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AHC Media

New opportunities opening for occ health in health care reform

Employers offering more health services onsite

There is no shortage of discussion on how the Patient Protection and Affordable Care Act will change things for patients and providers, but big changes are also in store for occupational health.

"Health care reform is a great opportunity," says **Talei Akahoshi**, director of occupational health at Piedmont Healthcare in Atlanta. "We are taking advantage of it by having a nurse practitioner onsite, and providing minor care services."

The way health care is delivered is going to change, says Akahoshi, and employers are going to look for different and convenient solutions. "This is an exciting time for us," she says. "We are already seeing how we can make a difference and be a part of an Accountable Care Organization."

Health care reform also ties in with your efforts to promote wellness, says Akahoshi. "As employees come in, we can work with their acute or chronic problems or identify gaps in care," she says. "We can refer them to wellness programs, or provide health education."

With the employee's permission, adds Akahoshi, occupational health nurses can use integrated electronic medical records to coordinate care with their primary care providers. "This improves care coordination, which is an objective of health care reform," she says.

According to **Linda McCauley**, PhD, RN, FAAN, FAAOHN, dean of the Nell Hodgson Woodruff School of Nursing at Emory University in Atlanta, "all occupational health nurses and physicians need to be aware of the health reform momentum, and how we might play a role in that."

EXECUTIVE SUMMARY

Opportunities for occupational health in health care reform include more employees offering onsite care and starting wellness initiatives. Some likely trends:

- Occupational health services will coordinate with primary care physicians.
- Nurse practitioners will need education in occupational health.
- Most Americans will remain covered by employer-sponsored plans.

Higher level education needed

McCauley sees a definite trend of employers offering more health services onsite, which she says is good news for occupational health nurses.

"There is a potential for great growth in that area," she says. Nurse practitioners are particularly skilled in caring for workers with chronic diseases, she adds.

"It would be really exciting to see a model of care delivery in work settings where chronic diseases are managed, and workers can stay at work," says McCauley.

This is a "win-win" situation, she says, because the business benefits from increased productivity, while employees benefit from the convenience of being able to see a provider without leaving work.

McCauley notes that not all occupational health settings have nurse practitioners onsite, and many occupational health nurses have two-year-degrees. The October 2010 Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*, is closely aligned with what is called for in health care reform, she says. "It points out that nurses need to achieve higher levels of education, particularly nurses with two-year degrees," McCauley says.

"Ultimately, the worker benefits as the nurses move toward more independent roles with increased education," she explains. "There need to be easier pathways for nurses to return to school. Industry has to figure out how they can support that."

Conversely, says McCauley, nurse practitioners need additional education on occupational health. "That has been a challenge for many years," she says. "Primary care clinicians need to be cognizant with occupational health issues."

With the onset of health care reform, one of the biggest challenges is access to care. If it takes a worker with a chronic illness several months to get an appointment — and it ends up being inconvenient to miss work on that particular day — that isn't good for the company or the worker, McCauley says.

"Clearly, people are going to have difficulty getting in to see physicians," she says. "We have to have other models of care — either at the worksite, or a network of companies utilizing a central clinic for occupational health services."

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Onsite health programs, wellness to get boost

Reimbursement is the reason

All signs in health care reform point to preventive incentives. **Paul Papanek**, MD, MPH, chairman of the board for the San Francisco, CA-based Western Occupational Environmental Medical Association and former chief of the occupational health service for the Kaiser on the Job Program in Los Angeles, expects to see these changes in occupational health as a result of health care reform:

• **Employers will be more likely to implement wellness initiatives.** Employers may now be hesitant to spend extra money on prevention programs, says Papanek, but they'll be more likely to implement these approaches as a result of health care reform. This, he explains, is because workplace preventive services, including health risk assessments and other health and productivity interventions, are more likely to be reimbursed by insurers.

"The employer will have an incentive to ask you to do that, because those services are going to be paid by the health plan," he says. "The employer is more likely to implement such services, because there aren't any short-term costs."

• **There will be a shortage of occupational medicine physicians.** "We are going to have a health personnel shortage in occupational medicine in the next few years, in my opinion," Papanek says. "That means we're going to have to train way more occupational medicine physicians."

• **There will be different rules for health plans under the Health Insurance Exchanges to be set up by the states, than for employer-sponsored plans.** Papanek points to a recent study which estimated that after 2014, 60% of Americans are still going to be covered by employer-sponsored plans.[1]

"Some predictions were for a bunch of employers leaving in droves, but it doesn't look that way," he says. "It's still going to be a pretty big chunk."

Papanek notes one section of the Patient Protection and Affordable Care Act (PPACA) says that employers are permitted to give cash discounts on premiums or copays, provided that the enrollee meets certain health targets. "These are permitted to be very broad," he says. "We are now smarter than we were ten years ago about what kind of preventive measures work. If you take your migraine pills, you are more likely to show up at work."

If the insurance carrier offers incentives for enrollees who meet benchmarks, says Papanek, this means that somebody has to make a decision about which chronic conditions will be targeted.

"Somebody has to be looking at what measure you are going to target. Then you can make a decision about rate setting," he says. All of this means a bigger role for occupational health, according to Papanek.

"As we work with employees to try to get their health behaviors and risk factors to improve, we are going to end up being benefits administrators," says Papanek. "We are talking about hundreds of billions of dollars flowing through occupational medicine."

This is good news, both for employees and the company's bottom line, says Papanek. "All of these forces are converging on occupational medicine doing its job way better than we do it now," he says.

• Workplace services will need to be integrated with medical homes.

If you give a worker influenza vaccine, for instance, this will need to become part of the employee's medical record, says Papanek.

• **Smaller companies will be able to apply for grants.**

Papanek notes that the PPACA includes grants for companies with less than 100 employees to offer preventive services. "Small employers are not going to be in a position to do that without help," he notes. "So an additional role for occupational health is to be grant writers for some of those programs."

• **Preventive services will become more common.**

If you ask an occupational medicine physician today what percentage of his or her income comes from preventive services, as opposed to workers compensation or injury care, says Papanek, it's likely to be a very small percentage.

With the onset of PPACA, he says, "the percentage of the income stream is going to swing way over. We will get a bigger stream of our income from doing preventive services. There is going to be plenty of money over there, and there should be."

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Don't let soreness turn into full-blown MSDs

Manage symptoms early

It's highly unlikely that a costly piece of machinery would get absolutely no maintenance for years in your workplace. This is what's happening to employees who are exposed over time to risk factors for musculoskeletal diseases, warns **Susan Murphey**, BS, CECD, president of Essential WorkWellness in Shoreline, WA.

"I liken it to a preventative maintenance schedule for equipment. It prevents more expensive breakdowns that come down the line," she says.

Soreness and discomfort are underreported, though, because workers fear losing their job or other repercussions, notes Murphey. "Very often, even the worker may not understand why they are hurting," she says. (*See related story on reducing repetitive strain injuries, p. 41.*)

Musculoskeletal injuries are costly in more ways than one, according to **Pam Dannenberg**, RN, COHN-S, CAE, ergonomic and occupational health services manager at EK Health Services in San Jose, CA. "They cause good people to have pain and discomfort. They also cost losses in terms of productivity, quality and financially," she says.

If one of EK Health Services' employees is having soreness and discomfort, a professional ergonomic specialist is assigned to see that person, Dannenberg says.

The ergonomist makes equipment and behavior recommendations, which are then implemented, says Dannenberg. "We are preventing symptoms from turning into full-blown musculoskeletal diseases," she says. "Employees are happier and more productive."

Big differences

There are some big differences between setting up safety programs to prevent acute injuries, versus chronic injuries, says Murphey. "If an employee falls off a ladder at work, it's pretty clear what the mechanism of injury is," she says. "There's likely already a safety policy, but perhaps it just wasn't followed."

In this case, the policy may need to be revised, she says, or workers may need a refresher to

EXECUTIVE SUMMARY

Musculoskeletal injuries are costly to employers in multiple ways, but are often unreported by employees. To prevent these injuries:

- Assign an ergonomics specialist to employees.
- Remember that injuries may be caused by multiple factors.
- Reward workers for ideas to improve safety.

How to use data to make a case for MSD program

If you only count the musculoskeletal injuries reported in the Occupational Safety and Health Administration's Form 300, Log of Work-Related Injuries and Illnesses, you may be left with insufficient evidence that a prevention program is justified.

"The OSHA 300 Log will give you this information to an extent, but these are only the reported injuries. Many chronic exposure injuries are underreported," says **Susan Murphey**, BS, CECD, president of Essential WorkWellness in Shoreline, WA. "Lack of complaints shouldn't deter you from moving forward."

To get a more accurate idea of the number of musculoskeletal injuries in your workplace, Murphy recommends doing an anonymous symptom survey. This way, she says, workers can report symptoms without fearing any repercussions.

Ask these questions: How long have you been on the job? How long have you been doing this type of work? Do you have any symptoms related to work? If so, what body area? "Draw an outline of the body and let them mark it," says Murphey.

Ask whether there have been any recent modifications to the employee's usual duties, the frequency and severity of pain, and whether they received medical treatment. "If so, ask if they used their personal medical benefits, workers compensation, or paid out of pocket," says Murphey. "That's when you find out that there are a lot of symptoms going on under the radar."

If you go solely by your OSHA 300 logs, you're unlikely to find enough injuries to substantiate getting administrative support and monies allocated, explains Murphey. "But if you find out 100% of the staff is symptomatic and used sick or vacation time because of an injury, suddenly they will sit up and pay attention," she says. ■

improve compliance.

"The return to work for that employee is pretty straightforward," she says. "They are likely not walking back into the same risk factors that caused their injury. With repetitive use injuries, it's a whole different ball game."

It's very difficult for occupational health to carve out the time to set up prevention programs for chronic exposure injuries, explains Murphey. "Their job description is often 'mind-numbing. The occ health role may include handling exposure hazards, acute injuries and flu vaccines, just to name a few," she says.

Finding time to identify risks for chronic work-related injuries is therefore difficult, says Murphey. While acute injuries demand your attention, says Murphey, chronic injuries may go unrecognized.

"It is hard to demonstrate the need to address them. They are often not evident, and go unreported," she says. "It is difficult to allocate resources to prevention. That is a shame, because repetitive use injuries are a huge cost to organizations." ■

Are too many strain injuries occurring?

Causes are many: Here are solutions

If an employee reports shoulder soreness, this could be caused by her job, sports activities she does on weekends, or both. "Risk factors and the mechanism of injury are often both unclear with repetitive strain injuries," says **Susan Murphey**, BS, CECD, president of Essential WorkWellness in Shoreline, WA.

If you don't recognize the risk for injury, hazard-free light duty or job restrictions are more difficult to identify, says Murphey. She gives these recommendations to reduce repetitive strain injuries:

• Remember that the injury may have been caused by cumulative effects of years of exposure, and risk factors from multiple sources.

"To just say one activity is causing it is a little short-sighted," says Murphey. "It is often not one event, but a combination of things."

• Understand the risk factors in "light duty" jobs.

"Often, errors in judgment are made in assigning light duty," says Murphey. The 'light duty' job may have the same risk factors as the work that caused the original injury, she explains.

• Dedicate a period of time to develop a template for moving forward.

"That allows you to get the ball rolling," says Murphey. "The most time-consuming part is just getting started."

• Do not measure a program's success by the number of injuries reported.

This can dissuade workers from reporting injuries, cautions Murphey. "When you start a process like this, it's not unusual that the injuries reported go up. That is actually a good thing," she says.

This is because workers are reporting concerns earlier, which is a sign that you should keep going with the program and see it through, says Murphey.

"Then you start to see a reduction in the severity of injuries, and therefore the cost. The total number of reported injuries starts to go down," she says.

Instead of giving incentives for safe days without an injury reported, Murphey recommends rewarding workers for coming up with ideas to improve safety. "The goal is to change the work environment and promote healthy behaviors, rather than discourage reporting of concerns," she says.

•Ask employees, "How do you think you are most likely to get hurt in the work you are doing?"

"It's pretty interesting what can come out of a conversation like that," Murphey says. "Never underestimate what you can learn just by asking them. They know the job better than anyone else."

Next, encourage workers to come up with their own ideas for work safety solutions, she recommends. "With some of the projects I've done, the solutions they come up with are things I never would have thought of," says Murphey. "The things that they want changed are usually not a big deal."

SOURCES

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Expand occ health role to that of a health coach

Make healthy choices obvious

Cindy Luebbering, RN, a senior health systems manager and occupational health nurse at the Cincinnati, OH-based Proctor & Gamble Company, says that her goal is to give employees information on how to get healthy, stay healthy, and how to live a full and healthy life if diagnosed with a health condition."

Luebbering is responsible for the company's Cincinnati Vibrant Living Health Centers, and supporting the Vibrant Health Center program at its Toronto General Offices. "Being proactive about ways we can all maintain a healthy lifestyle is important to us," she says. "This is not new to P&G."

Information about how to get and stay healthy, says Luebbering, is not always readily available, and discussions do not always happen when the employee sees their physician.

"Our vision is to have the healthiest, most engaged employees in the world," she says. "To that end, we have established two significant initiatives. These really maximize all the great health and wellness programs that we offer our employees."

The first initiative establishes criteria to create a culture of health at all of the company's sites. For example, it's easier for employees to stay fit at work with on-site fitness centers, fitness classes, and marked walking paths, and easier to eat healthy because of a wide variety of healthy meals and snacks in cafeterias and vending machines.

"This is aimed to create an environment that enables our employees to make healthy choices," says Luebbering. "We are creating a workplace where making healthy choices is the obvious choice."

A collaborative approach

The second initiative involves health coaching, done by occupational health nurses for employees who take advantage of onsite health services that are offered, says Luebbering. The nurses were trained in effective health coaching and listening, she says.

"We also did in-depth training with our nurses on all company programs and benefits that touch the health of our employees and their families," says Luebbering.

With the expanded health coach role, the occupational health nurses are taking a more collaborative approach, she says.

Luebbering says that in order to put health choices "front and center" for an individual employee, it helps to know his or her biggest health concerns. "Focus on what matters most to his or her personal health," she says. "Connect the employee to the right health and wellness benefit or program at that time."

Personal health goals

Because occupational health nurses are trained in all internal health and wellness programs, they are able to connect employees to the right program at the right time, says Luebbering.

The occupational health nurses talk with employees about meeting their personal health goals, she says, which may be staying healthy, getting healthier, or living a full, healthy life with a health condition.

"The health coaches also talk with employees about questions they need to ask their doctor and other health care providers, about the health issue or concern the employee has," she says. "We believe that health coaching will positively impact both the quality of and access to care. It is the right care, at the right time, and with quality."

When an employee is diagnosed with a health condition, adds Luebbering, the coaches explain how to manage it effectively and tell them about programs that will help.

"Focusing on our employees and their families and what is important to them in managing health care costs is of paramount importance in how we approach benefits," she says. ■

EXECUTIVE SUMMARY

Taking on the role of a health coach can help employees get and stay healthy. Some effective approaches:

- Be knowledgeable on all programs and benefits.
- Find out the worker's biggest health concerns.
- Inform workers about programs to target specific health conditions.

Mandatory flu shots: Is science strong enough?

APIC cites 'ethics,' AOHP says 'science'

Everyone agrees that health care workers should receive the influenza vaccine each year to protect themselves and their patients. But the call for mandatory policies relies on the premise that gaps in vaccination jeopardize vulnerable patients. Although a number of studies are widely cited to support mandatory vaccination, there is actually little evidence of the impact of flu vaccination in hospitals.

As momentum grows for mandatory vaccination, *OHM* examined major studies and spoke to experts to assess some common assertions made about influenza vaccination of health care workers. Emotions run high on this issue, which is framed either as an imperative to "do no harm" or an unnecessary coercion with limited benefit.

"The science at best weakly supports voluntary vaccination of nursing home staff, achieving a goal rate in the 40% to 70% range," says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic at Vanderbilt University in Nashville, TN. "I think to extrapolate any benefit in the acute care setting beyond that is not supported by the evidence."

Swift, who is vice chair of the Medical Center Occupational Health Section of the American College of Occupational and Environmental Medicine (ACOEM), notes, "We already have a vaccination rate in acute care hospitals that meets or exceeds that [level achieved] in all of the studies."

Infection preventionists support mandatory vaccination as the way to catapult rates from about 62% of health care workers to close to 100%.

The rates from voluntary programs simply aren't high enough, says **Linda Greene**, RN, MPS, CIC, director of infection prevention at the Rochester (NY) General Health System. "What we're looking at is the ethical responsibility to protect those who are most vulnerable. We really felt that was a very strong message we needed to bring forth to our health care workers," says Greene, who was lead author of the position paper of the Association for Professionals in Infection Control and Epidemiology (APIC).

In February, APIC became the most recent infection control organization to support mandatory programs: "As a profession that relies on evidence to guide our decisions and actions, we can no longer afford to ignore the compelling evidence that supports requiring influenza vaccine for [health care personnel]. This is not only a patient safety imperative, but is a moral and ethical obligation to those who place their trust in our care."[1]

However, occupational health professionals, as a group, have not supported mandatory policies. The Association for Occupational Health Professionals in Healthcare (AOHP) issued a statement emphasizing the importance of health care worker vaccination but opposing the policies that require vaccination as a condition of employment: "AOHP respects the individual [health care worker's] right to make an informed decision regarding accepting or declining the influenza vaccine."

ACOEM also has declined to endorse mandatory programs: "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," ACOEM said in its guidance statement.[2]

Examining the evidence

Here are some of the assertions about flu vaccination of health care workers and the scientific basis:

Low vaccination rates of health care workers are associated with higher rates of mortality among patients: The evidence that influenza vaccination reduces the risk of mortality among patients or residents comes from long-term care facilities and is relatively weak. In one often-cited article from 1997, mortality rates declined in British long-term care facilities in which health care workers were offered vaccine. (Sixty-one percent of them were vaccinated.)

However, there was very little laboratory-confirmed Influenza: 6 of 107 in patients in the staff-unvaccinated group and 5 of 118 in the staff-vaccinated group. The authors noted that some elderly people do not have a rise in antibody titer after influenza vaccination — or perhaps after influenza infection — which may have resulted in an undercount of influenza cases. Other respiratory illnesses were circulating as well and were detected in the study population. The authors cautioned, "... we do not have any direct evidence that the reduction in rates of patient mortality and influenza-like illness that were associated with HCW vaccination were due to prevention of influenza."[3]

Other studies have shown effects on mortality in long-term care, with caveats. In one, vaccination of caregivers (51% vaccinated) was associated with overall lower mortality but not lower rates of non-fatal influenza infection.[4] A 2009 study found that doubling the vaccination rate of health care workers (32% to 70%) did not produce a statistically significant difference in mortality — although an analysis that adjusted for other possible contributors to mortality did show an impact from vaccination.[5]

A Cochrane Review of five studies on influenza vaccination among health care workers in long-term care (including the three cited here) found that "all [are] at high risk of bias....We conclude there is no evidence that vaccinating HCWs prevents influenza in elderly residents in long-term care facilities."

Overall, influenza infection causes less than 10% of mortality in people 60 years of age or older, the Cochrane authors noted. Future studies should test for the impact of a variety of interventions, including hand-washing, mask use, quarantine of ill patients/residents, and restriction of visitors, they said.[6]

Increasing vaccination rates reduces nosocomial transmission of influenza. There have been few studies of nosocomial transmission of influenza in hospitals, and they include other variables that make it difficult to assess the impact of vaccination. A widely cited 2004 study at the University of Virginia Health System found that the proportion of nosocomial flu cases to community-acquired cases among hospitalized patients dropped over 12 years (in 13 influenza seasons), while health care worker vaccination increased. The overall number of nosocomial cases varied, but averaged about 4 cases per year. (It was zero in 1994-95, 1995-96, and 1999-2000, the final season of the study.) Community cases also varied but spiked in the last years of the study. The peak vaccination rate of health care workers was 67%.

Although other infection control interventions also were used to prevent nosocomial spread, the authors concluded that the change over time could be attributed to the rise in vaccination.[7]

A recent French study found patients had an increased risk of a health care-associated influenza-like illness (ILI) if they were exposed to a health care worker with ILI — but the risk was even greater if they were exposed to a patient with ILI and greatest with exposures to both a patient and health care worker who were sick. Only 20% of the ILI cases were laboratory-confirmed influenza. The study was not designed to detect the protective effect of influenza immunization.[8]

Interestingly, a recent German study did not find that health care workers were at increased risk of influenza because they worked in an acute care facility. The greatest risk: Having children in their home. Most (74%) of the ILI was not influenza, and 30% of the lab-confirmed influenza was asymptomatic.[9]

Mandatory vaccination results in lower absenteeism. Studies have found only a modest impact on health care worker absenteeism. The flu vaccine varies in effectiveness, and influenza typically causes only a small portion of the respiratory illness seen each winter.

But there's one other reason: Health care workers often come to work sick. One study of hospital-based physicians, nurses and respiratory therapists found a lower amount of absenteeism and febrile respiratory illness in the vaccinated group, but the results weren't statistically significant. "The health care professionals in our study seem unlikely to be absent from work even when they experience a febrile respiratory illness," the authors noted.[10]

Virginia Mason Medical Center, the first hospital to require flu vaccination as a condition of employment, achieved vaccination rates above 98% but wasn't able to demonstrate a significant impact on absenteeism.[11] There are simply too many variables, notes **Joyce Lammert**, MD, PhD, chief of the Department of Medicine. For example, employees may take leave to stay home with a sick child, or there may be other diseases, such as norovirus, circulating in the community.

A mandatory program greatly increases the proportion of health care workers who receive the vaccine. There is no question that a mandatory policy produces almost universal health care worker vaccination. When Virginia Mason implemented the policy in 2005, the vaccination rate rose from 29.4% (a low rate in 2004 due to supply shortages) to 97.6%. The rates have since been above 98%.

When BJC Healthcare in St. Louis implemented a mandatory policy, vaccination rates rose from 71% in 2007 to 98.4% in 2008. The health system granted medical exemptions to 321 employees and religious accommodations to 90 employees, and eight employees were terminated for failing to comply with the policy.[12]

In a survey conducted by the RAND Corp. for

the Centers for Disease Control and Prevention, 21% of hospital workers reported that their employers have a flu vaccination requirement. Overall among health care workers in various settings, flu mandates led to a vaccination rate of 97.6% compared with 64.5% when employers recommended the vaccine.

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Injuries drop in OSHA crackdown on OR safety

Tenn. OSHA expects safer practices

It is notoriously difficult to convince surgeons to change their methods and tools in the operating room to improve sharps safety. But in Tennessee, intransigence is apt to lead to a citation from the Tennessee Occupational Safety and Health Administration.

A "special emphasis program" honed in on the bloodborne pathogen hazards in the operating room, and TOSHA has made it clear that they expect to see safe work practices (such as double-gloving and hands-free passing of instruments) and safer devices (such as blunt suture needles and safety engineered scalpels).

From October 2006 to October 2010, TOSHA conducted 175 inspections and issued 1,280 citations for serious hazards, 10 for repeat hazards, and 57 for other than serious hazards. The total fines: $587,000.

Needless to say, that has gotten some attention. And it has made a difference. TOSHA's modest goal was to reduce sharps injuries in the state's hospitals and ambulatory surgery centers by 10% over five years. In four years, the sharps injuries dropped by 14.5% in hospitals and by 17.1% in surgery centers. The reductions came despite an emphasis on better recordkeeping.

"There's an increased awareness. Most everybody's on board," says **Jan Cothron**, manager of health compliance at TOSHA in Nashville.

Cothron and her colleagues knew it would be

a challenge to address sharps safety in the OR. For example, an analysis of sharps injury data showed that injuries rose by 6.7% in the OR from 1993 to 2006 while they declined by 31.6% elsewhere in the hospital.

Cothron knows the burden of needlesticks, both in actual costs and in repercussions for the health care worker. She was stuck 34 years ago when she managed a blood-testing lab for a doctor's office. She was pregnant at the time but never reported the injury. She worried, over the years, that the source patient had hepatitis, but she was never tested.

As she travels the state, Cothron also hears from health care workers who have had needlesticks and have contracted hepatitis B or C. "We're trying to stop these [events] however we can," she says.

ORs must comply with law

Since the federal Needlestick Safety and Prevention Act was passed in 2000 and the U.S. Occupational Safety and Health Administration beefed up its Bloodborne Pathogen Standard, safety needles have become commonplace. Everywhere, that is, except the OR.

Tennessee has its own law, passed in 1999, which requires the use of safety devices and the reporting of sharps injuries within six days of an incident.

"People are not complying with this law," Cothron says bluntly. TOSHA's job was to make sure they complied, through awareness, compliance assistance, and enforcement, she says.

Cothron began by obtaining baseline data. TOSHA requested submission of sharps injury logs from the state's 161 hospitals and 158 ambulatory surgery centers.

The logs and previous inspections revealed common problems, including: Removing scalpel blades with forceps or hands, hand-washing contaminated surgical instruments without cut-resistant gloves, failure to use safer devices, hands-free passing or double-gloving, and lack of compliance by anesthesiologists and surgeons.

TOSHA offered free seminars across the state and compliance assistance. The agency also created randomized inspection lists of hospitals and surgery centers.

"We developed a checklist and provided it to participants" to indicate what TOSHA would look for in inspections, says Cothron. "Are people double gloving where they can? Are they using blunt tip suture needles where appropriate?

"We're interviewing employees to find out if these [measures] that are in written programs are being implemented," she says.

If surgical kits came with non-safety devices, TOSHA informed hospitals and surgery centers that they must replace those items with a safety-engineered device. Exceptions to using safety-engineered devices needed to be explained in writing — and they needed to be specific to a procedure. After all, the American College of Surgeons has endorsed the use of blunt suture needles and safety scalpels.

"We've had hospitals tell surgeons, 'It's a condition of employment at our hospital,'" says Cothron.

This tough stance has paid off. From 2009 to 2010, TOSHA found that sharps injuries stayed steady or declined at 106 out of 161 (65%) hospitals and 125 out of 158 (80%) ambulatory surgery centers. Some individual facilities had dramatic results. One hospital system experienced a 58% decrease in suturing injuries from 2001 to 2010, Cothron says.

"Overall, it's made work safer for the employees," she says. ■

Zero in on high-risk, high-cost employees

Give individual attention

You probably know, more than anybody else in the workplace, which workers have the greatest potential for positive health changes, says **Dawn Stone**, RN, a nurse practitioner and former occupational health nurse at Miller's Brewing Company, University of California — Los Angeles'

COMING IN FUTURE MONTHS

- Data you must have to justify wellness programs
- Strategies to respond to unfounded complaints
- Smart ways to use Health Risk Appraisal data
- Become the "go-to" person for employee concerns

EXECUTIVE SUMMARY

Occupational health professionals know which workers have the greatest potential for positive health changes. To take advantage of this:
- Give information directly to individuals at risk.
- Offer programs at different times and days.
- Provide wellness presentations online.

Occupational Health Facility and Northrop.

As an occupational health professional, says Stone, "you are aware of workers with interest in improving their health situations."

Giving information directly to these at-risk individuals "can be very powerful," says Stone. "Cost savings occur when a disease is prevented, and time off work for illness is not needed. Also, health insurance premiums are kept low." She recommends these approaches:

• Hold wellness program at work, and offer the program at different times and days of the week.

"This provides convenience and flexibility for workers with demanding schedules," says Stone.

• Use technology to stream wellness presentations or interactive online programs.

"This can reach audiences that work offsite, travel often or those who simply cannot get away from their work stations," says Stone.

• Offer monetary incentives.

Gift cards are an additional incentive to boost participation, she says.

• Follow up with the committed worker.

Once an employee has made a commitment to participate in a health behavior change, what next? "Individual attention from face-to-face meetings or regular online communication becomes especially valuable," says Stone. "This provides guidance and promotes motivation."

Difficult to measure

Stone says to survey workers to assess their needs, the type of programs they are interested in, and the best days and times to offer programs. Then, use multiple methods to advertise programs, she recommends, including e-mail, printed flyers, postcards, and posters displayed in areas that are well-traveled by employees.

"Quite often, attendance can be low simply because employees are unaware of what is available," she says.

Stone recommends featuring stories about employees who have been successful in meeting health goals. "Reading about people you know provides tremendous authenticity. That is very motivating," she says. "Disseminating success stories may also invite the development of spontaneous support systems within the workplace."

The cost savings of prevention are always difficult to measure, since the development of disease is not typically a certainty despite poor health behaviors, she notes.

"However, promoting a healthy workforce is the best way to keep people on the job, prevent injury, and enhance endurance and work performance," she says.

SOURCE

For more information on reaching high-risk employees, contact:
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CE OBJECTIVES / INSTRUCTIONS

The CE 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 true regarding changes in occupational health as a result of health care reform, according to Linda McCauley, PhD, RN, FAAN, FAAOHN, dean of the Nell Hodgson Woodruff School of Nursing at Emory University?
A. An employee's chronic diseases will be less likely to be managed onsite.
B. Fewer employers will offer health care services onsite.
C. Nurse practitioners will need additional education on occupational health.
D. There will be too many occupational medicine physicians.

14. Which is likely regarding wellness initiatives in workplaces, according to Paul Papanek, MD, MPH, chairman of the board for the Western Occupational Environmental Medical Association?
A. Smaller companies can obtain grants to offer preventive services.
B. Workplace services will not be integrated with medical homes.
C. Workplace preventive services are less likely to be reimbursed by insurers.
D. Employers are less likely to offer wellness programs.

15. Which is recommended to prevent musculoskeletal injuries, according to Susan Murphey, BS, CECD, president of Essential WorkWellness?
A. Assume that repetitive strain injuries are caused by a single factor, not multiple sources.
B. Always measure a program's success by the number of injuries reported.
C. Expect to see a significant decrease in injuries immediately after starting a prevention program.
D. Reward workers for coming up with ideas to improve safety.

16. Which is recommended to get an accurate idea of the number of musculoskeletal injuries in a workplace, according to Susan Murphey?
A. Count only those injuries reported in the Occupational Safety and Health Administration's Form 300, Log of Work-Related Injuries and Illnesses.
B. Assume that virtually all injuries are reported by employees.
C. Avoid doing an anonymous symptom survey.
D. Ask employees whether there have been any recent modifications to their duties.

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