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Joint Commission: You can't have patient safety without HCW safety

Encourage reporting of 'near-miss' incidents

The silos that separate patient safety and worker safety are coming down. Preventing medical errors and protecting health care workers are part of the same continuum, The Joint Commission accrediting body asserts in a new monograph.

For employee health professionals, growing recognition of the link between worker safety and patient safety may mean greater collaboration, more support from hospital leadership, and enhanced resources.

"To be a truly safe environment, you have to be safe for patients, workers and everyone who enters the facility," says **Barbara Braun**, PhD, project director of the Department of Health Services Research at The Joint Commission, which is based in Oakbrook Terrace, IL.

Raising awareness of the link between patient and worker safety also is a top strategic goal of the National Occupational Research Agenda (NORA) council for Healthcare and Social Assistance. NORA brings stakeholders together to create a research framework for industry sectors for the National Institute for Occupational Safety and Health (NIOSH).

"We decided the best way to [improve occupational health in health care] was to address explicitly the interface between patient safety and worker safety," says **Eileen Storey**, MD, MPH, co-chair of the Healthcare and Social Assistance NORA council and branch chief for surveillance in the NIOSH Division of Respiratory Disease Studies in Morgantown, WV.

The Joint Commission focus on worker as well as patient safety does not involve any new standards and it doesn't change the way surveys are conducted, says Braun. But it does reflect a broadening of the approach to safety.

There are other signs of The Joint Commission's focus. A sentinel event alert on fatigue in 2011 raised concerns about the impact of extended work hours on patient and worker safety, and in 2010 a sentinel event alert highlighted violence in hospitals. In October 2012, the *EC News*, an environment of care newsletter published by Joint Commission

Resources Inc., wrote about using the OSHA 300 log to reduce work-related injuries and illnesses.

The nation's hospitals should get this message, says **Melissa A. McDiarmid**, MD, MPH, DABT, director of the Occupational Health Program at the University of Maryland School of Medicine in Baltimore, who served as an advisor on the monograph. "The ideas of silos of safety have to now give way to systems of safety," she says.

Be 'deeply concerned with safety'

Health care is a high-hazard industry. And to be successful, hospitals need to be high-reliability organizations, the monograph says.

The Joint Commission explains that high-reliability organizations "are deeply concerned with safety," integrate patient and worker safety and encourage reporting of near-miss incidents.

"High-reliability organizations are always mindful of safety issues, and from a logical standpoint it would apply to workers as well as patients," says Braun, noting that the concept of high reliability comes from high-risk industries such as nuclear power.

In fact, high-reliability organizations are "preoccupied with failure," the monograph says. In other words, leaders and workers are aware that adverse events can occur and they seek to learn from close calls.

The monograph highlights case studies that illustrate the benefits of an integrated safety program that includes techniques such as daily huddles to discuss incidents or hazards, safety coaches and root cause analysis of safety events or near-misses.

"There's an increasing amount of research that shows that worker safety perception of safety culture and the work environment also has an impact on patient safety. The two are basically inseparable," says Braun. "You cannot have patient safety without having safe workers who feel they're operating in a culture that supports them and supports the patients simultaneously."

Since the 1990s, when The Joint Commission began a partnership with the U.S. Occupational Safety and Health Administration, the accrediting agency has acknowledged that the "environment of care" is also an environment of work, says McDiarmid. The monograph includes a crosswalk matching Joint Commission standards with OSHA regulations, which was first developed in the 1990s.

This monograph provides a new forum for an integrated safety culture, she says. "It enlarges the audience who will appreciate the contribution that employee health can make to the wider organization," she says.

SPH prevents falls and injuries

Safe patient handling is an example of a safety initiative that has an impact on patients and employees. In manual lifting, patients are at risk of being dropped or getting skin tears or bruises, the monograph notes.

Improved patient handling means higher quality of care, The Joint Commission says. For example, using ceiling lifts to support unsteady patients can

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Seek common ground on patient,worker safety

The Joint Commission's recent monograph on patient and worker safety offers these suggestions for integrating safety activities:

- Build and raise awareness of linkages and cross-cutting topic areas.
- Recognize shared health and safety risks between health care staff and patients.
- Align patient and worker safety improvement initiatives having common goals. Consider integrating with organizational quality improvement priorities.
- Convene multidisciplinary safety committees that include representation from patient safety, employee health, occupational/environmental safety and health, infection prevention, risk management, human resources, and other areas.
- Examine policies for their impact (positive or negative) and unintended consequences on worker and patient safety.
- Remove structural and functional organizational systems and processes that maintain traditional "silos" for patient and worker health and safety.
- Develop a business case for integrating patient and worker safety initiatives; calculate a cost-benefit analysis or return on investment for specific initiatives. ■

help them ambulate while preventing patient falls. Repositioning slings also make it easier and safer to adjust patients in bed, which also can mean fewer pressure ulcers.

The payback of safe patient handling is better patient outcomes and fewer worker injuries, says **Guy Fragala**, PhD, PE, CSP, CSPHP, senior adviser for ergonomics at the Patient Safety Center of Inquiry at the James A. Haley Veterans Hospital in Tampa, FL.

"This whole area of patient safety and worker safety offers us some great opportunities for cost savings without compromising quality of care," says Fragala, who was not involved in drafting the monograph.

Yet changing practice – and changing the hospital culture – isn't easy. "Oftentimes, safety is an after-the-fact science," says Fragala. "Once something has gone wrong, we make great investments in change. It's been difficult to get people to be more proactive and understand that we need to do some investment in prevention."

The monograph outlines other hazards that affect both workers and patients, including slips and falls, sharps injuries, infectious diseases, radiation and hazardous substances.

The integration of patient and worker safety becomes even more important with the increasing health care needs of an aging population – and the greater vulnerability of an aging workforce. "NIOSH does feel this [monograph] is an extremely important development and will have an impact on a large segment of the American workforce," says Storey.

[*Editor's note: The Joint Commission monograph, "Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation," is available at* www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf.] ■

Safe lifting becomes standard practice

ANA draft standards for employers, HCWs

Safe patient handling should be standard practice, not best practice. That is the message behind new, draft standards issued by the American Nurses Association (ANA).

The ANA hopes to spur new action at health care facilities around the country while providing a basis for federal action on a safe patient handling law, says **Suzy Harrington**, DNP, RN, MCHES, director of the Department for Health, Safety and Wellness for the ANA, which is based in Silver Spring, MD. Final standards are expected in late 2013.

"The intent is to make them the standards of care. We want them to be realistic and attainable while raising the bar," Harrington says.

A working group of leading safe patient handling experts crafted the standards with expectations for both health care employers and employees. They call for health care employers to create a "culture of safety," a safe patient handling program with appropriate equipment and training, patient assessments

and accommodations for injured employees. *(See box on right.)*

The standards provide an important framework for hospitals, says **Mary Bliss**, RN COHN, coordinator of Employee Health Services at Methodist Medical Center in Peoria, IL, and the working group representative from the Association of Occupational Health Professionals in Healthcare (AOHP).

While 10 states have laws requiring a safe patient handling program, and the Veterans Health Administration has guidelines, the ANA standards create a set of expectations. "[With the standards,] there's no question about what needs to be done to protect workers when they're moving patients," she says.

"It will define some of the essential ingredients [for safe patient handling]," while allowing facilities flexibility to find solutions that work for them, says **Guy Fragala**, PhD, PE, CSP, CSPHP, senior adviser for ergonomics at the Patient Safety Center of Inquiry at the James A. Haley Veterans Hospital in Tampa, FL, a member of the working group.

Eight in 10 nurses work in pain

The backdrop for these draft standards is somewhat bleak. Health care remains one of the nation's most hazardous industries with the highest levels of MSD injuries despite 10 state laws and years of research showing the benefits of safe patient handling.

Nursing assistants had a higher number of work-related musculoskeletal disorders (MSDs) than any other occupation in 2011, according to the U.S. Bureau of Labor Statistics. In a 2011 ANA survey, about 80% of registered nurses said they worked with musculoskeletal pain and 62% cited a disabling musculoskeletal injury as one of their top health and safety concerns.

Patients with impaired mobility are also at risk of falls and skin ulcers. Safe patient handling advocates are increasingly pointing to the link to patient safety. "Nurses are still getting injured, patients are still getting injured," says Harrington. "Something needs to be done. This really needs to be moved to the next level."

The ANA standards are voluntary. But ANA hopes to promote change through collaboration with the U.S. Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health.

"We need to move [safe patient handling to the place] where personal protective equipment has moved, where it's not optional, it's required. It's just a part of doing business," Harrington says.

The standards set the expectation for health care workers, as well. "We know sometimes there's resistance to change among nurses," says Fragala. "We're trying to change practice, going from manual lifting to safe lifting. I think this is going to empower [employees] to change practice and accept that equipment is the way to do this."

Safety culture starts at top

The standards begin in the broadest context with a "culture of safety." Employers are expected to create a blame-free environment that encourages reporting of incidents, provide adequate levels of staffing, and promote safety as a corporate value.

Employees are expected to actively participate in safety measures and promptly report hazards, incidents and accidents. Employees also have the right to refuse or object to an assignment that puts them

Setting a new SPH standard

The American Nurses Association recently released a draft version of safe patient handling standards, including elements of performance. The ANA's eight core standards are listed below:

1: Create a Culture of Safety
2: Implement and Sustain a SPHM Program
3: Incorporate Prevention through Design Providing a Safe Environment of Care
4: Select, Install, and Maintain SPHM Technology
5: Establish a System for Education, Training and Competency
6: Incorporate Health Care Recipient Centered Assessment, Care Planning, and Use of Technology
7: Include SPHM in Reasonable Accommodation and Post Injury Return to Work
8: Establish a Comprehensive Evaluation Program

The ANA draft standards are available at: www.nursingworld.org/MainMenuCategories/WorkplaceSafety/SafePatient ■

in danger, the draft standards say.

The culture is ultimately set by the hospital's top leadership, Bliss says. "No program within a facility is going to be successful unless the top executive leadership is supportive," she says. "They have to have a commitment to it and an expectation."

The standards also prompt the development of a safe patient handling and movement program with broad language that allows employers to determine the specific policies or mix of equipment. They call for written policies with goals and objectives, sustainable funding, integration throughout the organization, and communication about its importance.

Training is a standard in itself, as is the incorporation of safe patient handling into building design. To help hospitals implement the standards, the ANA plans to follow up with additional resources and a re-launch of the Handle With Care program, says Harrington.

"People [often] think they have a safe patient handling program, but it's not really comprehensive," she says. "We wanted to address all the different components that are really vital for a true safe patient handling program."

SPH leads to drop in injuries

Ultimately, safe patient handling becomes an integral part of patient care, says Bliss. At Methodist Medical Center, for example, communication about the program reaches patients, workers, managers, and even the board of directors.

When patients are admitted, they receive a brochure that shows patient handling equipment and how it is used. Mobility assessment is an integral part of the daily patient assessment.

Meanwhile, the CEO showed her support for safe patient handling by testing out the equipment herself. And following Illinois law, the hospital has a multidisciplinary safe patient handling committee and reports patient handling injuries to the hospital's Patient Steering Committee (an environment of care committee) and the board of directors.

There has been good news to report. In 2005, before implementing the program in May 2007, the hospital had 40 OSHA-recordable patient handling incidents that led to more than 2,000 restricted work days and up to 288 lost-time days. In 2011, there were only two incidents and there have been three consecutive years of no lost-time days.

"You have to keep monitoring [the program], working through issues and making it better," says Bliss. "It is time consuming, but it is well worth it." ■

Hard to handle: Risk rises as obesity surges

Take steps to help patients, protect HCWs

About one-third of American adults are obese. If trends continue on their current trajectory, by 2030, about half of all American adults will be obese.

Those sobering statistics have prompted a call to action to address the nation's obesity epidemic. But they also underscore why hospitals need to be prepared to handle heavier patients.

The Veterans Health Administration is releasing a new bariatric toolkit to help hospitals handle obese patients in a safe and sensitive manner. (*See editor's note below*).

"We must be able to care for obese patients on a daily basis," says **Judee Gozzard**, RN, MSN, BC, safe patient handling coordinator at Bay Pines (FL) VA Healthcare System.

Bariatric equipment isn't just for hospitals that offer gastric bypass surgery or other specialized bariatric care. Any hospital should be prepared to receive a severely obese patient, Gozzard says. More than 15 million Americans are severely obese with a BMI of 40 or above, and that population increased by 70% in the last decade.[1]

Hospitals will be admitting more patients with a BMI of 40 or 50 and above, but standard patient handling equipment often has a weight limit of 300 pounds, she says. "Once [severely obese patients] arrive at the hospital, you have to have specialized equipment to support their weight," she says.

In fact, severe obesity leads to medical problems that complicate patient care, notes Traci Galinksy, PhD, research psychologist with the National Institute for Occupational Safety and Health in Cincinnati. Severely obese patients are susceptible to pressure ulcers, a risk that requires them to be turned frequently, and they often have cardiopulmonary issues that require proper positioning in bed, she says.

Galinsky is studying bariatric patient handling at 10 VA hospitals and hopes to produce recommendations for evidence-based practices. The NIOSH researchers also will quantify the proportion of patients who weigh more than 300 pounds and the frequency of bariatric patient handling.[2]

The VA developed a previous version of the bariatric toolkit in 2003 and updated it in 2006. Here is some advice shared by Gozzard based on experience with bariatric patient handling:

Use a scoring system to assess patient mobility

needs. The new toolkit recommends using a scoring system to make it easy to identify the equipment and level of assistance each patient needs. A score of 0 means the patient is ambulatory and alert, although they still may use grab bars, a walker or some supervision as they stand or walk. A score of 1 indicates that a patient needs coaching as they use grab bars, a trapeze or a walker to move or reposition themselves. Patients with a score of 2 or 3 have limited mobility or need moderate help. Caregivers may use lateral transfer devices, sit-to-stand devices and chairs that have removable arms to make transfers easier.

Patients with a patient handling score of 4 are fully dependent. They can provide minimal assistance or they may be combative or confused. In those cases, caregivers choose from a variety of devices, including ceiling lifts, air-assisted lateral transfer devices, and repositioning slings.

Weight should be considered along with the safe patient handling score to determine the proper equipment, Gozzard says. If a patient is morbidly obese, a ceiling lift is the preferred device. Even with equipment, if the patient is unable to assist and they weigh 200 pounds or more, you should have additional caregivers to safely lift, move, or reposition, she says. In non-urgent situations, each employee should not lift more than 35 pounds of patient weight, she says.

Beware of borderline bariatric patients. Your staff will readily understand that they can't handle a 600-pound patient without specialized equipment. But what about the 250- or 300-pound patient? "They often don't go and get what they need because they don't consider them bariatric," says Gozzard. Employees should be educated about how weight interacts with mobility and cognitive impairments to determine what equipment and staff assistance is necessary, she says.

Have specialized beds available. Whether you rent or own, you should have ready access to special beds for bariatric patients. The beds are larger and have a 1,000-pound capacity. Ideally, the beds can be converted into a chair for powered transport. They also require a larger room with wide doorways.

Make sure all care is performed at the correct ergonomic height. Even with appropriate equipment, caregivers can be injured if they are using awkward postures. They should be working at waist to elbow height, says Gozzard. Even with equipment, more than one caregiver may be needed to assist. For example, lifting a leg into a sling may require more than one person because of the patient's weight.

Have bariatric admission carts available. Sensitivity is an important aspect of bariatric care. You don't want caregivers hunting for "big boy pajamas," says Gozzard. If you have large capacity items stored on a special cart, they will be readily available and will make a bariatric admission occur more smoothly, she says.

(The VA toolkit is available at www.visn8.va.gov/visn8/patientsafetycenter/safePtHandling/toolkitBariatrics.asp.)

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Election gives energy to OSHA

Look for I2P2, MSD column rules

Expect a re-energized OSHA with the reelection of President Barack Obama: New recordkeeping rules, a proposed Injury and Illness Prevention Program (I2P2) standard, and possibly an infectious diseases standard.

David Michaels, MD, MPH, assistant secretary of labor for the U.S. Occupational Safety and Health Administration, has called I2P2 his highest priority. The proposed standard would require employers to assess their worksites, identify hazards and work to reduce the risks. Health and safety experts now expect that initiative to move forward.

"Anybody who supports reasonable regulations to protect health care workers so they can provide higher quality patient care should be happy with the outcome of the election," says **Bill Borwegen**, MPH, safety and health director of the Service Employees International Union (SEIU).

In a regulatory agenda, OSHA had signaled that the first step of its rule-making process on I2P2 would begin in June 2011, with the release of a draft version for the Small Business Regulatory Enforcement Fairness Act (SBREFA) review. That release never came, but OSHA did issue a white paper extolling the virtues of I2P2.

OSHA said that injuries and illnesses declined by 9% to 60% in eight states that either require an injury and illness prevention program or provide incentives or requirements through workers' compen-

sation.

The agency estimates that a national I2P2 rule could reduce injuries by 15% to 35% among employers who don't currently have prevention programs. "At the 15% program effectiveness level, this saves $9 billion per year in workers' compensation costs; at the 35% effectiveness level, the savings are $23 billion per year," OSHA says.

OSHA promises flexibility

Although the details of I2P2 are not yet available, occupational health professionals have lauded the concept. "We have been supportive of an I2P2 process," says **Pat O'Connor**, director of government affairs for the American College of Occupational and Environmental Medicine (ACOEM).

OSHA has promised to provide flexibility in an I2P2 standard so that current, successful programs will not be disrupted. "Our primary goal in our proposal is to reach those employers that do not have an effective program," OSHA said in online comments. "It is not the agency's intention to require that employers who have previously implemented effective programs that share the basic elements of OSHA's rule to make unnecessary changes."

Meanwhile, OSHA is also expected to pursue an infectious disease standard that would cover airborne and droplet exposures. A proposed standard would likely be patterned after the California Aerosol Transmissible Diseases standard, which requires health care facilities to maintain an aerosol transmissible diseases exposure control plan.

Under the California standard, facilities identify their hazardous procedures and job classifications with potential exposure, determine how to reduce those hazards with personal protective equipment and other measures, and provide training. As with requirements for a bloodborne pathogen exposure control plan, frontline employees must be involved in drafting the exposure control plan and annual updates.

Seven years for a new rule?

A second term gives the Obama administration more political leeway. But it typically takes OSHA more than seven years to finalize a new standard, according to the General Accounting Office.

So it is far from certain that OSHA can take an I2P2 rule through the opposition from business interests and political challenges. (When Rep. Darrell Issa (R-CA), the chairman of the House Committee on Oversight and Government Reform, asked more than 150 trade associations to identify regulations that they consider to be "burdensome," I2P2 was on the list of several leading industry organizations.)

Yet even the rule-making process could spur changes. Employers may begin to adjust their policies even before a rule becomes final, says **Brad Hammock**, Esq., workplace safety compliance practice group leader at Jackson Lewis LLP in Washington, DC.

"Many people within OSHA believe strongly that a proposed rule has that effect," says Hammock, who was counsel for safety standards at OSHA from 2005 to 2008.

OSHA has already signaled an emphasis on injury prevention through enforcement. In 2012, OSHA launched a three-year National Emphasis Program on nursing homes and trained compliance officers on patient/resident lifting and identification of a range of hazards in the health care industry.

The compliance directive prompted inspectors to determine "whether there is a process to ensure that work-related disorders are identified and treated early to prevent the occurrence of more serious problems and whether this process includes restricted or accommodated work assignments."

But Borwegen notes that any emphasis program is short-lived. "At the end of the day, the legacy of the administration will be how many standards they get out that are meaningful," he says. "The next administration can wipe clean these initiatives. The only thing that has lasting changes is a standard."

Recordkeeping will emerge from OMB

Other changes are certain as long-delayed efforts move forward. The recordkeeping revision that would create a special column on the OSHA 300 log for musculoskeletal disorders has been held up in the Office of Management and Budget. In the past year, Congress also had blocked OSHA from implementing the rule through a "rider" on the FY2012 bill that funds OSHA.

That rider will expire, and the MSD column rule is expected to emerge from OMB, Hammock says.

Other recordkeeping proposals under review by OMB also may advance to rule-making. "There's long been a concern that injuries aren't being completely or accurately reported," says O'Connor. "There is a proposal to tighten that up, to move from a paper-based recordkeeping to electronic recordkeeping. We'd like to see that discussion move forward."

More generally, occupational health may gain a higher profile as the Affordable Care Act is fully implemented. The health reform places a greater

emphasis on prevention, including worksite wellness programs.

"ACOEM believes there's a huge benefit to be gained for the health care system through effective wellness programs," O'Connor says. ■

Report: Why we need a better flu vaccine

Science lacking on many current recs

Bring science back into the discussion of influenza vaccination.

That is the essential message of an extensive exploration of influenza vaccination by the Center for Infectious Disease Research & Policy (CIDRAP) at the University of Minnesota in Minneapolis. While supporting flu vaccination as providing "moderate" protection from disease, CIDRAP says U.S. public health authorities have focused too much on expanding the uptake of the existing vaccine and not enough on promoting the development of a better vaccine.

CIDRAP lobbed its biggest indictment at the Centers for Disease Control and Prevention and its Advisory Committee on Immunization Practices (ACIP) for overstating the effectiveness of the vaccine and relying on expert opinion while failing to acknowledge the weak scientific basis for many recommendations.

"There was such an emphasis placed on getting more people vaccinated that they lost sight of the [question] of 'How well do these vaccines work?'" says **Michael Osterholm**, PhD, MPH, director of CIDRAP, former Minnesota state epidemiologist and lead author of the study.

CIDRAP calls on the U.S. government to declare that development of a new influenza vaccine is a "national priority" and to provide financial resources to make that a reality.

"It's going to take at least a billion dollars, if not more, to get a new influenza vaccine that will work more effectively than the current one. There is no financial source even close to supporting the vaccine at that level," he says.

From 2005 to 2011, the United States spent about $2 billion to develop manufacturing capacity for the influenza vaccine – but none of it on a novel, "game-changing" version, he says.

Overstatement of the effectiveness of the current vaccine essentially creates a barrier to moving forward, he says. "We have basically frozen in time real progress toward a game-changing vaccine," he says.

Vaccine effectiveness overstated

Here are some issues that have a questionable scientific basis, according to the CIDRAP report:

- The expansion of flu vaccination to universal vaccination. ACIP's recommendation for universal flu vaccination was based on consensus opinion but not data on vaccine effectiveness or benefits for various age groups, CIDRAP said. "We found that a number of the new references cited to support the revised recommendations were actually unrelated to specific aspects of the new recommendations and did not present findings from new studies," the report said.
- The vaccine efficacy and effectiveness, including the optimal dose. Some studies used methods that overstate the vaccine effectiveness, CIDRAP found. "Our review identified 30 instances in which the authors of the current ACIP influenza vaccine statement did not apply current standards of scientific rigor to their analysis or did not cite relevant work," the report said.
- The impact of health care worker vaccination on influenza transmission. CDC advisors asserted that the recommendation for HCW vaccination had the highest quality evidence (category 1A), but CIDRAP found that two of four studies cited did not provide support with statistically significant results and two provided "some support."
- The use of the nasal vaccine (live attenuated influenza virus or LAIV) in adults. A CIDRAP meta-analysis of randomized controlled trials found that the efficacy of the nasal vaccine was 83% for children ages 6 months to 7 years, but there was no evidence of efficacy in those 8 years to 59 years of age.

"The single most important currency that public health owns is trust," says Osterholm. "We owe it to the public to tell them exactly what we know and what we don't know.

"We can still make recommendations," he says. "But do we have the data to show that it's going to have a dramatic impact on hospitalized patients? The answer is no."

No LAIV for HCWS?

This question of the science behind influenza vaccination is not just an intellectual discussion. Osterholm suggests changes in the approach to health care worker vaccination.

He does support and encourage vaccination; the vaccine is about 59% effective and very safe. "Influenza vaccination offers more protection than not

being vaccinated," he says.

But offering the nasal vaccine as an equivalent to the traditional vaccine isn't warranted, based on current scientific evidence, he says. "I don't know if you vaccinate health care workers with LAIV that you've accomplished anything," he says. "That's the kind of discussion we need to be having."

Osterholm also finds insufficient evidence for mandating vaccination or requiring health care workers to wear masks if they aren't vaccinated. "I think that is just not in keeping with good public health," he says of the mask policies. "If they really wanted to have the most impact right now, not just on influenza but respiratory illnesses in general, they should mandate that workers who have signs and symptoms of any respiratory illness not come to work."

Ultimately, Osterholm says a greater awareness of the limitations of the current influenza could lead to a greater demand for a better one. A severe, global influenza pandemic remains a threat. As the CIDRAP report says, "A universal vaccine should be the goal, with a novel-antigen game-changing vaccine the minimum requirement."

[*Editor's note: The CIDRAP report, "The Compelling Need for Game-Changing Influenza Vaccines: An Analysis of the Influenza Vaccine Enterprise and Recommendations for the Future," is available at* www.cidrap.umn.edu.] ■

Why aren't health care workers healthy?

Heart disease, asthma higher in HC industry

Health care workers aren't actually very healthy. They have higher rates of heart disease and asthma than workers in all other sectors, and they are the most likely to have functional limitations or to ever have had cancer, according to an analysis of 1997-2007 data from the National Health Interview Survey (NHIS).[1]

That track record for poor health has been long-standing. Four major occupations in the Healthcare and Social Assistance sector ranked among the top 10 unhealthiest in a previous analysis of NHIS data. Social workers ranked No. 1, psychologists were No. 4, nursing aides were No. 6 and licensed practical nurses ranked No. 10 out of 206 occupational groups.[2]

Those workers had more lost or restricted workdays, hospitalizations, physician visits, and chronic conditions and were more likely to have poor or fair health status.

The diminished health status of health care and social workers poses significant challenges for health care employers, says **David J. Lee**, PhD, professor in the Department of Epidemiology and Public Health at the University of Miami (FL).

"We have an aging population that is going to place severe demands on this workforce sector in the coming years," says Lee. "We need to do whatever we can to have workplace accommodations to extend the careers of individuals in this sector who wish to remain in the workforce. Otherwise we're going to have serious shortages [of nurses and other health care workers]."

Nurses' aides unhealthiest

A closer look at the data reveals some deep health disparities among health care workers as they reach middle age and beyond.[3]

Overall, health-diagnosing professions, which include physicians, dentists, veterinarians and podiatrists, are the healthiest, although at age 60 and above they have higher rates of coronary heart disease and hearing impairment than other health care workers.

By contrast, the health services workers, such as nurses' aides, suffer from poor health. They are the poorest and least educated workers; one in four is "near poor" and one in 10 lives below the poverty line.

Obesity is their most striking problem. About 36% of the health service workers who are 45 to 59 years old have a BMI of 30 or above, and about 15% have a BMI of 35 or above. "These are epidemic numbers," says Lee.

By age 60, about half of the health service workers (49%) have some functional limitation and have been diagnosed with hypertension (51%). "The group that is most vulnerable seems to be suffering disproportionately from a variety of [health problems]," he says.

Health assessing and treating occupations, including registered nurses, physician assistants, and other non-physician health professionals, also show signs of problems emerging as they age. Two-thirds (35%) have some functional limitation at age 60 and above, and 48% in that age range have hypertension.

HC jobs are stressful

The survey findings underscore the need for health care employers to promote wellness and healthy habits, such as better nutrition and exercise, Lee says.

As the U.S. population ages, the health care workforce also is projected to grow — and employers will need to retain their employees, Lee notes. "We have an aging population that is going to place severe demands on this workforce sector in the coming years," he says. "We need to do whatever we can to have workplace accommodations to extend the careers of individuals in this sector who wish to remain in the workforce."

Long work hours, shift work, stress and physical demands of the job may contribute to the higher rates of some health problems, Lee suggests. One in four workers (25%) in the Healthcare and Social Assistance sector reported having a functional limitation, such as walking a quarter-mile without special equipment. The industry average was 21.6%. Some 18.5% of the health care and social assistance workers reported having an emergency room visit in the past 12 months, compared to 17.6% overall.

There may be a silver lining to this unhealthy profile of health care workers, Lee says. Health care employers may provide accommodations to help their employees remain on the job, even as they develop chronic conditions, he says.

"The health care sector is a sector that, on average, can be much more accommodating to workers who have a disability than workers in another sector," he says.

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Focus on 'well care' turns to health workers

Health system targets risk factors

In a futuristic paradigm, health care is not sick care. It is a continuum that provides acute care, rehabilitation and wellness, and one that encompasses both hospital patients and employees.

That is the vision behind the "Be Well" employee wellness program at Akron (OH) General Health System and its patient health care and wellness centers called LifeStyles. Akron General is promoting a model of health care that seeks to keep patients out of hospitals and encourages employees to get and stay well.

While the Akron General "well-care" model predates the current health care reform, it provides an answer to some of today's health care challenges, says president and CEO **Thomas "Tim" Stover,** MD, MBA. "Everybody is starting to realize that we can't pay for all the sick folks. There just isn't enough health care money and providers," he says. "There has to be a change in the way we look at health care and I think this is one of the fundamental changes that have to occur."

Meanwhile, Akron General is also remaking aspects of the hospital to promote healthy lifestyles for employees, patients and visitors. Healthy snacks have replaced junk food in vending machines, and the food service has been revamped. Healthy items in the cafeteria will be more reasonably priced to add an incentive to make the better choice.

Akron General is a nicotine-free campus, and the health system does not hire new employees who test positive for nicotine.

This year, the American Heart Association named Akron General a Gold level "Fit-Friendly Worksite" because of its employee wellness initiative.

From sickness to wellness

Akron General's LifeStyles centers are the centerpiece of the well-care concept. Located in three suburban campuses as well as at the urban Akron General Medical Center, they provide a nexus of health care services, including an emergency department, radiology lab, outpatient surgery, and physician offices.

"It's all about helping people get well and stay well in a safe environment," says **Doug Ribley,** MS, vice president of health and wellness services.

The LifeStyles center also has a fitness and health education component that incorporates physical therapy, cardiac rehabilitation, and chronic disease prevention. Athletic trainers and nutritionists work alongside physical therapists, exercise physiologists, and cardiopulmonary rehabilitation nurses. The flagship LifeStyles center has 9,000 members.

"We're after a different segment that would never go to a [traditional fitness] facility," says

Stover. "The goal was to have non-well people working out next to well people."

Akron General launched health and wellness centers in the 1990s, but only recently brought the focus more sharply toward employee wellness. Employees who use the LifeStyles centers 12 times a month for 12 consecutive months receive a 50% rebate on the cost of membership.

Incentives to get healthy

But most importantly, the Be Well employee wellness program provides financial incentives for the system's 5,000 employees to meet targets on four key measures: body mass index, LDL cholesterol, blood pressure and nicotine/smoking status.

Employees earn points for taking a health risk assessment and for meeting certain goals. With those points, employees can gain an annual discount of up to $250 on a PPO plan or $850 in a health savings account for those on a high-deductible plan. Comparable savings are available for spouses. About 2,000 employees signed up to participate in the first two years.

Be Well also actively helps employees meet those goals. Employees have free access to health coaches. They also can join Litestyles, a chronic disease risk reduction program that includes a twice-weekly meeting with a physical trainer, meetings with a nutritionist, and weekly education sessions.

"It's for anyone who either wants to maintain health or improve their health by reducing risk," says Ribley.

It's too soon to know what impact the Be Well program will have, but based on research related to health promotion, Stover expects to see reduced health care costs (the health system is self-insured), reduced absenteeism, and improved health status of employees. The LifeStyles program has showed success in other areas. For example, coronary artery bypass patients who completed cardiac rehab and stayed with the LifeStyles program were half as likely to need another bypass compared with those who did cardiac rehab only, says Stover.

Meanwhile, Akron General is offering its employee wellness model to other employers and its well-care model to other communities. Chronic disease prevention is an imperative nationwide, Stover says.

"In five to 10 years, there will not be a major health care system that does not have a wellness [focus] or well-care aspect," he predicts. ■

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following 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. ■

CNE OBJECTIVES

After reading each issue of Hospital Employee Health, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- describe how the clinical, administrative and regulatory issues particular to the care of hospital employees affect health care workers, hospitals, or the healthcare industry at large;
- cite solutions to the problems faced in the care of hospital employees based on expert guidelines from relevant regulatory bodies, or the independent recommendations of other employee health professionals.

COMING IN FUTURE MONTHS

■ The Joint Commission turns attention to worker safety

■ How the VA tackles workplace violence

■ NIOSH training seeks to improve nurses' sleep

■ Case studies of integrating patient and worker safety

■ What to learn from a profile of hospital shootings

CNE QUESTIONS

1. In a monograph on patient and worker safety, The Joint Commission described "high-reliability organizations" as:
   A. Showing little change over time.
   B. Preoccupied with safety.
   C. Having little turnover of staff.
   D. Having few errors.

2. According to draft safe patient handling standards from the American Nurses Association, a culture of safety includes:
   A. A blame-free environment and adequate staffing.
   B. Incentives for low injury rates.
   C. Integration of wellness and safety.
   D. Use of proper body mechanics.

3. According to **Judee Gozzard**, RN, MSN, BC, hospitals should be prepared for bariatric patients because:
   A. bariatric surgery is a growing field.
   B. new regulations require special bariatric equipment.
   C. severe obesity is rising in the United States.
   D. many nurses don't know how to handle bariatric patients.

4. According to an analysis of 1997-2007 data from the National Health Interview Survey, how does the health status of health care workers compare to other industry sectors?
   A. They are healthier and have lower rates of heart disease and diabetes.
   B. They are heavier and have the highest rate of diabetes and hypertension.
   C. They are older and have a higher rate of arthritis and poor vision.
   D. They have higher rates of heart disease and asthma and are more likely to have functional limitations.

2012 SALARY SURVEY RESULTS

Hospital Employee Health®

In changing times, EHPs find they must do more with less

Most receive salary boost, more responsibilities

Do more, but don't expect more resources. Money's tight.

Does that sound familiar? Employee health professionals have gained greater stature as the nation's attention turns to preventive care and workplace wellness. Add to that a huge emphasis on influenza vaccination and a renewed regulatory focus in health care, which also place employee health at the forefront.

Hospital leadership may be learning to appreciate the role of employee health, but that hasn't yet translated into a surge of budgetary support, say experts in occupational health nursing.

"To do more with less is generally the rule of thumb. [Occupational health nurses] are constantly doing more. They have less people to do the work," says **Ann Lachat**, RN, BSN, COHN-S/CM, FAAOHN, CEO of the American Board for Occupational Health Nurses, a certification organization based in Hinsdale, IL, which recently released an analysis of the practice of occupational health nursing.

The salary picture improved slightly for employee health nurses, according to the 2012 HEH salary survey. Most respondents (61%) said they received a raise of 1% to 3%. But one in four said they had no change in salary.

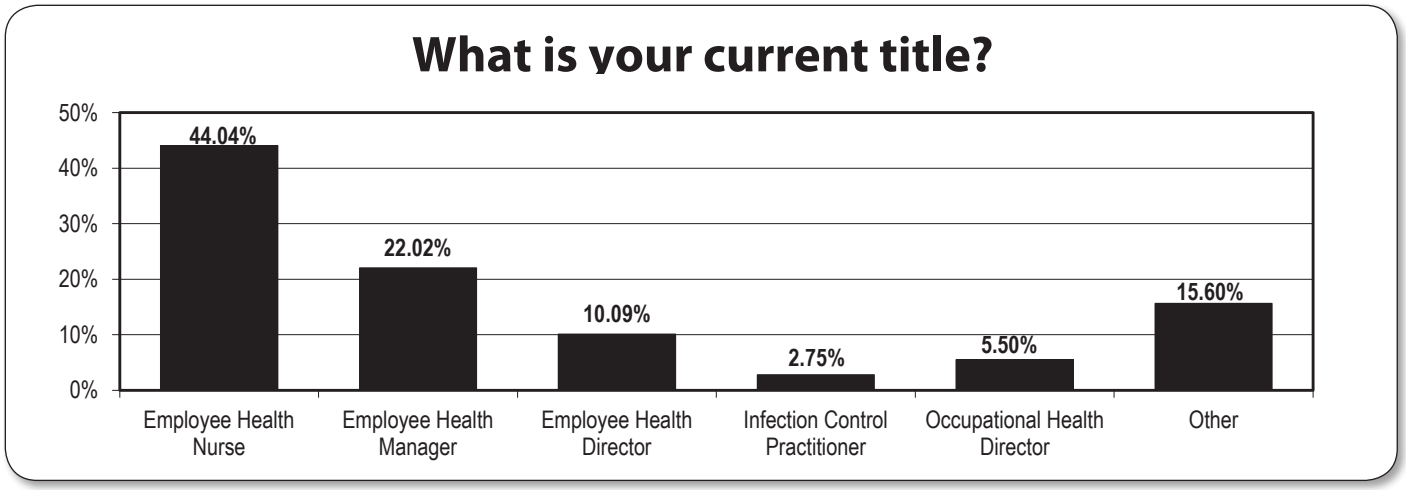
Some 27% of 108 survey respondents said they earn between $60,000 and $69,999 and 15% said they earn between $70,000 and $79,999. (*See chart on p. 2.*)

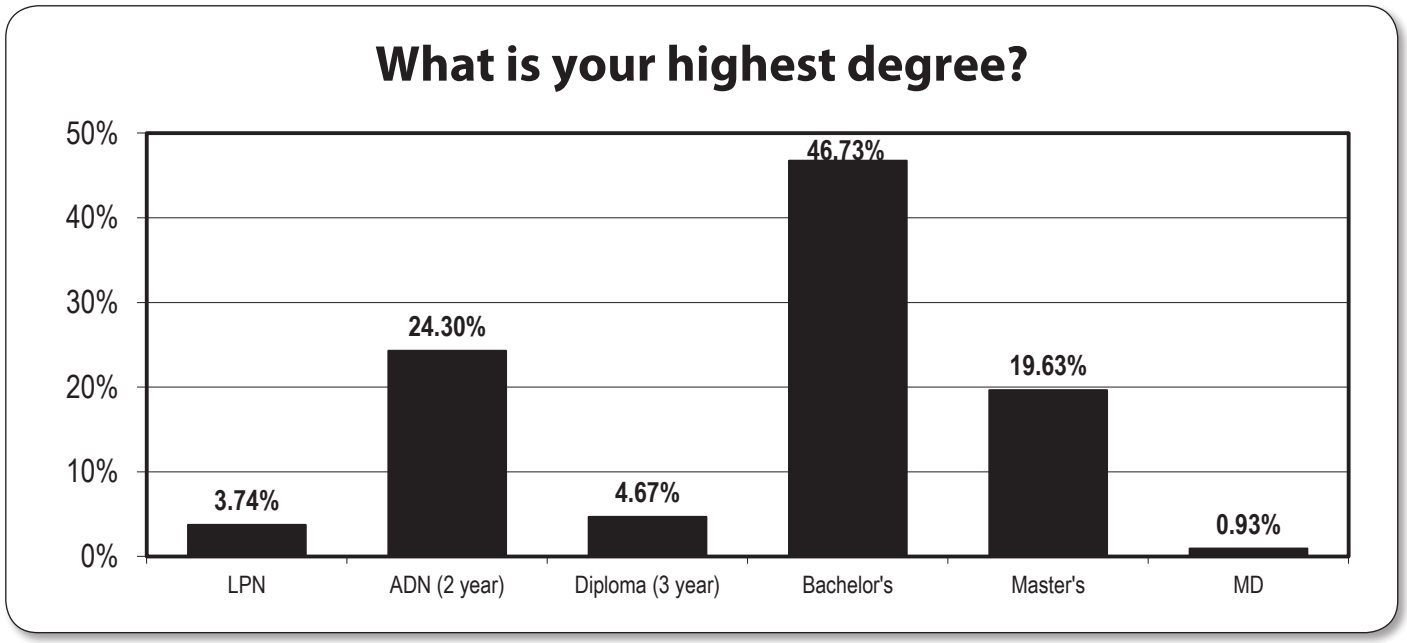
The challenge for employee health professionals is to convince hospital leadership to make them key players in the quest for cost-effective care, says **Barb Maxwell**, RN, MHA, COHN-S, CCM, CWCP, QRP, FAAOHN, Division Director Company Care in Occupational Health Services for HCA's- West Florida Division in St. Petersburg.

"They have got to get in front of the senior leaders to communicate the value that they bring to the organization, and how they can partner with that organization to help with the Affordable Care Act," she says. "But they're going to need resources. They can't do it on a shoe string."

Is EH gaining recognition?

Occupational health nursing is sometimes overlooked





or misunderstood. "Some folks will say, 'Are you an occupational therapist?'" says Maxwell, who promotes occupational health nursing in schools of nursing.

Hospital leadership may still view employee health as "non-revenue producing" – even though EH professionals help prevent costly injuries, manage workers' comp cases, and improve employee wellness, notes Maxwell.

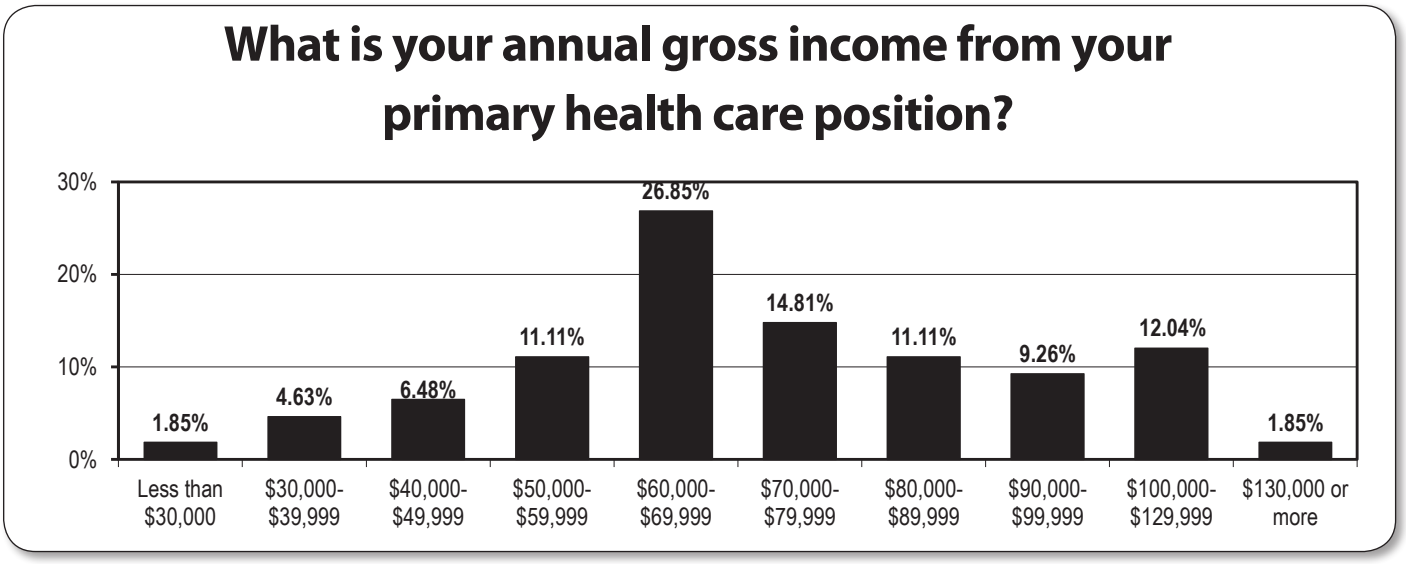
That attitude may be changing. The Joint Commission accrediting body recently issued a 171-page monograph linking patient and worker safety. The U.S. Occupational Safety and Health Administration has trained inspectors to recognize hazards in health care and announced plans to draft an infectious diseases standard that would include respiratory protection programs.

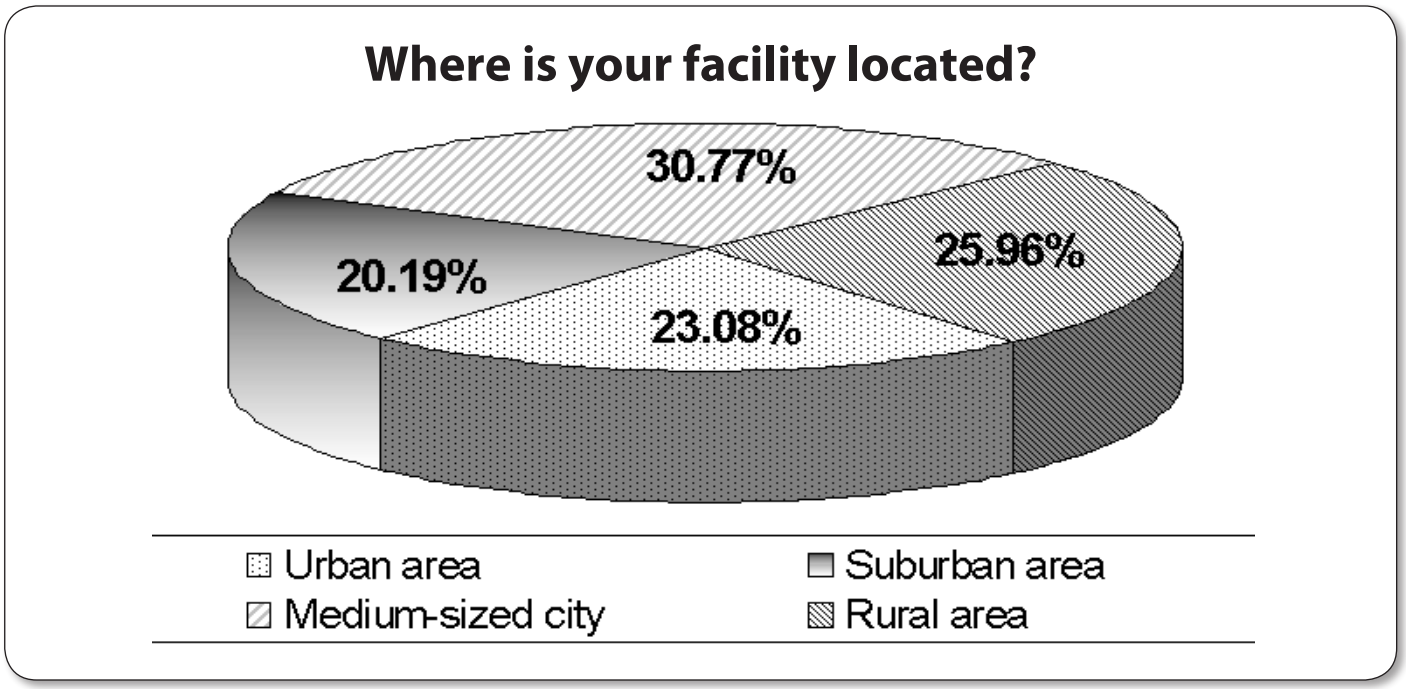
The Affordable Care Act emphasizes prevention and allows employers to increase their incentives for employee wellness programs. (*See* HEH, *November 2012, p.129*.) And the Center for Medicare & Medicaid Services (CMS) even added worker safety issues to its infection control survey. (*See* HEH, *July 2012, p.73*.)

At many hospitals, the employee health department now provides clinic services, including monitoring of chronic diseases such as diabetes and high blood pressure and treatment of minor ailments. "There will be new ways in which you see patients," says Lachat.

In the ABOHN practice analysis, 56% of occupational health nurses said they have had increased responsibilities in the past few years. ABOHN's 2011 web-based survey had 2,409 responses; about 29% were hospital-based, which was by far the largest industry group represented. (*The practice analysis is available at* www.abohn.org/documents/ABOHN2011PracticeAnalysisReport.pdf.)

Occupational health nurses continued to place the greatest emphasis on the primary tasks of treating work-related injuries and illnesses, maintaining recordkeeping and confidentiality of records, and managing workers'





compensation. (*See box on p. 4.*)

ACA brings challenges, opportunity

Yet even as the scope of employee health expands, the health care workforce is on the verge of a major transition.

The Affordable Care Act has created uncertainty about the future, with new alliances and even mergers among large health systems, notes **Dee Tyler,** RN, COHN-S, FAAOHN, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP). Reimbursements are tighter. "There will be some tough choices" for hospitals," Tyler says.

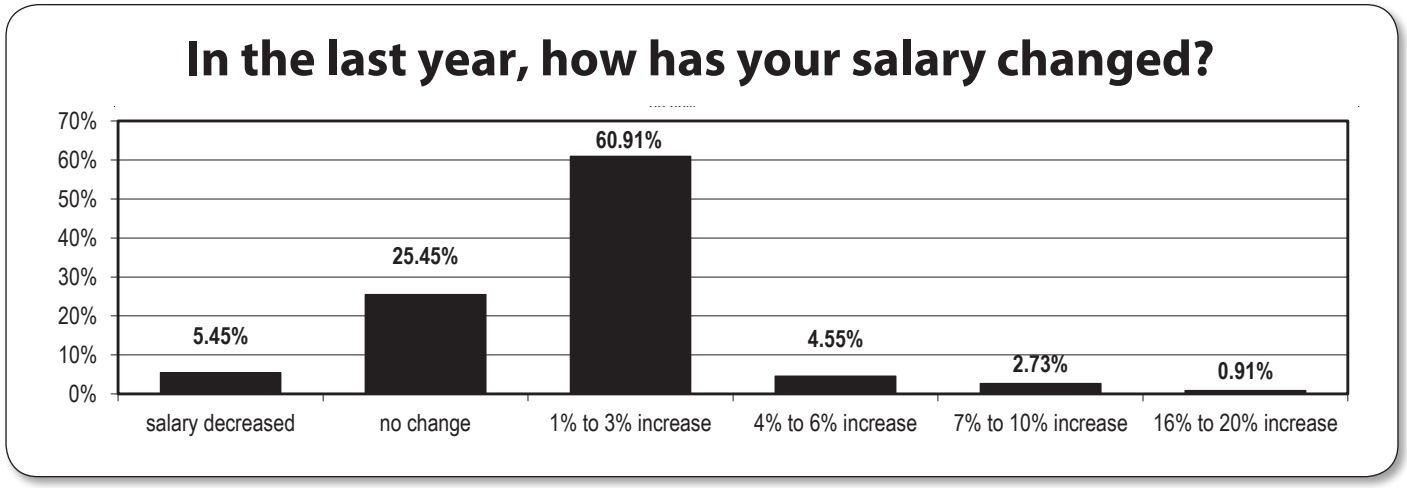
It's not clear how the changing health care scene will impact employee health. Employee health professionals need to continue to promote their value to the organization and the cost-savings they provide in reduced workers' compensation claims, medical claims and absenteeism, notes Maxwell.

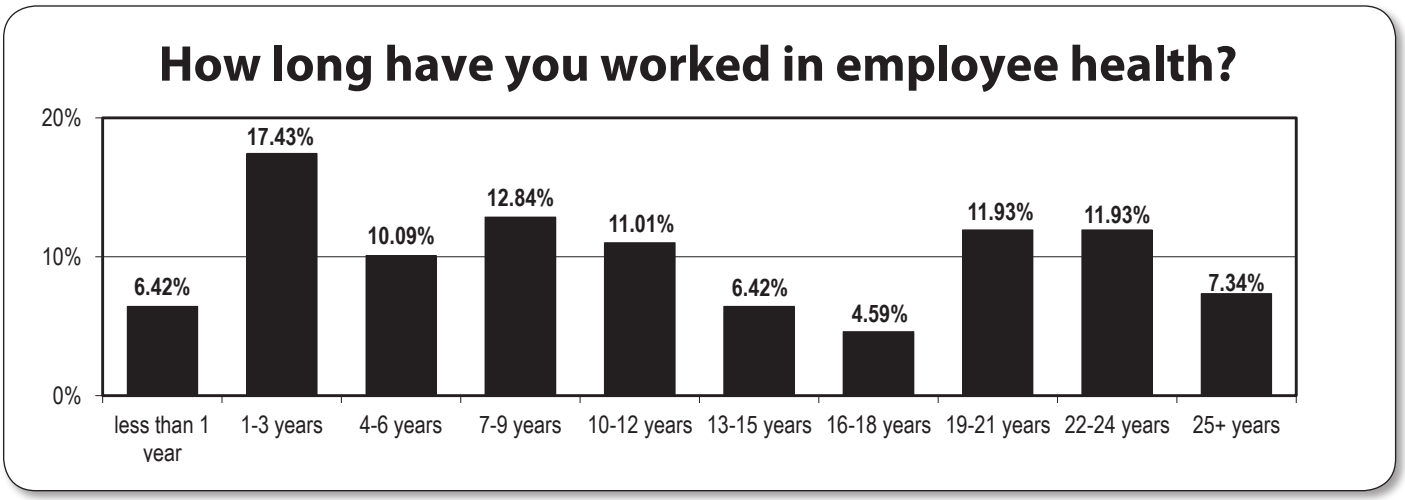
Employee health could play a key role in wellness, she says. "Our employers will be looking toward us as the subject-matter expert," she says.

Meanwhile, there are major demographic trends that will reshape employee health. In the ABOHN practice analysis, the mean age of occupational health nurses was 54. Almost one in four (24%) was 60 or older. In the *HEH* reader survey, 50% of respondents were 56 or older.

"We're hoping to get more and more of the younger nurses to become interested in our profession so they can replace some of us that are nearing retirement age," says Maxwell.

That may require reaching out to nursing schools and educating nursing students about the role of employee





health, she says. Some young nurses may choose to specialize in occupational health, she says.

Aging workforce forces changes

How do you pass on wisdom from one generation of employee health professionals to another? Professional organizations are providing that bridge, says Tyler.

AOHP has long been known for the "Getting Started" workshops at the annual conference, and the "Getting Started" manual is now available for purchase online (www.aohp.org). AOHP maintains an email list serv for members, and the American Association of Occupational Health Nurses (AAOHN) conducts periodic webinars (www.aaohn.org).

"The long-term career-seasoned occupational health nurses are really serving as the mentors for the young ones coming in," says Maxwell. "That's just part of the succession."

With the uncertainty involving the Affordable Care Act and changes in health care delivery and reimbursement, professional organizations also provide a resource for the established employee health professional.

"We're going to be changing very drastically in everything that we do in the next few years," says Tyler. "It's tough to stay abreast with those changes. "It's not just employee health [that's changing], it's our entire environment, from regulatory to reimbursement. All of that is going to affect what we have to respond to in employee health."

With chapter meetings, networking and email lists, professional organizations enable employee health professionals to support each other through turbulent times, Tyler says. ■

What matters most in occ health nursing

Recordkeeping, treatment are keys

According to the "Occupational Health Nursing 2011 Practice Analysis" by the American Board of Occupational Health Nurses in Hinsdale, IL, these are the most significant tasks performed by certified occupational health nurses (COHN):

1. Assure confidentiality of personal health information and comply with established codes of ethics and legal or regulatory requirements.
2. Provide treatment of work-related injuries or illnesses.
3. Maintain OSHA-required logs and documents.
4. Use and maintain an employee health recordkeeping system.
5. Manage workers' compensation cases.
6. Assess employees with work restrictions or limitations and make appropriate job placement recommendations (i.e., fitness for duty).
7. Perform audiometry.
8. Implement policies and procedures for maintenance of confidentiality.
9. Conduct health surveillance of individuals/groups for specific hazards (e.g., hearing conservation, respiratory protection, laser safety).
10. Interpret results of screening tests and refer as indicated.

[*Editor's note: The ABOHN 2011 practice analysis is available at* www.abohn.org/documents/ABOHN2011PracticeAnalysisReport.pdf.] ■

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