Occupational Health Management™

A monthly advisory for occupational

Note: New CNE procedures. See p. 83 for details.

July 2011: Vol. 21, No. 7
Pages 73-84

IN THIS ISSUE

Statement of Financial Disclosure:
Stacey Kusterbeck (Editor), Gary Evans (Executive Editor), and Grace K. Paranzino (Nurse Planner) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

Cutting-edge strategies: Fatality focus, reporting `near misses'

Eight sentinel hazards that could take a life

The question "What can kill a worker?" will give you a different kind of answer than asking "What can hurt a worker?" says **Gregg Clark**, director of global occupational safety and hygiene for Dallas-based Kimberly-Clark Corporation, where a strategy of focusing on fatality elimination is currently being implemented.

"A lot of major corporations are experiencing that the incident rate is tending to go down, but fatality rates are stable," explains Clark. "We are on a couple of key benchmarking task forces that are looking at this phenomenon."

One possible reason for this is that companies are using an incident rate to drive safety performance. "That is a lagging indicator. It is not reflective of what safety is really going on at the facility," says Clark. "We have come up with something that is rather cutting-edge."

Eight Sentinel Event hazard categories were identified as having the potential for a fatal or catastrophic loss. These are falling objects, lift truck events, confined spaces, contact with energized equipment, fire and explosion, falls, transportation, and electrical contact. "If we hit a grand slam in those eight categories, we will eliminate fatalities forever," says Clark.

At the same time, the organization will drive compliance with all required regulations. "It's not that compliance is not important to us, since we believe it is a given," says Clark. "But if we drive safety performance in terms of 'What can kill me?' compliance comes along with that."

Employees will probably think twice before reporting injuries, if the incident rate is used as the sole metric of safety performance. "From a business standpoint, we know what gets measured will get accomplished — one way or another," says Clark. "As business magazines and other periodicals have shown, there is a lot of pressure not to report."

Clark encourages employees to understand, identify and eliminate the hazards associated with Sentinel Events by reminding them that each one has the potential of saving a life. As more events get reported, fewer hazards

EXECUTIVE SUMMARY

Strategies of eliminating fatalities and encouraging reporting of "near misses" are yielding results for leading occupational health programs.

will exist in the company's facilities. "Zero injuries should be a given or the norm," says Clark.

Over 50,000 employees and contractors at over 100 facilities across the globe are currently being trained in identifying Sentinel Events at their site, and how to resolve them. The expectation is that over 2000 Sentinel Events will be reported over a one-year time period.

"Part of the power of the sheer number of these events is to emphasize our vulnerability and eliminate complacency," says Clark.

Encourage reporting of near misses

It's human nature to want to keep accidents that almost happened, but didn't, to ourselves. However, this is dangerous for employees, according to **Frank Ginocchi**, director of safety and health at Columbus, OH-based American Electric Power, which has seven electric utility operating units serving over 5.2 million customers in 11 states.

At American Electric Power, where an employee may be working 100 feet in the air on high-voltage electricity or driving a 60-ton bulldozer, a near-miss can result in a catastrophe the next time it occurs. For this reason, the company is creating a culture without fear of retaliation or retribution for reporting near misses.

This message is consistent, from the employee's front line supervisor all the way up to the CEO. "I often repeat messages that start with the CEO all the way down through the organization, that we want people to report both misses and actual hits," says Ginocchi.

"Zero harm" is the company's goal, with workers going home every day, and also at the end of their career, without having any negative health impacts. "We want people to go home at the end of 30 years with their hearing not affected from working near a diesel bucket truck, or negative respiratory impact from working with chemicals, coal, or asbestos," says Ginocchi. "Likewise, we don't want them to go home with a broken arm or a cut."

Reporting near misses is an important part of this approach. "When a worker almost gets injured, that is the best time to learn," says Ginocchi. "The best events to learn from are the ones that have not hurt somebody."

Here are some of the steps that the company has taken:

• Employers are encouraged to stop a job if they see a worker doing something unsafe, including contractors.

One employee recently stopped a contractor on a tractor mower from mowing grass on a steep and slippery embankment, due to a high risk of roll-over.

• The practice of "peer coaching" was borrowed from the aviation and medical industries.

Two front line employees with the same rank are given the responsibility to remind each other to work safely, such as putting on safety goggles or obtaining a fire extinguisher before starting a job. "We have seen the tide turned, so that those reminders are now being viewed as a positive intervention," Ginocchi says. "We want employees to understand that we are all wired to make mistakes."

Since mistakes are more common before and after holiday weekends, employees are reminded to

Occupational Health Management™ (ISSN# 1082-5339) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Occupational Health Management™, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is intended for occupational nurses, occupational health managers and directors. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customer service@ahcmedia.com). Hours: 8:30-6:00 M-Th; 8:30-4:30 F.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $82 each. (GST registration number R128870672.)

Editor: **Stacey Kusterbeck.**
Executive Editor: **Gary Evans**, (706) 310-1727, (gary.evans@ahcmedia.com).
Production Editor: **Kristen Ramsey.**

AHC Media

EDITORIAL QUESTIONS

For questions or comments, call Gary Evans at (706) 310-1727.

be extra diligent.

"The first day back, we spend extra time on prejob briefings to get people's heads back in the game," says Ginocchi.

• Job-specific hazards are carefully identified and mitigated.

Whether an employee is changing a light bulb in a power plant, working on power lines, or working under water, the hazards unique to the job are identified. "Controls are then put into place, to be sure what they've identified doesn't manifest itself in the way of an injury," says Ginocchi.

• Videos about actual events are sent out to employees.

Depending on the event, a video of a "Safety Success Story" may be sent out to all 19,000 employees or targeted to a specific business unit. One worker involved in a vehicle rollover emphasized how fortunate he was to be wearing a seatbelt.

"He spoke about how wearing a seatbelt was instilled in him as a core value from the day he started working here," says Ginocchi. "He reflected on how quickly his life could have been changed."

SOURCES

For more information on evaluating workplace safety programs, contact:

• **Frank Ginocchi**, Director, Safety and Health, American Electric Power, Columbus, OH. Phone: (614) 716-1220. E-mail: fmginocchi@aep.com.

• **Gregg Clark**, Director, Global Occupational Safety and Hygiene, Kimberly-Clark Professional, Dallas, TX. E-mail: Gregg.L.Clark@kcc.com. ■

Unintended consequences with injury rate reporting

OSHA data shouldn't be only source

While walking through a work area, an employee steps into a hole that was left unguarded, and twists his ankle. He doesn't tell his supervisor because he doesn't want to negatively affect Occupational Safety and Health Administration recordable injury rates.

Your company may be trying to do the right thing by putting a great deal of focus on injury rates, but there could be an unintended consequence. "While recordable injury rates and severity rates based on days away from work or restricted duty can be one indicator of success, these shouldn't be the only indicator," says **Frank Ginocchi**, director of safety and health at Columbus, OH-based American Electric Power.

In many workplaces, employees fear retaliation if injuries are reported. "Companies may impose pressure on employees not to report, to keep injury rates low and therefore, keep incentive plan payouts higher," says Ginocchi.

Measuring failures

Recordable injury rates are actually failures that have already occurred. "We are moving towards measuring leading indicators of safety and health improvement," reports Ginocchi. "The idea is to identify hazards ahead of time, before they become a trap for somebody."

Metrics include the number of job hazard analyses that have been completed, the number of job observations done by supervisors, and the amount of peer coaching done by employees. "Those things are a better indicator of success," says Ginocchi. "Then, the injury rates just fall in line. We don't have to worry about the injury rates — they are taken care of."

Two common mistakes are blaming an employee for his or her injury, says **Gregg Clark**, director of global occupational safety and hygiene for Dallas-based Kimberly-Clark Corporation, or jumping to the wrong conclusion about what caused the injury.

"If you stop too quickly before identifying the system failure, it can recur in the future," says Clark. "It's always a challenge to get everyone to really drive to get to the root cause."

While incident rates are overly emphasized at many companies, these do need to be tracked. "But it should be one piece of data, not the only piece of data," says Clark. "You can achieve an incident rate of zero for weeks or months and have a fatality the next day. If you are surprised when that happens, there's something wrong with that." ■

Ignore indirect costs of injuries at your peril

Direct costs of workplace injuries are fairly straightforward, but indirect costs are often ten times that amount. If occupational health doesn't consider indirect costs, which may be difficult to compute, prevention programs may appear not worth the expense.

Pam Dannenberg, RN, COHN-S, CAE, ergonomic and occupational health services manager at EK Health Services in San Jose, CA, recommends looking at the actual cost of claims at your location for a year, and multiplying these by two to ten times to get the indirect cost of claims.

"Various sources differ on the multiplier, but the true cost to a company includes the indirect costs," she explains. "Compare each year to see if your costs are going up or down."

Direct costs include medical care, physical therapy, medicines, medical equipment, and litigation costs, while indirect costs include down time right after an injury due to stopping production. "People hesitate to go back to work right away," adds Dannenberg.

There is also time lost to care for the injured employee, investigate the incident, calm people down, and possibly, training a new person. "Quality can also take a hit," says Dannenberg. "This will have a negative effect on the bottom line."

If you add the direct and indirect costs of near-miss and first aid cases to those of actual claims, this will give you some powerful data. "You will probably have enough cost to cause management to care deeply about safety and to allocate money for solutions," says Dannenberg. "This has worked in many companies that EK Health has worked with."

SOURCE

For more information on indirect costs of workplace injuries, contact:

• **Pam Dannenberg**, RN, COHN-S, CAE, Ergonomic and Occupational Health Services Manager, EK Health Services, San Jose, CA. Phone: (877) 861-1595. Fax: (415) 643-6775. E-mail: pdannenberg@ekhealth.com. ■

No loss, no gain with design change

No single answer to worker health

Keeping employees from gaining weight is a major challenge in any workplace, but a new study shows that in fact, very simple workplace design changes can help stave off weight gain.[1] However, these interventions by themselves aren't likely to lead to weight loss.

Changes were made at several of The Dow Chemical Company's worksites, such as making healthy options accessible, encouraging employees to take the stairs, increasing leadership engagement and establishing workgroup ambassadors. The company also implemented a low-intensity individual weight-management program, with 60% of workers participating and 13.5% reducing weight by 5% or more.

"It is our experience, and is generally supported by the research literature, that environmental modifications provide a good support for behavior change, but don't necessarily generate a lot of change by themselves," says **Mark G. Wilson**, HSD, one of the study's authors and director of the Workplace Health Group at the University of Georgia's College of Public Health.

An employee is likely to choose healthy options provided in the company cafeteria if he or she is already being careful about what they eat, in other words, but those same healthy items won't necessarily get someone who is not predisposed to that behavior to take action.

Environmental prompts, such as reminding individuals to use safety equipment or take the stairways, and including healthy choices in the vending machines and cafeterias, turned out to be very effective.

"A number of other modifications have been tried with mixed success," says Wilson. "Virtually

EXECUTIVE SUMMARY

Simple workplace design changes can help prevent weight gain, but aren't likely to lead to weight loss. Use these approaches:

- Remind employees to use safety equipment and take the stairways.
- Use a combination of interventions.
- Make healthy foods available right at the worksite.

all of these modifications are low-cost, compared to other options. That is what makes them so attractive."

John White, health promotions leader at Dow, says that over the two-year period, a lot was learned about environmental interventions related to weight management. Here are key lessons learned:

• Leadership engagement is critical.

Leaders need to be educated and engaged. "Help them understand the business case. We have a shared responsibility here, and they play a part," says White. "That is really the secret."

• Employees should be given recognition for supporting each other.

Workers may choose to make their own lifestyle changes, or actively encourage co-workers to do so. Either way, they deserve some credit. At Dow, this is done by asking employees to nominate one another for a "Point of Light" award. "Recognition is a low-cost intervention," says White.

• A combination of interventions work best.

Employee behavioral programs, individual counseling, and environmental interventions all work together at Dow. While individualized counseling helps employees to begin taking appropriate action to reduce their own personal risk, a supportive environment helps them in their efforts to maintain lifestyle changes and feel as though they can be successful.

"We don't believe there is one answer or intervention, because employees have a variety of reasons for their behavior," says White.

• It should be easy for workers to find healthy food and to exercise.

Employees can be encouraged to move more at work by taking walking breaks, taking the stairs or using other supports appropriate for their location.

In addition to stocking cafeterias and vending machines with healthy food items, some of Dow's worksites also stock high-fiber bars and fruit on shelves right where employees are working, as part of its Healthy Cupboards program.

"The employees replenish it by putting in a designated amount of money for the food they used," says White.

REFERENCE

1. DeJoy DM, Parker KM, Padilla HM, et al. Combining environmental and individual weight management interventions in a work setting: results from the Dow Chemical study. *J Occup Environ Med* 2010; 33(3):245-252.

SOURCES

For more information on workplace design changes, contact:

• **John White**, Dow Health Services Leader. Phone: (979) 238-2485. E-mail: JMWhite3@dow.com.

• **Mark G. Wilson**, HSD, Director, Workplace Health Group, College of Public Health, University of Georgia, Athens. Phone: (706) 542-4364. Fax: (706) 542-4956. E-mail: mwilson@uga.edu. ■

Tension with safety? Defuse it together

Best bet is respectful communication

If your workplace is downsizing, don't be surprised if this causes some tension between occupational health and safety.

"There may be fear about the perception of duplication of services by administration, and a decreasing need for health and safety services due to a reduced workforce," says **Dawn Stone**, RN, a Fullerton, CA-based nurse practitioner and former occupational health nurse at Miller's Brewing Company, University of California — Los Angeles' Occupational Health Facility, and Northrop.

Your best bet to defuse tension is respectful communication. "Seek to understand what each team member brings to the situation, so that collaboration can truly occur," she advises.

It is also important that the work of the occupational health team is visible and known to the workers and administration. "Sharing success stories at meetings, and publishing results of the improvements made by safety, can provide a sense of accomplishment," says Stone.

EXECUTIVE SUMMARY

There may be tension between occupational health and safety due to concerns about downsizing and the perception of duplication of services. To work together:

- Understand what each team member brings to the situation.
- Make the work of the occupational health team visible.
- Offer a program to reduce stress in the workforce.

This will also illustrate the value of maintaining occupational health and safety services when downsizing decisions are being made. "Offering a program to reduce stress within the workforce may be sensitive and timely, too," she says.

Work as a team

Occupational health professionals at PeaceHealth's facilities, which include both hospitals and medical clinics, identify Occupational Safety and Health Administration compliance issues using a comprehensive assessment tool. The tool includes a survey of the physical environment, observations of staff at work, and questions for staff.

"The observations of work practices and interviews with staff allow us to determine their knowledge level on subjects such as fire response, hazardous chemical knowledge, emergency response, and security measures," says **Lisa Rodriguez**, RN, COHN, HEM, PHOR, PeaceHealth's safety coordinator.

Two approaches are used for the site surveys. Quarterly assessments are done by the department's safety representative and manager, and group assessments are done twice a year for patient care areas and annually for other areas.

The group assessments, called Environment of Care rounds, are done by leaders from environmental services, facilities and bio-medical engineering, environmental/life safety, safety, security/emergency preparedness and executive management.

"During the rounds, the group has time to hone in on the special areas that they represent, to assess for any compliance or regulatory gaps," says Rodriguez. "There is immediate verbal feedback given to department leadership."

The ability to have department management or leadership accompany the team and discuss issues has been very powerful for both sides. Working together has brought a deeper understanding of the functions performed in each department.

"The relationships that I develop with my departmental safety reps and department management are crucial," she says . "They need to know my expectations of them."

Managers review injuries with their staff, and enlist Rodriguez' help to work on prevention strategies. The safety rep's role is to perform the self-assessments for the department, and identify new hazards in the department.

"The more that the employees who do the work understand about the safety program, and the importance of their participation, the better the chance at improving the safety in the department," she says

SOURCES

For more information about improving the relationship between occupational health and safety, contact:
• **Lisa Rodriguez**, RN, COHN, HEM, Safety Coordinator, PeaceHealth Oregon Region. Phone: (541) 222-2539. E-mail: LRodriguez@peacehealth.org.
• **Dawn Stone**, RN, Fullerton, CA. Phone: (714) 516-2695. E-mail: dawnstonenp@yahoo.com. ■

Occ health, safety partner to prevent

Occupational health nurses noticed that employees were reporting skin irritation from wearing safety goggles, and reported this to safety. After safety reviewed the situation, a new process was implemented for cleaning the goggles.

"The cleaning process involved rinsing in a combination of chemicals. The conclusion was that the chemical used to clean these goggles may have increased the irritation to the forehead and cheeks," says **Robin Alegria**, RN, COHN-S, CM, a Thousand Oaks, CA-based occupational health nurse who experienced this situation at her workplace.

Here are other real-life examples from Alegria's former workplaces, of occupational health successfully collaborating with safety:

• In one facility, there was an increase in cumulative injures to a manufacturing support team.

"This caused the occupational health and safety departments to collaborate, to determine some of the root causes of the sudden increase of these injuries," Alegria says.

When an occupational health nurse or physician notices a trend or frequency, it becomes a bigger concern than if it were just a single case. "The cause should be corrected, to prevent it from occurring again," says Alegria. "If several people are affected, the risk to employee and employer is greater."

Members of both safety and occupational health shadowed the manufacturing support team for four hours, videotaping employee processes and procedures. "Measurements of their movements, and the weight of the tool employees used, were

documented," says Alegria.

Ultimately, more ergonomically appropriate tools were approved and purchased. Safety provided employee training to correct unsafe practices, such as the degree of arm angle distance an employee uses to swing a mop. "Occupational health nurses introduced a stretching program to be performed at the beginning of each work shift," says Alegria.

• Occupational health noted increased complaints of lower extremity pain by manufacturing employees who spent 80% of their time standing and walking on concrete.

The solution was to provide added insoles, which are available without a prescription, at the same time the employee gets their steel-toed shoes. Employees are authorized to purchase them at the same time they purchase their safety shoes.

"Safety implemented the process," says Alegria. "The insole provides a cushion effect, and results in less discomfort. In the future, it may reduce cumulative injury."

SOURCE

For more information on collaborating with safety, contact:
• **Robin Alegria**, RN, COHN-S, CM, Thousand Oaks, CA. Phone: (805) 375-5524. E-mail: robin.alegria@gmail.com ■

AHA: Time for hospitals to step up for workers

Create a 'culture of health,' be a role model

It's time for hospitals to stand up for the health and wellness of their own.
The American Hospital Association has issued a call to action for hospitals to embrace wellness and health promotion for their employees.

"[Wellness] is an important piece of what we do as health care organizations," says **Maulik S. Joshi**, DrPH, senior vice president of research for the AHA in Chicago. "You've got to be a role model [for the community]."

While hospitals are increasingly embracing the mission of wellness for their employees, outcomes-oriented programs are rarer, according to an AHA-sponsored survey of 876 hospitals, conducted in 2010. The report and survey were coordinated by the AHA's Long-Range Policy Committee.

About three out of four hospitals offer the basics: Weight loss, smoking cessation, healthy food options, and health risk assessments, the survey found. But only 47% have biometric screenings, such as cholesterol and blood pressure, and only 37% offer personal health coaching to help employees alter their habits and lifestyles.

"We have been good at the initial triage, the assessment of where we all are," says Joshi. That's an important first step, he says. But it needs to be followed up with goals, strategies, and tracking of outcomes, he says.

Hospitals have the same financial incentive as other employers: Employee health and wellness programs provide a healthy return on investment. A majority of hospitals that tracked their ROI reported a return of investment of $2 or more for every $1 they spent on wellness. In fact, the AHA is promoting the sharing of "best practices" from hospitals that have developed their wellness programs.

Healthcare reform provides a new basis for promoting wellness. The Affordable Care Act provides incentives for preventive health programs and creates a fund to invest in prevention and public health. It requires insurers to cover some preventive services, screenings, and immunizations with no co-pay.

Importantly, the Affordable Care Act also creates "Accountable Care Organizations" for Medicare to encourage doctors and hospitals to coordinate care and emphasize prevention. "Your own employees' health is an accountable care organization," says Joshi, who notes that hospitals can focus on their own employee base to improve prevention and management of chronic diseases.

Health risk assessments and biometric screening can identify the employees who have risk factors for chronic diseases. But how can you convince them to take significant steps to improve their health?

The AHA advocates the use of employee incentives to promote participation in wellness programs. About two-thirds of hospitals already report using some incentives, according to the survey. Most of the incentives are based on participation, such as completing a health risk assessment or biometric screening, or participating in disease management or weight loss programs.

One-third of hospitals surveyed offer $100 to $300 in annual deductions from health insurance premiums. Other incentives include lower deductibles, contributions to health savings accounts, subsidized gym membership, gift cards, or small tokens such as T-shirts and mugs.

Incentives vary based on an organization's culture, says Joshi. But it's important to identify goals and measure your progress, he says. "There should be clear measurable goals for the longer term as well as the short term," he says.

Focus on sustainability

The AHA report provides seven recommendations, with some specific suggestions on goals and strategies:

• Recommendation 1: Serve as a Role Model of Health for the Community

As part of fulfilling their mission, hospitals are beacons of trust in the community. Hospitals must create robust health and wellness programs as examples to the communities that they serve.

• Recommendation 2: Create a Culture of Healthy Living

Improving the health of employees is more than implementing individual health and wellness programs or activities. Hospitals need to strive for a culture of healthy living for all employees, which starts at the top with the CEO and the board of trustees. Wellness should be a strategic priority for the hospital.

• Recommendation 3: Provide a Variety of Program Offerings

While health and wellness is more than a set of activities, it is important for hospitals to offer a variety of activities to promote health within their organizations.

• Recommendation 4: Provide Positive and Negative Incentives

Positive and negative incentives are effective in improving health and wellness program participation levels. Hospitals can use incentives to increase participation and to improve outcomes.

• Recommendation 5: Track Participation and Outcomes

To track the success of their health and wellness programs, hospitals must first measure and increase participation and then build systems to track outcomes.

• Recommendation 6: Measure for Return on Investment

A strong financial case accompanies the strategic mission of striving for robust health and wellness programs. To achieve ROI, hospitals must first commit to effectively measuring ROI over several years.

• Recommendation 7: Focus on Sustainability

For program effectiveness, hospitals must motivate employees over time, effectively communicate, and constantly reinforce wellness as a leadership priority.

REFERENCE

1. American Hospital Association. 2010 Long-Range Policy Committee, John W. Bluford III, chair. A Call to Action: Creating a Culture of Health. American Hospital Association, Chicago, January 2011. Available at: http://bit.ly/dOhrla ■

OSHA targeting ambulatory care

Surprise inspections in four states

Outpatient centers have historically attracted little attention from the Occupational Safety and Health Administration, although needle market data shows they have lagged in sharps safety. But that hands-off approach is ending with a regional emphasis program in four states.

In Alabama, Florida, Georgia and Mississippi, inspectors will pay unannounced visits to ambulatory surgery and urgent care centers and medical clinics to gauge compliance with the Bloodborne Pathogen Standard. Those centers are not required to maintain OSHA 300 logs, so little is known about their sharps injury protection, says **Billy Kizer**, MPH, CSP, team leader for enforcement programs in OSHA's Region IV.

They also are not the focus of sharps safety surveillance efforts, which mostly have collected data from hospitals. Yet there is evidence that "alternate care" sites have much lower uptake of safety devices. In 2010, GHX, a healthcare supply chain management company based in Louisville, CO, reported that about one in five blood collection needles and blood collection sets in alternate sites were conventional devices, and about half (52%) of hypodermic needles were not safety-engineered.

The special emphasis program "is a great way to determine how many sharps injuries they're really having [in alternate sites] as well as making sure they're following the Bloodborne Pathogen Standard and they're providing the protection for sharps," says Kizer. "It's time that we reach out and ensure they are protecting their employees."

The attention from OSHA will send a message that outpatient centers need to get into compliance, says **Bruce Cunha**, RN, MS, COHN-S,

manager of employee health and safety at the Marshfield (WI) Clinic and a surveyor for the American Association for Accreditation of Ambulatory Surgery Facilities.

Cunha was surprised to find facilities that had essentially ignored the Bloodborne Pathogens Standard. "I went in the ORs and they had absolutely no safety needles," he says.

Surgeon or physician preference alone is not a sufficient reason to use conventional needles, says Cunha. The facilities must provide documentation of an exemption from sharps safety for medical reasons, he says.

OSHA's random inspections will include free-standing facilities that are owned by hospitals. However, it will not include physicians' offices, Kizer says. The regional special emphasis program will run through Sept. 30, 2012, and involves states that are under federal OSHA jurisdiction. State-plan states in the region, including Tennessee, Kentucky, North Carolina and South Carolina, may do a similar program but are not required to do so.

OSHA inspectors rarely go into outpatient centers unless there is a complaint from an employee, Kizer notes. But outpatient centers have been the focus of a different national awareness program to improve injection safety. The One & Only Campaign of the Centers for Disease Control and Prevention and the Safe Injection Practices Coalition is emphasizing the importance of using a needle and syringe only one time. Reuse of needles or syringes with multi-dose vials has led to recurrent outbreaks of hepatitis C in a variety of ambulatory care sites.

The OSHA program extends that safe injection message to worker safety. "Our hope is that we'll find that employers are doing what they're supposed to do, that employees are being protected," says Kizer. "If they're not, we can help to bring them into compliance." ■

Money motivates HCWs to be healthy

Sentara program slows the rise in HC costs

As with most employers, the cost of health insurance was rising year after year for Sentara Healthcare of Norfolk, VA, an integrated health care delivery system that includes eight acute care hospitals, outpatient centers, long-term care, and Optima Health Plan, an insurance subsidiary.

Employees had access to education programs, Weight Watchers at Work, discounts at local gyms, and some disease management. The programs weren't coordinated, though, says **Karen Bray**, PhD, RN, CDE, vice president of clinical care services. "We found that they were generally underutilized," she says. In fact, they were mostly used by people who already had a healthy lifestyle, she says.

Sentara worked with Optima Health to create Mission: Health, an incentive-based wellness program.

Six months before the open enrollment period for health insurance, employees participate in a health screening that measures blood pressure, cholesterol, height and weight. Employees also report whether they smoke and if they exercise at least three times a week.

Based on that information, employees with 0 or 1 risk factor receive a premium discount of $550. Employees with two or more risk factors can receive the same discount, but they are required to have telephone sessions with a health coach.

"They have to at least speak with their health coach on a quarterly basis. If they don't, their premium reverts to the higher level and stays that way for the rest of the year," Bray says.

About a third of the employees have two to five risk factors — and about half of those people fail to maintain contact with a health coach, she says.

Taking a closer look, Sentara realized that diabetes, coronary artery disease and congestive heart failure accounted for 14% of the overall health care costs. So an additional incentive program provides an additional $460 in a medical savings account if people with one of those conditions participate in a disease management program.

"We wanted to have at least 80% participation in the programs and we achieved that," says Bray. "We wanted to be able to show improvements in those items we measure in the personal health profile. In every one but body mass index, we showed statistically significant improvements starting in the first year."

Interestingly, Sentara actually saw an initial rise in health care costs — due to the increased treatment of the diabetes and cardiac conditions. In the second year, costs dropped back down by 10%. Since then, the rate of increase in health care costs has been significantly lower than it was before the program began. Employees also have fewer risk

factors. "This is an investment in your [employees'] health," says Bray.

At first, some employees were skeptical about their employer being involved in their personal health. The Sentara message: "We care about you. We're a health care organization. We should model good health for the community," says Bray.

The program has evolved, with online education, wellness awards, and eligibility for spouses to participate in the disease management program — for an additional $460 medical savings account incentive.

Coaching is an integral part of the success, says Bray. "People understand intellectually what they're supposed to do. But to execute a plan requires some help," she says. ■

Better lift programs raise bottom line

Policies, leader support make difference

Safe lift programs save money, and they save more if they are comprehensive and have leadership support. That finding from a new study of workers' compensation and lift-related injuries in long-term care provides a strong, new underpinning for the financial benefits of safe patient handling.

"Now we finally have the data: There's a good return on investment. It will pay for itself," says **Melissa A. McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore, which collaborated on the study with the National Council on Compensation Insurance (NCCI) in Boca Raton, FL.

Previous studies have demonstrated cost-savings from safe patient handling programs in hospitals and nursing homes. For example, a 2004 case study showed that an investment of $158,556 in lift equipment and training resulted in a savings of $55,000 a year in workers' compensation costs, providing a return on investment after just three years.[1]

This study adds a new dimension: The quality of the overall program makes a difference in cost savings.[2] "When you have a stronger program, it does seem to reduce your frequency and total cost in claims due to lifting," says **Tanya Restrepo**, an economist with NCCI and lead author of the study.

Lifts are now commonplace in nursing homes, so the study authors couldn't simply compare facilities with a lift program and those without one. Instead, they created a safe lift index based on 11 variables related to the facility's policies and procedures, the preferences of the director of nursing, barriers to safe lifting and lift policy enforcement. The study included only facilities that had a lift program in place for three or more years — or about half (48%) of the facilities surveyed.

Nursing homes with a higher safe lift index score had fewer workers' compensation claims and lower total cost of claims, the study found. "Having lifts is a necessary requirement but not the only requirement to reducing frequency," says Restrepo.

Or, to put it another way, "it's not enough to have the lifts," says **Pat Gucer**, PhD, assistant professor in the Occupational Health Project at the University of Maryland School of Medicine, who developed the safe lift index. "You need the policies and procedures in place to maximize the use of those lifts."

Lifts catch on at nursing homes

The NCCI study found a promising trend in long-term care, which has high rates of injury due to overexertion. Nursing homes have been purchasing lift equipment.

"When we first started collecting the data and thinking about the study we thought we might look at facilities that have a program versus facilities that don't have a program, but most of the facilities that answered our surveys had powered mechanical lifts in place," says Restrepo. "A large percentage also used them routinely."

In 2005, one in four (26%) long-term care facilities had two or fewer lifts per 100 residents. By 2007, that had dropped to 10%. The median ratio of lift equipment also rose, from 3.8 lifts per 100 residents in 2005 to 5.7 lifts per 100 residents in 2007.

Most of the facilities actually exceeded the ratio of lift equipment that is recommended by the National Institute for Occupational Safety and Health (NIOSH) — one full-body lift for every eight to ten non-weight-bearing residents and one sit-stand lift for every eight to ten partially weight-bearing residents.[3] In fact, the average ratio was one for every three non-weight-bearing (0.351) or partially weight-bearing (0.329) residents.

Nursing homes may have begun by using lifts out of necessity to move bariatric patients, then discovered the benefits for other residents who needed assistance, says McDiarmid.

Beyond the increased availability of lift equipment, the most effective programs in the study had a combination of important elements, including robust policies that required the use of lifts and mandated appropriate training of the certified nursing assistants (CNAs). They provided for rigorous enforcement of the lift policy. The preferences of the director of nursing and perception of barriers to using the lifts also played an important role, as reflected in the safe lift index, says Restrepo.

"The institution's commitment to effectively implementing a safe lift program appears to be the key to success," the study concluded.

NCCI is continuing to analyze the data to quantify how changes in the variables affect workers' compensation claims. If enforcement of a safe lifting policy becomes more stringent, for example, the analysis will determine how much that affects the magnitude of claims, says Restrepo.

REFERENCES

1. Collins JW, Wolf L, Bell J, et al. An evaluation of a 'best practices' musculoskeletal injury prevention program in nursing homes. *Injury Prevention* 2004; 10:206-211.
2. Restrepo T, Schmid F, Shuford H, et al. Safe lifting programs at long-term care facilities and their impact on workers compensation costs. NCCI Research Brief, 2011. Available at http://bit.ly/m6AOCP
3. Collins JW, Nelson A and Sublet V. Safe lifting and movement of nursing home residents. DHHS (NIOSH) Publication No. 2006-117. Cincinnati, OH, 2006. Available at http://1.usa.gov/lpi4sW ■

OSHA extends comment deadline on MSD rule

The U.S. Occupational Safety and Health Administration (OSHA) briefly reopened the comment period on the proposed rule to record work-related musculoskeletal disorders (MSDs). The comments came from May 17 to June 16, about a month after two teleconferences focused on concerns of small businesses.

"The more feedback the agency receives from small businesses on this topic, the better informed we will be in crafting a proposed regulation that protects workers without overburdening employers," OSHA administrator **David H. Michaels**, MD, MPH, said in a statement.

According to an OSHA summary of the teleconferences, some employers expressed concern that employees would report MSDs that were not work-related and that MSDs might be over-reported as work-related even by physicians.

For the purposes of the proposed recordkeeping, OSHA defines an MSD as "a disorder of the mus-

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.

To earn credit for this activity, please follow these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

COMING IN FUTURE MONTHS

- Common misconceptions on which injuries are reportable
- Make workplace stairways irresistible to employees
- Effective responses when others disparage occ health
- Novel ways to get junk food out of the workplace

cles, nerves, tendons, ligaments, joints, cartilage or spinal discs that was not caused by a slip, trip, fall, motor vehicle accident or similar accident."

The proposed rule would require employers to check a box on the OSHA 300 log indicating that a work-related MSD occurred. ■

CNE QUESTIONS

25. Which is recommended regarding evaluation of a workplace's safety performance, according to Frank Ginocchi, director of safety & health at American Electric Power?
A. Use recordable injury rates and severity rates based on days away from work or restricted duty as the sole indicator of success.
B. Measure leading indicators of safety and health improvement, such as the number of job hazard analyses that have been completed.
C. Measure only injury rates, not the number of job observations done by supervisors.
D. Avoid spending time determining the root cause of most injuries, as system failures are not generally the cause of an injury.

26. Which is true regarding the safety approach at American Electric Power?
A. Only injuries that have actually occurred, not near misses, are reported by employees.
B. Employees are encouraged to stop a job if they see a worker doing something unsafe, but this does not include contractors.
C. Only supervisors, not employees with the same rank, are encouraged to give safety reminders.
D. Videotaped interviews with employees injured in the workplace are shared with other employees to prevent future incidents from occurring.

27. Which is true regarding the cost of workplace injuries, according to Pam Dannenberg, RN, COHN-S, CAE, ergonomic and occupational health services manager at EK Health Services?
A. Indirect costs of injuries should not be calculated by occupational health.
B. To calculate the indirect costs of injuries, occupational health should multiply the actual costs of claims by two to ten times.
C. Down time right after an injury due to stopping production should not be included when calculating the cost of an injury.
D. When calculating the costs of an injury, occupational health should not include time lost to care for the injured employee or investigating the incident.

28. Which is true regarding workplace design changes, according to a study published in Journal of Occupational Environmental Medicine?
A. Workplace design changes can help stave off weight gain.
B. Workplace design changes are likely to lead to significant weight loss all by themselves.
C. Workplace design changes will have no impact on preventing weight gain.
D. Workplace design changes are most effective when used alone, not along with other interventions such as employee behavioral programs or individual counseling.

Dear *Occupational Health Management* Subscriber:

This issue of your newsletter marks the start of a new continuing medical education (CME) or continuing nursing education (CNE) semester and provides us with an opportunity to tell you about some new procedures for earning CME or CNE and faster delivery of your credit letter.

Occupational Health Management, sponsored by AHC Media, provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options. Our intent is the same as yours — the best possible patient care.

The objectives of *Occupational Health Management* are to help physicians and nurses be able 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.

The American Medical Association, which oversees the Physician's Recognition Award and credit system and allows AHC Media to award *AMA PRA Category 1 Credit™*, has changed its requirements for awarding *AMA PRA Category 1 Credit™*. Enduring materials, like this newsletter, are now required to include an assessment of the learner's performance; the activity provider can award credit only if a minimum performance level is met. AHC Media considered several ways of meeting these new AMA requirements and chose the most expedient method for our learners.

HERE ARE THE STEPS YOU NEED TO TAKE TO EARN CREDIT FOR THIS ACTIVITY:

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. You will no longer have to wait to receive your credit letter!

This activity is valid for 36 months from the date of publication. The target audience for this activity is occupational nurses, occupational health managers and directors.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5560. You can also e-mail us at: customerservice@ahcmedia.com.

On behalf of AHC Media, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,

Valerie Loner

Valerie Loner
Continuing Education Director
AHC Media