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August 2014: Vol. 33, No. 8
Pages 85-96

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Hospitals hit the 90% mark for health care worker flu shots

Tracking doctors continues to challenge EHPs

A majority of U.S. hospitals has achieved the Healthy People 2020 goal of vaccinating at least 90% of their employees against influenza, but they have struggled to track the vaccinations of doctors, advanced practice nurses and physician assistants.

By mid-May, 4,254 hospitals reported their 2013-2014 influenza vaccination rates, as required by the Centers for Medicare & Medicaid Services (CMS), and their median vaccination rate for employees was 90%, according to a preliminary review of the data.

That represents great progress in vaccinating health care personnel, says **Megan C. Lindley**, MPH, deputy associate director for science at the Immunization Services Division of the National Center for Immunization & Respiratory Diseases at the Centers for Disease Control and Prevention. "It's definitely impressive and worthy of congratulations to the hospitals," she says.

The high rates also reflect a steady movement toward mandatory vaccination policies. The Immunization Action Coalition in St. Paul, MN, maintains an "honor roll" of hospitals and other health care organizations that have mandated influenza vaccination. It now contains more than 400 hospitals.

Every month, more hospitals ask to be added to the list, says **Deborah Wexler**, MD, executive director of the Immunization Action Coalition. The coalition began the honor roll as a recognition program in October 2009 with 11 hospitals and health systems. "It's snowballing," she says.

Hospitals also achieved a median rate of 92% influenza vaccination for students, trainees and volunteers. But one in five reported the vaccination status of licensed independent practitioners — doctors, advanced practice nurses and physician assistants — as "unknown."

"The licensed independent practitioners are very difficult to track,"

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acknowledged Lindley. "They're infrequently at the facility if they only occasionally round on patients, and their vaccination data isn't stored at the hospital as it is for employees."

This is the first year that CMS will include hospital influenza vaccination rates in its public reporting, available at www.hospitalcompare.hhs.gov.

Tracking is a challenge

Behind the scenes, employee health professionals have been working hard to provide all these influenza vaccinations and to track employees, students, volunteers and licensed independent practitioners. It hasn't been easy.

CDC adjusted the measure for this year, which is reported through the agency's National Healthcare Safety Network, to count individuals who spent even part of a day in a hospital. Last year, hospitals were told only to count employees and others who had worked in the hospital for 30 days or more.

That 30-day threshold was difficult — or even impossible — for many employee health professionals to track. "Our members were very pleased that they listened to their stakeholders," says **Dee Tyler**, RN, COHN-S, FAAOHN, executive president of the Association of Occupational Health Professionals in Healthcare (AOHP) and director of Medical Management for Coverys in East Lansing, MI.

Yet there are still substantial challenges, particularly related to people who worked at the hospital only near the October 1 beginning of the influenza reporting period.

"The volunteers were our biggest challenge because they may have volunteered in October and they may not have volunteered since, and they may no longer live in the state," says **Melanie Swift**, MD, director of the Vanderbilt Occupational Health Clinic in Nashville, TN.

"They're hard to track down," she says. "If they didn't get their vaccine from us, we're tracking them down to see if they got it someplace else."

CMS allows individuals to sign an attestation that they received the vaccine elsewhere.

EHPs partner with other departments, such as volunteer services, to gather the vaccination data. But employees often require repeated follow up. Some people seem to need to be nagged before they respond, says Swift.

"About the third time you notify them, they wake up and realize you really don't have the flu shot record they thought you had all the time," she says.

Licensed independent practitioners often work at multiple hospitals, and it hasn't been easy for hospitals to gather their vaccination information. AOHP had requested more modifications in the measure to ease that burden.

"Our occupational health professionals are taxed," says Tyler. "It is a lot of extra work for them to report these numbers. It takes time and

Hospital Employee Health® (ISSN 0744-6470), including The Joint Commission Update for Infection Control, is published monthly by AHC Media, LLC One Atlanta Plaza, 950 East Paces Ferry NE, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
Web: www.ahcmedia.com

POSTMASTER: Send address changes to Hospital Employee Health®, P.O. Box 550669, Atlanta, GA 30355.

Subscriber Information

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

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

This activity is intended for employee health nurse managers. It is in effect for 36 months from the date of publication.

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man hours away from caring for employees."

CDC will continue to consider changes in the measure, Lindley says. "It's a constant effort to balance having a measure that is comprehensive and useful from an infection control and risk standpoint with a measure that is feasible for facilities to report," she says. "We're certainly aware of the difficulties. It's something we're continuing to keep an eye on."

Because of those difficulties, the CDC measure doesn't require reporting of vaccinations of contract workers — even though hospitals use a large number of agency nurses, Lindley notes.

Will the public pay attention?

What will the public think of the influenza vaccination reporting? How will they interpret or use this measure of quality?

"We're establishing a protection rate for the patients and health care personnel in that facility," says Lindley. She notes that the Joint Commission accrediting agency also requires hospitals to monitor their influenza vaccination rates and to work toward a goal of 90% vaccination.

Wexler of the Immunization Action Coalition says she believes the reporting will have an impact. "A high level of vaccination indicates a high level of attention to patient safety," she says. "I hope the public will pay attention to it because that will help drive the effort to make sure that health care workers get vaccinated."

Tyler is less sure of the value of the reporting, particularly as it relates to licensed independent practitioners. Because they work at multiple facilities, they are counted multiple times in vaccination measures, she says.

In a position statement, AOHP endorsed the use of a comprehensive influenza vaccination program, including education of health care workers. If the hospital cannot achieve a 90% rate through a voluntary program, then "the organization may need to consider mandating the vaccine," AOHP said.

Some hospitals have been able to reach the 90% goal without a mandate, Tyler says. "We feel that vaccination is an important way to protect our patients and prevent the spread of infection," she says. ■

[Editor's note: CDC compiled a list of strategies for collecting influenza vaccination data, which is available at www.cdc.gov/nhsn/PDFs/HPS/General-Strategies-HCP-Groups.pdf.]

New HIV testing eases HCW fears

But state 'stigma' laws create PEP barriers

The aftermath of a needlestick is fraught with anxiety, but thanks to advances in HIV testing and treatment, health care workers can get swift and clear post-exposure guidance. A new drug regimen lowers the risk of contracting HIV, with fewer side effects.

But the mostly positive news about changes in post-exposure prophylaxis (PEP) is clouded by one drawback: Many states have neglected to update their HIV testing laws in light of new developments — laws that were mostly written in the 1990s when fear of HIV greatly exceeded our knowledge or ability to treat it.

"That was an era when the stigma of having HIV was enormous," says **Ronald H. Goldschmidt**, MD, director of the national HIV/AIDS Clinicians' Consultation Center at the University of California-San Francisco, which runs the PEPline advice call line for clinicians (1-888-HIV-4911). "There's been such a societal and cultural shift that dealing with the stigma has become a lesser issue."

In fact, in 2006, the Centers for Disease Control and Prevention recommended routine, universal testing of everyone ages 13 to 64 in health care settings, with an "opt-out" option, and annual HIV testing of people at high risk. With that policy, the HIV status of a source patient in an occupational exposure might already be known.

But can you reveal the HIV status to the health care worker who sustained a needlestick? That depends upon state law. "When the CDC came out with its 2006 recommendations, they really were at odds, to various degrees, with the laws of about 48 of the states," says **David M. Korman**, JD, program manager for Special Projects at the Pennsylvania/MidAtlantic AIDS Education and Training Center at the University of Pittsburgh.

For example, many state laws required pre-test counseling, while CDC recommended HIV testing as a part of the general consent on admission to the health care facility.

Certify a 'significant exposure'

In practice, hospitals seek ways to maneuver within the law while responding to the post-exposure needs. That may mean putting health care

workers on post-exposure prophylaxis immediately while waiting for consent to test to the source patient's blood.

In Pennsylvania, the health care worker must ask a physician to certify that there was a "significant exposure." The law allows the physician 72 hours to provide that written certification — even though CDC recommends starting PEP as soon as possible after an exposure.

The health care worker then would have baseline HIV testing. If that is positive, the source patient's blood is not involuntarily tested — even though different strains of HIV have been identified and physicians now know that co-infection can occur. Pennsylvania law allows only involuntary testing of existing blood and not involuntarily drawing a source patient's blood after an exposure.

The risk of seroconversion after being stuck with a needle containing HIV-positive blood is low (estimated at 3 in 1,000), but that doesn't lessen the anxiety that health care workers feel, says Korman. In a German study of health care workers who sustained a needlestick injury, 80% reported feeling a high level of anxiety if the source patient was known to be HIV-positive.1

"We demand a lot of our health care workers," says Korman. "We shouldn't aggravate their mental or physical state [in the post-exposure response]."

Arizona updated its HIV testing law this year to make it easier to respond to needlesticks. After a licensed health care provider confirms that a "significant exposure" occurred, the health care worker can be told the source patient's known HIV status or can request HIV testing of an existing blood sample. Source patients cannot be required to give a blood sample for testing.

The law change had widespread support from hospital organizations, nurses, emergency physicians and first responders, and advocates in the HIV community did not oppose it, says David Landrith, vice president of policy and political affairs for the Arizona Medical Association in Phoenix.

"We dealt with it upfront as a medical issue that needed changing because the medicine had changed," he says. "The arguments really were on our side."

With better treatment options, early diagnosis has become more important than ever, he notes. Knowledge of the source patient's HIV status also could affect the choice of post-exposure prophylaxis.

New PEP regimen is safer

Beyond the source-patient testing issues, advances in technology have transformed post-exposure follow-up.

In August 2013, the CDC issued new guidelines for post-exposure prophylaxis, which recommended a three-drug combination (emtricitabine plus tenofovir DF, or Truvada™ combination tablet, and raltegravir) for most exposures. *(See HEH, October 2013, p.109.)*

"One of the best things about the new drug recommendations for PEP is how safe and well tolerated they are," says Goldschmidt.

It's still important to know the status of the source patient. "Part of risk assessment involves knowing as much as one can about the source," he says. But if the information is not available, the PEP regimen is less onerous than in the past, he says.

Rapid HIV tests provide information about the source patient within two hours, which gives many health care workers piece of mind after a needlestick and helps guide treatment, Goldschmidt says. "If you know someone is rapid-test positive, that clarifies the dialogue with the exposed person about how important it is to take PEP," he says.

If the rapid test is negative, it is possible the source patient is in the window between infection and the test's capability to detect the infection. "The chance of that is extremely small and the chance of that person being infective is extremely small," he says.

To assuage those fears, there are "fourth-generation" HIV tests that narrow the window to about two to four weeks. ■

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HCWs are nation's most stressed workers

High work load, long shifts lead to burnout

Health care workers are more stressed than workers in any other industry, a recent survey found.

The finding made national headlines, mirroring other recent studies of worker stress. It is a bell-

wether of problems that could affect both patient care and worker health, says Naomi Swanson, PhD, chief of the Organization Science and Human Factors branch of the National Institute for Occupational Safety and Health (NIOSH) in Cincinnati.

"The turnover rate among nurses can be very high, and burnout is one of the main reasons they give [for leaving]. All these stressors are major contributors to burnout," she says. "If we're going to keep our nursing and health care workforce, we definitely need to deal with these issues."

Researchers can cite a list of factors: compassion fatigue, long shifts with few breaks, understaffing and high acuity of patients, even bullying and workplace violence. But employers should survey their own workers to find the problem areas and possible solutions, Swanson and others say.

"It's vital to ask your employees," she says. "One organization may have issues with communication. Another organization may have issues with how work is distributed. They need to be able to recognize that and recognize the correct solution."

Survey: One in four HCWs plan to quit

Last fall, the national survey firm Harris Interactive asked about 3,200 workers about stress. Some 69% of health care workers reported feeling stressed and 17% said they were "highly stressed," according to CareerBuilder Healthcare, the survey sponsor.

Survey results also indicated a cause of the stress – 55% of HCWs surveyed said their workload has gone up in the past year – and as a result, 25% said they plan to change jobs in 2014.

As employers evaluate the stress level and its causes, they should solicit input from employees, says Jason Lovelace, president of CareerBuilder Healthcare. "It's the responsibility of the employers to take a close look and make sure people are not being overworked," he says. "Highly stressed workers would be very concerning to me if I were an employer."

Nurses also have reported their concerns about stress in surveys by the American Nurses Association. In a 2011 health and safety survey of more than 4,600 nurses, the nurses cited the acute and chronic effects of stress as their top health and safety concern at work.

Stress also rises to the top of health concerns in an ongoing Health Risk Appraisal conducted by the ANA. Of almost 2,700 nurses responding to a question about stress, 80.6% said that "In my current work environment, I feel I am at a significant level of risk for workplace stress."

The Health Risk Appraisal is designed to provide feedback to nurses about their occupational and personal risk factors. In its aggregate data, Carpenter notes that the Health Risk Appraisal offers a "snap shot" of working and student registered nurses. ANA hopes to eventually gather the input from 30,000 nurses. (For more on the Health Risk Appraisal, see HEH, February 2014, p.21.)

"The most important thing employers can provide to reduce stress is a safe and healthy workplace, along with offering wellness promotion," says **Holly Carpenter**, BSN, RN, senior staff specialist for nursing practice and work environment at the ANA in Silver Spring, MD.

Employers can tap into the concerns of their own employees by providing a confidential survey or small discussion groups, suggests Swanson. Consulting firms or local universities can provide expertise to structure a survey tool, she says. Strategies can then be tailored to the needs of employees, she says.

"The primary issue is to find ways to reduce the stressors that are present," she says. For example, nurses may need shorter shifts or more breaks and fatigue-reducing strategies, she says.

Sleep deprivation adds to burden

The personal health habits of health care workers also play an important role in stress. About one-third of health care workers get six hours of sleep or less in a 24-hour period and about half (52%) of HCWs on the night shift have a short duration of sleep.1 The National Sleep Foundation defines healthy sleep as seven to nine hours per day.

Employers can provide education through a health promotion program and counseling through an employee assistance program. But the workplace design should encourage healthy habits, says Carpenter. Healthy food should be available for all shifts, and employees should have time for breaks, she says.

Nurses also benefit from a place to recharge, perhaps with deep-breathing, relaxation techniques, or even a quick nap, she says. That space could vary from a nap room, private break room,

or even a small chapel, she says.

Resilience helps nurses get through times of stress, she says. "That can come from support groups or some other sharing mechanism. Sometimes it's just a good friend," she says.

There are some positive signs in the research about HCWs, despite their stressful work lives. Health care employees are passionate about their work, and overall are more satisfied with their jobs than workers in other industries, says Lovelace.

"They really believe they're making an impact," he says. "They're there for a reason, and they see the results of their work firsthand."

Teamwork, communication and a balanced work load can help employees reduce stress — and the serious health risks that go with it, says Swanson. Stress has been associated with depression and cardiovascular disease, and fatigue leads to a higher risk of medical errors, she says.

Greater awareness of the impact of stress could lead employers to be more proactive, says Swanson. Shift work, scheduling and staffing have an overriding impact on the work life of nurses, she says.

For optimal patient care, "you want [nurses] to be at peak performance," says Swanson. "Employers need to invest in their workforce." ■

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Global workforce brings in other cultures

Don't let employee health get lost in translation

Hospitals have long been at the forefront of hiring salaried and hourly staff from other continents. This trend becomes more apparent during periods of nursing and physician labor shortages. From a hospital employee health perspective, this can mean addressing communication and cultural issues that might impact delivery of safety and wellness education.

"One of the biggest obstacles I'm seeing in California is language and literacy," says Dawn Stone, PhD(c), RN, associate professor at Western University of Health Sciences in Pomona, CA. "These are very important considerations for workers from around the globe. Being able to communicate with them is critically important for their health and safety."

Having access to bilingual staff or interpreter services is a first step.

"The harder part and real test of comprehension is having a supervisor or health and safety team – whether it's a supervisor, certified safety professional, or certified industrial hygienist – make sure that what is taught is implemented," Stone says. "That's the true test of comprehension."

Whether an employee is lifting patients and using the correct lifting procedures or using sharps and following blood-borne pathogen exposure precautions, someone needs to make sure all employees understand what to do and how to do it safely, she adds.

While health care professionals from other countries typically know English, this may not be true of all immigrant workers in a hospital, notes Julia Faucett, PhD, RN, professor emeritus at the University of California-San Francisco. Faucett has conducted research in occupational health and has experience working with immigrant farm workers.

"I'm concerned about [immigrant] facilities management staff, the janitors, cafeteria workers, and other people who don't have a high level of English or education," she explains.

Stone and Faucett suggest employee health programs address an increasingly multicultural workforce by initiating these efforts:

Identify your workers' country of origin: "Find out where the workers are coming from," Stone suggests. "Know which countries, which cultures, races, and ethnic groups are involved."

Developing an employee demographics profile can be helpful in understanding cultural issues as they arise.

"Look at the laws and standards in countries where they come from because this can tell you about the kind of exposures they've had and what their labor laws are like," she says. "Do they have an OSHA or workers' compensation?"

Employees from other nations might have had injuries that were unreported because of a lack of health and safety protections in their country of origin. So if they are injured while at the U.S. hospital, it might be challenging to obtain records related to earlier injuries or illnesses, Stone says.

Nurture rapport between employees and employee health: Extra efforts need to be made

to reassure immigrant staff that employee health is there to help them when they have any aches and pains.

"You want people to feel comfortable coming to the occupational health nurse and to understand that these visits are confidential," Faucett says. "You want this to be an open door for all employees."

The key is to create an overall environment of safety, which contributes to employees' well-being at work, she adds.

"Engage with informal leadership – for both non-immigrant and immigrant workers," Faucett explains. "Make sure you have people on the unit who are supporting this."

Informal leaders among workers can help spread the word about employee health's benefits and promote vaccinations and other hospital health initiatives. Hospital leadership support of employee health is crucial for a hospital's entire workforce, Stone notes.

"Especially in this economy, American workers could be fearful of reporting an injury or illness," Stone says. "They could be under-reporting out of fear of losing their jobs, so you have to explain that you are here to take care of them and to keep them well while they are working."

This strategy works for both American and immigrant workers who are hesitant to report their health issues to their employer, she adds.

"I have found it to be very effective," Stone says. "When they find that you really care about the worker and their health, they'll tell you more."

Another strategy is for employee health to educate workers about the most common causes of illness and injury, letting employees know that they are there to protect them from these and other problems, she adds.

With this type of workplace culture, employees would be more likely to ask for assistance from employee health.

Take histories with a translator: When working with international employees who might not have complete immunization and health records on file, it's important to screen for exposure to hepatitis, tuberculosis, and other diseases.

"Assess workers individually by getting a careful history and using a certified medical interpreter," Stone says.

It goes without saying that employee health professionals must know which hazards are associated with various workers' jobs.

"Think about the common hazards in health care: biological exposures, blood-borne pathogens, lifting, moving, and transferring people," Stone says. "How do we assess and screen for those once someone is hired?"

During the post-hiring physical exam, it's a good time to reassure workers that the hospital wants to protect the employee's health, so they need to be honest about their health history, she adds.

Include global staff on advisory committees: When a hospital has a significant population of workers from different regions and countries, it helps to have those groups represented on an advisory committee, Faucett suggests.

"If you are designing a program for people from a different culture then go to them – that makes all of the difference," she adds. "Ask them: 'These are the health and safety issues we've identified in our setting. How do you suggest we present them to workers?'"

"If there's a large contingent of folks newly arrived from the Philippines, then I might have a separate focus group," Faucett adds.

Focus groups: Questions a focus group might address include:

- Should we be presenting health, safety, and vaccination information bilingually?
- How would you phrase these questions?
- Would you use more picture or only text information?
- Which words should we avoid because it might have a different connotation in another culture?

Faucett recalls a problem with words when she was conducting research among migrant farmworkers. When investigators held focus groups they found that workers did not like it when asked by occupational health nurses to report pain related to musculoskeletal problems.

"They said they didn't want to use the word 'dolor,' which is pain in Spanish when talking about musculoskeletal problems because that's when they're working, and they don't think of that as pain because they are not disabled from work yet," she explains.

Even illustrations can be misinterpreted. In another study researchers used line drawings to illustrate a work situation. One picture showed a man bent over in a field with a star coming from his back. Health care professionals thought this indicated pain, but the migrant farm workers thought it meant the sun was coming up while the man worked, Faucett says. ■

Assessing back pain, injuries, interventions

Medical history is first priority

Occupational back injuries are an ongoing hazard in health care, particularly among nurses who have to move patients and perform other tasks that could cause injury.

"Most people with back injuries will get better within two weeks without any medical intervention," notes **Melody Rasmor**, EdD, FNP, an assistant clinical professor at Washington State University in Vancouver, WA. Rasmor has published articles about neuro-musculoskeletal health assessments for occupational health nurses over the past two decades.

"So it's really important for health care providers to understand the job the person is doing, their age, and any hobbies or activities of daily life," she says. "Take a good history and listen to their stories to see what kind of lifestyle they have because this tells you about their overall health." In general about 80% of the diagnosis will come from medical history, 10% through diagnostic tests, and 10% is from the physical exam, Rasmor says.

"I don't order X-rays very often because for the most part you can get a lot of information from the history and the physical exam."

She suggests these five steps for conducting a neuro-musculoskeletal assessment of injured workers:

1. Assess pain: Workers with back pain might complain about pain in the lumbar area that also radiates down the leg. Once the worker describes the pain, then ask these questions:

- Is this is the first time you've had an injury?
- Have you ever had surgery?
- How did the injury happen?
- Are they having a tingling sensation and, if so, where?
- Have there been any similar episodes?
- What are their typical activities?
- Are there any bladder problems?
- How is your pain on a scale of zero to 10?
- How well are you sleeping?

"If they're sleeping like a baby and have pain they describe as a 10, then there's incongruence there," Rasmor says. "Ask what they're taking for sleep, and if they're not taking anything then it makes me think about why their history is not congruent with what they're telling me about their sleep."

Questions about previous injuries are important because sometimes workers will have an injury that they do not report, thinking it will get better. Then the second time it occurs, they'll say something, she notes.

Also, bladder problems could indicate a more serious problem, she adds.

"You can hit the bulls-eye if you take a careful history," Rasmor says. "You can discover the mechanism of injury, how the pain feels now, and how long ago the person had that injury and how it manifests."

2. Worker examination: Examine wrists, back, and ankles. Look at the area that's in pain, searching for signs of previous injuries: scars, swelling, edema, discoloration, and deformities, Rasmor says.

"Palpate for pain, joint swelling, and spasms," she adds.

Assess the person's range of motion, looking for swelling and a decrease of range of motion from side to side.

"I ask if it's hurting when they move the back or neck, and you can watch for grimacing to see if the range of motion is decreased," she says.

For example, someone might have had a cervical whiplash of the neck and can't turn his head. Ask this person how he is driving.

"You watch the person with a back injury walk into the room, get on the table and off the table. Watch the range of motion," Rasmor explains. "All of this gives you information."

3. Test the worker's strength: For neck injuries, put pressure on one side and have the person turn his or her head to the side. You put your hand on their cheek area and have them turn to the side your hand is on, and see if that causes pain, Rasmor says.

"Then put your hand on the forehead and ask them to push forward, or put your hand on the occipital and have them push back," she adds. "See how much strength they have, and have them turn the head to the left."

Test deep tendon reflexes. These should be consistent. If they're not then maybe there's an infringement of the nerve, Rasmor says.

"I have the person get off the table and toe-walk and heel-walk," she says. "With back injuries, that can tell us if there's problems with the L5 lumbar disk 5 and S12 — sacral area — first vertebrae."

4. Solve the problem: "Now that you have the history and physical assessment, you have to figure out what's wrong," Rasmor says. "Is it a herniated disk, where most people will get better within two weeks?"

Occupational nurses might place the worker on light duty that involves no heavy lifting. If the work-

er's injury is in the wrists, then it's wise to limit the worker's repetitive duties that involve their hands, she adds.

5. Follow-up in two weeks: "If workers come back to you and have had pain for two weeks, it's time to move them along into physical therapy or occupational therapy," she says.

It might also be time to order a diagnostic test, such as an MRI, which is more useful for neuro-musculoskeletal injuries than is an x-ray test, she notes.

"We have to think outside the box and identify the kinds of things that could cause this pain," Rasmor adds.

For instance, some patients can have a long-term, complicated recovery because of other health issues, such as obesity, diabetes, degenerative joint disease, or arthritis, she says.

"If the nurse or health care worker is deconditioned then this can make things more complicated," Rasmor says. "You want to get them into recovery sooner and need to keep track of them." ■

Stretching dollars through partnerships

Case managers, PT, safety officers can help

In health care every dollar spent must be justified in some way. Hospital occupational health departments and clinics might find this to be especially true since they are considered non-revenue producing departments.

One effective strategy for enhancing the department's return on investment is to partner with other organizations and other departments within a health system, says **Barb Maxwell**, RN, MHA, COHN-S, CCM, FAAOHN, division director of company care in occupational health services at HCA — West Florida Division in St. Petersburg, FL.

"When you can control costs on workers' compensation claims it will affect the organization's bottom line," Maxwell says.

Partnerships that bring important services to employee health's mission will help with costs containment, she adds.

This isn't the same as outsourcing occupational health services, she notes.

"If organizations start outsourcing to other companies to perform occupational health services then senior teams must understand there's a cost for administration of the program, along with the full time equivalents they want to outsource for," Maxwell explains.

Instead, occupational health departments should develop a plan that outlines each service the department provides and see if there are in-house or community partners that could provide value for any of these additional services.

For example, vocational case management services could be provided by a partner.

"Vocational case management is one of our partners," Maxwell says. "They bring value, job searches, knowledge of transferrable skill sets, and they actually do an assessment on the injured worker."

Vocational case managers also confirm labor market opportunities and look for suitable job placement, she says.

"Another partner we utilize are the safety officers," she adds.

"The value they bring is they do the thorough accident investigations, the follow-through for corrective action, providing trending data," Maxwell says. "And they can collaborate with the medical case manager and link case management services with prevention activities."

Other partnerships are intuitive and might be expected to occur naturally, although that's not always the case. For instance, injured employee's managers or supervisors can be on the employee health team.

"We educate them on their role in handling that injured worker's medical plan of treatment," Maxwell says. "We tell them how important it is to stay in contact with the injured employee and bring the employee back to a transitional duty program, which transitions the person from the injury phase to getting back physically to the way they were."

Senior hospital leaders also play a role in partnering with employee health.

The case managers are the hub of the employee health department when it comes to managing workers' compensation claims, Maxwell notes.

"We look to them to do appointments with the authority level of your injury coordinators and to provide adequate resources," she says.

"They support monthly allocation reports that are delivered to our senior teams," Maxwell adds. "I hold all my occupational health nurses responsible for managing their monthly allocation reports, entailing how many lost-time days and restrictive/transitional duty time they monitor."

Take-home points

Maxwell offers these additional tips on how to

develop effective partnerships:

Make use of free partners: In-house medical case management, supervisors, and safety officers are examples of partners that could help at no charge to employee health. Others, such as vocational case management might come at a contracted cost, but the price likely would be less than if a case manager were hired to work full-time on staff.

Health care systems also could contract with insurers to provide these services, Maxwell notes.

Various hospitals have physical therapists (PT) on staff, and PT services also could be available at an affordable rate.

Identify weaknesses: Conduct an opportunity analysis, looking at strengths, weaknesses, and opportunities for enhancing employee health services, Maxwell suggests.

"If a service is outsourced, how do we provide continuity? Will it impact employee morale?" she adds. "These are things you can't put a dollar to, and this is a fluid type of process that needs to be re-examined constantly."

Consider partnerships in light of all aspects of care: Injured or ill employees might need a variety of services, including psychosocial and ergonomic, Maxwell says.

"Is there symptom magnification?" she says. "Whenever there's a reduction in the workforce, people end up with no job, and [may be tempted] to claim a workers' compensation than to have no income at all."

Physical therapists can assist with ergonomic issues, and the health system's legal department might be needed for any claims reviews, she adds. ■

Show employee health's return on investment

Greatest value is staff satisfaction

Hospital employee health directors often find it difficult to quantify a return on investment (ROI) for hospital leadership because much of their department's value cannot be measured.

"We bring a sense of trust into the workplace, a sense of caring, and people feeling valued," says **Karen Mastroianni**, EdD, MPH, president of Dimensions in Occupational Health & Safety in Raleigh, NC.

"That's where the greatest value is for hospitals because if you're not taking care of your staff, and they don't feel valued and trusted and recognized, then that will show in the work they perform," she says. "I truly think that's what occupational health nurses influence in all industries, and — in my mind — that's even more important in hospitals."

From a hospital employee health perspective, the key is to demonstrate this value to hospital leaders through ROI indicators that can be measured or at least described.

For instance, job satisfaction surveys measure staff's sense of well-being in the workplace. Some questions could be added to address employee health services in particular.

The employee health office could give each employee receiving services a short patient satisfaction survey to complete.

"So every time someone comes in you will receive feedback," Mastroianni says. "With this information you can make changes and see how well you are fulfilling your mission, goals, and objectives."

Another possibility for demonstrating ROI involves collecting data on case management of employee injuries and illnesses.

"There are disability manuals that indicate — for whatever condition — how long a person could be expected to be out and what the medical cost is for those cases," Mastroianni says.

Employee health case management programs that strive to bring employees back to work and good health can show a cost savings by limiting lost work days and medical costs.

"A lot of times for case management we use the disability manuals to show an average of what it would cost if we didn't manage that case, showing a significant cost savings," she says.

For example, there might be an employee who is scheduled for back surgery but who had not tried injections or physical therapy. An employee health case manager could discuss non-surgical options with the employee. As a result, the employee might choose to try injections first, a strategy the surgeon also would approve. This would cut costs and return the employee to work sooner, Mastroianni says.

For hospitals with onsite employee health clinics, convenience is another ROI.

"Convenience really saves money," Mastroianni says. "People are more apt to come to work when they're not feeling well if they know they could see a physician or nurse practitioner who would help them feel better."

Data show that onsite clinics can reduce absenteeism and time away from work, she adds.

Ergonomics programs can provide tangible ROI for employers. The Occupational Safety and Health

Administration has an online tool involving ergonomic assessments, called Safety Pays (http://1.usa.gov/THK9ah).

"This OSHA tool can show direct costs and indirect costs," Mastroianni says. "It's an online calculator, and it can show significant savings."

Employee health programs can further impact costs through workplace ergonomics programs or by routinely assessing workplace ergonomics whenever an employee reports pain related to the job.

"Nurses can teach them exercises or how to change the work area to address the cause of the pain and make it better," Mastroianni says. "Maybe it was the employee's posture or the device they were using to do the lift. If you help with it you can relieve that back pain and prevent back injury — showing significant cost avoidance by doing that." ■

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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

■ How did voluntary programs attain 90% influenza vaccination rates?

■ AAOHN toolkit boosts knowledge about respiratory protection

■ Elastomerics: An option for emergency preparedness?

■ Latest on OSHA's infectious disease standard

■ CMS taking a closer look at employee health

■ Should employee health professionals take a stand in anti-vaccine movement?

CNE QUESTIONS

1. What proportion of hospitals reported "unknown" influenza vaccination status for licensed independent practitioners in the 2013-2014 season?
   A. One in twelve
   B. One in ten
   C. One in five
   D. One in three

2. Despite improved HIV testing and treatment, post-exposure follow-up remains a challenge because:
   A. state laws governing testing have not been updated.
   B. source patients often decline testing.
   C. source patients aren't in the hospital when testing needs to occur.
   D. CDC recommendations are too restrictive.

3. One good strategy for addressing the needs of immigrant hospital workers would be to form a focus group that includes this population. Which of the following would be a good question to address in this focus group?
   A. Should we be presenting health, safety, and vaccination information bilingually?
   B. Would you use more picture or only text information?
   C. Which words should we avoid because it might have a different connotation in another culture?
   D. All of the above

4. When conducting a neuro-musculoskeletal assessment of an injured worker, which of the following is not suitable question to ask the worker?
   A. Is this is the first time you've had an injury?
   B. How did the injury happen?
   C. Have you filed a workers' compensation claim yet?
   D. Are they having a tingling sensation and, if so, where?

HIC wins 1st as best healthcare newsletter

We are proud to announce that our sister publication, *Hospital Infection Control & Prevention*, recently won First Place for Best Healthcare Newsletter at the annual awards of the Specialized Information Publishers Association (SIPA) in Washington, DC.

Written by long-time *HIC* editor **Gary Evans**, the 2013 coverage included "Have virus will travel," which anticipated the arrival of the first MERS cases in the U.S.

The trusted source for the infection preventionist for over four decades, *HIC* has won numerous editorial honors that include five prestigious awards from the National Press Club for analytical reporting. For breaking news, and posts both thought provoking and relatively mindless, check