



HOSPITAL EMPLOYEE HEALTH



THE PRACTICAL GUIDE TO KEEPING HEALTH CARE WORKERS HEALTHY

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AHC Media

CMS targets employee health in new infection control survey

Survey tool cites TB screening, fit-testing, sharps, and vaccinations

The high-profile effort to reduce health care associated infections (HAIs) nationally is casting light on employee health programs as well, as the Center for Medicare & Medicaid Services recently finalized an infection control assessment tool that blends patient and worker safety.

"This is a great opportunity for hospital leaders to take a look at the role of the employee health department and bring them out of the shadows," says **Sena Blickenstaff**, RN, MBA, BSN, principal consultant with Compass Clinical Consulting in Cincinnati, OH.

The 49-page Infection Control Survey, which has been under development for two years, will be a guide for CMS surveyors and a risk

assessment and improvement tool for hospitals. That said, the survey also includes many provisions that CMS can cite under its conditions of participation requirements. Although it emphasizes the role of the "infection control officer" and doesn't specifically

mention employee health, it includes many fundamental occupational health tasks.

Reducing hospital-acquired infections is a high priority for CMS. More than 700,000 Americans develop infections in a hospital annually and about 75,000 die, according to the Centers for

Disease Control and Prevention. CMS has begun reducing payments by 1% to hospitals that have the highest rates of medical errors and hospital-acquired infections.

The survey includes directives and

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recommendations on tuberculosis screening, sharps injury prevention, respiratory protection, and health care worker vaccinations. The CMS document enables employee health professionals to partner with infection control and quality improvement on these issues and gain a higher profile with the hospital leadership. The tool was released along with similar CMS surveys on quality assessment and performance improvement and discharge planning. Although The Joint Commission uses a different methodology in its surveys, the accrediting body must align its standards with CMS requirements, says Blickenstaff, who has served as a Joint Commission surveyor. CMS also conducts validation surveys, in which hospitals are selected at random for an unannounced survey.

"Anybody potentially runs the risk of CMS turning up at their doorstep, so it's best to be prepared," Blickenstaff says.

CMS to observe PPE use

In small hospitals, the roles of employee health and infection control are often merged. In large facilities, the departments may work so independently that they are like "siloes," as one exclusively deals with employees and the other handles patient safety.

When the CMS worksheet refers to the "hospital infection control prevention system," it is allowing hospitals to define different ways of handling the tasks, says **MaryAnn Gruden**, MSN, CRNP, NP-C, COHN-S/CM, manager of employee health services for the Allegheny Health Network in Pittsburgh and association community liaison for the Association of Occupational Health

Professionals in Healthcare.

"They're giving the employer the option of deciding how these things get accomplished," she says.

For the first time, CMS surveyors will observe whether health care workers are properly wearing personal protective equipment — gloves, gowns, facemasks or respirators, as appropriate, notes Gruden. The worksheet advises surveyors: "If possible, observe health care personnel use of personal protective equipment in two different patient care areas or settings in hospital."

"It will be incumbent upon employers to make sure employees know how to wear their PPE, including N95 respirators," Gruden says.

The spread of Ebola to two nurses in Dallas brought sharp national attention to issues surrounding health care worker protection, she notes. "For a small segment of the workforce, that has beefed up the importance of properly donning and doffing PPE," Gruden says. "That needs to cascade down to frontline employees."

Hospitals must track, reduce exposures

When it comes to employee health, the CMS worksheet is not all-encompassing. Some items just offer a starting point, says **Mary Gene Ryan**, MPH, BSN, RN, COHN-S/SM, CSP, FAAOHN, an occupational health consultant and executive director of MGRyan & Co. in Ventura, CA. For example, "they just mention that you have to have an ongoing respiratory protection program," she says.

CMS calls for fit-testing "at regular intervals" and doesn't

mention medical screening. The Occupational Safety and Health Administration requires fit-testing of N95 respirators at least annually and medical evaluations before an employee wears a respirator.

Beyond the items on the CMS survey, hospitals need to make sure they're complying with both state and federal regulations, Ryan says. Some of the provisions in the CMS survey related to employee health include:

- The hospital infection control system puts in place and monitors efforts to prevent needle sticks, sharps injuries, and other employee exposure events.

- The hospital tracks healthcare personnel exposure events, evaluates event data, and develops corrective action plans to reduce the incidence of such events.

- The hospital infection control system ensures all personnel are screened for tuberculosis (TB) upon hire and, for those with negative results, determine ongoing TB screening criteria based upon facility/unit risk classification.

- The hospital infection control system ensures personnel with TB test conversions are provided with appropriate follow-up (e.g. evaluation and treatment, as needed).

In a section that is “for information only,” CMS suggests

hospitals ensure and document that all personnel have immunity to measles, mumps, rubella and varicella, that they provide Tdap (tetanus, diphtheria, pertussis) to all personnel and the hepatitis B series to employees with potential occupational exposure, and that they offer the annual influenza vaccine. (*See related article on Tdap on page 23.*)

An opportunity for quality improvement

Many of the items in the CMS survey can be numerically tracked, and Blickenstaff suggests working with the hospital's quality improvement team to set goals.

“Identify where you have an opportunity to improve and ask to champion that project,” she says.

The worksheet offers an opportunity to improve communication with other departments and with senior leadership, she says. Employee health professionals can provide feedback on compliance with the employee-related items to hospital leadership and improve documentation of that compliance, she says. For example, sometimes employees continue to work despite not having had their required TB screening or a

vaccination.

“A lot of times there's a disconnect between human resources and the department manager about who they think is responsible for tracking that information,” she says. “Organizations need to have clearly defined processes for who is responsible for collecting the information, who is responsible for follow up, and whether employees can continue to work.”

The CMS survey calls for education of health care workers about infection prevention, providing another opportunity for employee health to assist and raise awareness about employee protections. “It helps to validate what we're doing,” says Gruden.

Employee health professionals should be proactive in addressing the personnel-related aspects of the CMS worksheet, Ryan says.

“These [items] are becoming standards of practice. It's seen as a line of achievement,” she says. “You don't want to be below it.”

[Editor's note: A copy of the CMS Infection Control Survey Worksheet is available at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-1.pdf.] ■

HCV can be cured—but it's better to prevent

At \$1,125 per pill, needlesticks can be costly

A newly approved drug for hepatitis C offers a complete cure in as little as eight weeks – but at \$1,125 a pop, the price tag is harder to swallow than the pill. For health care employers, the optimistic medical news offers a harsh reminder: it can be staggeringly expensive to

treat a single seroconversion from a needlestick.

Much has changed since Congress passed the Needlestick Safety and Prevention Act almost 15 years ago. Needlesticks have declined by about 38%.¹ Post-exposure prophylaxis has reduced the risk of occupational

transmission of HIV even as hepatitis B cases plummeted with widespread vaccination. In 1983, a staggering 17,000 health care workers contracted HBV. By 2010 occupational HBV infections were down to an estimated 263 cases.²

But with no vaccine or

prophylaxis, health care workers remain at risk of contracting hepatitis C from needlesticks. Conversions are rare; an estimated 1.8% of those exposed to HCV through a needlestick acquire the infection. But the consequences can be dire. About two-thirds of those infected with HCV develop chronic liver disease, and up to 20% will develop cirrhosis. Five percent will die.

For employers, a needlestick can lead to a lifetime of medical costs. “Their responsibility is to cover the cost of the treatment to resolve that occupational injury or illness,” says **Joseph Paduda**, MS, principal with Health Strategy Associates, a consulting firm based in Skaneateles, NY, that specializes in managed care for workers’ compensation.

“[Conversions from] needlesticks have always been a low-frequency, high-risk injury,” says **Elise Handelman**, RN, MED, an occupational and environmental health consultant in Annapolis, MD, and the former director of the office of occupational health nursing at the Occupational Safety and Health Administration. “It doesn’t happen often, but when it does, it can be devastating.”

3 million HCV carriers

Health care workers also are becoming more likely to encounter patients with hepatitis C. The Centers for Disease Control and Prevention estimates that more than three million Americans have chronic hepatitis C infection, with infection most prevalent in people born between 1945 and 1965. “As the population ages, we’re seeing huge numbers of people identified with hepatitis C who were not identified before,” Handelman says.

New hepatitis C drugs have

literally been life-savers. In 2013, the U.S. Food and Drug Administration approved Olysio (simeprevir) and Sovaldi (sofosbuvir) to treat chronic HCV infection, genotype 1. Olysio was approved for use in combination with peginterferon-alfa and ribavirin. In 2014, the FDA approved an Olysio-Sovaldi combo. A randomized trial found that Olysio and Sovaldi in combination produced a sustained virologic response (non-detectable HCV, which is considered to be a cure) in 93% of participants after 12 weeks and 97% after 24 weeks. That included patients with cirrhosis.³

In October 2014, the FDA approved another combination drug called Harvoni (ledipasvir and sofosbuvir) that showed a success rate of up to 99% in treating chronic HCV, genotype 1. (The most common HCV genotype found in the United States.)

“In cases where there was active hepatitis C, the current treatment plans were no better than a 30% to 60% cure rate,” says **Jim Andrews**, RPh, executive vice president of pharmacy services for Healthcare Solutions, a Duluth, GA-based company that provides medical cost management for workers’ compensation. “Now we have a cure rate of [more than] 90%.”

As this issue was going to press, the FDA also approved Entyvio, a three-drug combination (ombitasvir, dasabuvir, and paritaprevir) that costs \$5,000 a vial. Also greenlighted was Viekira Pak, which includes dasabuvir and costs \$83,000 for a 12-week regimen.

While the cure rates of this new vanguard of HCV drugs are astonishing, so is the price. A 12-week regimen costs about \$66,000 for Olysio and \$84,000 for Sovaldi, making the combination about

\$150,000. People with cirrhosis may need a 24-week supply, bringing the price tag to \$300,000. Twelve weeks of Harvoni costs \$94,500. (In December, the Southeastern Pennsylvania Transportation Authority in Philadelphia filed suit against Sovaldi-maker Gilead, accusing it of price-gouging.)

Yet treatment for advanced cases of HCV has always been expensive – particularly if the patient treatment endpoint is a liver transplant. In that context, the new drug treatments avoid ongoing liability.

“You could potentially close the entire claim if they’re cured,” says **Brenda Wood**, PharmD, BPharm, director of clinical services for Healthcare Solutions.

Determining the best drug combination can be complex, so patients need support from a hepatologist, she advises.

The emotional toll

Beyond the cost-benefit issues of treatment, HCV infection from a needlestick is an emotionally charged event.

It is one that stays in the forefront for **Doris Dicristina**, RN, BSN, MS, COHN-S/CM, director of employee health services for Robert Wood Johnson University Hospital in Hamilton, NJ, as she works to reduce needlesticks.

Just before she came to the hospital in 2009, a clinical care tech had a needlestick while activating the safety feature on a forward-shielding butterfly device. Bloodwork showed he converted to hepatitis C. He was in his 20s.

The hospital immediately referred him to an infectious disease specialist who started him on anti-viral medications, which had some

significant side effects. Within five years, the hospital had already spent about \$100,000 on his care.

“If the antivirals continue to work, [the infection] will not progress,” says Dicristina. “What we know about hepatitis C is that if it’s not successfully treated, it can ultimately lead to further liver disease, liver cancer, liver failure and the need for a liver transplant. Ultimately it could lead to death.

“He is continuing to work, but this will be his health status for the rest of his life. It will have an impact on him for the rest of his life. We’re responsible for all the care he needs to receive,” she says. “Our hope and plan is that he will be maintained in a healthy state and have a long and healthy life.”

Honing in on devices

Meanwhile, Dicristina works continuously to evaluate devices and reduce needlesticks. For example, the hospital has switched to a retractable butterfly-style phlebotomy device and reduced needlesticks to fewer than five per year from that source.

“Prevention has to be through best practice and using the safest

equipment available on the market at the time,” she says.

Dollars are just one way to measure the impact of needlestick prevention. In 2000, the General Accounting Office projected that 69,000 needlesticks could be prevented each year through safety devices – for a savings of between \$37 million and \$173 million in post-exposure treatment costs.

Safer work practices and eliminating the use of sharps where possible could further reduce needlesticks by 109,000 per year, the GAO said. In all, the measures would prevent 42 cases of hepatitis C in health care workers in one year.⁴

In fact, those savings have been realized.

Annual needlesticks declined by more than 100,000 between 1995 and 2005, resulting in a savings of \$69 million to \$415 million, researchers concluded.¹

Cost, however, is just one part of the story.

“The bottom line is that it’s the right thing to do,” says **Elayne Kornblatt Phillips**, RN, MPH, PhD, clinical associate professor of nursing and research program officer at the University of Virginia

in Charlottesville and an author of the study on needlestick cost savings. “Our health care workers are the ones who protect everybody else. We need to take care of them.”

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No viral load means no HCV restrictions

Hospitals follow SHEA guideline for HCWs

Everything seemed in order for the certified surgical first assistant to start a new job. He filled out the human resources paperwork and went through the routine screening in employee health. He was healthy and had been working as a contractor at the

hospital for 15 years, so he didn’t expect any stumbling blocks.

But one question put a temporary hold on his hiring. The technologist had been treated for hepatitis C — and doctors had told him he was cured. RNA testing and routine monitoring by

a gastroenterologist confirmed that he had no detectable viral load.

But when he revealed his prior infection, the hospital was unsure how to respond. It lacked a system for evaluating the potential risk of employees with hepatitis C or handling the growing number of

people who are cured of the disease.

“I have this fear that my whole career is over,” the surgical tech said at the time.

Some weeks later, the hospital approved his hiring, subject to bi-annual testing to make sure he maintains an undetectable or very low viral load. That is in keeping with the guidelines on the management of health care workers infected with hepatitis B, hepatitis C or HIV issued by the Society for Healthcare Epidemiology of America (SHEA). (See HEH, *May 2010, cover story*.)

But the case highlights the continuing need for hospitals to update their policies, almost five years after those guidelines were released. New treatments for hepatitis C and HIV enable patients to have a very low or undetectable viral load and greatly reduce the risk of transmission, says **David K. Henderson**, MD, deputy director for clinical care at the National Institutes of Health Clinical Center in Bethesda, MD, and lead author of the guidelines.

“The group did not feel that simply having had one of those infections precluded you from doing anything in health care,” he says. It would be up to an expert review panel to evaluate the health care workers’ job tasks and viral load, he says.

The certified surgical first assistant reached out to HEH to share the impact of outdated employee health policies related to HCV. “My hope is that every healthcare institution will now update their HCV policies and stop discriminating and treating HCV as a disease once considered as a ‘junkies’ disease,” he says. “It is now treatable and curable.”

‘Ethical obligation’ to know HCV status

An estimated 3 million Americans have chronic hepatitis C — and many of them don’t know it. Because many of those undetected cases are among Baby Boomers, the Centers for Disease Control and Prevention recommends anyone born between 1945 and 1965 be tested. However,

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CDC has no recommendations for testing or management of health care workers with HCV.

The SHEA guidelines don’t advise mandatory testing, but they state that health care workers performing exposure-prone procedures — such as extensive surgeries — are “ethically obligated” to know their status related to hepatitis B, HCV and HIV.¹

An expert review panel evaluates each individual situation and determines if any restrictions are necessary, according to the SHEA guidelines. The panel may be convened at the hospital level or by the county or state health department, and typically includes infectious disease experts and other specialists, such as occupational medicine physicians.

In North Carolina, for example,

the state Department of Public Health convenes a panel that includes the health care worker’s personal physician. Confidentiality is maintained, says **David J.**

Weber, MD, MPH, professor of epidemiology at the University of North Carolina at Chapel Hill and a co-author of the SHEA guideline.

“To my knowledge, nobody has been denied the ability to work, although there have occasionally been some restrictions,” he says.

Health care workers should feel that they can seek advice from an expert review panel without fear of discrimination, says Henderson. “It’s an advocate for the provider and will help the provider provide safe health care,” he says.

Marshfield (WI) Clinic tests new employees for hepatitis C as a way to avoid future workers’ compensation claims of occupationally acquired infection. Since 1996, nine new employees have tested positive. None of them had been aware of their HCV status, says **Bruce Cunha**, RN, MS, COHN-S, who recently retired as the clinic’s manager of Employee Health and Safety.

Those employees did not work in a high-risk job, he says. If they had, the clinic would have sought guidance from an expert review panel. But the employees would still have a job. “It is not a condition of employment to have a negative hepatitis C [test],” he says.

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Healthy worksite toolkit calls for ‘participatory interventions’ to engage frontline workers

‘We were primed and ready for this kind of program.’

Hospital employee health directors often wear a lot of hats: wellness, safety, ergonomics/injury prevention, and overall staff health. The challenge is implementing a program that addresses these different needs and engages employees in the process.

The Center for Promotion of Health in the New England Workforce in Lowell, MA, has created a free online toolkit to help organizations with their wellness efforts. (<http://bit.ly/1vodD8r>) Since launching the healthy worksite toolkit and website a year ago, the center has provided a series of seven webinars to teach users how to implement the program materials in any organization, says **Suzanne Nobrega**, MS, project director of the center, which is part of the University of Massachusetts Lowell and University of Connecticut.

“We had 200 people participate in one or more of those training seminars, and hospital people make up 70% of participants, she says.

Training covered these topics:

- How to gather support for the program;
- How to assess health safety and wellness needs among the workforce;
- How to form program committees;
- How to train a program facilitator, and
- How to guide a participatory intervention planning process where they’re engaging people on the front lines of their jobs.

“We want to engage the people closely connected with the work,”

Nobrega says. “We’re trying to improve safety and health in their working environment.”

Drill down to root cause, brainstorm interventions

Some of the meetings during the planning process involve drilling down on an issue to discover the root cause. Then it’s followed by a creative brainstorming session to set the hospital’s wellness team on the path to formulating an intervention and to winning management’s approval for that plan, she adds.

Among the early adopters of the program was Frisbie Memorial Hospital in Rochester, NH. The hospital has had some wellness infrastructure in place for years, including an ergonomics team of front-line workers, and a safety committee of middle and senior management, says **Janice Parker**, MSN, APRN, FNP-B, employee health nurse practitioner/manager at Frisbie Hospital.

The hospital had collected employee health data for decades. The information is discussed in the safety committee, and hospital leadership had been looking for a way to use the data to inform employee health efforts, Parker notes.

Then, Parker saw the healthy worksite toolkit and knew this could help her organize a more effective wellness program.

“So our structure was already there,” she says. “We were primed and

ready for this kind of program.”

The center’s website contains links with tools and information to help sites set up their wellness programs, including a 45-page pdf with flow charts and a step-by-step guide to its implementation. (*See story on hospital implementing program, page 20.*)

Nobrega visited the hospital, speaking with the safety committee last spring, and by June, the wellness program was being implemented.

“We followed the instructions on the web page pretty directly, looking at the highest risk and cost injuries,” Parker says. “Then we went to the steering committee and asked for people to give us their priorities.”

Frisbie Memorial has done a good job with their implementation, Nobrega says.

“What I like about their implementation is they’ve really dovetailed the implementation of the program with existing committee structures, building on what they already have and taking it to the next level,” she explains. “They’re also doing a very good job of getting employee input, developing their own survey around the patient handling for the nurses, and getting feedback from nurses and other people working with patients.”

The Center for Promotion of Health is in the process of evaluating how well wellness programs based on the toolkit are being implemented, Nobrega says.

“We’ve had about 50 people participate in a follow-up survey, and we’re following those folks,” she adds.

Ideal outcomes for the program would be to see more organizations do in-house program designs for employee wellness initiatives, Nobrega says.

“Right now a lot of organizations have their wellness or safety services

delivered to them through a vendor, and a vendor has a packaged program that may or may not fit well with what people in the workforce feel is important,” she explains.

“I’d like to see a lot more engagement of regular working

people in the design in the kinds of health and safety wellness programs they have available to them, and I’d like to see a lot more participation and a stronger culture around employee health generally in organizations.” ■

New Hampshire hospital uses healthy worksite kit, reports ‘more input from all levels of the hospital — the front line, management, finance.’

‘We found many employees didn’t get adequate sleep’ due to inconsistent scheduling

A Rochester, NH hospital was among the first to implement a healthy workplace program based on the toolkit provided online by the Center for Promotion of Health in the New England Workforce, which is part of the University of Massachusetts Lowell and the University of Connecticut.

The toolkit provides seven steps, as follows:

Step 1: Identify problems and contributing factors. The healthy worksite toolkit recommends sites consider all possibilities and then focus on a single health and safety problem.

“We identified that patient handling injuries were a problem for one unit, so I took that information to our ergonomics team, which they call the design team,” says **Janice Parker**, MSN, APRN, FNP-B, employee health nurse practitioner/manager at Frisbie Memorial Hospital in Rochester, NH.

The ergonomics/design team looked at contributing factors, using the tool’s worksheet. Immediately, they could see that they didn’t feel like they had enough information,

even with information from the injury reports.

The Frisbie Hospital team asked for more information, related to these questions:

- Did employees get enough sleep?
- Do they take their work breaks?
- Do they work shifts back to back, or do they have time between shifts?

“We brainstormed and designed a survey, sent it to the unit, brought data back, collated data, and we got a lot of good information that we would not have known if we had not asked,” Parker explains.

From the survey and from having a member of their team who had first-hand knowledge of the unit, the team learned that the unit did not schedule breaks regularly for staff. Also, sometimes the unit would have a full shift of work when a large number of post-operation patients were sent there. There were no additional employees to handle the increased workload, Parker says.

“This was a very, very helpful process, and the people on the safety committee were very excited about it,” she adds.

Step 2: Develop intervention objectives and activities. Site facilitators should ask the team to focus on objectives that are realistic, measurable, and achievable, according to the toolkit.

“We brainstormed, looking at all data and came up with several possible solutions,” Parker says.

One of these was to reduce hazards associated with patient handling and moving. This was an equipment solution and related to storage and staff knowledge of how to handle equipment.

Another idea was to address workflow and staffing issues, including staff orientation. The unit would use a resource team or float team that was designed to be called anywhere in the hospital when needed.

“One thing we found was the employees who worked on the unit knew their workflow and equipment, while the resource team was slower to find things and understand what the workflow was,” Parker says.

This suggested that resource staff would benefit from equipment orientation training.

“We wanted to encourage healthy

habits in employees,” Parker says. “We found many employees didn’t get adequate sleep, and we found that some of this had to do with inconsistent scheduling, which [affects] healthy sleep patterns.”

There were only two 12-hour shifts on the unit, so if someone assigned to one shift had to suddenly work a different shift, this would significantly impact their sleep-wake schedule.

Also, the team suggested using a block scheduling model instead of alternating days off, Parker says.

“We suggested they stop working more than 12 hours out of 24,” she says. “All of these factors added together can cause people to have disrupted sleep patterns.”

A stumbling block for employee health

Step 3: Set selection criteria.

A worksite’s design team should prioritize interventions according to those that benefit a larger number of people, but also consider how one solution might be of benefit to different areas, the toolkit notes.

This step was a stumbling block for employee health, Parker notes.

“We had trouble,” she says. “We followed the form, but when it came time to use it we felt maybe we had not understood it.”

For step 3, the organization outlines the scope and impact, benefits and effectiveness, resources and cost, obstacles and barriers, of the wellness project. “You select criteria to later use to evaluate your intervention,” Parker says.

“Under the question about who the program would reach and benefit, we felt it would reach all staff and patients and benefit all of them,” she adds.

The team chose to define short-

term as a year. They reasoned it would take at least a year to see any effect. This partly is because the injuries — even on the selected unit — were low. “We really have a good safety program, and we have a good handle on what’s going on,” Parker says.

Resources and costs also served as criteria. The team determined the cost of buying equipment, providing education and training and adding more staff to the unit.

“This encourages you to think outside the box, so we suggested providing fitness equipment for the staff to use when they are working 12 hour shifts and don’t have a lot of time to exercise,” Parker says. “Under obstacles and barriers, we found that money was a huge obstacle.”

Another barrier was determining how to educate off-shift staff.

Step 4: Apply selection criteria. Selection criteria may include key performance indicators set by the group. These are used to measure the effectiveness of activities and overall success of the intervention alternatives.

“We selected criteria for the activities and created three intervention alternatives,” Parker explains.

They got into nuts and bolts details about reducing hazards, including purchasing new patient lifts for one unit.

Adding more ceiling lifts

“One solution was to increase the number of ceiling lifts,” Parker says. “The portable lifts are wonderful, but having staff get them and get storage for them is a challenge.”

The portable lifts also needed to be stored in a way that would make it easier for staff to select and use the correct one.

“We also needed to improve

equipment storage and organization,” Parker says.

Assessment of impact

Step 5: Rate interventions and select intervention alternatives. The toolkit recommends rating interventions according to a high (H) rating for those that meet or exceed what is stated in the selection criteria; a medium (M) rating for those that only partly accomplish the goals, and a low (L) rating for those activities that fail to accomplish or barely accomplish what’s stated in the selection criteria.

As a safety team thinks about the issues and rates the effort, the team should consider how much impact the activities will have and all of the anticipated benefits, Parker says.

“Rate the resources and rate the anticipated obstacles for each one,” she adds.

For instance, an activity involving hazards and equipment might already have processes and precautions in place. A solution involving workflow and staffing would require action on the part of management, she says.

“Promoting healthy habits is the easiest to implement, but the hardest to actually achieve end results,” Parker says. “Our ergonomics team wanted to go with the focus being on workflow and staffing.”

Step 6: Plan and implement interventions. The toolkit recommends that the site facilitator think in terms of changes to specific work units versus changes to the entire organization because a one-size fits all approach could be risky.

“The healthy workplace program online suggested different tools for tracking this step,” Parker says. “We developed a timeline and strategies, looking at who would implement the change, when, and how.”

Step 7: Monitor and evaluate interventions. The last step, which Frisbie Hospital had not yet reached at press time, involves measuring results and evaluating the program's

success, Parker says. "This program has helped us organize and plan approaches," she says. "We've gotten much more input from all levels of the hospital: the front line,

management, finance."

This has helped the hospital create a wellness program that is more productive, while bringing all stakeholders into the conversation. ■

Hospital's wellness program cuts health care costs by more than \$5 million in five years

Key action: Linking employee health to health care benefits

At the place where employee health and hospital benefits and wellness programs intersect, some striking results can be achieved. For JFK Health in Edison, NJ, an employee wellness program, fueled by individual and group biometric data, has resulted in these encouraging outcomes:

- 31% decrease in hospital admissions among employees and their families;
- 50% decrease in hospital readmissions;
- 48% higher cancer screening compliance than the national average;
- 35% higher diabetes disease management than the national average;
- \$2.8 million in benefit savings returned to employees in 2013, and more than \$5 million in health care cost savings over the past five years.

"Back in 2006-2007, we initiated our wellness initiative within our health system," says **Pat Cooke**, corporate director for human resources for JFK Health. Cooke's roles include some employee health services.

Hospitals should start with some sort of wellness program as a building block to achieving employee population health improvements, she suggests.

"We started with an employee

wellness team, identifying what our vision was for wellness and the three main strategies we were trying to accomplish," Cooke says. "Our vision was to help employees lead healthier lives, to build awareness, and to get employees involved in our education, awareness, and wellness activities."

Another goal was to create a workplace atmosphere that reflects wellness and chronic disease prevention.

The hospital started by promoting walking and stairclimbing. They put inspirational posters on stairwells throughout the hospital.

"We used posters that showed someone running and not giving up," Cooke says. "We painted the hospital staircases and made them bright, trying to encourage people to take the stairs."

Then the hospital added some healthy snacks to the vending machines.

"The biggest thing we did was create a passport to wellness, rewarding employees for getting health screenings," she says.

Linking employee health to health care benefits

These efforts raised awareness and created a foundation that made

employees aware of the hospital's focus on healthy behavior, but they didn't result in significant population health improvement until a third component was added: a health care benefit program that provided financial incentives for positive health actions.

The hospital teamed up with San Francisco-based SeeChange Health to unite employee health and wellness into JFK Health's benefit plan.

"The trick is to engage employees continuously and in a sustainable manner over a long period of time," says **Jon Watson**, senior vice president of operations at SeeChange Health.

"There's a dynamic that has changed," Watson adds. "We measure and look at data and see how employees' behavior affects the hospital across the health care continuum."

The more buy-in a health system achieves from employees, the more engaged employees are and the better the results.

"We started a Healthy Plus Plan," Cooke says. "There are six different benefit plans for employees, and three of these are Healthy Plus Plans."

When an employee selects the Healthy Plus Plan, he or she is committed to doing health screenings and taking preventive care actions. In

return, the employee receives lower employer health care contributions and other rewards that the hospital provides, such as taking a half day off to get wellness screening and lower co-pays for prescription drugs, Cooke explains.

One incentive is extra life insurance: “It doesn’t cost us a lot, and they appreciated it,” she says.

“We rolled this out, and it’s perfectly voluntary, but if they choose the Healthy Plus Plan, they have to do the cancer screening: PAP smears, mammographies, PSAs, and colon-rectal, which only 20% to 25% of employees were doing,” she adds.

Only one in four employees participated in the Healthy Plus Plan

at first, but that has grown over the past few years to 82% of employees.

The last piece to the employee wellness puzzle was to obtain biometric screenings of employees. These include body-mass index, blood glucose levels, blood pressure, nicotine and cholesterol levels.

“We told employees they could earn additional rewards based on goals we set up related to these results, so our program’s progression is moving from efforts to results,” Cooke says.

All of these population health efforts are a growing trend thanks to the accountable care organization model of the Affordable Care Act, she notes.

“Our employee benefit plan was doing population health before population health became cool,” Cooke says.

The hospital’s wellness team continues to focus on traditional employee health issues like slips, trips, and falls through education and exercise physiology and on employee stress reduction. But it’s in the wellness side – following the collection of biometrics – that the most impressive results have occurred.

“We tell employees that they have lost two carloads of weight,” Cooke says. “We communicate their wellness results in a way that employees can understand.” ■

CDC panel cites lack of evidence for Tdap booster

Vaccination rates remain low for single dose

Health care workers who receive the pertussis vaccine do not need additional boosters, a federal advisory panel decided.

Outbreaks of pertussis in some states have raised concerns about the potential for hospital-based transmission. Only 31% of health care workers have been vaccinated with Tdap, according to data from the National Health Interview Survey, although the Centers for Disease Control and Prevention has recommended the one-time vaccine since 2006.

Studies show that Tdap’s effectiveness wanes significantly within three years after vaccination. However, vaccinated individuals are less likely to develop symptoms and transmit the disease, epidemiologist **Jennifer Liang**, DVM, MPVM, told the CDC’s Advisory Committee on Immunization Practices.

CDC continues to recommend post-exposure prophylaxis for health care workers who are exposed to pertussis, particularly those who care for high-risk patients, such as pregnant women and newborns. Health care workers who do not care for high-risk patients may be monitored for symptoms for 21 days, Liang said.

Rather than backing a booster vaccine to increase immunoprotection, CDC called for better coverage of health care workers with the single dose of Tdap.

“There is no evidence that additional doses would be preventive,” Liang said.

Because Tdap coverage is low among health care workers, and the duration of protection afforded is unknown, post-exposure antibiotic prophylaxis is indicated for vaccinated workers in contact with patients at risk for severe pertussis infections (e.g. hospitalized neonates).

Recommended post-exposure drugs for exposed workers include azithromycin, clarithromycin, or erythromycin. ■

COMING IN FUTURE MONTHS

- CMS reporting begins for influenza vaccination
- WA hospitals work to boost safety culture
- Investigating workplace reports of illness clusters among HCWs
- OSHA recordkeeping and reporting strategies
- Highlights from the AAOHN 2015 conference in Boston



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CNE QUESTIONS

1. The new Infection Control Survey from the Center for Medicare & Medicaid Services calls for surveyors to monitor personal protective equipment in what way?

- A. Review documentation of a PPE stockpile
- B. Evidence of training of HCWs in PPE use
- C. Observing HCWs as they don and doff PPE
- D. There are no requirements related to PPE

2. Hepatitis C is a significant concern related to sharps injuries because:

- A. There is no cure for HCV.
- B. About 3 million Americans have HCV and many don't know it.
- C. There is a high rate of conversion of HCV after a needlestick.
- D. Most sharps injuries can't be prevented.

3. A randomized trial found that

Olysio and Sovaldi in combination produced a sustained virologic response (non-detectable HCV, which is considered to be a cure) in what percentage of HCV patients after 12 weeks?

- A. 85%
- B. 90%
- C. 93%
- D. 97%

4. When a hospital's ergonomics team looked at contributing factors to injuries in a particular unit, one of the questions they asked as part of their investigation included which of the following?

- A. Did employees get enough sleep?
- B. Did employees take their work breaks?
- C. Did employees work shifts back to back, or do they have time between shifts?
- D. All of the above

CNE OBJECTIVES

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

1. Identify particular clinical, administrative, or regulatory issues related to the care of hospital employees;
2. 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;
3. 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.