to ascertain whether a new policy, health and wellness initiative or facility renovation results in increased productivity, less absenteeism or improved scores on HRA reports," says Weiss.

For this reason, it is important that occupational health care providers use a "triangulated approach" to measuring and reporting presenteeism.

Quantitative statistics, such as sick days, days worked and OSHA–reported absences, must be evaluated in conjunction with more subjective data, she explains, such as responses to items on HRA questionnaires.

"These metrics must also be tied to other financial metrics which measure business activity, such as sales or production revenues," says Weiss.

No objective metrics

Many types of employment have no objective ways to assess employee performance and productivity, says **Diane Lack**, RN, MS, CCM, cardiology case manager at the University of Michigan Health System's Cardiovascular Center in Ann Arbor.

"Self-reported measurements, especially with short recall periods of one or two weeks, can be vital sources of information in health promotion programs," says Lack. These provide high validity and reliability for measuring health risk as well as planning, implementing, and assessing interventions, she notes.

Lack says that an integrated approach to health and productivity improvements is the best strategy to decrease presenteeism.

However, she notes that research indicates that the complex nature of presenteeism, and uncertainties that still surround its measurements, warrant caution while translating measurements into monetary value.[1]

"There is no consensus regarding how best to measure, quantify, and evaluate productivity costs," Lack explains. "Inordinate emphasis on projected cost analysis should be discouraged, while standardization of presenteeism measurements should be encouraged."

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Half measures, full fines: OSHA resp violations

Partial compliance a common problem

An employee may have had a respiratory examination, as required by the Occupational Safety and Health Administration's (OSHA) Respiratory Protection Standard, but no mask fit testing. This means your workplace is only in partial compliance with the standard, warns **Michelle L. McCarthy**, RN, COHN, on-site medical case manager for Genex Services in Norcross, GA. "Many times, you will see that only part of the standard is being met," she says.

In addition, says McCarthy, "there may be no records of annual training, not enough types of protection offered, or no enforcement. Even if all this was done correctly, there may be poor documentation."

Frequent violations

The most frequently violated paragraph in the Respiratory Protection Standard is the lack of a respiratory protection program, says OSHA spokesperson Richard DeAngelis, followed closely by the lack of a medical evaluation of respirator users and the lack of fit-testing. These violations make up 52% of all penalties, he adds.

"The fourth most commonly violated paragraph is the voluntary use of respirators," DeAngelis says. This includes failing to provide voluntary users with mandatory information, failing to ensure that the respirator itself does not create a hazard, and failing to have a written program when respirators other than filtering facepieces are voluntarily used, he says.

"Less frequently but still commonly cited are not evaluating the respiratory hazards in the workplace, lack of training before being assigned to wear a respirator, improper storage of respirators, and wearing respirators with facial hair," DeAngelis says.

DeAngelis adds that any facility that uses respirators needs to designate one or more individuals to maintain and evaluate their program.

Tom Ostendorf, lead respiratory protection specialist at Lab Safety Supply, a Janesville, WI-based provider of safety products, notes that non-compliance with the Respiratory Protection Standard is on OSHA's list of the most frequently cited occupational safety violations for fiscal year 2010. "It once again made the infamous list, coming in at number four for the second straight year," says Ostendorf.

This is significant, says Ostendorf, in light of OSHA estimates that approximately five million workers wear respirators at 1.2 million U.S. workplaces. To avoid violations, Ostendorf says, "If you're uncertain where to even begin, oftentimes a quick call to a comprehensive safety equipment supplier will get you pointed in the right direction."

Below are recommendations to avoiding citations:

• Create a written program.

Ostendorf says that this must address the selection process; medical evaluations; fit testing; procedures for use; procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing and discarding; procedures to ensure adequate air quality; quantity and flow; training in respiratory hazards; training in use limitations; and maintenance and procedures for regularly evaluating the effectiveness of the program.

• Review the annual OSHA respiratory questionnaire for accuracy and completion.

McCarthy recommends comparing it to the

EXECUTIVE SUMMARY

Incomplete documentation, training, or fit testing will result in only partial compliance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection Standard. To avoid violations:

- Compare annual respiratory questionnaires to previous years.
- Give employees written copies of recommendations.
- Do another fit testing if employees gain or lose weight.

prior year's questionnaire, and looking for any major changes or discrepancies.

"If there are flags — the employee is a smoker or has heart disease or high blood pressure — refer them to a qualified medical professional for further evaluation," she says.

• Perform a medical evaluation prior to fit testing or respirator use.

The physician or licensed health care professional performing the evaluation should do the following, Ostendorf says:

— Administer evaluations confidentially and conveniently during normal work hours;

— Ensure the employee understands the results of the examination;

— Note any limitations the employee may have, and if there is a need for follow-up exams;

— Provide the employee with a written copy of any recommendations.

"If medical conditions prevent an employee from using a negative-pressure respirator, a PAPR [Powered Air Purifying Respirator] will be provided," adds Ostendorf.

• Do additional medical evaluations as necessary.

These should be done if the employee reports symptoms, if observations or evaluations indicate a need, or a change in the workplace occurs that would affect the employee's physical burden, says Ostendorf. "The medical evaluation is discontinued when the employee is no longer required to use a respirator," he says. *(See related story, below.)*

SOURCES

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Don't overlook training needs with respirators

"What good is a respirator if the wearer is not properly trained?" asks **Tom Ostendorf**, lead respiratory protection specialist at Lab Safety Supply, a Janesville, WI-based provider of safety products. He gives these recommendations:

• Perform fit testing before an employee is required to use the respirator.

After the initial fit testing, employees will be required to be fit tested annually thereafter, says Ostendorf. "Fit testing should also be done whenever there is a change in the respirator type; a change in physical condition, such as weight gain or loss, that could affect the fit; or upon observations or reports," he adds.

• Conduct proper training on respirator selection and use.

"Proper selection is critical to a respiratory program," says Ostendorf. "Respirator selection is based on the hazards to which the worker is exposed, and workplace and user factors that affect respirator performance and reliability."

This requires the employer to evaluate the respiratory hazards in the workplace by identifying the contaminants and determining the employee's exposure, he explains.

"Employees must be able to demonstrate why a respirator is necessary, consequences of improper fit, usage and maintenance," says Ostendorf. "They must be aware of limitations and capabilities of the respirator, and know how to use it in emergency situations or upon failure of the respirator."

• Be sure that employees know how to inspect, maintain and store the respirator.

Make workers aware of medical signs or symptoms that would limit or prevent the use of the respirator, advises Ostendorf. "Retraining should occur whenever there are changes in the workplace or new types of respirators are used," he says. ■

Protect worker info from supervisors

Has a supervisor asked you for an employee's diagnosis, the medications he or she is taking, or for information about the worker's medical history? Supervisors do not need this information, according to **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principle of Partners in BusinessHealth Solutions in Toledo, OH.

"The information that they need is whether an employee is capable of performing the job duties, with or without accommodations," says Strasser. She notes that both the American Association of Occupational Health Nurses and the American College of Occupational and Environmental

EXECUTIVE SUMMARY

Supervisors need to know only whether an employee is capable of performing job duties, with or without accommodations. To avoid problems:
- Don't divulge information on the employee's diagnosis or medical history.
- Release only information related to fitness for duty.
- Demonstrate that you will maintain medical information in a confidential manner.

Physicians have developed standards regarding confidentiality of employee medical information.

"These documents reinforce the ethical obligation that occupational health nurses and physicians have to release only information related to fitness for duty," she says. The only exceptions to this, she says, are if the employee consents to release of additional information or there is a legal requirement mandating release.

If employees do not believe that their medical information will be maintained in a confidential manner, they may not be willing to share it with the company's health care providers — including yourself, notes Strasser.

"Such an omission may result in inappropriate care or potential harm," she warns. She gives the example of some individuals being more at risk in a hot environment because they are taking certain medications.

"If an employee or prospective employee is afraid to disclose the medication he or she is taking, the person might be placed in a job that could result in a serious heat-related incident," says Strasser.

SOURCE

For more information on employee medical information, contact:
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Find the right balance for wellness incentives

A fun, fair approach is best

Incentives for wellness program participation is becoming more common, but "it can be challenging to settle on the optimal design," according to **Daniel Buckalew**, a health coaching program manager for Minneapolis-based Ceridian, a global business services company.

"Some corporate leaders feel they shouldn't have to pay people to practice a healthy lifestyle, even though they understand the impact unhealthy employees can have on the bottom line," says Buckalew. "This opinion is understandable, but it would be shortsighted to ignore incentive programs altogether."

Incentives can increase utilization of available programs and services, says Buckalew, adding that they have not typically been proven to directly improve health outcomes.

However, you must get adequate utilization and engagement before you can get the desired return on investment, he adds. "This is where incentives come in," says Buckalew. He recommends these approaches:

• Don't offer only low-value incentives.

"Incentive plans that only provide low-value rewards, such as T-shirts and water bottles, don't dramatically increase participation," says Buckalew. "Incentives must be of a certain value to have a significant impact."

The potential for total annual rewards in amounts of $100 or more, "is much more successful in driving higher engagement," he says.

• Carefully consider the perceived fairness of the incentive being offered.

"Some employees may view it as unfair if they don't feel there is an equal opportunity to earn the incentive," says Buckalew.

For instance, a program mimicking "The Biggest Loser" with a higher-value reward needs to consider those who are already at an optimal weight, he explains, and therefore don't have an opportunity for that reward.

• Hold competitions between departments, business units, or work sites.

"This can add an element of fun, and may promote teamwork," he says.

• Recognize individuals.

"Featuring names and pictures of high-level participants or those individuals who achieved significant goals in company newsletters or Intranet

EXECUTIVE SUMMARY

Use of incentives to increase utilization of available programs and services is becoming more common. Some recommendations:
- Offer rewards that total at least $100 annually.
- Feature names and pictures of high-level participants.
- Link program participation to prize drawings.

sites, can be motivating," he says. "However, be sure to get permission, as not all employees may agree to this."

Opposite approach

Some companies are now taking the opposite approach to incentives, says Buckalew, by implementing a surcharge on health insurance coverage for unhealthy behaviors such as smoking. Although this can be successful in motivating some employees to attempt to quit, it may have other negative impacts that aren't easily measured, he warns.

These may include distrust and negative feelings toward the employer, and decreased morale, says Buckalew. "A better approach might be to discreetly raise premiums for all, then offer sizable refunds to those who practice healthful behaviors and achieve specific outcomes," he suggests. "This approach may be considered more fair, but may take more resources to administer."

Buckalew says to consider linking participation in programs to prize drawings. The more an employee participates in an exercise, nutrition, or smoking cessation program, for example, the more chances he or she will get toward a grand prize drawing.

"Those who achieve specific goals might also get more chances than those who just participate, but don't achieve goals," he explains.

Buckalew says that above all, your incentive program design should be an integral part of the organization's health promotion strategy, and should be closely aligned with the marketing and communication plan. "This is a critical component," he says. "Without adequate utilization, even the best designed programs will not produce the outcomes or ROI desired."

SOURCE

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Hospitals pressured to mandate flu shots

Even as more volunteer for shot

More health care workers responded to this season's push for influenza vaccination by rolling up their sleeves and getting the vaccine. By mid-November, 56% reported having gotten the vaccine and 7% said they definitely planned to get the vaccine, according to a web-based survey conducted for the Centers for Disease Control and Prevention. About 68% of hospital employees had received the vaccine, and another 5% said they definitely intended to be vaccinated, for a total of 73%.

But while that vaccination level was similar to last year and higher than rates that hovered near 40% in recent years, it wasn't enough to stem the call for mandatory programs, particularly within the infection control community. Unions and occupational medicine physicians continued to press for voluntary programs as the best way to boost vaccination.

Although some hospitals have been able to get vaccination rates above 80%, it requires such an intense focus and strong leadership involvement that a hospital must create an expectation that all employees will be vaccinated, says **William Schaffner**, MD, an infectious disease expert who is chairman of the Department of Preventive Medicine at Vanderbilt University in Nashville, TN. Most hospitals, however, can't reach that level, he asserts.

"[The survey] affirms my notion that the era of voluntary compliance is over. I think influenza immunization for all health care workers ought to be mandatory," he says. "We have been promoting health care workers immunization in a very intense way for 10 years. We have seen the national proportion of health care workers inch up but we're not making great progress. The thing that seems to get health care workers almost completely immunized is a mandatory policy."

However, **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN, remains unconvinced about the merits of mandatory vaccination. In fact, studies have failed to demonstrate the benefits of vaccination on patient outcomes, even in long-term care settings, she says.

"Employer-mandated vaccinations are fraught with logical, ethical, and administrative pitfalls and constitute a false sense of security even though they may create the impression of strong action," Swift said as an author of recent comments to the U.S. Department of Health and Human Services on its draft Flu Action Plan

from the American College of Occupational and Environmental Medicine (ACOEM). Swift is vice chair of ACOEM's Medical Center Occupational Health section.

Resources spent on vaccination programs "should not drain resources from other important programs to protect the health of workers," she cautioned.

Ironically, the most persuasive message to send to health care workers may be one of self- interest. According to the CDC survey, 85% of health care workers received the flu vaccine because they didn't want to get the flu. About 58% said they wanted to protect their family and friends. Transmission to patients was a concern for just 38% of health care workers, according to the survey, which is unpublished.

How high can you go?

One thing is clear: The pressure continues to grow for hospitals to improve health care worker immunization rates.

In Iowa, hospital rates of health care worker influenza immunization are publicly reported, along with health care associated infections. A number of hospitals have adopted mandatory vaccination programs, and the state touted a 91% vaccination rate in 2009-2010.

Wisconsin opted to promote voluntary programs that require health care workers to sign a declination form if they don't want to be vaccinated. The state's median rate rose to 72%. About 40 hospitals reached the state's target of 80% or more. The state provided feedback to hospitals and nursing homes and offered recommendations to improve rates.

"We want health care workers to do this because it's the right thing, and so far, it's working," **Gwen Borlaug**, CIC, MPH, infection control epidemiologist with the Wisconsin Division of Public Health, said in a statement.

The Maryland Partnership for Prevention in Baltimore has been promoting health care worker influenza immunization for about six years, with an emphasis on education and making vaccinations free and convenient. The partnership offers a free online toolkit to assist hospitals and other health care employers. (See www.immunizemaryland.org.)

Hospital vaccination rates range from a low of about 30% to 100%, says **Tiffany Tate**, MHS, executive director of the partnership.

"We have been reluctant as an organization… to make that recommendation that [health care employers] should make it mandatory," she says. "But we do think people should really push for vaccinations and ask people to sign a declination form if they don't have the vaccine."

Meanwhile, the list of hospitals requiring influenza immunization continues to grow, says **Deborah Wexler**, MD, executive director of the Immunization Action Coalition in St. Paul, MN, which tracks mandatory programs on its "honor roll." (Those include institutions that allow declinations or exemptions for personal reasons.)

"We need every health care worker who can be vaccinated to be vaccinated," says Wexler. "That's how we're going to optimally protect the patients we take care of." ■

OSHA cites hospitals for recordkeeping flaws

Problems with forms top bloodborne lapses

Beware of recordkeeping violations. That's a word to the wise based on recent enforcement activity by the U.S. Occupational Safety and Health Administration.

In the last fiscal year ending Oct. 1, 2010, federal OSHA cited hospitals more frequently for failures related to the OSHA 300 log than any other standard. (Bloodborne pathogens came in second.)

Meanwhile, OSHA's pending new rule on recording of work-related musculoskeletal disorders would add a new requirement for employers to check a box on the OSHA 300 log indicating that an MSD occurred. It has been delayed due to an extended review from the U.S. Office of Management and Budget.

The proposed rule also removes the language in an OSHA compliance directive that says that "if a health care professional determines that the employee is fully able to perform all of his or her routine job functions, and the employer assigns a work restriction for the purpose of preventing a more serious injury."

"We're seeing them taking [recordkeeping] more seriously than they have [in recent years]," says **Brad Hammock**, Esq., workplace safety compliance practice group leader at Jackson Lewis LLP in the Washington DC region office.

Some common errors: Failing to post summary

forms, improperly completing particular recordkeeping entries, not recording an injury or illness that should have been recorded, failing to have a proper signature on a form.

That increase in recordkeeping citations coincided with an OSHA national emphasis program on recordkeeping, which was announced in October 2009. The program focused on workplaces that reported low rates of injury that were in high-rate industries. Nursing homes were among the targeted employers, but hospitals were not.

Yet the increased scrutiny on recordkeeping may have been reflected in some hospital inspections, Hammock says.

"[OSHA is] citing employers for underreporting injuries and illnesses. That's a major problem because if hazards are underreported then there's no urgency to address them," says **Bill Borwegen**, MPH, health and safety director of the Service Employees International Union (SEIU).

Overall, hospitals typically do not receive many OSHA inspections relative to their workforce. Federal OSHA inspections overall rose by 5%, but declined in hospitals by about 7%, according to industry-specific OSHA data.

Yet that may change as well. In Fiscal Year 2011, OSHA included hospitals and nursing homes among the "high hazard" workplaces that are subject to unannounced, targeted inspections.

Hospitals that receive the targeted inspections have a rate of days away, restricted or transferred (DART) of 15.0 or more per 100 full-time equivalent employees or a case rate of days away from work due to injury and illness of 14 or higher. For nursing homes, the rates are somewhat higher, with a DART rate of 16 or above and a "days away from work" case rate of 13 or above.

In nursing homes, OSHA said it will focus on "ergonomic stressors; exposure to blood and other potentially infectious materials; exposure to tuberculosis; and slips, trips, and falls." Citations related to ergonomics would require use of the General Duty Clause, which requires employers to keep the workplace free of "recognized hazards that are causing or are likely to cause death or serious physical harm" to employees.

"OSHA will be doing more programmed inspections in the hospital sector, so it's good to know what OSHA is focusing on," says Borwegen, noting that OSHA is interested in recordkeeping and bloodborne pathogens. ■

OSHA: Employers must reduce noise hazards

Agency says PPE isn't enough

Ear plugs aren't protection enough from high levels of noise at work. The U.S. Occupational Safety and Health Administration wants employers to rely more on eliminating or mitigating a noise hazard than on using personal protective equipment.

In a proposed new interpretation of the Occupational Noise Protection standard, OSHA would change the meaning of what's "feasible." Employers can't choose ear protection rather than other methods of controlling the noise hazard simply because personal protective equipment is less expensive, says OSHA.

"Although OSHA has not changed its interpretation of the standard, its enforcement policy since 1983 has allowed employers to rely on a hearing conservation program based on PPE if such a program reduces noise exposures to acceptable levels and is less costly than administrative and engineering controls," the agency said in a Federal Register notice. The interpretation applied to noise less than 100 decibels. (edocket.access.gpo.gov/2010/2010-26135.htm)

Instead, OSHA would consider "feasible" to mean "capable of being done" or "achievable" and would consider administrative or engineering controls to be economically feasible "if they will not threaten the employer's ability to remain in business or if the threat to viability results from the employer's having failed to keep up with the industry safety and health standards."

Under the new interpretation, employers would rely on PPE only if the administrative and engi-

COMING IN FUTURE MONTHS

- Be the go-to person when a crisis happens
- How health care reform will change occ health
- Strategies to respond to unfounded complaints
- Dramatically reduce musculoskeletal injuries

neering controls weren't completely effective in reducing the noise hazard.

"There is sufficient evidence that hearing protection alone cannot prevent workers from suffering preventable hearing loss," Assistant Secretary of Labor for OSHA **David Michaels**, MD, said in a statement. "Easily applied administrative or engineering controls can and must be used to protect workers. There are plenty of employers out there who play by the rules and want to do the right thing, and we're hopeful we can work with them to craft a policy that's good for all."

This proposed interpretation "represents a major change in how OSHA enforces its noise standard," says **Brad Hammock**, Esq., workplace safety compliance practice group leader at Jackson Lewis LLP in the Washington DC region office. "My opinion has been that stakeholders really need to comment on this to provide as much information as possible."

OSHA extended the comment period to March 21. Comments may be submitted to www.regulations.gov or to the OSHA Docket Office, Docket No. OSHA-2010-0032, U.S. Department of Labor, Room N-2625, 200 Constitution Ave. NW, Washington, DC 20210, 202-693-1648 (fax). ■

Fall program keeps $ from slipping away

Slips, falls are becoming the No. 1 injury

As more hospitals tackle the injuries from patient handling, a second major cause of musculoskeletal injury is coming to the forefront: Slips, trips, and falls.

In 2008, there were about 14,000 slips and falls in U.S. hospitals that led to days away from work, second only to cases of work loss due to overexertion, according to the U.S. Bureau of Labor Statistics.

Just as you have a comprehensive program to reduce patient handling injuries, you should design a program to address slip and fall hazards, advises **Jennifer Bell**, PhD, a research epidemiologist with the National Institute for Occupational Safety and Health (NIOSH) in Morgantown, WV.

"Hospitals tend to look at the nature of injury. We have a lot of sprains and strains," says Bell. "But they don't necessarily look at what's causing the sprains and strains. If they looked at the events, they would find a good percentage of them are actually due to slips and falls."

Bell and colleagues found that a comprehensive approach can reduce slips and falls by as much as 59%.[1] "There are so many different causes of slips and falls that any one change seems insignificant," says Bell. But the evidence shows that approaching the problem systematically can produce results, she says.

That is the approach taken by Trinity Health in Novi, MI. When workers' compensation director **Terry Fisk**, CIH, CSP, analyzed injury claims, she found that slips, trips, and falls were No. 1. "It was a little bit of a surprise," she says. "You'd think it would be lifting. It's starting to surface what a huge problem this is."

REFERENCE

1. Bell JL, Collins JW, Wolf L, et al. Evaluation of a comprehensive slip, trip and fall prevention programme for hospital employees. *Ergonomics* 2008;51:1906-1925. ■

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

5. Which is true regarding measuring presenteeism in the workplace?
A. It is not advisable to use a company-generated performance scale or self-reported measurements.
B. The number of risk factors an individual has is not linked in any way with presenteeism.
C. Information on presenteeism should be obtained through careful measurement using the appropriate tools, and used to develop interventions.
D. Costs related to presenteeism are estimated to be far less than the cost of absenteeism.

6. Which is true regarding the Occupational Safety and Health Administration's Respiratory Protection Standard?
A. It is not necessary to provide voluntary users with information.
B. A written program is not required when respirators other than filtering facepieces are voluntarily used.
C. Any facility that uses respirators needs to designate one or more individuals to maintain and evaluate the program.
D. The only circumstance under which additional medical evaluations become necessary is an employee reporting symptoms.

7. Which of the following is true regarding sharing medical information about an employee?
A. The only information that supervisors need is whether an employee is capable of performing the job duties, with or without accommodations.
B. Supervisors have a legal right to information about an employee's diagnosis.
C. It is appropriate to disclose general information about the worker's medical history to a supervisor.
D. It is necessary for an employee to consent in order to release information related to fitness for duty.

8. Which is recommended when offering incentives for wellness participation, according to Daniel Buckalew, a health coaching program manager for Ceridian?
A. Provide only lower-value rewards, such as T-shirts and water bottles.
B. Never offer incentives that are linked to participation.
C. Avoid holding competitions between departments, business units, or work sites.
D. Offer employees the potential for total annual rewards in amounts of $100 or more.

Answers: 5. C; 6. C; 7. A; 8. D.