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AHC Media

Is OSHA neglecting its duty to protect health care workers?

Agency promises to 'hold employers accountable'

An aide in a state-run nursing home is more likely to be injured than a police officer. More work-related injuries and illnesses occurred in the nation's hospitals than in any other industry in 2011. Nursing assistants suffered more serious musculoskeletal injuries than truck drivers, according to the U.S. Bureau of Labor Statistics.[1]

Yet despite a "national emphasis program" to target inspections on the nursing home industry, the U.S. Occupational Safety and Health Administration (OSHA) has rarely used its enforcement latitude on the single most common cause of injury in health care — overexertion due to patient handling. OSHA has never used its "general duty" clause powers to cite a hospital for patient handling injuries. And in about 1000 inspections of nursing homes in the past two years, OSHA inspectors issued only seven such citations.

Some 25,000 nursing assistants and almost 12,000 registered nurses suffered MSD injuries in 2011 that required days away from work, according to the U.S. Bureau of Labor Statistics.

The "general duty" clause of the Occupational Safety and Health Act of 1970, which created OSHA, requires employers to maintain a workplace "free from recognized hazards that are causing or are likely to cause death or serious physical harm to … employees."

It has been used thousands of times from 2010 to 2012 to address other hazards in health care and other industries. For example, nine hospitals were cited under the general duty clause in that timeframe for incidents related to workplace violence, most commonly related to assaults by psychiatric patients.

The lack of MSD-related general duty citations reflects a broader failure by OSHA to address hazards in the health care industry, which has the nation's fastest growing workforce, according to a report by the Washington, DC-based advocacy group, Public Citizen.[2]

In an emailed response to HEH, OSHA said it has turned its focus to health care. "Employers have the legal responsibility of providing workplaces free of recognized hazards. They must take ownership over this issue, and our

role is to see that they do," OSHA said.

"OSHA has a variety of tools at its disposal to hold employers accountable for safety and health, and we are committed to improving safety and health conditions for our nation's health care workers. Under this administration, OSHA has done more than any previous administration to address the issues that persist in this industry."

More injuries, fewer inspections

Still, inspections statistics show that the nation's worker safety efforts are skewed toward industries that involve traditional manual labor, where heavy loads are handled with fork lifts and dollies.

In 2010, almost as many injuries requiring days away from work occurred in the healthcare and social assistance sector (176,380) as in construction and manufacturing combined (74,950 and 127,140), yet the healthcare and social assistance sector had less than one-twentieth of the number of inspections as those other major industries, according to the Public Citizen report, "Healthcare Workers Unprotected."

While construction and manufacturing have a higher number of fatalities, health care has a higher rate of injuries overall.

"The sad part about all this is that OSHA knows. OSHA would be the first to agree that health care workers are exposed to many hazards," says co-author **Keith Wrightson**, a worker health and safety advocate for Public Citizen.

OSHA has too few resources, too much interference from Congress, and an inability to create new regulatory standards to address modern work hazards, the report says. For example, Congress rescinded a comprehensive ergonomics standard in 2001 in an action that prohibits the agency from issuing a "substantially similar" regulation.

"I think it's beyond dispute that this agency has tremendous political interference in trying to fulfill its mandate," says **Taylor Lincoln**, a research director for Public Citizen and report co-author. "It is the law of the land that it's the government's job to provide for safe workplaces. OSHA acknowledges that there are pressing concerns that they're not addressing – because they can't."

In the past few years, OSHA rulemaking has virtually ground to a halt. But despite political headwinds and a climate of budget-cutting, the agency has asked for an additional $2 million to develop new standards. With new money to fund scientific, technological and economic analyses, the agency optimistically predicts it could issue a final infectious diseases rule in Fiscal Year 2014, which ends September 30, 2014.

"OSHA's current highest rulemaking priority is the Injury and Illness Prevention Program (I2P2) rule," the agency said in its Congressional Budget Justification. "I2P2 will produce a significant change in how workplace safety is approached in this country and will substantially reduce the number and severity of workplace injuries…"

In an even more daunting item on OSHA's wish list, the agency said it wants to update permissible exposure limits on chemicals.

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AHC Media

Injured, and bleeding red ink

Hospital injuries cost $4 billion a year

Amid the heightened attention to hospital costs and how to contain them, one fact has largely escaped public notice: Injuries to hospital workers are hurting the bottom line and ultimately adding to patients' bills.

Preventable injuries to workers are costing hospitals about $4 billion a year, estimates **Scott Harris**, PhD, MSPH, senior employee health and safety advisor at UL Workplace Health and Safety in Franklin, TN. It would take $54 billion in patient billing to offset that cost, he says.

"Going billions of dollars in the hole on back injuries is not a winner. You can't sell enough Tylenol to get out of that," says Harris, who has written a white paper about the disproportionate health care injury rate. "If this were Toyota or GE or anybody else, they would never stand for this. They would never tolerate those kind of losses. The high rates, the injuries, the dollars, we just don't see that anywhere else."

So far, hospitals have largely operated under the regulatory radar, with many fewer inspections relative to their size than other employers, he notes.

(*See cover story, p. 97*)

"I think the perception is that hospitals are calm, quiet and relatively safe. Maybe compared to some places they are," he says. "But if you look at the numbers that come out of industry, you're way safer working at that car plant than working at the hospital."

Hospitals should expect greater scrutiny as awareness grows of the dismal injury rates, he says. "In the last few years, the statistics in hospitals have been so consistently bad, that OSHA can't ignore it anymore."

But hospitals don't simply need to respond to OSHA citations. The costs of injuries should be a "wake-up call," he says.

"If they were losing $10 billion bucks a year on water leaks, there would be a bunch of plumbing going on," Harris says.

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A change in philosophy

Despite the obstacles, OSHA is using some new strategies to address the imbalance between hazards and enforcement.

General-duty clause citations are difficult and time-consuming to document, but OSHA promises to try harder. In its Congressional Budget Justification, the agency acknowledges that an emphasis on continually raising the number of inspections conducted makes it less likely that inspectors will focus on those time-consuming issues.

"Under the current system, the only incentive for a compliance officer is to meet the inspection goals. There is no incentive for them to do the larger, more complicated inspections," OSHA said.

OSHA said it will change its philosophy of enforcement to conduct fewer but more complex inspections in high hazard industries. "OSHA will prioritize its resources to programs and initiatives capable of achieving the greatest impact on improving workplace safety and health, addressing new and emerging hazards in safety and health," the agency said.

How much of this new attention will be directed toward health care? Nursing homes are in the spotlight because of the three-year National Emphasis Program. But in its budget document, OSHA specifically mentions industries with a high risk of fatalities, such as construction. There is no mention of health care, beyond nursing homes.

In public statements, OSHA administrator **David Michaels**, MD, MPH, has vowed to address health care hazards. "It is unacceptable that the workers who have dedicated their lives to caring for our loved ones when they are sick are the very same workers who face the highest risk of work-related injury and illness," he said.

Outreach letters target MSD hazards

When OSHA doesn't have enough information to document an ergonomics citation under the general duty clause, the agency sends out "hazard

alert" letters as a warning to employers. In Region 3, which encompasses Pennsylvania, Delaware, Maryland, Virginia, West Virginia and the District of Columbia, the agency has gone a step farther.

The regional office sent 2,200 letters to health care facilities, offering information and assistance to reduce musculoskeletal disorder (MSD) hazards.

"We're trying to bring awareness to the industry of this alarming injury trend," says Regional Administrator **MaryAnn Garrahan**. "We're looking for better compliance through effective injury and illness prevention programs."

OSHA also has found an effective partner for getting the word out: the Center of Medicare & Medicaid Services (CMS). CMS will disseminate guidance and best practices on safe patient handling through its Hospital Engagement Network, Garrahan says.

The awareness campaign also potentially lays the groundwork for further enforcement. The general duty clause applies to "recognized hazards" — and health care employers would be hard-pressed to say that patient handling is not a recognized hazard.

Inspectors also are gaining awareness of hazards in health care, Garrahan says. "Certainly, there has been a reemphasis since 2011, in terms of getting our people better trained in using our general duty clause to be able to cite for MSD hazards in the workplace," she says.

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Questions arise over vaccine-or-mask rules

'It quickly becomes obvious how ridiculous it is'

Get the flu vaccine or wear a mask during flu season. That ultimatum is becoming increasingly commonplace in the nation's hospitals. But it still leaves employee health professionals with a number of questions: Just who should be covered by the policy? And when or where do they need to wear the masks?

Hospitals have taken a variety of approaches to masking policies that encourage employees to roll up their sleeves for the flu vaccine. Some use stickers on ID badges to identify employees who did or didn't receive the vaccine. (The unvaccinated don't get a smiley face.) Others rely on supervisors to track the need for mask-wearing and the usual human resources procedures if employees don't comply.

Some hospitals require the masking when employees are within a certain number of feet of a patient — such as 50 feet. Others require unvaccinated employees to wear a mask anywhere in the hospital. Many of the policies include contract workers, such as physicians, and volunteers.

The Centers for Disease Control and Prevention does not have any recommendations on implementing a policy of masking unvaccinated health care workers because there is no data on such programs, says **David Kuhar**, MD, medical officer with the CDC's Division of Healthcare Quality Promotion. "There's not really an evidence base to review to come up with recommendations. This is simply a matter of expert opinion," he says.

The unpredictability of influenza and variability in the effectiveness of the vaccine add to the infection control questions, says **William Schaffner**, MD, chairman of the Vanderbilt University Department of Preventive Medicine and an infectious disease expert. It is reasonable for hospitals to establish policies that work best for them, with the ultimate goal of maximizing vaccination, he says. "I think they're going to be looking for practical solutions that can be implemented and that are workable," he says.

'Achieve the highest … protection'

Vaccine-or-mask policies have become popular because they are very effective at raising influenza vaccination rates without resorting to threats of termination. For example, Methodist Health System in Omaha, NE, allows employees to decline for any reason – after they receive education on influenza and the value of the vaccine.

Anyone who has not been vaccinated must wear a mask during flu season while they are in the hospital hallways or patient care areas. (Break rooms and the cafeteria are excluded.) Hospital infection control determines the dates of the flu season, says **Sue Davis**, MS, BSN, RN, CCRN, NE-BC, Service Leader for the hospital's Learning Center &

Employee Health.

Methodist Health System adopted the policy in response to an American Hospital Association policy advocating vaccine-or-mask policies "to achieve the highest possible level of protection." Other hospitals in the area had already adopted mandatory vaccination policies, Davis says. "It's a community standard here," she says.

Last year, the masking period began in December. But because the outpatient clinic sees the first flu patients, the official flu season began there on Oct. 15 and lasted until April 30. Signs on the hospital entrance alert patients that some employees may be wearing masks because they are unable to have the flu vaccine. Patients with respiratory symptoms also are asked to wear a mask, Davis says.

When the policy first began, some employees vented their frustration. But vaccination rates also shot up, from the 70s to 95%.

Little infection control benefit?

Yet some hospitals are bucking this trend toward vaccine-or-mask policies as they question the infection control rationale.

Hospitals feel pressured to show very high vaccination rates without threatening to fire employees, says **Melanie Swift**, MD, medical director of the Vanderbilt Occupational Health Clinic. But the policies inadvertently raise other issues if their stated goal is patient protection, she says.

"This kind of policy puts you on a slippery slope," she says. "You then have no justification not to mask for early epidemics before you've got a vaccine, for any novel strain of flu, when vaccine is delayed in a year, or any year that surveillance shows a poor match [between the vaccine and the prevailing strains].

"If you try to follow it as a logical patient safety intervention, it quickly becomes obvious how ridiculous it is," she says.

Swift also expresses concern about the breach of privacy of the employees' medical information. Patients, visitors, co-workers and supervisors are all aware of the employees' vaccination status, and some of those unvaccinated employees have a medical condition that precludes vaccination, she notes.

Marshfield (WI) Clinic has taken a strong stand for vaccination, while bypassing the masking mandates. At Marshfield, all recommended vaccines are a condition of employment, including measles, mumps, rubella, varicella, pertussis, influenza and hepatitis B.

People with religious or medical exemptions are evaluated on a case-by-case basis, and some unvaccinated employees may be transferred out of patient care areas, says **Bruce E. Cunha**, RN, MS, COHN-S, manager of Employee Health and Safety. However, unvaccinated employees are not asked to wear a mask.

"We do not feel it provides a significant improvement in infection control to be warranted," Cunha says. "I really question how many of these facilities are actually enforcing it."

Marshfield tells employees to stay home if they feel sick, but if they return to work and still have some respiratory symptoms, they must wear a mask while caring for patients, he says. "Regardless of whether you've been vaccinated or not [against influenza], if you have symptoms you wear a mask," he says. ■

Opiod overuse a 'public health emergency'

Workers' compensation doses rise

Doctors are prescribing more and more narcotics to injured workers every year. Oxycontin, an opioid associated with prescription drug abuse, is the most commonly prescribed medication in workers' compensation claims.[1]

Meanwhile, overdose deaths from prescription pain killers are rising dramatically, especially among women.[2] These troubling trends underscore the importance of following guidelines on chronic pain management, occupational medicine experts say. They also urge physicians to limit or eliminate high-dose, long-term use of opioids for non-cancer pain.

"The dosing problem in workers' compensation is huge," says **Gary Franklin**, MD, MPH, medical director of the Washington Department of Labor and Industries and a pioneer in addressing the risks of opioid use in chronic pain. "There are probably tens of thousands of high-dose users in every state in workers' compensation."

Sales of opioids have grown exponentially in the past decade, and in 2010, the opioids sold could have medicated every American adult with 5 mg of hydrocodone every four hours for one month, according to the Centers for Disease Control and Prevention.[2]

This is driven in part by high prescribed doses, says Franklin. "If their pain and function wasn't better on 120 (mg) than it was on 60 or 40, don't keep moving it up," he says. "Get a consultation. Do something different."

Physicians also need to take a comprehensive approach to pain management, using different therapies and screening for depression, other medication use and abuse risk factors, says **Kathryn Mueller**, MD, MPH, FACOEM, an occupational medicine physician at the University of Colorado in Denver and a contributor to the American College of Occupational and Environmental Medicine (ACOEM) guideline on chronic pain management.

"We've been overprescribing for acute and subacute pain, so there are just too many pills out there in circulation," she says.

As costs rise, both in dollars and lives, opioid overuse and abuse is getting increased attention. "Now that we know what we know, why is it taking so long to make changes? That's the frustration," says Franklin. "If these were Salmonella [food-borne] deaths, it wouldn't have taken this long. It's a public health emergency."

A human right to be pain-free?

The increase in opioid prescriptions began with good intent. In 2001, The Joint Commission released a pain management standard that emphasized the importance of assessing and treating pain. In 2010, the International Association for the Study of Pain organized a global summit, which issued a declaration calling access to pain management a human right. In 2011, an Institute of Medicine report called chronic pain "a national public health challenge."

Occupational medicine experts don't dispute the need to better manage both acute and chronic pain. But simply writing a prescription for a hydrocodone — and upping the dosage if there is residual pain or discomfort — is not the answer, says Mueller.

A comprehensive pain management approach includes screening for depression, monitoring the overall use of medications, and encouraging physical activity or return to work, according to the ACOEM guidelines. In some cases, psychotherapy or periodic drug screening may be warranted, and patients should sign a treatment agreement stating that they understand how they should use the opioids, the guidelines state.

Yet a study of longer-term use of narcotics by injured workers (who had prescriptions 12 or more months after the date of injury) found that only 7% had undergone a psychological evaluation and 4% had received psychological treatment. About one in four had drug testing, which is recommended to ensure that patients are not taking multiple types of narcotics or contraindicated drugs, and that they are taking the prescribed medicine and not filling prescriptions that are used by others.[3]

The study, based on 300,000 worker's compensation claims in 21 states, analyzed cases with injuries that occurred from Oct. 1, 2006 to Sept. 30, 2009 and revealed great variation among states.

"If you're moving into that phase where you're considering prescribing opioids for a longer period of time for pain relief, then you really need to be following all of the recommendations for monitoring patients to prevent abuse and unintentional misuse," Mueller says. "These include checking the prescription drug monitoring programs (PDMP), treating any psychological issues, performing random drug screening, and establishing doctor-patient agreements."

Prescription drug monitoring programs provide a database for physicians to check whether patients may be receiving additional drugs from another doctor or are taking other medications that would interact with opioids. Such programs are available or under development in 48 states. In addition to Washington state, other states such as Colorado and Massachusetts have adopted revised pain management guidelines for workers' compensation.

Workers' compensation case managers also can play a role in monitoring the narcotics' prescriptions of employees, says Mueller.

The patterns of use among injured workers reflect the broader problem of narcotics use: A subset of injured workers takes high doses of narcotics. Based on prescription costs, the top 10% of claimants account for 80% of the narcotic use.[4]

"The share of claimants that are getting five or more narcotics prescription within a year of the date of injury has been growing," says **John Robertson**, FCAS, MAAA, director and senior actuary of the National Council on Compensation Insurance (NCCI) in Boca Raton, FL.

Overdose deaths top traffic accidents

Women are more likely to die from a drug overdose than a traffic accident. In 2010, 6,631

women died of an opioid overdose. From 2004 to 2010, emergency room visits by women from opioid misuse or abuse more than doubled.[2]

Turning around those trends will require adherence to guidelines and careful prescribing, says Franklin. New workers' compensation guidelines in the state of Washington call for using assessments of function and pain to determine whether injured workers taking opioids have "clinical meaningful improvement." *(http://www.lni.wa.gov/claimsins/Files/OMD/MedTreat/FINALOpioidGuideline010713.pdf)*

Prescribing opioids if there is no "clinical meaningful improvement in function…is not considered proper and necessary care" by the state workers compensation insurer, according to the guidelines.

Doctors in other states also should recognize the potential for legal liability if there is an opioid overdose and they failed to properly monitor a patient's use, Mueller says.

The initial treatment for acute low back pain should be non-steroidal anti-inflammatory drugs, according to ACOEM. Doctors should discuss the risks as well as the benefits with patients before starting them on opioids, ACOEM says.

"Our new guidelines say you should not use opioids for strains and sprains," says Franklin of the Washington state guidelines. "You should not start opioids, even a first prescription, in someone who does not have a severe injury."

Patients also need to have realistic expectations about pain management, says Mueller. Physicians may not be able to get rid of all their pain, she says. "In the end, the person is going to have to manage their life by adopting strategies they can largely do on their own – such as exercise, stretching, applying heat or cold and using mind/body techniques," she says.

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Recommendations for opioid use

The American College of Occupational and Environmental Medicine (ACOEM) provides these recommendations from the Evidence-based Practice Panel on Chronic Pain. The Guidelines for the Chronic Use of Opioids is available at http://ow.ly/nQV1s

1. Routine use of opioids for treatment of chronic non-malignant pain conditions is not recommended, although selected patients may benefit from judicious use.

2. Opioids are recommended for select patients with chronic persistent pain, neuropathic pain, or complex regional pain syndrome (CRPS).

3. Screening of patients by asking about prior substance abuse with simple tools and using currently available screening tools designed for use in populations on or considering opioid therapy is recommended as there is evidence that patients with a prior history of drug or alcohol abuse or psychological problems are at increased risk of developing opioid related use/abuse problems. A psychological evaluation would also be indicated in most cases.

4. The use of a treatment agreement to document patient understanding and agreement with the expectations of opioid use is recommended. There is evidence that many patients do not adhere to prescribed treatment (including with an agreement); however, these agreements are felt to be needed and coupled with a urine drug screening program. Patients should be informed about what is responsible use of opioids and how to interact with their physician and pharmacy in obtaining medication. If literacy is a problem, the physician should read the agreement to the patient and ascertain that they understand it or revise the agreement so they can read and understand its content.

5. Routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician. ■

Are you crushed by HCW absences?

One of the highest rates of FMLA leave

Too many hospital employees are missing in action. Health care workers have among the highest rates of family and medical leave, with about 39% missing an average of almost a month of work each year, according to a recent report from a human resources consulting firm.

About half of the Family and Medical Leave Act (FMLA) leave is intermittent, with health care workers missing an average of 13 days, or about one day per month, according to customer data from ComPsych Corp., a Chicago-based international provider of employee assistance programs and other human resources services to more than 19,000 employees.

That intermittent leave causes a great difficulty for health care employers, who have to staff a 24-7 operation with specialized employees, says **JoAnn Shea**, ARNP, director of Employee Health Services at Tampa (FL) General Hospital, who is scheduled to speak on managing FMLA at the upcoming conference of the Association for Occupational Health Professionals in Healthcare (AOHP). (*See editor's note below for information on the conference.*)

It is meant for people who are periodically disabled by ailments such as migraines or who care for a child or other family member with an episodic serious disease, such as asthma. The problem lies with a subset of employees who abuse their ability to take intermittent leave, she says.

"It is an important law to protect people with illnesses. I truly believe in it," she says. "But working with that small element that doesn't use it appropriately is tough."

Out of 6,500 employees, Tampa General has about 1,500 new FMLA cases a year and recertifies about 1,300, says Shea. At any one time, about 2,000 may be on FMLA, which includes pregnancy leave. About half of those cases involve intermittent leave.

Here are some strategies for preventing FMLA abuse or managing employees who may be using it inappropriately:

Require employees to give proper notification. The employer can set up a system of notification that the employee is required to follow. For example, you may require two hours' notice for intermittent leave and 30 days for a doctor's appointment. If the employee provides less notification — and it's not an emergency — that counts as an unscheduled absence, not leave time, and could trigger disciplinary action, says Shea.

Reassign employees, if necessary. Employees must be able to perform the essential functions of the job. For example, in the hospital's ambulatory surgery center, an anesthesia tech on intermittent leave said she could not stay late and work past her eight hours. Yet because there is no evening shift at the center, employees there share the responsibility of staying late, when necessary to complete a case. The tech was offered a transfer to another patient care area, Shea says.

Set a system of re-certification. Some employees are on intermittent FMLA leave for years. That may be appropriate for someone with a serious chronic disease, but health circumstances often improve with treatment. You can periodically ask an employee to be recertified, says Shea. If the employee is taking more absences than allowed under the doctor's certification, you also may ask for a recertification, she says.

Communicate with physicians. If an employee is missing an excessive amount of time, is that an indication that the disease isn't adequately managed? Or that the employee is taking advantage of FMLA? In either case, it may be helpful to communicate with the doctor. The doctor might change the treatment, approve the higher use of leave, or indicate that the level of absence isn't warranted by the severity of the illness, says Shea.

Confront employees over discrepancies. Let's say an employee calls in with migraines on a Friday, then posts photos from Disney World on Facebook. Some co-workers are likely to see the photos, and they may not be too happy that they're working extra to cover for someone who lied to get their leave. One employee called in for intermittent leave, then texted a coworker to complain that she was still at her daughter's school, trying to register her. In another case, an employee called in for intermittent leave while he was fishing with co-workers. "We immediately bring the employee in and ask them," Shea says. Texts and Facebook posts are damning evidence, and employees can be terminated for lying, she says.

Keep up with changes in the law. Between FMLA and the Americans with Disabilities Act, it's complicated to accommodate employees with chronic diseases. Changes in the law may affect who is allowed to take leave or what documentation is required. When in doubt, Shea relies on the

advice of an HR lawyer who specializes in FMLA and ADA.

(*Editor's note: The AOHP 2013 annual conference will be held September 14-16 at the Walt Disney World Resort in Orlando, FL. More information is available at* www.aohp.org.) ■

A touch of grey: Time to become age-friendly

Make changes to help HCWs of all ages

The average age of an American nurse is 50. By 2020, half of all registered nurses will be 65.[1] As the demand for health services continues to grow with the aging of the U.S. population, the people who care for them are aging, too. That's why hospitals are ground zero in the new push for an age-friendly workplace.

Two leading voices for occupational health and safety have teamed up to spur employers to address the aging of the workforce – with policies that will benefit all workers. The American College of Occupational and Environmental Medicine (ACOEM) and the National Institute for Occupational Safety and Health (NIOSH) held a "Summit on Advancing the Health Protection and Promotion of an Aging Workforce" in 2012 and recently issued a report to help guide employers in creating an age-friendly workplace. (*See box on p.106.*)

They start with an important premise: Don't target older workers, but create adaptations that will benefit them and their younger colleagues.

"We need to focus on [encouraging] healthy aging, even starting when someone comes into their workforce in their 20's," says **Ron Loeppke**, MD, president of U.S. Preventive Medicine and president of ACOEM.

Work injuries don't discriminate by age

Similar risk for ages 35 and up

When it comes to work-related injuries, "old age" starts young. A 55-year-old worker is similar to one who is 35, according to an analysis of workers' compensation claims data by the National Council on Compensation Insurance (NCCI) in Boca Raton, FL.

The rate of injury for younger workers has dropped significantly, so it more closely mirrors the lower rate of older workers, says **Tanya Restropo**, MBA, an economist with NCCI. Yet younger workers also are increasingly likely to have more severe injuries, such as rotator cuff or knee injuries, NCCI researchers found.1

"We used to think that younger workers had much higher injury rates than older workers. We found that now there is very little difference in injury rates by age," says Restropo. "The injury rates for older workers have been falling more slowly than the injury rates for younger workers."

The types of injuries have been changing. "We're finding that definitely older workers have higher severity, but older seems to be starting with age 35," she says. "A lot of people think it's 55 and older. The 35 and older now, they're all right in line [with them]."

A sedentary lifestyle and rise in obesity may have contributed to the greater severity of injuries of younger workers, NCCI researchers speculated. In any case, the aging of the workforce isn't likely to significantly affect workers' compensation costs because those workers aren't actually much different from younger workers, Restropo says.

"An aging workforce does not pose a significant challenge for workers compensation," said NCCI chief economist **Harry Shuford**, PhD, in a report.2

But, of course, there is a different worry. "Perhaps we need to shift our concerns from older to younger workers," he concluded. "If there is little difference in their health status today, just imagine what condition these younger workers may be in 30 years from now."

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1. Restrepo T, Shuford H. Workers compensation and the aging workforce: Is 35 the new 'older‖ worker'? *NCCI Research Brief*, October 2012. Available at http://ow.ly/nQZMh. Accessed on July 8, 2013.
2. Shuford H. Our workforce is rapidly aging – Is this bad news? Workers' Compensation 2013 Issues Report, NCCI, Boca Raton, FL. Available at http://ow.ly/nQZXC. Accessed on July 16, 2013.

In fact, older workers have occupational health needs that are very similar to that of younger workers. A study of workers' compensation claims found that the injuries and costs of treatment are similar for workers 35 years and older. (*See related article on p.105.*)

"One of the myths is that health care costs for older workers are higher than they are for younger workers," says **Anita Schill**, PhD, MPH, MA, senior science adviser at NIOSH and co-manager of the agency's Total Worker Health program.

Many younger workers have health risks, such as obesity, and chronic conditions, such as diabetes, she notes. "We're actually seeing more chronic disease in younger people than we ever have before," she says.

Health and work are interconnected

As a centerpiece of an age-friendly workplace, employers should integrate health promotion with occupational health and safety, the summit experts agreed.

"All of us in the occupational health and safety specialty of health care have acknowledged for years that health impacts work, and work impacts health," says Loeppke. "People don't leave their health risks at home in the morning when they come to work and they don't leave their work risks at work when they come home. We need to find ways to promote a 24-7 culture of health and shift the paradigm."

For example, shift work and long hours lead to fatigue, which is associated with a greater risk of occupational injury, says Schill. Shift work and sleep disruption also have been linked to diabetes and obesity, she says.

The summit report suggests providing a flexible work schedule to accommodate older workers. But a new perspective on scheduling could produce a wide range of benefits, she says. "There's an opportunity here to look at this age-old problem of shift work," she says.

NIOSH's Total Worker Health program provides resources for integrating wellness programs with traditional employee health services. For example, the agency suggests incorporating joint health and arthritis prevention with ergonomics programs, tobacco cessation with respiratory protection programs, and work risks with preventive health screenings. *(Related information is available at www.cdc.gov/niosh/programs/totalworkerhealth/.)*

Action steps for an age-friendly workplace

- Integrate health protection with health promotion to create a "culture of health" throughout the workplace.
- Create and implement "age-friendly" programs and policies, including:
  - Prioritize workplace flexibility, and give additional control over work schedules, work conditions, and work location, which benefit workers of all ages.
  - Use adaptive technology and design work tasks to meet older workers' physical needs.
  - Manage noise hazards, slip and trip hazards, physical hazards, and conditions that are more challenging to older workers.
  - Provide ergo-friendly work environments, such as workstations, tools, floor surfaces, adjustable seating, better illumination where needed, screens and surfaces with less glare.
  - Provide health promotion and lifestyle interventions.
  - Accommodate medical self-care in the workplace and time away for health visits.
  - Invest in training and skills-building at all age levels.
  - Proactively manage reasonable accommodations and the return-to-work process after illness or injury absence.
  - Require aging workforce management skills training for supervisors that addresses the specific needs of older workers in addition to the needs of all generations of workers.
- Broaden the dialogue about workforce aging through stronger collaboration in the workplace between employers and worker. This requires honestly discussing issues related to aging and engaging employees, employers, and key stakeholder groups, such as labor representatives, occupational safety and health professionals, health promotion professionals, community health care providers, academics, advocacy organizations and governmental agencies in discussions of policies and strategies.
- Raise awareness of the workforce aging issues among employers and policymakers. ■

The SafeWell Guidelines, developed by the Center for Work, Health and Well-being at the Harvard University School of Public Health, provides a template specifically for health care organizations to integrate health promotion and occupational health. *(See related article in* HEH*, September 2012, p. 103. More information is also available at http://centerforworkhealth.sph.harvard.edu/.)*

Adapt to needs of older workers

The specific challenges for aging workers also can trigger improvements in the workplace that will benefit all workers, says Schill.

Improved lighting helps those who have diminished vision – whether they are health care workers or hospital visitors. Slip-resistant floors reduce the risk of falls. "Employers should really be motivated to look at these issues and see how they can improve the work environment," she says.

In fact, addressing the needs of older workers is just one way of accommodating the physical demands of health care work, says Loeppke.

Employers should take a positive approach to retaining older workers, he says. "We're all recognizing that as the workforce ages, we have to embrace age-friendly adaptations," he says. "It's a tremendous asset to have people that have the institutional knowledge and experience in any given industry to continue to be healthy and productive at work."

That is especially true in health care, which is the fastest growing segment of the workforce, according to the U.S. Bureau of Labor Statistics.

"The reality is your workplace is aging, so just go ahead and address it," says Loeppke. "Incorporate age-friendly elements in health protection and health promotion programs. Be proactive about it, embrace it. This should just be an ongoing part of the safety and health training.

REFERENCES

1. Harrington L, Heidcamp M. The aging workforce: Challenges for the health care industry workforce. Issue brief of the NTAR Leadership Center, New Brunswick, NJ, March 2013. Available at http://ow.ly/nQYmI. Accessed on July 5, 2013.

2. Loeppke RR, Schill AL, Chosewood L, et al. Advancing workplace health protection and promotion for an aging workforce. *J Occup Environ Med* 2013;55:500-506. ■

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

- CDC issues new post-exposure HIV guidelines
- A proposed infectious diseases rule?
- Finding a model for wellness
- Gearing up for the flu season – with many vaccines
- Profile of the HC sector: Which HCWs are at risk?

CNE QUESTIONS

1. The Washington, DC-based advocacy group Public Citizen issued a report criticizing the U.S. Occupational Safety and Health Administration, saying that the agency:
   A. does not focus enough resources on the health care sector.
   B. uses inaccurate data in its targeted inspection program.
   C. needs to improve its outreach to employers.
   D. has failed in its mission to protect workers overall.

2. According to the Centers for Disease Control and Prevention, what is the appropriate way to manage a masking policy for employees who have not received the influenza vaccine?
   A. Require all unvaccinated employees to be masked at all times from October 15 to April 15.
   B. Require unvaccinated employees, contractors and visitors to wear a mask before entering a patient room.
   C. Focus masking requirements in areas with patients who are at high risk of complications from influenza.
   D. CDC has no recommendations on a vaccinate-or-mask policy because of a lack of data.

3. According to new workers' compensation guidelines from the state of Washington, what is required to justify continued use of opioids?
   A. Reports of significant residual pain by patients.
   B. A second opinion from a pain expert.
   C. clinical meaningful improvement.
   D. Failure to return to work.

4. According to an analysis of workers' compensation claims data by the National Council on Compensation Insurance (NCCI) in Boca Raton, FL, workers who are 55 or older have injury rates that are similar to what other group of workers?
   A. Workers who are 45 and older.
   B. Workers with chronic diseases.
   C. Workers who are 35 and older.
   D. Workers who are obese.