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Occ-health pros look at stay-at-work programs to keep workers on the job

Spot employees with problems before issues become serious

Helping injured or ill employees return to work as quickly as possible has become a major concern for occupational health professionals **(see the cover story in the April 2003 *Occupational Health Management*)**. It may be, however, that an even greater opportunity for improvement and cost savings lies in preventing workers from being absent in the first place.

Whether they are called stay-at-work programs, absence management, or attendance management, proactive efforts to spots problems *before* they become absences have caught the attention of a number of occupational health experts.

"The bottom line is you can have a substantial number of employees stay on the job," says **Peter Rousmaniere**, MBA, a workers' comp and related disability consultant in Little Rock, AR. "However, in order to do that, one probably needs to invest a lot more energy in looking at symptomology prior to an event," he adds.

"A survey we did in 1997 on attendance rates in companies shows that rates at organizations that have good absence management programs are a lot higher — absences averaged 1.4%, compared with 5.3% at companies that did not practice it," adds **Jennifer Christian**, MD, MPH, chair of the Arlington Heights, IL-based American College of Occupational and Environmental Medicine's Work Fitness and Disability Section and president and chief medical officer of Webility Corp., a disability management consulting firm based in Wayland, MA.

David Brown, DSL, a principal in Clarke, Brown Associates, Ltd. in Toronto, says that absence management really has two major components — attendance management and disability management — that must be approached in tandem. "We have found that with this approach, we save on average 32% off disability costs, and we just don't get any lawsuits," he asserts.

Brown's approach to attendance management involves the actual tracking, through proprietary software, of employees' attendance. "You periodically review the results; and if certain employees cross the threshold you have established, you sit down with the people who fail to attend work the most," he explains.

The goal of attendance management, he explains, is to address multiple short absences (one or two days) that normally are too short to manage. "The goal is to reduce the frequency and to keep the person at work more than in the past," he notes.

Management's attitude plays a major role, adds Christian. "In fact, it may not be that injury and illness are the only way to look at this," she notes. "People who come into the field really focus on the fact that the employer goes from a passive to an active position; he decides to actively manage attendance and view work force availability as critical to business success. Once the employer makes that decision, they start to look around for opportunities to intervene."

How it plays out

Brown's approach plays out in a systematic fashion. If an employee knows he or she is not going to be at work, he or she has an 800 number to call. The computer system logs the absences, as well as the reason, sends an e-mail to the employee's manager and enters the fact that he or she is not at work into the database.

"If you track attendance properly, you can put up a spreadsheet; and if you focus only on one or two standard deviations from the norm, that means you only have to have discussions with the top 2.5% people. In other words, 97.5% of the population has better attendance than they do," Brown explains. "The focus is to help them find ways to be at work."

Those employees sit down with their manager and a facilitator. They confirm that the absence records are correct and try to group them into "like" reasons. "Say the threshold is four absences per four months, and this person has six — most of them due to transportation problems," Brown offers. "You ask the employee, 'How can we work through this?'"

Even something such as transportation is an occupational health problem, Brown insists. "There's almost always a mix of causes," he notes. "Besides, you're trying to change attendance behavior."

If the main cause turns up as sickness, you've got to be careful because of privacy issues. "But, you can ask if there's anything in the workplace that makes the condition worse," he suggests. "You can ask if there is something you can do at work to make it easier for the employee."

In addition, if a person has missed too much work and has identified the problem as health-related, you can check with the occupational health nurse or physician, or his or her primary care doctor and ask if all of the absences are related to the same medical condition, and what the prognosis is.

This moves the health care professional into a consultant role, Brown explains. "You're not using the doc as a policeman, and you're not treating the employee like a child, asking for a note every time they're out," he asserts.

Whatever the cause, at the end of the meeting, both parties sign off on a game plan that outlines the future steps the employer and the employee will take to remedy the situation. "This sends a message to the employee that the employer expects him to be at work; but if he's not, they want to deal with him in a supportive way," Brown says.

He adds that if you solve the problem with one meeting, you're really lucky. "What you often

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Editor: **Steve Lewis.**
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Managing Editor: **Alison Allen**, (404) 262-5431, (alison.allen@ahcpub.com).
Production Editor: **Nancy McCreary**.

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Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

have to do is wait three to six months, review the situation, and if the problem has been fixed, you throw the employee out of the attendance management program. If not, you sit down and have a more serious conversation with them, and wait another six months — because the result of failed attendance management is often a lawsuit. But if you go through three or four of these meetings, you have a full record of how the company has tried to work with the employee."

The ergo approach

For an ergonomic symptomology approach to work, you've got to cast a wide net, Rousmaniere says. "If you randomly pick 10 different soft-tissue injuries in this country, you'll find on average there are six other people at that very work site who have like jobs and whose injury risks are similar to the one being presented," he notes. "For the most part, the symptomology began well before the injury took place. What follows is that if you want to do a true remain at work approach, you probably need to get into symptomology not only on the employee who has the injury, but on the others as well."

Those symptoms often include numbness, pain, or guarding behavior (favoring), he notes.

Rousmaniere says he has been working with The Wyndham Group in Manchester, NH, and that Wyndham has found that well over 75% of the time there is a no-cost or low-cost solution to the problem. "The solutions often involve temporary changes to work — like work pace changes, the order in which tasks are done, surges of work, and so on," he explains.

They all address one or more of what Wyndham calls "the five horsemen of ergonomics": posture force, cold, stress, repetition, and vibration. "It usually shows up as multiple factors," Rousmaniere notes. "The key is to not wait until the symptomology gets so bad the employee has to miss work."

Wyndham also has found that 50% of the time it resolves symptomology the solution includes productivity improvement. "This is consistent with the belief that inside every worker injury, there is a productivity improvement struggling to get out," Rousmaniere offers.

There still is much to learn in this relatively new field, he concedes. "There is a piece of data which this field would love to have — and someone may have it — which is the median and average elapsed time for soft-tissue injuries between the onset of injury and the recognition of injury," he notes. "That process can go on for months."

Since absences never will be entirely eliminated, Christian says it's important to be as prepared as possible — in advance — to deal with those absences when they do occur. "We must be able to respond on a dime," she says.

That ability can only come from practicing what she calls disability preparedness. "If companies can realistically predict they have people who will become injured or ill, they can have a whole plan laid out in advance so that when the injury or illness surfaces, it can kick right in," she explains.

There are several components to disability preparedness. First, there is the expectation within the company that when someone's ability to work is altered, that the attempt will be made to minimize disruption. Second, any available, appropriate transitional tasks should be identified ahead of time. "There should be notebooks with those tasks described, and checkoffs for the docs," says Christian. Third, she says, you should have clearly identified incentive alignment and accountability associated with absences.

"Set it up so it is a win-win-win situation," Christian advises. "Have financial accountability in the management structure so that managers do better if they bring back an employee quickly or hold them accountable for leaving work, and see that the employee does better by staying."

Finally, have someone there as an advocate and support for both the supervisor and the employee. "It can be HR or medical," Christian offers. "If the employee is not experiencing this process as positive, if they feel treated unkindly or unfairly, or if they feel they are being put in danger, they need to have a place to go. For management, which is trying to figure out how to manage a problematic employee or a difficult interpersonal relationship on top of a medical condition, they may require help trying to figure out how to find appropriate transitional work and how to manage the employee. Failure to provide support to either of them can be the cause of a lot of problems."

[For more information, contact:

- ***Peter Rousmaniere**, MBA, Little Rock, AR. Telephone: (501) 347-7689. Fax: (309) 218-5376. E-mail: pfr@rousmaniere.com.*
- ***Jennifer Christian**, MD, MPH, Webility Corp., 95 Woodridge Road, Wayland, MA 01778. Telephone: (508) 358-5218. Fax: (518) 358-0169. E-mail: mail@webility.md. Web: www.webility.md.*
- ***David Brown**, DSL, Clarke, Brown Associates Ltd. Telephone: (416) 410-1096. Web: www.clarkebrown.com.]* ■

Workplace relationships can make or break you

If rapport isn't there, program won't work

An optimal stay-at-work program entails a delicate balancing act, both in terms of employee relationships and interventions.

"For example, some companies have safety programs that have created abusive treatment of employees," notes **Jennifer Christian**, MD, MPH, chair of the Arlington Heights, IL-based American College of Occupational and Environmental Medicine's Work Fitness and Disability Section and president and chief medical officer of Webility Corp., a disability management consulting firm based in Wayland, MA.

Establishing the proper balance can be an ethical dilemma, she continues. "For example, when a company sets up its safety program, it has to be careful it sets up rewards for people who perform safely, but it can create a really strong potential for people to hide [unsafe practices]. You can end up with the same need to balance when you set up an absence management program. When do you get a case that looks like abuse?"

The facts alone don't necessarily tell the whole story, she notes. "If I hurt myself and I was home, and the employer called and asked if I would you mind laying on a cot in the office and doing some work, I might not feel abused," she posits.

One of the key issues deals with the point at which an employer becomes paternalistic. "You would obviously have to protect yourself if it was something dangerous," she says. "But in the case of release to work, is it the doc's job to tell the employer they are being unfair, or is it the employee's? It's not a black-and-white issue. When is it appropriate for the doc to become an 'avenging angel?'"

Balanced programming

You also must strive for balance in your programming, says **David Brown**, DSL, a principal in Clarke, Brown Associates Ltd. in Toronto. "If you just deal with attendance management, you'll drive people to go on short-term disability. They'll think, 'I may as well stay off work an extra day or two.' On the other side, if you are really harsh on your disability side, you will drive people to multiple short absences."

On the disability side, "Too often we in occupational health cut out the two people who are often most important — the employee and the manager," he explains. "The manager is told not to deal with the employee. Then, he hears Joe is coming back to work with the following restrictions."

But it's the employee who really knows what he feels capable of doing, and the manager who knows how flexible he can be. With the Clarke, Brown approach, the employee calls into a phone line, records his absence, and on day five he automatically pops up on the "to-do" list of the coordinator. The coordinator then calls the employee to see when he might return. If it's a couple of days, he just makes a note. If it's going to be longer, he sets up a meeting with the manager.

"This usually happens in the second week of absence," says Brown. "You confirm the tasks of the job with the manager, and go through the list asking the employee what he feels capable of doing, like, for example, taking phone calls."

In each case, the employee responds yes, no, or "maybe with some help." What you end up with is a list of things the employee can do, cannot do, or may be able to do with some help, he says. "The manager's role is to see if they can accommodate the employee; you keep meeting until the employee has resumed all of the tasks."

The ultimate benefit of this balanced approach is improved manager/employee relationships, Brown says. "And in any research I've done, I've found the greatest predictor of whether someone will be at work regularly — or how long their disability will be — has very little to do with their medical condition but everything to do with their relationship to their manager." ■

Performance testing may be better safety indicator

Drug testing may miss ability problems

Testing for substance abuse through traditional methods such as urinalysis or saliva analysis may be a given in many businesses and industries today, but it is not without its flaws. In fact, say some observers, there are much better methods available to help ensure safety and optimal performance.

"Drug tests are a remarkably bad idea, but they are required [in many industries]," says

Raphael H. Warshaw of Workers' Disease Detection Services (WDDS), a screening and consulting company based in Claremont, CA.

"Remember, drug testing is mandated in transportation and in several other areas," he continues. "But if you're trying to prevent accidents — that's where you need performance-based alternatives."

Performance-based testing, says Warshaw, can be divided into three major groups:

- neurological testing;
- fit-for-duty testing;
- toxicology.

Traditional testing has limits

There are quite a few limitations to urinalysis and more traditional forms of drug screening that create the need for performance-based alternatives, says Warshaw. "Certainly, there's the issue of what you are trying to accomplish," he notes. "If you're trying to determine if someone is fit to do a particular task, then drug testing will not help too much. It merely gives you the level of a substance [in someone's system]."

WDDS' services grew out of work Warshaw conducted at the University of Southern California. "What we've done is develop tests on balance, vigilance [the ability to concentrate and react appropriately], and speed of reaction, all in one test," he says.

Warshaw has done a lot of this type of testing for construction firms. "Our system is simply a computerized device with a specially constructed keypad that reports the difference between normal and abnormal readings," he explains. "The big contribution we've made isn't in the test itself, but we have developed reference values in a number of different occupations. For example, if you are an employer at a nuclear plant, you want to know your employee is watching his console. Also, in the amusement industry, if you have a ride operator watching a roller coaster, you want to be sure that individual is actually paying attention."

Warshaw recalls a study he conducted with the Los Angeles County Sheriff's SWAT team. "We took a group and put them in a hotel. Then, we took an equal number in a separate group and dosed them selectively with alcohol," he reports. "A small number of the participants failed on the tests with a blood alcohol level of zero. Then, we dosed them all the way to a 0.1 level of alcohol, and about half *passed* the test. OK, it's time to go home — whom do you ride with? The one who passed the test or the one with an alcohol level of zero?"

The message here is that as an employer, in many cases you want to find out if someone at a particular time can do a particular thing; and drug testing, says Warshaw, just will not do that.

No system is perfect

WDDS is just one of many organizations working with performance-based alternatives, says Warshaw. "There are very sophisticated devices developed through the military — eye tracking, for example, to evaluate very subtle changes," he notes. This can be used by sports organizations to evaluate, for example, individuals who want to be race drivers, he adds.

"Some electrophysiological systems look at the actual performance of the nerves; visual testing is being looked at and used, as well as some simulators." In the area of toxicology, researchers at UCLA are "making superb use of technology," Warshaw says.

As impressive as they appear to be, performance-based alternatives also have their limitations, Warshaw admits.

One of the negatives is that in order for these methods to be effective you have to use them frequently, he notes. "You can do it once a year, but you'll be giving away a large benefit. That will tell you the baseline, but what's more important is whether there has been any change."

For example, if you have a driver who is tested once a year and passes, you might assume he is fine. But if you test him more often, on the occasions he flunks you can refuse to send him out. "In order to get the maximum benefit, optimal testing would be done before every dispatch," says Warshaw.

Of course, he concedes, that can get expensive, depending on what you are using. "Our system is pretty inexpensive — less than $3,000," he says. If you use the system for recruitment and training, it will likely pay for itself, Warshaw says. It beats having no performance testing. "If you put someone to work who will fail out," he says, "you've made a bad investment."

The bottom line, says Warshaw, is that there is no one method at present that serves all employers' needs to ensure optimal employee health and performance. "Someone who really wanted to do a good job would use a combination of methods," he concludes.

[For more information, contact:

• ***Raphael H. Warshaw**, Workers' Disease Detection Services, Claremont, CA. Telephone: (909) 579-0289. Web: www.wdds.com.]* ■

Simple incentive gets workers up and walking

Pedometer spurs participation in walking program

Not all incentives have to come in the form of large checks or expensive prizes to be effective. Just ask the folks at Comprehensive Health Services (CHS). With a simple, inexpensive device and a basic team competition, they have gotten thousands of employees to participate in a walking program.

Inspired by the nationwide "10K-A-Day" walking program, the fitness director at the Tucson office of one of CHS' client companies, a major manufacturing firm, devised a program that involved giving each participant a pedometer to measure his or her daily progress. "He developed the program and brought it to company's wellness council last summer," recalls **Karen Eray**, RN, COHN-S/CM, CHS' unit manager in Tucson, AZ. "We liked it because it gave employees a reason to get out and walk, either as individuals or as part of a team."

Walking cross-country

Basically, the program involved an imaginary walk across the country to visit different corporate sites. The trek begins in El Segundo, CA, and takes walkers to seven or eight other stops before ending at corporate headquarters in Lexington, MA.

Employees were told about the program through the company's weekly newsletter, e-mails, their web site and information posters. They could participate as individuals or create teams of up to eight people. "Since individuals could not travel as far as a team they got bonus miles when they hit certain milestones," says Eray. "Everybody was issued a pedometer for free, and then kept track of their own mileage and entered it into a log."

There are about 12,000 employees at the worksite, and "I heard there were about 3,000 who took part," says **Jennifer J. Lim**, RN, MSN, COHN-S/CM, FAAOHN, national manager/health services for in CHS in Westminster, CO. "That's a very high participation level."

Each time a participant walked the equivalent of miles between company locations, they received a small gift, such as a book mark or a pencil. "At the end, they got a pen that said, 'I made it to Lexington, Massachusetts,'" Eray explains.

"Even though these trinkets were not that valuable, they gave people motivation," says Eray. "You were especially motivated if you were a team member, because you did not want let your teammates down."

In addition, the built-in team structure support network led to a nonthreatening atmosphere, says Lim. "It's hard sometimes to do behavior change all by yourself," she asserts.

Employees put the pedometers on when they woke up and took them off when they went to sleep, and all the steps taken during that time were counted and logged.

The benefits spread

News of the program has spread, and so have its benefits. "The corporation will now take it nationwide because it's proven to be so successful," reports Lim.

Why has it been so successful? "In health and wellness programming, it's hard to empower people if you don't give them control," says Lim. "This was just one little device, but it put participants in control; that's what I heard from people — that they could always know what their progress was."

"Also, when you wear it ever day, if you consistently walk and one day you forget the pedometer you can still judge your progress by how active you are," says Eray.

"Sometimes, you don't realize you've walked as much as you did," adds Lim. "I'd walk through an airport to get my luggage, and the distance was much more than I thought."

Lim was so impressed she sent pedometers to all CHS managers. "I told them that if their clients were not currently involved in the program, that they should encourage them to participate," she notes. "And, for their own health and wellness, they should serve as role models."

She believes this program can serve as a springboard for other wellness initiatives. "From this, you can build additional participation," she asserts. "By the way, now that we have your attention, we're going to be doing a cholesterol screening — and so on."

The program also has touched families, says

Eray. "We all did it, our spouses did it, our kids did it. Some employees went and out and got extra pedometers on their own," she recalls. "I even had my mother-in-law do it!"

[For further information, contact:
*• **Jennifer Lim**, RN, MSN, COHN-S/CM, FAAOHN, national manager/health services, CHS, 10869 Grove Court, Westminster, CO 80031. Telephone: (303) 916-2859.]* ■

COPD program can help improve productivity

Behavioral changes focus on initiative

A new disease management program being introduced by Health Management Corp. (HMC) will help improve quality of life for employees suffering from chronic obstructive pulmonary disease (COPD) and reduce expenses for their employers, says the Richmond, VA-based health and disease management company.

COPD, while a good deal less publicized than other chronic diseases, is the fourth-leading cause of death in the United States, ranking just behind heart disease, cancers, and stroke, according to the American Lung Association.

"Clinicians are familiar with COPD, but it is not given the same amount of publicity as other respiratory conditions," concedes **Bob Kolock**, MD, HMC's medical director.

He explains that COPD is typically includes one of two conditions: emphysema and/or chronic bronchitis. "The nature of the chronicity is that it develops over time, and we typically start to see it in the older population," says Kolock.

Nevertheless, he says, COPD is very much an occupational health concern. "You need to look at it from two viewpoints," he says. "First, COPD is due to ongoing damage to lung tissue, and the primary source is smoking. Second, occupational hazards and irritants can also contribute to the disease. So, depending on the industry, employees can be exposed to irritants that lead to COPD." Kolock notes, however, that many of these irritants are hydrocarbons, and due to environmental laws exposures are "probably relatively rare in this day and age."

HMC's COPD program will focus on smoking cessation, home oxygen therapy and optimizing physician-prescribed medications. The overall program is based on the Guidelines for COPD Management established by the Global Initiative for Chronic Obstructive Lung Disease, or GOLD. GOLD (www.goldcopd.com) is a joint effort of the World Health Organization and the National Heart, Lung, and Blood Institute. Its multifaceted smoking cessation component is derived from U.S. Department of Health and Human Services guidelines.

The program follows the model HMC developed for its asthma, diabetes, coronary artery disease, congestive heart failure, and maternity programs. It features predictive modeling to identify participants most in need of nurse interventions and individualized patient management focused on behavior change.

"Certain medical claims indicate that a person has COPD," Kolock explains. "So first, we analyze claims to see which individuals have that diagnosis. Once we have the population, we apply a predictive model that allows us to stratify the population."

In other words, if a health plan member population is 500, the patients are ranked from one to 500, according to which of them are more likely to have complications over the ensuing 12 months. The goal is to match the high-intensity program with those who would most benefit. This would also have the greatest impact on health costs.

COPD Facts

- Chronic obstructive pulmonary disease (COPD) includes emphysema and chronic bronchitis, diseases that are characterized by obstruction to air flow.
- COPD is the fourth-ranking cause of death just behind heart ailments, cancers, and stroke.
- COPD claimed the lives of more than 112,584 Americans in 1998.
- The annual cost to the nation for COPD is approximately $30.4 billion, including health care expenditures of $14.7 billion and indirect costs of $15.7 billion.
- Smoking causes approximately 80%-90% of COPD cases. A smoker is 10 times more likely than a nonsmoker to die of COPD. Other known causes of COPD are frequent lung infections and exposure to certain industrial pollutants.

Source: American Lung Association Fact Sheet: Chronic Obstructive Pulmonary Disease (COPD), March 2002.

"The upper 15%-20% would be contacted. We'd explain the high-intensity program and seek their agreement to participate," says Kolock. Others who are not at such a risk for complications would get mailings on periodic basis, access to a 24-hour nurse line, and their claims will be reviewed on a monthly basis. The claims are regularly reviewed, Kolock explains, because individuals who are considered stable at first may later move into a riskier category.

The high-intensity program participants receive all of the information the others do, but they also will be contacted proactively. "They will have nurse care managers, based on their clinical needs, and a tailored program that compares where the patient is vs. where they should be," says Kolock. "For example, they may have stopped smoking five years ago, but the condition has advanced, in which case we may need to look at their medications. In another, they might still be smoking, so we'll try to get them to stop."

The sobering truth about COPD is that you can't reverse the disease. With progression of the disease comes an inevitable impact on productivity.

"This is an insidious disease," says Kolock, "But it has its exacerbations. A person who has chronic bronchitis is more of a setup to get acute infections of the lung, which affects absenteeism. Such a person also takes longer to recuperate."

Besides smoking cessation, are there other behavior changes that can help slow the progress of the disease? "That's the big one," says Kolock. "The chance of getting COPD if you're a smoker is 80%."

Since the disease cannot be reversed, the aim of the program is to optimize quality of life, both at work and at home.

"Meds do help control the symptoms," says Kolock, noting than many are bronchodilators quite similar to those used for asthma. "Our other goal is to make sure the patients optimize their use of meds. Patients often don't want to bother their doctors, so we give them better self-management skills."

When appropriate, oxygen therapy also can be appropriate. "Some patients need it continuously, while others only need it with exercise, or during sleep," she notes.

Another alarming fact of COPD is the comorbidities with which it is associated. "It's not unusual for someone who is smoking to be a great candidate for coronary artery disease and COPD," says Kolock. "The coronary artery disease will probably show up earlier. Also, you'll tend to see congestive heart failure because of the stress that's put on the heart as well as the lungs."

For working people, COPD can be a particularly debilitating disease. "I think it bears saying from my perspective that while we deal with a lot of diseases, the exacerbations of many of them might not be as frequent as those for COPD," says Kolock. "COPD is something you live with almost constantly when its gets to severe levels."

The goal of the HMC program, of course, is to delay the progress of the disease to those levels. "We want to keep people at work longer, with a better quality of life," he concludes.

[For more information, contact:

• ***Bob Kolock**, MD, Medical Director, Health Management Corp., 6800 Paragon Place, Suite 500, Richmond, VA 23230. Telephone: (800) 523-9279. E-mail: hmc@choosehmc.com.]* ■

Violence against nurses may be underreported

Nurses are experiencing a high number of violent acts in the workplace — but not just from patients; much of the abuse comes from co-workers as well. A University of Alberta (Canada, U of A) study that investigated workplace violence in hospital settings found the majority of the acts are not reported, and that tolerance might be contributing to the problem.

Researchers from the faculty of nursing at the U of A drew on data they collected for an earlier study. They surveyed more than 9,000 nurses in Alberta and British Columbia, asking if they had experienced any of the five types of violence — physical assault, threat of assault, emotional abuse, verbal sexual harassment, or sexual assault — within the past five shifts worked. They also were asked to indicate the sources of violence: patient, family or visitor, physician or nursing co-worker.

One in five nurses experienced more than one type of violence in a five-shift period. While patients still represented the largest proportion of perpetrators overall, hospital co-workers were responsible for 56.7% of all emotional abuse and 53.6% of all verbal sexual harassment in the critical care setting. Nurses tended not to report violent episodes in general, but were even less likely to report violence if a co-worker was the abuser.

In this latest study, published in the March issue of the journal *Health Policy*, the researchers

tried to determine why this behavior continues in hospital settings. One theory that might explain the violence is the "Broken Windows" theory of criminal behavior, says **Katie Rickers**, the lead author of the paper. "There is nothing else out there in the literature on how to treat violence in health care organizations, so we turned to a theory in criminal behavior," she reports.

In the Broken Windows theory, tolerating lesser criminal acts — such as vandalism — in a community creates an environment where more crime takes place. Petty crime in a neighborhood is a signal of social disorder and that criminals sense little resistance to their illicit activities. The same explanation can be applied to hospital settings, says Rickers. "Part of the problem is that if co-workers are abusing each other and that is seen as OK, patients are more likely to commit violent acts," she notes.

Taking a Broken Windows approach to violence prevention would require an immediate visible response to all incidents, no matter how serious. Considering the current difficulty in retaining health professionals and the link between violence in the workplace and lowered job satisfaction, investigating the impact of workplace violence in hospitals is even more timely, says the U of A. ■

OSHA alerts worksites with high injury rates

The Washington, DC-based Occupational Safety and Health Administration (OSHA) is alerting 14,200 employers across the country that their injury and illness rates are higher than average and encouraging them to take steps to reduce hazards and protect their workers. The 14,200 sites are listed alphabetically by state on OSHA's web site at: www.osha.gov/as/opa/foia/hot_9.html. However, the list does not designate those earmarked for programmed inspections.

"The purpose of the notification process is to alert employers that their injury and illness rates are above average," says OSHA administrator **John Henshaw**, "and then offer assistance that will help reduce those rates. This process not only raises awareness among employers of their higher-than-average injury and illness rates, but it also affords them a golden opportunity to take steps to reduce those rates."

OSHA identified establishments with the nation's highest lost workday injury and illness rates based on data reported by 93,000 employers surveyed by the agency last year (that survey collected injury and illness data from calendar year 2001). This was the first year the data collection initiative included the construction industry (13,000 construction employers were surveyed).

The two major groups of industries that received the most alert letters were manufacturing (7,108) and construction (1,692). When broken down into individual industries, they ranked as follows:

- skilled nursing facilities (1,579);
- nursing and personal care facilities not elsewhere classified (322);
- trucking, except local (303);
- plastics products, not elsewhere classified (291);
- plumbing, heating and air conditioning (279);
- department stores (256);
- general warehousing and storage (250);
- courier services, except by air (208);
- general contractors — nonresidential buildings — other than industrial buildings and warehouses (196);
- electrical work (187).

Workplaces receiving the alert letters had six or more injuries or illnesses resulting in lost workdays or restricted activity for every 100 full-time workers. Nationwide, the average U.S. workplace had just under three lost-time instances for every 100 workers.

Henshaw sent letters to all employers with high injury and illness rates, and provided copies of their injury and illness data, along with a list of the most frequently violated OSHA standard for their specific industry. While addressing his concerns for the high rates, Henshaw also offered the agency's help in turning those rates around, suggesting, among other things, the hiring of outside safety and health consultants and using free safety and health consultation services provided by the agency through the states.

"The data collection initiative, which is conducted each year, gives us a clearer picture of those establishments with higher-than-normal injury and illness rates," says Henshaw. "Armed with this information, we'll not only be able to place our inspection resources where they're most needed, but we can also use the information to plan outreach and compliance assistance programs where they will benefit the most." ■

NEWS BRIEFS

Healthcare@Work survey under way

All health care employees are invited to complete the fourth annual Healthcare @Work survey at www.hcatwork.com/. The national survey by Aon Consulting's Loyalty Institute, in partnership with the American Hospital Association's American Society for Healthcare Human Resources Administration, is designed to measure health care employee commitment and the organizational practices that drive it.

The survey takes about 10 minutes to complete and covers topics such as employees' perceptions of their jobs and managers and what they think the health care field must do to better recruit and retain health care workers. Preliminary results of the 2003 survey will be presented at the ASHHRA Annual Conference Aug. 17-20 in Denver. ▼

Study: Occ-med clinics save money, time

Using occupational clinics to treat injured workers not only saves money but gets employees back to work faster and provides more patient satisfaction than other medical care methods, an Atlantic Mutual study found. The study was published in a recent edition of *National Underwriters Newsweekly*, published by The National Underwriter Co. in Erlanger, KY.

The New York City-based insurer said its findings followed a review of 4,200 of its closed claims files for the 10 most common worker injuries over a one-year period. The study examined claims in nine states: Georgia, Illinois, Maryland, Michigan, Missouri, New Jersey, Pennsylvania, Texas, and Wisconsin.

Atlantic Mutual said it found that claims handled through an occupational clinic were 52% less expensive than those handled either by a general practitioner or the emergency department. Average indemnity costs on lost-time injuries were 49% lower; average medical costs were 29% lower; and the number of lost-time claims fell by 14%.

The clinics in the study were selected by Atlantic Mutual to treat workers. According to the study, the clinics were more effective at treating workers' injuries because they are geared to this treatment and are able to render therapy and care more quickly than other facilities.

A measure of the quality of care, the company said, is that only 5.1% of claims handled by the occupational clinics went to litigation, and legal costs fell 54%.

For more information, contact The National Underwriter Co. at (800) 543-0874. ▼

Find NIOSH emergency planning tools on the web

A comprehensive plan for dealing with terrorism-related events should include specific instructions to building occupants, actions to be taken by facility management, and first responder notification procedures, says the Cincinnati-based National Institute for Occupational Safety and Health (NIOSH). NIOSH has provided links to the following guides to assist in the development of these plans:

- **Emergency Management Guide for Business and Industry (FEMA)** www.fema.gov/library/bizindex.shtm — Provides information on how to create and maintain a comprehensive emergency management program. It can be used by manufacturers, corporate offices, retailers, utilities, or any organization where a sizable number of people work or gather.
- **Critical Incident Protocol (Michigan State University)** — www.cj.msu.edu/~outreach/CIP/CIP.pdf — Provides information about the public and private sectors working together to plan for emergencies. Elements include planning, mitigation, business recovery, lessons learned, best practices, and plan exercising.
- **OSHA Evacuation Plans and Procedures eTool** —www.osha.gov/SLTC/evacuation_etool/index.html — Guidance for retail businesses on implementing an emergency action plan. Also includes information on workplace evaluation, education, and training.
- **Small Business Disaster Planning Guide (Small Business Association/Institute for**

Business & Home Safety) — www.ibhs.org/docs/openforbusiness.pdf — Disaster planning toolkit that enables small businesses to identify hazards, as well as plan for and reduce the impact of disasters. Also provides advice on insurance, disaster supplies, and other items that make a small business more disaster-resistant.

• **Developing a Preparedness Plan and Conducting Emergency Evacuation Drills (National Fire Protection Association)** — www.nfpa.org/Research/nfpafactsheets/emergency/emergency.asp — Fact Sheet provides information about developing an emergency action plan, including fire prevention plans.

• **Model Shelter-in-Place Plan for Businesses** (National Institute for Chemical Studies) www.nicsinfo.org/SIP%20plan%20for%20offices%20NICS.pdf — Provides information about establishing a shelter-in-place program for your office building.

• **Business and Industry Preparedness Guide** (American Red Cross) — www.redcross.org/services/disaster/beprepared/busi_industry.html#fema — Guidance about planning for disasters, reducing potential damage, and protecting employees, customers and business.

For more information, visit: www.cdc.gov/niosh/topics/prepared/. ▼

CDC mails smallpox info packets to U.S. clinicians

In an unprecedented effort, the Atlanta-based Centers for Disease Control and Prevention (CDC) has begun mailing smallpox information packets to 3.5 million clinicians nationwide as part of the agency's established plan to educate medical professionals about smallpox and the smallpox vaccine.

"Ensuring clinicians have accurate information about smallpox is critical as we continue to work to enhance our nation's preparedness for a possible terrorism attack," says CDC director **Julie Gerberding,** MD. "This mailing is unprecedented, and the information in these packets is a valuable resource to those health care providers on the front lines who would be the first ones to recognize smallpox cases."

The packet includes up to date information that will help clinicians identify a case of smallpox, recognize and manage patients with an adverse reaction to the vaccine, and help others make decisions about receiving the vaccine. The packet contains:

• **Evaluating Patients for Smallpox:** A poster with color pictures to assist clinicians assess patients who present with rash illnesses.

• **Smallpox Vaccination Methods and Reactions:** A pocket guide with color pictures and information about smallpox vaccination, responses to vaccination, and adverse reactions.

• **Vaccine Information Statement:** A three-page document being used in vaccination clinics across the country with information about who should get vaccinated, associated risks, and information regarding adverse reactions.

Included in the mailing is an invitation for clinicians to join a registry. The registry will provide real-time information to help health care professionals prepare for possible terrorism events. Clinicians who choose to register will receive regular e-mail updates on terrorism preparedness issues as well as training opportunities.

The CDC is reaching health care providers through a variety of formats. In October 2002, the agency introduced comprehensive, web-based training to assist clinicians in monitoring and treating adverse reactions following vaccination. In January 2003, CDC published updated clinical guidance (Smallpox Vaccination and Adverse Reactions: Guidance for Clinicians, *MMWR*,52, RR04) and released a corresponding teaching tool to assist clinician specialists in training other clinicians in their communities. A satellite-training course of this material (Clinical Management of Adverse Events following Smallpox Vaccination: A National Training Initiative, Feb. 4, 2003) was broadcast live and continues to be available through web streaming or videotape.

Information about the CDC's training tools for

COMING IN FUTURE MONTHS

■ How self-care can help your employees survive a heart attack

■ Terror: Is it an occupational health hazard?

■ OSHA cracks down on violators of safety and health regs

■ Preventing and treating noise-induced hearing loss

■ Are efforts to boost participation in smallpox vaccination program succeeding?

clinicians can be found at www.cdc.gov/smallpox. Additional information about smallpox can be found on the web sites of both the Department of Health and Human Services (www.hhs.gov) and CDC. ▼

CDC offers vaccine monitoring system

The Centers for Disease Control and Prevention in Atlanta has released a Hospital Smallpox Vaccination Monitoring System intended to help hospitals monitor and track workers who receive the smallpox vaccine.

The web-based application is a component of the CDC Smallpox Vaccination Program being offered as a free service to hospitals. It is designed to capture data such as symptoms reported by vaccine recipients, fitness for duty and workdays lost, and to produce summary and overview reports of the hospital's experience.

More information, including how to enroll in the voluntary program, is available at www.bt.cdc.gov/agent/smallpox/vaccination/hsvms/. ▼

CDC alerts clinicians to atypical pneumonia

The Atlanta-based Centers for Disease Control and Prevention (CDC) has issued an alert to U.S. hospitals and health authorities in response to reports of a rapidly spreading atypical pneumonia that as of March 15 had infected more than 150 people in other countries and had been associated with four deaths. More than 90% of the cases have occurred in health care workers.

No cases have been identified in the United States. The CDC issued the alert after learning of several cases of the so-called severe acute respiratory syndrome (SARS) in Canada among travelers recently returned from Southeast Asia and their family members. Also on March 15, a health care worker from Singapore, who was ill after having recent close contact in Singapore with a reported case of SARS, was transferred to an isolation unit in Frankfurt, Germany after boarding a flight from New York.

Between Feb. 26 and March 15, the World Health Organization (WHO) has received reports of cases from Canada, China, Hong Kong, Indonesia, Philippines, Singapore, Thailand, and Vietnam. WHO is defining a case as someone with a fever higher than 100.4° F, respiratory symptoms such as a cough, shortness of breath or difficulty breathing, and either close contact with someone who's been diagnosed with the syndrome or recent travel to areas reporting cases of the syndrome.

The CDC said clinicians should notify infection control personnel immediately if such a patient is admitted to the hospital. It said infection control measures should include airborne and contact precautions and the use of standard hand hygiene and eye protection for all patient contact.

CDC currently is not recommending any specific treatment for the syndrome because its cause has not yet been determined and is being investigated. It said health care providers and public health personnel should report cases of the syndrome to their state or local health departments. Information updates will be posted at www.cdc.gov/ncidod/sars/. ■