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Push for HCW vaccine mandates goes beyond flu

'When you make something mandatory, it happens'

Health care workers should be required to receive all vaccinations — not just seasonal flu shots — recommended by federal public health authorities, according to a consensus of three leading infection prevention organizations, *Hospital Employee Health* has learned.

Under this broader approach, employers would mandate measles, mumps, rubella (MMR), varicella, pertussis and hepatitis B vaccines, in addition to the annual influenza vaccine.

The organizations — the Infectious Diseases Society of America (IDSA), the Society for Healthcare Epidemiology of America (SHEA), and the Pediatric Infectious Diseases Society — were poised to issue a joint statement as this issue of *HEH* went to press. They were expected to endorse hospital mandates for all vaccinations recommended by the Advisory Committee on Immunization Practices, an expert panel that advises the Centers for Disease Control and Prevention.

Voluntary programs are "somewhat successful, but they don't reach the level of universality," says **W. Charles Huskins,** MD, MSc, consultant in pediatric infectious diseases at the Mayo Clinic in Rochester, MN, and a liaison from SHEA to the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC). "When you make something mandatory, it happens."

That has been clear from the dramatic effects of mandatory influenza vac-

Special report: Occ health and the ACA

The Affordable Care Act seeks to promote prevention and to better manage chronic conditions. Health care networks will have incentives to improve the health of their members. Sound familiar? As we explain in this special issue of *HEH*, occupational health professionals have important skills and perspective to share as employers manage this new health care marketplace. ■

cination policies. Infection preventionists pushed for mandates, and several organizations issued position statements in 2010 and 2011 calling for influenza immunization to be a condition of employment for health care workers.

Hospitals responded either by creating a mandate or putting greater resources into voluntary programs, and the vaccination rates of health care workers rose dramatically. In the 2012-2013 flu season, 30% of hospitals had a mandatory influenza vaccination policy, and the overall vaccination rate in hospitals was 83%.[1]

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Outbreaks drive immunization effort

Recent outbreaks of measles, mumps and pertussis have placed a greater emphasis on other vaccines for health care workers. State laws vary, but most do not require hospital employees to be vaccinated.

By 2011, only about one in four (26.8%) health care workers had received a Tdap booster to protect against pertussis, according to the CDC.[2] Yet pertussis is a growing problem nationally, including nosocomial outbreaks in which health care workers were infected and transmitted pertussis to vulnerable patients.

Concerned about the reemergence of pertussis, Geisinger Health System in Danville, PA, made Tdap a condition of employment in 2010. A committee considered requests for exemptions and granted 314: 307 medical, 7 religious, one ethical. Only one person was fired. The health system recently reported a pertussis vaccination rate of 97.8%.[3]

The severe pertussis illness of a Geisinger pediatrician also brought home the importance of vaccination, says **Lisa Esolen**, MD, system medical director of infection prevention and control and health services.

"Our goal was only to protect our staff and our patients," says Esolen. "Pertussis has been on the rise here and nationally, and we didn't want to accept responsibility for spreading it to one patient. One patient getting sick with this was not acceptable."

Mandatory Tdap policies are becoming more common elsewhere. A 2013 survey by the Michigan Department of Community Health found that 29% of the state's hospitals required the Tdap booster for at least some employees, such as those with direct patient care or in high-risk areas. That was more than twice the rate of 11% from a survey just two years earlier.

Health care workers have high rates of measles, mumps and rubella (MMR) vaccination, but those born before 1957 have been presumed to be immune. CDC is now encouraging health care facilities to vaccinate those employees who do not have laboratory evidence of immunity, a history of lab-confirmed disease, or two doses of the MMR vaccine.[4]

A 2009 measles outbreak in a Pennsylvania hospital revealed gaps in immunity. Five people, including a previously vaccinated emergency physician, acquired measles from an unvaccinated child who was initially misdiagnosed. The hospital reviewed the records of 168 potentially exposed employees

and found that 72 (43%) had no documented measles immunity.[5]

Influenza mandates have received the greatest attention nationally. But if mandates are effective, they should cover all recommended vaccines, contends **Tom Talbot**, MD, MPH, chief hospital epidemiologist at the Vanderbilt University Medical Center in Nashville, TN, and a member of HICPAC. "Why just single out flu?" he says. "Shouldn't this apply to all vaccine-preventable diseases and recommended vaccinations?"

'Vaccination is invasive'

Some occupational medicine physicians advocate a more nuanced approach, based on the specific disease.

Varicella and measles are airborne diseases, and occupational exposures can result in furloughs of susceptible, exposed workers, notes **Melanie Swift**, MD, director of the Vanderbilt Occupational Health Clinic.

Following an exposure, for example, employees without documentation of immunity would have to be placed on leave until their immunity could be verified, she notes. "Any found to lack antibody would have to remain out for the entire incubation period, because at that point it's too late for vaccination to protect them," she says. "That's an unsafe situation for patients and an unnecessary business interruption for the employer."

A mandate for a pertussis booster (Tdap) might be appropriate for health care workers who have contact with newborns or the neonatal intensive care units, she says. Tdap is recommended for all health care workers, but most would be at low risk for pertussis, she notes.

Hepatitis B vaccine is designed to protect workers. The U.S. Occupational Safety and Health Administration requires health care employers to offer the vaccine to all employees who have occupational exposure, but allows employees to decline the vaccine.

The IDSA-SHEA-PIDS statement is expected to encourage employers to make those vaccinations mandatory. Swift objects to a hepatitis B mandate, as well as mandates for the annual influenza vaccine. Influenza is typically widespread in a community and could easily be transmitted by family members and visitors, who aren't required to be vaccinated, she notes. And the influenza vaccine has varying effectiveness, she says.

In general, Swift advocates a conservative approach to mandatory vaccination policies. "Vaccination is invasive and comes with varying risks depending on the vaccine," she says. "A mandate essentially robs an individual of their autonomy over what goes into their body. I think the evidence [of benefit] should be extremely solid if you are going to force people to be vaccinated for the intended purpose of benefitting someone else."

Policies designed to protect patients

However, some hospitals have already adopted broader mandates in the name of patient safety. In

Tdap booster for HCWs a 'high priority'

Pertussis has reemerged in outbreaks across the country. More than 48,000 pertussis cases were reported in the United States in 2012, the highest number since 1955. Seventeen states reported an increase in pertussis cases from 2012 to 2013, according to the Centers for Disease Control and Prevention.

Against that backdrop, the American College of Occupational and Environmental Medicine (ACOEM) issued a position statement underscoring its support of pertussis vaccination (Tdap) of health care workers.

"ACOEM fully supports pertussis vaccination of health care workers with direct patient contact and urges physicians in its membership who oversee occupational health programs in medical centers to assign high priority to vaccinating health care workers as soon as feasible," the statement said.

Pertussis vaccination will protect the most vulnerable infants, ACOEM said. "It will also provide vital protection to millions of U.S. health care workers at enhanced exposure risk from pertussis," it said.

AOCEM also made reference to recent research that indicates that the Tdap protection wanes over time. *(See* HEH*, April 2013, p. 46.)* "Although licensed for a single dose, it is anticipated that for continued protection from pertussis, additional doses will be required periodically, possibly up to every 10 years," the AOCEM said. ■

2011, for example, the Texas legislature approved a new provision of the state's Health and Safety Code that requires health care facilities to "develop, implement, and enforce a policy to protect its patients from vaccine preventable diseases." The law requires HCW vaccines "specified by the facility based on the level of risk the individual presents to patients by the individual's routine and direct exposure to patients."

Paris (TX) Regional Medical Center decided to mandate vaccination against MMR, varicella, pertussis and influenza among employees who work in patient care areas. A medical exemption requires a note from a physician and a declination based on religious beliefs requires a signature from a clergy person. Employees with exemptions may need to wear a mask or other protective equipment, based on the disease and the potential for exposure, says employee health nurse **Diane Nation**, RN, BSN.

As the new policy unfolded in 2012, Nation worked laboriously to document every immunization and titer and offer necessary vaccination. Some employees needed titers for varicella, some needed titers for mumps or measles. Although hepatitis B vaccine remains voluntary, Nation also drew titers and offered additional HBV vaccination.

Now the hospital has detailed immunization records on all employees and volunteers, and virtually all of them are protected. "Safety is the number one initiative of our CEO," says Nation. "It's a culture that we have here at our hospital that I'm so proud to be a part of."

Marshfield (WI) Clinic requires an annual flu vaccine, MMR, varicella, Tdap and hepatitis B. Laboratory workers must receive the meningitis and tularemia vaccine and veterinarians receive the rabies vaccine. "If you work in health care, this has got to be part of what you do," says **Bruce Cunha**, RN, MS, COHN-S, manager of Employee Health and Safety.

Cunha also draws titers to check for immunity. After all, previous vaccinations could have been mishandled, he says. At Marshfield, refrigerator temperatures are monitored and vaccines are kept out of the refrigerator only for limited time, he says.

For all but the flu vaccine, the documentation of immunity will be lasting, Cunha notes. "Once we give you that piece of paper, you shouldn't have to have anything done again, no matter where you go," he says.

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ACA upside: Obamacare could boost occ health

Law emphasizes prevention, workplace wellness

On the surface, Obamacare and occupational health don't seem to have much overlap. But rip aside the controversy over the health insurance exchanges and medical benefits, and employee health professionals may find themselves in a familiar realm of preventive health.

In fact, the Affordable Care Act gives EHPs a unique opportunity to become involved in their hospital's containment of health care costs. After all, occupational health differs from other medical specialties because of its emphasis on prevention and population health, says **Kathryn L. Mueller**, MD, MPH, FACOEM, professor in the Department of Physiatry and the School of Public Health at the University of Colorado Anschutz Medical Campus in Aurora.

"It's an opportunity for growth, for the occupational medicine foundations of how we provide treatment to be expanded into the realm of overall medical care," says Mueller, president-elect of the American College of Occupational and Environmental Medicine (ACOEM).

The Affordable Care Act pushes payment systems towards rewarding functional outcomes rather than fee for service. Improving function is the laser focus of employee health, as EHPs seek to reduce disability and get employees back to work as quickly as possible, she notes. Occupational health professionals also have experience analyzing workers' compensation and injury data and seeking ways to reduce health costs — skills that are similar to those promoted by the ACA.

"We look at the population and say, 'How do we

improve the overall health?' That is unique [among medical specialties]," Mueller says. "Those values are the same ones you would use to manage chronic disease."

Employee health can play a direct role in helping employers lower health care costs, says **Craig D. Thorne**, MD, MPH, vice president and medical director of Employee Health & Wellness for Erickson Living, long-term care communities based in Baltimore, MD. Erickson provides health clinics for employees. (*See related article on p. 6.*)

"Onsite employee health can be more cost effective, you can provide work-related and non-work-related care, and we can remove some of the barriers to finding care," he says.

ACOs look for better outcomes

The new paradigm for medical care is the "accountable care organization," networks of doctors, hospitals and other health care providers who receive bonuses or incentives for keeping a population healthy. There are about 500 ACOs — at least one in every state — and the number is growing. About half of them operate under Medicare and the other half are private.

ACOs will focus on improving the care of people with chronic illnesses, such as asthma or diabetes. But they won't just look at numerical values, such as A1C scores, says Mueller. The ACOs will seek to improve function — something employers are particularly interested in, since it relates to productivity and absenteeism.

"It's designed to promote a change in culture focused on value outcomes," says Mueller.

This coincides with a push in occupational health to integrate injury prevention with health promotion. This is especially important as the workforce ages and copes with chronic conditions, says **Sheila Fitzgerald**, RN, PhD, director of Occupational and Environmental Health Nursing at the Johns Hopkins Education and Research Center for Occupational Safety and Health in Baltimore.

Obesity, in particular, has a dual impact. Obese workers are at greater risk of injury, and they have a higher rate of chronic diseases such as high blood pressure and diabetes. *(See related article on p. 7.)*

"Businesses have [financial] incentives to provide programs that help their employees remain healthy," Fitzgerald says.

While most employee health departments don't provide a full range of medical care to employees, they are a key part of health education and prevention programs, such as annual vaccinations. They help manage disability accommodations and the Family and Medical Leave Act and often coordinate wellness programs. They interact with employees through pre-placement exams and annual contacts, such as TB testing or fit-testing.

Yet they are rarely a part of committees that make decisions related to insurance and employee medical costs.

"It's going to require aggressive activity on our part to be sitting at the right places, talking to the right people, because we haven't always been included in these discussions," says Mueller. "That's the challenge."

Worksite wellness gets a boost

Even with health insurance exchanges that are not subsidized by employers, the workplace remains a focal point for health improvement.

The Affordable Care Act places worksite wellness at the center of a "national public health strategy," according to a report[1] in *Preventing Chronic Disease*, a journal published by the Centers for Disease Control and Prevention.

"One of the genius strokes of the Affordable Care Act is looking at the workplace as a perfect venue for encouraging healthy lifestyles," says **Laura Anderko**, PhD, RN, Robert and Kathleen Scanlon Endowed Chair in Values Based Health Care at the Georgetown University School of Nursing & Health Studies in Washington, DC. "It saves money, but it also keeps people healthy, keeps them at the workplace, and reduces insurance costs."

The ACA provides grants for small businesses to start wellness programs and it is funding a new Work@Health program administered by CDC. Six hundred employers of all sizes will participate in training sessions to learn how to implement a comprehensive workplace health program. (*More information is available at* www.cdc.gov/workathealth/get-involved.html.)

Meanwhile, the Affordable Care Act allows employers to increase employee incentives to participate in wellness programs.

Incentives rise for healthy habits

Employers may offer incentives, such as a premium discount, of up to 30% of the total cost of employee-only health care coverage (both employer and employee contribution). The incentives can be even greater if employers include programs to prevent or reduce tobacco use. Incentives for non-smokers or participants in smoking cessation programs can

rise to a maximum of 50% of the total health coverage cost. The previous limit for wellness incentives was 20% of health insurance premiums.

The law has some fine print. Different types of wellness programs may involve different incentives. In "participatory wellness programs," employers may reward employees who participate in a wellness program that has no specific goals or requirements. For example, they may reimburse the cost of fitness club membership, reward someone for attending an educational session, or offer an incentive to take a health risk appraisal that has no further requirements for attaining health outcomes.

The rule's incentive limits apply to activity-only and outcomes-based wellness programs. An employer can provide a discount on health insurance premiums to employees who perform certain activities (such as following a diet or participating in an exercise program) or the employees who reach a certain goal (such as losing weight or lowering blood pressure).

To guard against discrimination, the law requires employers to offer an alternate pathway to a reward if an employee cannot perform the activity or attain the goal for medical reasons. For example, if an employer offers a reward for a walking program, and an employee can't participate because of a medical condition, the employer either needs to provide another wellness option or waive the requirement for that employee.

"[The outcome or activity-based program] must have a reasonable chance of improving the health of, or preventing disease in, participating individuals, and not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease," the law states.

Editor's note: The rule on wellness incentives, which becomes effective on January 1, 2014, is available at www.federalregister.gov/articles/2013/06/03/2013-12916/incentives-for-non-discriminatory-wellness-programs-in-group-health-plans. ■

Onsite clinics boost employee health

Employer integrates wellness, occ health

When an employee isn't feeling well at an Erickson Living retirement community, she or he pops into the on-site clinic. She also can go to the clinic for a mammogram referral, or a wellness checkup, or a weight-management class. And that's the same place they will go if she needs an injury treatment, return-to-work assessment or a flu vaccine.

The average time for anything but a complete physical is 30 minutes, and even that is less than an hour.

By integrating wellness, sick care and employee health, Erickson Living has saved and increased employee satisfaction. But the national provider of long-term senior living, which is based in Baltimore, MD, also has proven the feasibility of integrated employee health care.

Over the past six years, Erickson Living's employee health care costs rose only 3.9% compared to an average of 5.6% nationally, says **Craig D. Thorne**, MD, MPH, MBA, vice president and medical director of Employee Health & Wellness for Erickson, which is based in Baltimore. The lower costs keep the health benefits affordable to the company and employees.

"It's part of the health and wellness philosophy of our company. We recognize caring for the health and the well-being of our employees is not only the right thing to do, but it is also a good long-term company investment," he says. "It reduces our long-term health care costs. Also, it has a direct impact on the quality of the services we provide to the seniors that we serve".

"Healthy employees can provide a higher quality of services," he says.

Erickson Living launched the onsite health clinics in 2007. But having the clinics gives the company a unique advantage as the nation transitions to life under the Affordable Care Act, says Thorne.

The ACA creates incentives for preventive care and better management of chronic conditions. In accountable care organizations, networks of hospitals, doctors and other providers, payments will be linked to improved functional outcomes.

Clinics prevent ER trips

Employees have embraced the accessibility of the clinics. In 2012, there were more than 22,000 visits to 13 Erickson clinics; about four in 10 of those visits involved occupational health issues. (There are now 15 clinics and Thorne predicts higher total visits for 2013.)

The clinics ask employees where they would have gone if they didn't have access to Erickson Living onsite clinic; about 25% to 30% respond that they would have gone to an emergency department.

"Emergency rooms are three to four times the cost of an office visit. We're saving three or four

times the cost by having the services done on site," says Thorne. "We're also saving at least three hours of lost work time which is important to productivity."

Employees don't need to pay a co-pay if they belong to Erickson Living's self-funded health plan. Other employees pay only a $20 flat fee for the services, including lab tests.

The clinics are staffed by nurse practitioners or physician assistants. "We don't consider ourselves to be their primary care provider," says Thorne. "If there's a serious or chronic health condition that's found, we help them find a primary care doctor."

They have uncovered numerous issues, such as arrhythmias, very high blood pressure, an evolving stroke and a leaky heart valve, enabling employees to get prompt treatment and avoid more serious problems.

The clinic services — and health insurance coverage — are available to all employees regardless of their insurance status, number of hours worked and duration of employment; and health insurance benefits are available to part-time and flex-time employees who work at least 30 hours per week, in keeping with the provisions of the Affordable Care Act.

Wellness incentives, too

Erickson Living has integrated its wellness program with the onsite clinics. A personal nurse health coach works with employees with chronic diseases or health risks, and health advocates help employees find a doctor and manage health insurance issues.

Every clinic has smoking cessation and weight management programs. Employees can receive a $10 discount every pay period off their health insurance premium cost if they are tobacco-free and participate in biometric screening and a health risk assessment.

They also can receive reimbursements of up to $240 per year for wellness expenses through their personal wellness fund for expenses such as gym membership, weight loss programs or home fitness equipment.

Another advantage of onsite clinics may become apparent as the nation's health care environment evolves under the ACA. An increase in the number of people with insurance and an emphasis on preventive care will place a greater demand on primary care, Thorne notes.

"Quick access to quality care will be an even greater benefit for Erickson Living employees," he says. And early diagnosis and treatment of disease will lead to lower health care costs for the employer. ■

Wellness program targets biggest problem: Obesity

Lose 16 tons and what have you got? Health

Like many of the nation's employers, Aurora Health Care in Milwaukee faced a problem that was large in every dimension: Girth, scope, cost, and health implications. Obesity is linked to higher rates of chronic illness than smoking and drinking.[1]

Health screenings revealed that more than one in three (35.3%) of Aurora employees had a BMI above 30, the definition of obese. While that prevalence was eye-opening, it mirrors the national experience. Some 35.7% of U.S. adults are obese, according to the Centers for Disease Control and Prevention.

Aurora decided to address the problem by boosting its wellness initiative, adding financial incentives, and providing support for weight management. "Our leadership knew we needed to do something when they found these statistics," says **Amy Confare**, Aurora's integration analytics manager.

The health system, which has more than 30,000 employees in 15 hospitals and more than 172 clinics, already had added healthier options in its cafeterias, smoking cessation benefits and an insurance premium increase for smokers. Its campuses are tobacco-free.

A closer look at employee health costs revealed that the health system was spending almost $250 million a year on medical care and prescriptions. The profile of employees: They had an average age of 44. Seventy-five percent were women, and 63% were overweight.

"We had to do something to help people lower their weight," says Confare. "Aurora looked at what other organizations were doing inside and outside of health care to help their employees maintain a healthy lifestyle."

Many options for weight management

Aurora developed a wellness initiative that began in early 2013. Employees on Aurora's health plan (about two-thirds of employees) can earn a discount of up to $13.33 per biweekly pay period by complying with three criteria: Being tobacco-free, completing a health risk appraisal, and being of a healthy weight or participating in a weight management program.

Weigh-ins began in January. Employees with

a BMI of 30 or higher had several options for achieving the premium discount: They could lose 5% of their body weight on their own by August. They could join a Weight Watchers program. They could participate in either a clinic-based or phone-based Health Management Resources (HMR) program, which involves meal replacement and coaching. Or they could obtain coaching from the Employee Assistance Program.

Only the on-your-own alternative required another weigh-in. The others were based on participation in at least 10 of 12 weeks, and Aurora provided a partial reimbursement of costs for the Weight Watchers and HMR programs.

The first weeks involved a flurry of weigh-ins — 17,704 in all — and some pushback from employees.

After all, weight is a sensitive subject, says Confare. "Imagine your company is telling you have to think about losing weight if you have a BMI of 30 or higher," she says.

Breaking old habits

Success stories soon overcame the sensitivities. "We definitely saw that people were thankful," says Confare. A sample employee comment: "You saved my life."

The wellness initiative demonstrated that a phone-based coaching and meal replacement program could be as successful as an in-person clinic, says **Doug Black**, chief commercial officer for HMR Weight Management Services Corp. in Boston. That's important because phone-based programs are more accessible, less expensive and able to handle more participants, he says.

"The purpose of this is to break old habits and to provide strategies," he says. For example, coaches help participants keep on a healthy eating plan while traveling, celebrating holidays, or juggling a busy family. "You do need a coach to help you pull it all together," he says.

Participants in the HMR clinic program lost an average of 45 pounds, or 17% of their body weight. Those in the phone-based program, called Healthy Solutions at Home, lost an average of 24 pounds or 11% of their body weight. The participants also increased their intake of fruits and vegetables and physical activity.

A study comparing the results of the two methods was presented at the annual conference of The Obesity Society in November.

Aurora is already gearing up for another wellness initiative in 2014. Meanwhile, the positive results provide a base for promoting a wellness program for corporate clients through the health system's accountable care organization, Confare says.

In all, about 3,200 employees lost 16 tons of weight, she says. Healthier employees can provide better care for patients, she says.

And when Aurora partners with other companies, the health system can say: "If Aurora can do this with our own employees, how can we help you with yours?"

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FDA moving to limit opioid overuse

Hydrocodone moves to Schedule II

In response to growing concerns about overuse of opioids, the U.S. Food and Drug Administration has recommended reclassifying hydrocodone products as Schedule II drugs — those with a high potential for abuse.

That means that prescriptions for drugs such as Vicodin or Lortab would be limited to 90 days, and patients would need to see their physician for a new prescription. The change must be approved by the U.S. Department of Health and Human Services and the U.S. Drug Enforcement Agency. The drugs are currently Schedule III.

"[T]he FDA has become increasingly concerned about the abuse and misuse of opioid products, which have sadly reached epidemic proportions in certain parts of the United States," **Janet Woodcock**, MD, director of FDA's Center for Drug Evaluation and Research, said in a statement.

"While the value of and access to these drugs has been a consistent source of public debate, the FDA has been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse," she said.

Opioid abuse is a growing concern in workers' compensation. The hydrocodone-acetaminophen combination is the third-most commonly prescribed drug in workers' compensation, according to the

National Council on Compensation Insurance, based in Boca Raton, FL. The top 1% of workers' compensation claimants consume 40% of all narcotics, NCCI found. (*For more information on opioid overuse, see* HEH*, September 2013, p. 101.*)

The change will have ramifications for injured workers who suffer from ongoing pain, 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.

"Whenever these types of decisions are made, we should think carefully about all the consequences," says Mueller, who is president-elect of ACOEM.

Reevaluate patients after a week

Limiting prescription duration to 90 days will provide better control over the drug and help prevent overuse or abuse, she said. But physicians are often reluctant to prescribe Schedule II drugs, and that may leave some people with unresolved pain, she says. Schedule II drugs involve additional documentation and reporting requirements.

For example, some people can't metabolize codeine, which makes codeine-containing prescriptions ineffective for them. "We're going to have a failure in some patients," says Mueller. "If that's the main choice, then those patients might not get any pain relief or very little."

Patients should be reevaluated after a week on pain medications to ensure that they are getting adequate relief, she says.

Interestingly, even as the FDA moved to restrict use of hydrocodone products, the agency approved Zohydro ER, an extended-release capsule form of hydrocodone bitartrate.

The FDA is requiring the maker, Zogenix, to conduct post-marketing studies "to assess the known serious risks of misuse, abuse, increased sensitivity to pain (hyperalgesia), addiction, overdose, and death associated with long term use beyond 12 weeks."

Zohydro ER provides another option for patients who need pain relief, the FDA said. "Due to the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with [extended-release, long-acting] opioid formulations, Zohydro ER should be reserved for use in patients for whom alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Zohydro ER is not approved for as-needed pain relief," the FDA said. ■

OR radiation is a top 10 technology hazard

ECRI urges broader radiation monitoring

The rapid growth of image-guided surgery has revolutionized procedures and reduced recovery time for patients, but it has increased risks of radiation exposure to the operating room staff.

To alert hospitals of this emerging hazard, ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, has included radiation in "hybrid" ORs as one of the nation's top 10 health technology hazards for 2014.

The concern arises because radiation use in the operating room has become much more common with the use of advanced imaging systems to guide surgery. "Suddenly, you're introducing a technology that has the potential to deliver a much higher dose than has previously been the case in the OR," says **Jason Launders**, MSc, director of operations for ECRI's Health Devices Group.

Traditionally, radiation safety officers monitor radiation exposure in radiology departments by assigning badges to the affected employees. Those badges are collected regularly, such as monthly, to monitor employees' cumulative dose. The goal is to keep the dose as low as reasonably achievable.

Yet broader uses of radiation throughout the hospital, it has become more difficult to track employee exposures, says Launders. "There is an opportunity here to reexamine your radiation safety program and make sure you are doing what is necessary to keep your staff safe," he says.

By highlighting the hazard in its top 10 list, ECRI hopes to spur hospitals to give more attention to these other uses, he says. So far, there are no reports of adverse events related to radiation use in the operating room, he says.

"We think people should be looking at these issues now," says Launders.

Include float staff in training

The first step is to determine where radiation is being used in the hospital, outside of traditional radiology. This includes imaging technology in the OR.

ECRI: Protect OR staff from radiation

ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, offered these recommendations for handling radiation hazards in hybrid ORs:

- Verify that all hybrid OR staff (including surgeons) obtain OR-specific radiation protection training and that they put this training into action. Consult with a medical or health physicist when developing your radiation protection and safety program.
- Nominate a member of the hybrid OR team to assume the day-to-day responsibility for verifying that radiation protection policies and procedures are being followed. This role is not to be confused with that of the radiation safety officer (who oversees procedures for the entire organization).
- Assess the adequacy of existing built-in radiation protection infrastructure. Consider implementing additional personal radiation safety equipment as needed, such as specialized radiation shield garments.
- Consider implementing real-time monitoring to ascertain the effectiveness of radiation safety training, particularly if the analysis of badges proves ineffective at determining the cause of — and steps needed to correct — clinician overexposure. ■

All of the employees who could be exposed should receive training about ionizing radiation and preventive measures, according to the ECRI recommendations. Because OR staff often float among different rooms, it's important to include everyone who could work in a hybrid OR, Launders says.

It's important to engage the OR staff and managers in this process, he says.

The amount of ionizing radiation that can be present in an OR varies based on a number of factors, including the length of the surgery and the techniques of the surgeon.

One way to educate OR staff about the presence of radiation is to give them electronic badges that display the radiation exposure on a real-time monitor in the room. Sometimes by simply moving a few feet, they can greatly reduce exposure, Launders says.

"There's no better way of teaching people than giving them instant feedback," he says.

Lead aprons are important protective gear, says ECRI. Other barriers also may provide a benefit.

As imaging becomes an increasingly important part of surgical procedures, hospitals will need to continually adapt their radiation protection programs, he says. They also will need to keep lifetime exposure records for those who are monitored, he says.

[*Editor's note: More information about ECRI's report on the "Top Ten Health Technology Hazards of 2014" is available at* www.ecri.org/2014hazards. *The Association of peri-Operative Registered Nurses (AORN) has a toolkit on reducing radiation hazards in ambulatory surgery at* www.aorn.org/Clinical_Practice/ToolKits/Tool_Kits.aspx.] ■

N95 use questioned for surgical smoke

More data needed, CDC panel decides

Surgical smoke plumes contain may intact viral DNA, but with no definitive evidence to show it's infectious, a federal advisory panel said the use of N95 respirators during smoke-generating procedures is not currently warranted.

The hazards of surgical smoke have long been a concern of peri-operative nurses. The Association of peri-Operative Registered Nurses (AORN) recommends the use of smoke evacuation systems for electrocautery and laser procedures and says facilities "should consider" N95 respirators as personal protective equipment when procedures involve infectious material.

The issue before the Healthcare Infection Control Practices Advisory Committee (HICPAC), an expert dvisory panel to the Centers for Disease Control and Prevention, related to laser and electrocautery procedures for Human Papilloma Virus (HPV), such as smoke-producing procedures to remove HPV warts.

A CDC research review of 25 articles found evidence of whole HPV genome in smoke plume. In one study, viable bovine papilloma virus was generated in smoke plume and then injected into cows. All three of them acquired the infection.

But that didn't mimic occupational exposure, and other studies did not clearly show a link between occupational exposures and HPV infection, **David Kuhar**, MD, medical officer with CDC's Division

of Healthcare Quality Promotion, told *Hospital Employee Health*.

"The epidemiology of disease is not here," says Kuhar. "With that piece missing, it makes it difficult to say there's disease transmission happening, because it hasn't been demonstrated.

Case reports also are lacking, he says. "We've had 20 years of these exposures happening and no clear signal of disease," he says.

Smoke evacuation use lacking

Nurses have long complained about irritation from surgical smoke plume, including exacerbation of asthma and allergic sensitivities. A 2010 web-based survey found that only about one in four (24%) of OR nurses said smoke evacuation was used "always" or "often" during cosmetic or plastic surgery that involved electrocautery or electrosurgery.[1]

The National Institute for Occupational Safety and Health (NIOSH), a division of CDC, recommends the use of smoke evacuators within two inches of the surgical site in laser or electrosurgery procedures. There is no regulation from the U.S. Occupational Safety and Health Administration related to surgical smoke.

In a 2001 Health Hazard Evaluation at a Virginia hospital, NIOSH researchers found formaldehyde, acetaldehyde, and toluene in OR air samples during five procedures that used electrocautery. Half of the OR nurses, technicians and nurse anesthetists said they had symptoms associated with surgical smoke, including physician-diagnosed asthma.[2]

Amber Jones, MSN, RN, CNOR, CIC, CPN, a perioperative nursing specialist and AORN liaison to HICPAC, said she was glad that the panel addressed the issue. "The message is getting out about the hazards of surgical smoke," she says. "We feel that further research is needed on this topic."

A number of toxic and carcinogenic chemicals have been detected in surgical smoke, and as Kuhar noted in his HICPAC presentation, "live and infectious HPV seems likely to be in smoke plumes." HICPAC members agreed that smoke evacuation is important, but worried that respirator use could have other consequences, such as health care workers touching their faces with contaminated hands to adjust uncomfortable respirators.

"We have to base [recommendations] on the risk we think is associated with exposure," **Mark Russi**, MD, chair of the Medical Center Occupational Health section of the American College of Occupational and Environmental Medicine (ACOEM) and director of occupational health at Yale-New Haven Hospital. Russi is the ACOEM liaison to HICPAC.

"The data are pretty scant … on the impact of respirator use in operating rooms," he said.

[*Editor's note: AORN provides a free surgical smoke toolkit that includes a sample policy and awareness posters at* www.aorn.org/smoketoolkit/.]

REFERENCE

1. Edwards BE and Reiman RE. Comparison of current and past surgical smoke practices. *AORN Journal* 2012; 95:337-350.
2. King B and McCullough J. Health Hazard Evaluation Report 2000-0402-3021, National Institute for Occupational Safety and Health. November 2006. Available at http://www.cdc.gov/niosh/hhe/reports/pdfs/2000-0402-3021.pdf. ■

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

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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 emailed 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.

CNE QUESTIONS

1. If health care workers were required to receive all recommended vaccines, what would that include?
   A. Influenza, pertussis, varicella, measles, mumps and rubella
   B. Influenza, pertussis, meningitis, pneumococcal, and measles, mumps and rubella
   C. Influenza, pertussis, varicella, hepatitis B, and measles, mumps and rubella.
   D. Influenza, pertussis, and measles, mumps and rubella

2. The Affordable Care Act encourages the creation of "accountable care organizations," which are:
   A. A new name for Health Maintenance Organizations (HMOs)
   B. Networks of doctors, hospitals and other health care providers with incentives for keeping a population healthy.
   C. Health insurance companies that offer products on the online exchange.
   D. Providers who agree to accept bundled payments under Medicare.

3. The U.S. Food and Drug Administration made what recommendation for change to drugs that contain hydrocodone?
   A. They would no longer be used in workers' compensation.
   B. They would be switched from Schedule III to Schedule II.
   C. They would no longer be produced in combination with other pain relievers, such as acetaminophen.
   D. They would have new warning labels.

4. ECRI Institute, an independent health care research firm based in Plymouth Meeting, PA, has included radiation in "hybrid" ORs as one of the nation's top 10 health technology hazards for 2014. What does it recommend?
   A. A reduction in the use of imaging devices that emit radiation.
   B. Greater radiation protections for patients in the OR.
   C. New construction to make ORs more protective.
   D. Radiation training and monitoring for OR personnel.

COMING IN FUTURE MONTHS

- Designing an age-friendly workplace
- A toolkit to guide you through a wellness initiative
- The unsolved problem of needlesticks
- How healthy are nurses?
- Problem-solving in TB screening programs

Hospital Employee Health®

2013 Index

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2013 SALARY SURVEY RESULTS

Hospital Employee Health®

EHPs must rise to the challenge of tough times

Gain an edge with education, certification, professionalism

When it's time for belt-tightening at your hospital, is employee health taking the squeeze?

With changes in reimbursements and uncertainty over the Affordable Care Act, hospitals are looking for ways to save money. Employee health professionals need to demonstrate their role in controlling costs and keeping employees healthy — so the department isn't wrongly viewed as a cost center, occupational health experts say.

"It's not good enough just to assume that management understands what you bring to the table," says **Dee Tyler**, RN, COHN-S, FAAOHN, director of medical management for Coverys Insurance Services in Lansing, MI, and executive president of the Association for Occupational Health Professionals in Healthcare (AOHP). "You have to be able to document in a very concise way that there is value in the position."

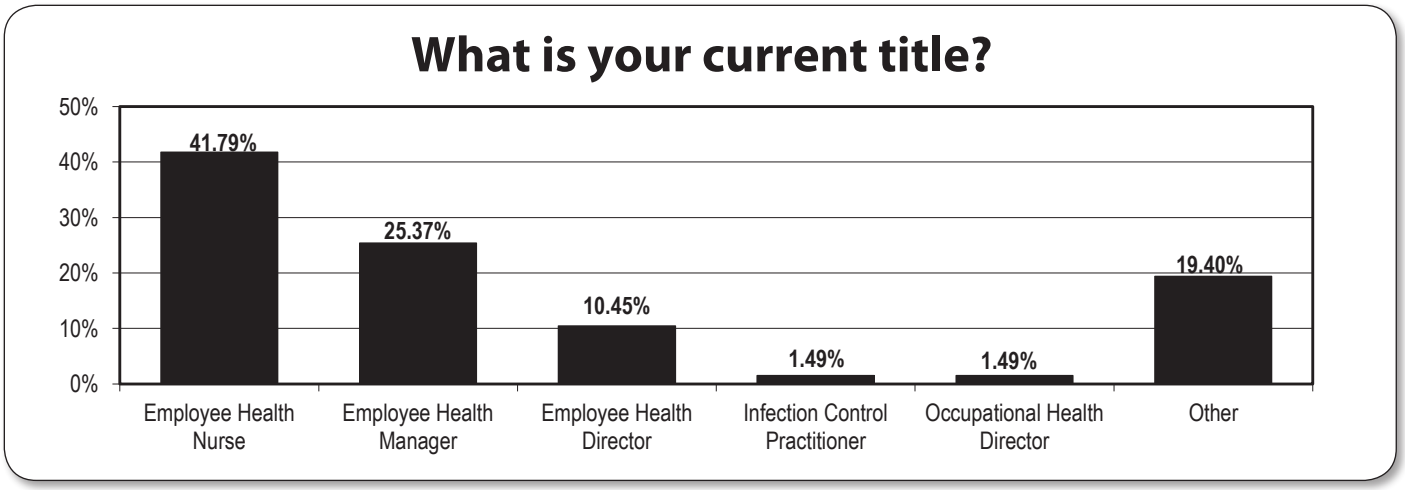
Promoting the role of employee health is also increasingly important as experienced EHPs retire and newcomers take their place. Today's experienced employee health professionals are mentoring a new generation to shape the health care environment of the future.

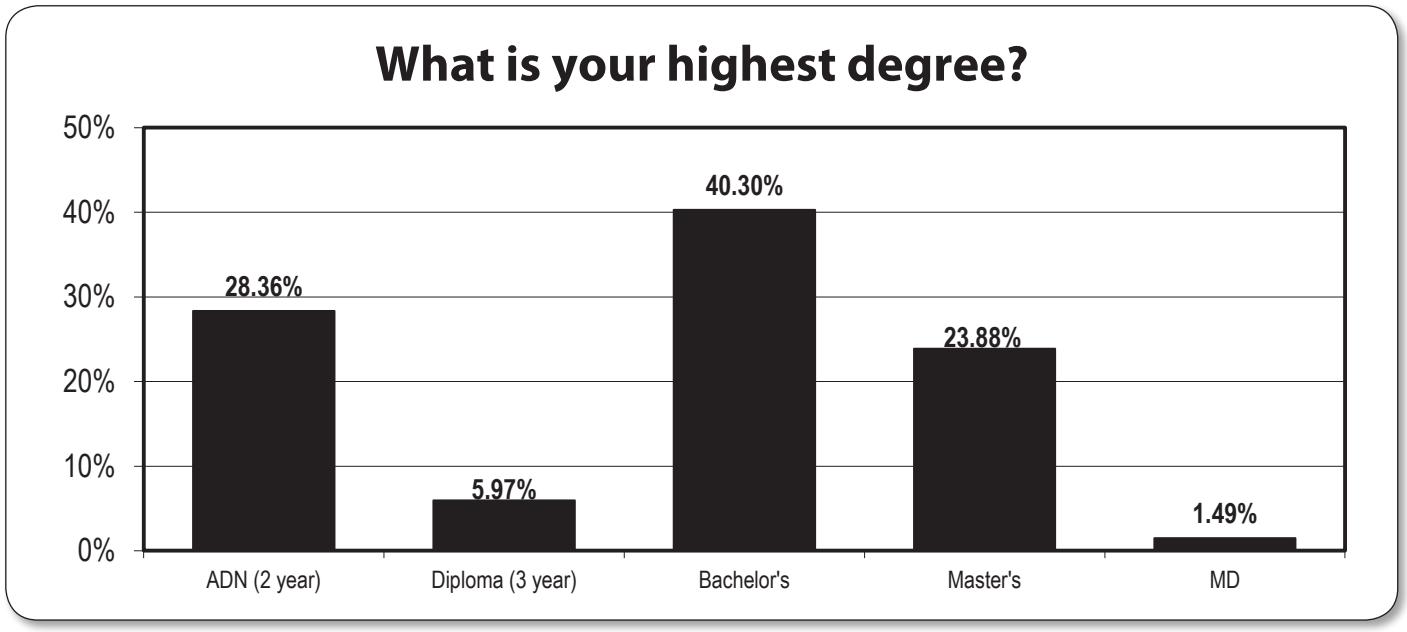
Most employee health nurses have many years of experience in nursing — three out of four (78%) have 22 or more years, according to the 2013 HEH salary survey. But as employee health nurses retire, a new group of nurses are taking their place; 36% of employee health nurses have six or fewer years in the field, the survey found.

Salaries have remained stable. For one in four EHPs, there were no raises in 2013. More than half (58%) of survey respondents said they received a raise of 1% to 3% last year, and 15% received a higher raise. Some 42% earned between $60,000 and $79,999, the survey found.

Gaining a specialty skill set

Occupational health experts have always advised EHPs to document cost-savings, such as reductions in





workers' compensation claims due to injury prevention or reduced absenteeism from a strong return-to-work program.

In uncertain times, some hospitals are consolidating employee health with other departments, such as safety or infection control, and EHPs need to make sure leadership is aware of the importance of the occupational health role, Tyler says.

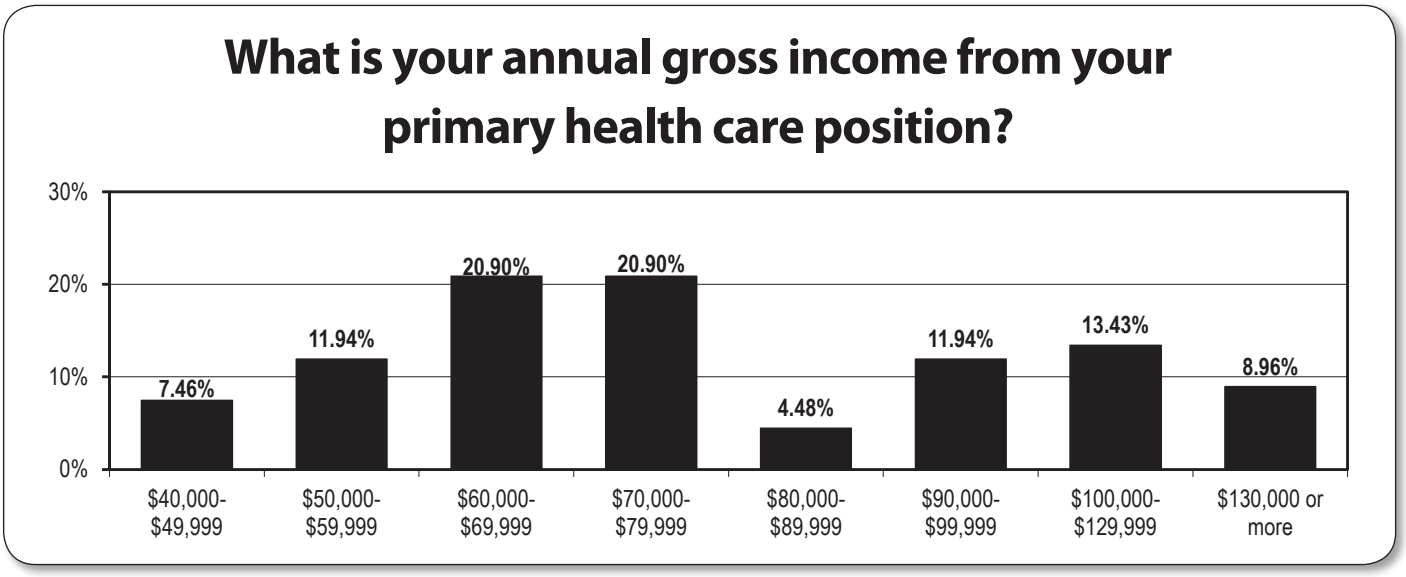
Another myth that needs busting: Any nurse can fulfill employee health duties. While any nurse can give flu vaccinations, that nurse isn't likely to be aware of occupational health and safety regulations, the requirements for respiratory fit-testing, the appropriate follow-up for bloodborne pathogen exposures, or a range of other hazards and issues.

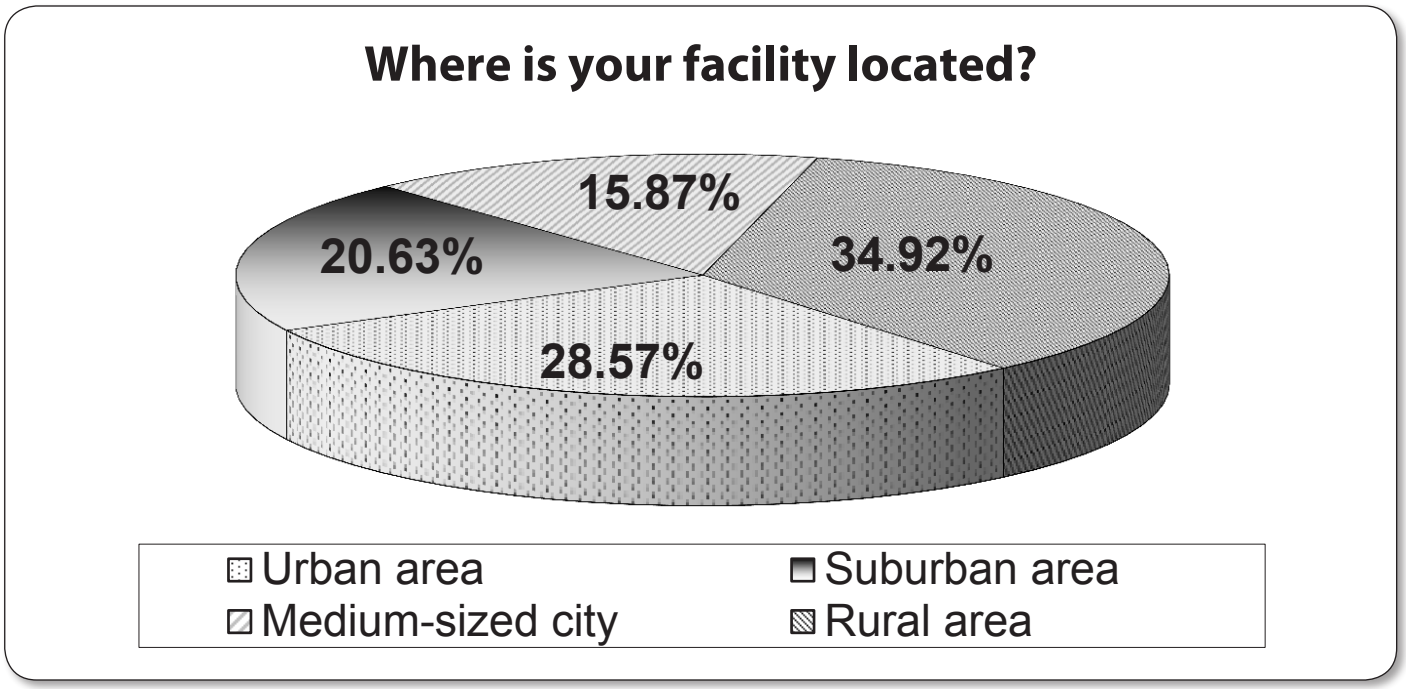
"There's definitely a specialty role with a specialty skill set that goes with that," says Tyler.

Where can you find the tools to present the business case for occupational health? Professionals associations such as AOHP or the American Association of Occupational Health Nurses (AAOHN) are a good place to start.

AOHP has "tools for your work" on its website (www.aohp.org) and a listserv that allows members to discuss current topics and issues. AOHP also offers a "Getting Started" manual with basics for EH newcomers. AAOHN has live webinars, and both organizations publish a journal and offer education at an annual conference.

The U.S. Occupational Safety and Health Administration (OSHA) also has a "Safety Pays" web page with a calculator to determine the direct and indirect cost of workplace injuries (www.osha.gov/Region7/fallprotection/safetypays.html).





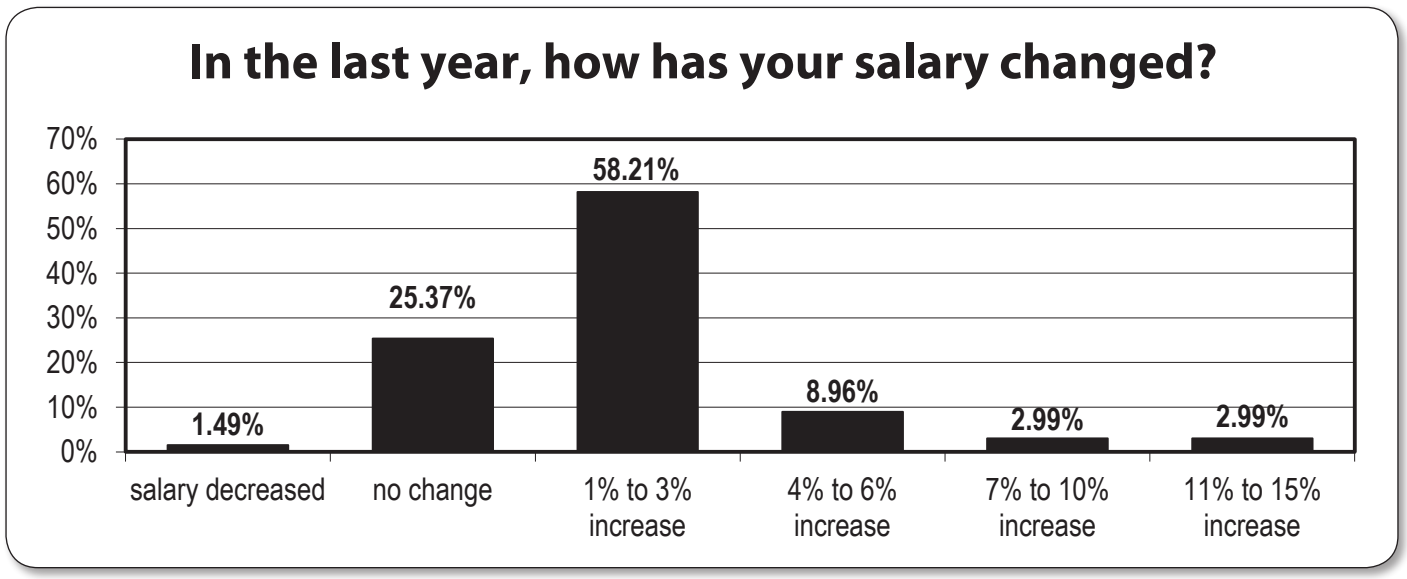
If you want to conduct an injury prevention program, such as an intervention to reduce patient handling injuries, but you don't have a budget for a consultant, consider contacting a local university, advises **Deirdre McCaughey**, MBA, PhD, assistant professor of health policy and administration at The Pennsylvania State University in University Park, PA. Students may need a health care research project — and you may have a real-world problem they can address.

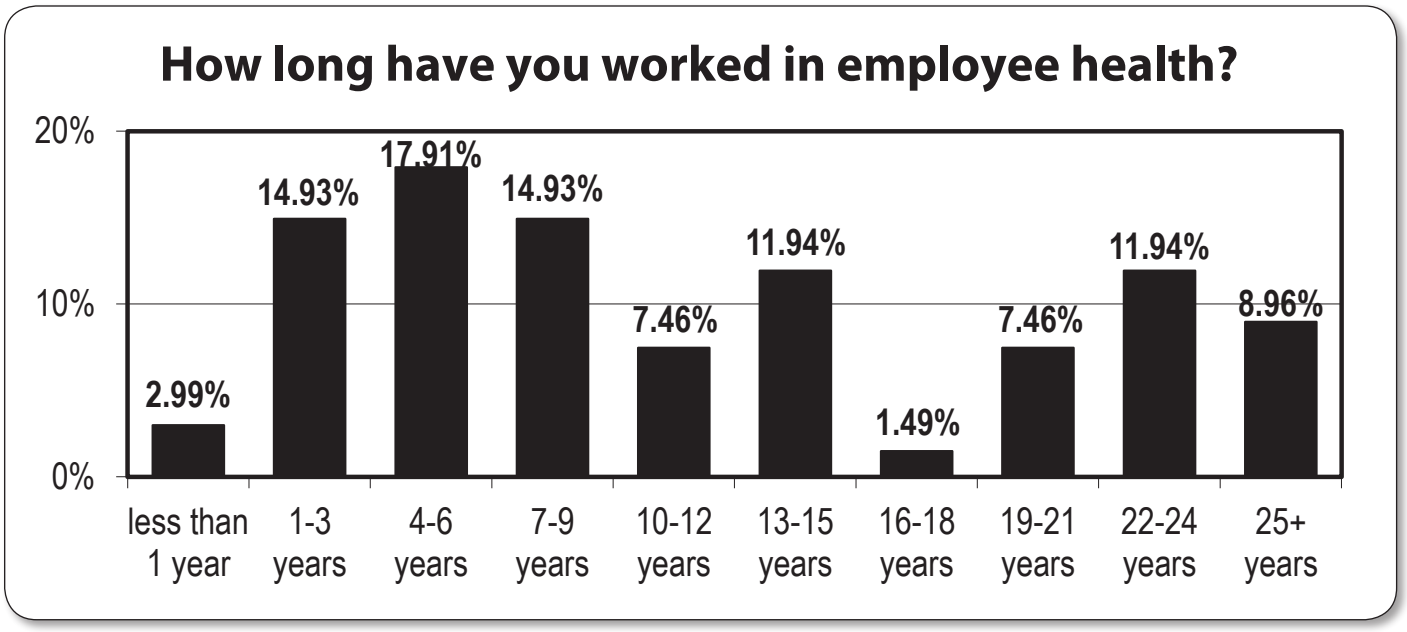
McCaughey also urges EHPs to become comfortable with some business terminology, such as return on investment, and to be aware of their own metrics, such as injury rates, as well as national benchmarks. "You never will be at the table if you can't speak the language of the people at the table," she says. "Make the business case for investing in occupational health and employee well-being."

The case for certification

Advancing your education or obtaining certification is another way to demonstrate your professionalism and value to the organization.

The Magnet Recognition Program, which honors nursing excellence in hospitals, encourages nursing specialty certification. If your hospital is seeking magnet status, you should have the opportunity that other specialized nurses have to obtain certification, says **Ann Lachat**, RN, BSN, FAAOHN, COHN-S/CM, chief executive officer of the American Board for Occupational





Health Nurses, based in Hinsdale, IL (www.abohn.org).

Studying for COHN certification also provides a foundation of knowledge in occupational health nursing. ABOHN provides a blueprint with core content areas, including chemical and biologic hazards, ergonomics, standards and regulations, and emergency response. The blueprint is based on periodic surveys of occupational health nurses to determine the scope of their practice.

"Certification rounds out your knowledge," says Lachat. "By using the blueprints of our exams, you find out what you need to know to be a well-rounded occupational health nurse."

ABOHN also is creating a free career guide to occupational health nursing to help explain the services and skills that are the foundation of the specialty.

Avenues for advanced education

EHPs also should take advantage of federally-funded education opportunities — while they still can.

The nation's 18 university-based Education and Research Centers for Occupational Safety and Health (http://niosh-erc.org/index.shtml) offer continuing education, including online courses and certificate and advanced degree programs, such as a master's in public health. But the funding is in jeopardy due to budget cuts.

The Obama administration's proposed budget does not include money for the ERCs, which receive funds from the National Institute for Occupational Safety and Health (NIOSH). If the ERCs lose their federal backing, there will be a gap in occupational health education just when those professionals are in increasing demand, says **Sheila Fitzgerald**, RN, PhD, director of Occupational and Environmental Health Nursing at the Johns Hopkins Education and Research Center for Occupational Safety and Health in Baltimore.

"It would be a real loss to the occupational health professional not to have ERCs available as a resource," says Fitzgerald.

The basic nursing curriculum contains little information that is specific to occupational health, which makes the specialized training an important foundation for employee health nurses, she says.

For example, a certificate in occupational health and safety would include coursework in toxicology, industrial hygiene, epidemiology and injury control, she says. EHPs need to understand how to evaluate and address job hazards, how to comply with safety regulations — and how to care for a wide range of employees. "You've got all levels of people from the maintenance worker to the CEO. Everybody has health needs," she says.

Gaining a certificate in occupational health and safety is one way to qualify for the COHN exam. Employee health nurses also can apply for COHN certification after 3,000 hours of work experience.

Even experienced EHPs can benefit from delving deeper into occupational health issues. "There is truly a journey of learning that has to be ongoing," says Lachat.

And those longtime EHPs have an obligation to mentor the newer employee health nurses, says Tyler. That can occur informally, within a health care facility, or through leadership positions in a professional organization, she says.

"We have a responsibility within the profession to one another," she says.

While enhancing your credentials, your education and your professional network, you can have an impact on the welfare of employees — and even on the future of your profession, Tyler says. ■

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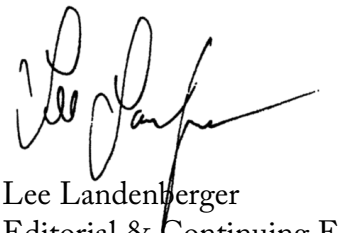

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Editorial & Continuing Education Director