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Unanswered questions make SARS an occupational health concern

Health care workers at risk, perhaps other employees as well

One of the nagging issues surrounding the newly identified disease severe acute respiratory syndrome (SARS) is that so many questions remain unanswered. Health care workers clearly are at risk, as has been demonstrated in several countries, but what about workers in general? Is it a broader occupational health concern? Does the relatively small number of cases in the United States mean we've stopped the disease in its tracks?

The Atlanta-based Centers for Disease Control and Prevention (CDC) has warned that we shouldn't stop worrying just yet. **(See SARS guidelines for the general workplace, p. 63.)** "One of the really important messages that we're emphasizing to the public health community today is that despite the fact that we do seem to be able to contain the spread of this disease in the United States, we have to remain vigilant because it [only takes] one highly transmittable patient [to] infect a very large number of people," **Julie Gerberding**, MD, CDC director, said in an April 17 update.

In the United States, local transmission of suspected SARS has been limited to health care workers and close contacts of suspected SARS patients who were travelers.

"By and large, the occupational medicine issues are issues of medical centers," asserts **Mark Russi**, MD, MPH, associate professor at Yale-New Haven (CT) Hospital, director of occupational health and chair of the Arlington Heights, IL-based American College of Occupational and Environmental Medicine's (ACOEM) Occupational and Environmental Infectious Disease Committee.

"In terms of health care workers, their probability of getting exposed is most likely the workplace," adds **Jean Randolph**, RN, COHN-S, a member of the Board of the Atlanta-based American Association of Occupational Health Nurses (AAOHN). "A person comes in who is real sick may not have been at work for a couple of days, and they need someone to take care of them. When you think of a health care worker seeing someone like that come to the door with what appears to be a cold or bronchitis, the reality is they will normally not wear a mask. They never catch things like colds from patients — you appear to develop an immune status. So we have this mentality that we're not going to catch anything."

With SARS, of course, all that has changed. "I think they weren't [wearing their masks at first] but I believe they are now," Randolph says. "One of the reasons they've become sensitized to it is precisely because they are health care workers. The message is coming home pretty quickly from infection control people, and their index of suspicion is way higher. The first thing they say to people with respiratory problems now is, 'Have you been out of the country?'"

This is a good thing, says Randolph — not just because of SARS, but because, she says, health care workers may be less cavalier about self-protection in general. "This may serve to be that wake-up call we need," she says. "You have to take care of yourself. It *can* happen to you."

What about other workers?

Occupational health professionals may well yet see SARS in workplaces outside of health care, says Randolph.

One possible means of transmission to the general working population, she offers, could be adoptions. "We have people within organizations who are adopting children, and may, for example, have gone to China to pick up a child and stayed there for four to six weeks. That long ago, we didn't have the same profile on this disease. So they find themselves in a country where SARS is running rampant, and they didn't know about it."

Or workers may have planned trips and left before that much was known about the disease, says Randolph. "My basic recommendation is if someone has come back to work after a vacation or after picking up an adopted child, you need to ask them to report to employee health before they go back to work, and check their temperature twice a day. I would also tell the health care professionals that when they are in direct patient contact, you would appreciate it if they wore a mask. We don't know how it's spread — whether it's communicable."

What we don't know . . .

Randolph's last comment is right on the money, says Russi — there is much we still don't know about SARS. "There's a lot of investigation going on as to whether the spread is just through droplets or whether it's airborne," he observes. "Droplet spread takes place within three to six feet. But certain diseases are spread through the airborne route — such as coughs. They can float their way up through HVAC [heating, ventilating, and air conditioning] systems and infect people within a much wider range. The answer to this question really isn't known. Also, researchers are investigating whether objects like doorknobs can be contaminated through touch. We think it can get into the blood and that's a possibility, although I'd be surprised if it emerged as major route of transmission; there's apparently one scientist in WHO [Geneva-based World Health Organization] who said that at least an incomplete version of the virus can be cultured out from the stool; but we're concerned most about the respiratory system."

All of that said, the precautions currently in place at hospitals and health care institutions are broader than what would be required to protect against droplet transmission. "They are instructed to use HEPA respiratory filters and gowning, gloving, and air protections. This is designed to be protective against a number of modes of transmission," notes

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SARS guidelines for the general workplace issued

Interim info puts health care workers on alert

The Centers for Disease Control and Prevention (CDC) is investigating the spread of a respiratory illness called severe acute respiratory syndrome (SARS). Because the outbreak has initially affected international travelers who have recently visited mainland China; Hong Kong; Singapore; and Hanoi, Vietnam, CDC issued a travel advisory for people traveling to those areas.

SARS is an infectious illness that appears to spread primarily by close person-to-person contact, such as in situations in which persons have cared for, lived with, or had direct contact with respiratory secretions and/or body fluids of a person known to be a suspect SARS case. Potential ways in which infections can be transmitted by close contact include touching the skin of other persons or objects that become contaminated with infectious droplets and then touching your eyes, nose, or mouth.

Workers, who in the last 10 days have traveled to a known SARS area, or have had close contact with a co-worker or family member with suspected or probable SARS could be at increased risk of developing SARS and should be vigilant for the development of fever (greater than 100.4° F) or respiratory symptoms (e.g., cough or difficulty breathing).

If these symptoms develop you should not go to work, school, or other public areas but seek evaluation by a health care provider and practice infection control precautions recommended for the home or residential setting. Be sure to contact your health care provider beforehand to let them know you may have been exposed to SARS.

For more information about the signs and symptoms of SARS, please visit CDC's web site (www.cdc.gov). More detailed guidance on management of symptomatic persons who may have been exposed to SARS, such as how long you should avoid public areas is available at the exposure management page.

As with other infectious illnesses, one of the most important and appropriate preventive practices is careful and frequent hand hygiene. Cleaning your hands often, using either soap and water or waterless alcohol-based hand sanitizers removes potentially infectious materials from your skin and helps prevent disease transmission.

The routine use of personal protective equipment such as respirators, gloves, or, using surgical masks for protection against SARS exposure is currently not recommended in the general workplace (outside the health care setting).

Source: Centers for Disease Control and Prevention, Atlanta. Web site: www.cdc.gov.

Russi. "We hope those will be effective."

This may be part of the reason that the outbreak has so far been much less severe in the United States. "It's a little hard to say," he observes. "It's probably largely attributed to the fact that the [index case individual] traveled to Toronto before we knew much about SARS."

Other questions still remain, he adds, such as concerns about so-called super-spreaders — people who are capable of transmitting the disease much more easily than the average individual. "Those are some of the unknowns," Russi sums up. "Why our experience differs so much from Canada is probably largely due to the fact that they were unlucky enough to have the index case early on, before screening mechanisms were put in. Anyone put in the hospital now with respiratory symptoms has to be asked questions about travel."

As long as health care professionals can recognize the individual who possibly has SARS based on symptoms and travel history, "I think we have the ability to deal with airborne contact," says Russi. "The trick is recognizing it. This may be more difficult if the epidemic keeps spreading and it becomes a more global phenomenon; then, it may not be as predictive to ask where you have been."

Researchers hope to develop more effective diagnostic tests than are currently available, he adds. "For example, PCR [polymerase chain reaction] tests become positive earlier than indirect immunofluorescent antibody tests [which are technically difficult to do, and are not positive until about 10 days], but there have been a number of false negatives," Russi notes.

Because of all of the aforementioned unknowns, this is not the time, he concludes, for occupational health professionals to relax. The bottom line, he says, is that "it is not time yet to breathe a sigh of relief and say we've dodged the bullet."

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Fatal heart attacks rock smallpox vaccine efforts

Link could damage national campaign

(*Editor's note: A 55-year-old man in the National Guard suffered a fatal heart attack following smallpox vaccination as this issue of* Occupational Health Management *went to press. That case is not reflected in the following seven cases described in the story below, which all occurred in hospital or public health workers*.)

Two fatal heart attacks following smallpox vaccination of health care workers threaten to further derail a struggling government immunization program already suffering from a striking lack of hospital participation.

Though a direct cause and effect has yet to be established in an ongoing investigation, the reports do not bode well for a program that has vaccinated only about 5% of the 500,000 hospital workers it originally projected.

A nurse at Peninsula Regional Medical Center in Salisbury, MD, died of a heart attack on March 23, 2003, five days after being vaccinated. She was reportedly in her 50s. On March 26, 2003, a 57-year-old health care worker in Florida died 10 days after suffering a heart attack that occurred a week after being vaccinated for smallpox.

Those cases and reports of five other heart-related adverse effects among vaccinees prompted the Centers for Disease Control and Prevention (CDC) to declare a history of heart disease as a new contraindication for receipt of smallpox vaccine. Health care workers should not receive smallpox vaccine if they have a history or a diagnosis of coronary artery disease, myocardial disease such as angina, heart attack, congestive heart failure, or any kind of cardiomyopathy. Health care workers who already have been vaccinated should immediately consult a physician if they have any symptoms of heart disease, such as shortness of breath or chest pain, the CDC advises.

There is some concern that the effect on the program may ripple out beyond the specifics of that contraindication. The new heart disease contraindication may give pause to workers — or their personal physicians — with any peripheral concerns about, for example, diabetes or blood pressure, says **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center. Beyond that — even if the deaths are later ruled entirely unrelated to the smallpox vaccine — a certain amount of "re-education" will be necessary to reassure health care workers about the program, he adds.

"Clearly, if we look at all known risk factors for coronary artery disease, we would potentially get to very, very large numbers of the population, and it would, in essence, be very difficult to enhance our preparedness," concedes **Walter Orenstein**, MD, chief of the CDC national immunization program. "What we've tried to do is pick out people with the very highest risk factors, in the absence at this point, of any known causal relationship."

Indeed, the CDC is determined to forge on, particularly with the threat of bioterrorism related to the war in Iraq.

"Certainly, we are a time in the history of our country where the potential for terrorism has probably never been higher," says **Julie Gerberding**, MD, MPH, director of the CDC. "And we recognize that we must continue to be prepared to deal with a threat of smallpox in our nation. We are going to continue the program. But we're also going to continue the program with the caveat that safety still is a high priority for us. And every time we put something on the list of medical conditions that constitutes a basis for deferral, we recognize that it does decrease, to some extent, the population of people who are willing to volunteer. But it's a balance. And I think, again, we want to err on the side of safety."

Two deaths after 25,000 vaccinated

The CDC discovered the seven cases of heart-related problems among the 25,645 health care and public health workers who have been vaccinated in the civilian program. The seven cases include three cases of myocardial infarction (heart attack), two of which resulted in the aforementioned deaths; two cases of angina (chest pain); and two cases of myopericarditis (inflammation of the heart muscle or sac surrounding the heart).

Issuing the contraindication is a clear case of erring on the side of caution, because a definitive link to smallpox vaccination has not been established in any of the cases.

"I think the first hypothesis is that this is not

causally related," Gerberding says. "That's the null hypothesis in this case that we're working from. But I think there is also at least the biological plausibility that when you have a viral infection — which is basically what happens when you issue the vaccine — that there could be inflammatory response that in some unidentified way exacerbates pre-existing coronary artery disease or inflammation."

The CDC convened a panel of expert cardiologists and immunologists to review the cases to determine if the problems are vaccine-related. Investigators will also look at comparable populations in other studies to assess the incidence of cardiac problems in unvaccinated people. The CDC also is trying to determine if the heart problems may occur at a higher rate in females, which comprise the majority of health care workers being vaccinated for smallpox.

"The five patients who have had the coronary artery disease related complications — the three with MI, and the two with angina — all have very clear, defined risk factors for coronary artery disease," she says. "That is known in their medical history, and these are people who would medically be considered to be at perhaps increased risk of these conditions, based on their past medical history."

Smallpox vaccination and cardiac problems have not been linked in the historical smallpox literature, but more older people are being vaccinated now than during the childhood immunization programs prior to smallpox eradication. The three workers who had heart attacks were all women in their 50s. In all seven cases, the time lag between vaccination and cardiac problems varied from five to 17 days. No adverse reactions were noted at the time of vaccination.

"We don't have a lot of epidemiologic or scientific information about the relationship between vaccine and cardiac illness in persons who are older and who were not involved in the childhood immunization program where we had the most experience in the '60s." Gerberding says.

The problem is that older staffers who have been previously immunized have been considered at lower risk of adverse effects. Might the CDC begin discouraging senior staff to be inoculated for smallpox?

"I don't think that we are prepared to take that step at this point in time," she says. "We'll defer to the expert input that we anticipate receiving from people who are the most credible in the world of cardiac risk assessment." ■

Special Series: HIPAA Compliance

Early response key to HIPAA compliance

Handle documentation on day one

[Editor's note: On April 14, 2003, the new Privacy Standard of the Health Insurance Portability and Accountability Act (HIPAA) went into effect. In the following three articles, we will take a look at different strategies occ-med professionals have employed to come into compliance with the new law.]

Compliance with the new privacy standard of HIPAA can be achieved much more easily and smoothly with some simple planning and proactive responses, says **Frank Tafelsky**, OTR, MS, MBA, program manager for Munson Occupational Health and Medicine in Travers City, MI.

Using simple, standard releases created in-house, Munson has patients authorize the sharing of medical information immediately upon their first visit — regardless of the reason for the visit — which, says Tafelsky, helps avoid potential problems down the road. (The privacy standard outlines a set of rights for all patients with respect to the privacy of, access to, and control over their personal health information.)

"The release basically says that you are authorizing us to share the medical information obtained from your visit with your employer and other medical professionals," he explains.

An occ-med concern

The new privacy standard is particularly significant for occupational health facilities, says Tafelsky. "As an occ-med clinic, we are frequently asked to supply information to employers and other medical personnel, attorneys, and anyone else who may potentially need this information," he explains. "For all of those disclosures outside of workers' comp, we would have to keep a list of who those disclosures were made to. By having these releases of information, we will avoid that."

Another big issue for occ-med clinics is the employer services they perform, such as drug screenings, physicals, or fit-for-duty exams, Tafelsky continues. "Even for a simple TB test, you would need to record a release of medical information on a form, so by having the releases signed on the front end, you avoid all that."

Munson has a designated individual whose responsibility it is to ensure that release of information forms will be following HIPAA standards. "The HIPAA forms *have* to be signed," says Tafelsky.

Even workers' comp affected

While many occupational health professionals assert that HIPAA does not apply to generic workers' comp visits, Tafelsky insists that it really does.

"Let's say you came in for a workers' comp injury — a torn knee," he proffers. "Let's say it gets fixed, and 10 years down the road you have another knee injury playing softball. The question, is where does workers' comp come in? Maybe nowhere, but the physician will want those records to be sure, and I can't give them to him if the patient hadn't signed a release of information. With our procedure, you will never have a question about whether you need an authorization to release information about medical care because of HIPAA."

Ultimately, says Tafelsky, HIPAA will make information flow more freely and will result in substantial savings for providers. "We will save money because down the road there will be a decrease in the amount of paperwork you need to have in place, so you'll save on staff time for releases of information and other related avenues," he says. "In the future, the increased use of the electronic medical record will be extremely important, and HIPAA will support that as well."

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Software can ease authorization process

Electronic records keep facilities connected

As with many areas of occupational health care, new approaches in technology have been sought to ease the way into compliance with the new Privacy Standard of the Health Insurance Portability and Accountability Act (HIPAA). One example is the HIPAA GUARD program from Monterey, CA-based Integritas Inc.

The program, which can be used either as a stand-alone or in concert with the STIX occupational health suite, was created in anticipation of the new HIPAA requirements, says **Mary Stroupe**, MA, MBA, vice president of sales for Integritas.

"We anticipated it would be needed," says Stroupe. "We were clear that HIPAA was going to apply to all our clients — both to freestanding occupational health and rehab organizations, and in the hospital-based environment, where we see an even greater need."

Authorization is the linchpin

While HIPAA GUARD addresses a number of concerns, including privacy notice acknowledgement and consents, authorizations, patient access requests, patient complaints, and accounting of disclosures, patient authorizations seemed to be an overriding concern for a number of clients. "Fundamentally, we saw that according to the law as we read it, the release of information to the employer for the purpose of a physical or a drug screening would require an authorization from the patient," Stroupe explains. "In a health system, if you go to three or four different places, should you have to be given three or four different privacy agreements? In the scheme of all issues, that's No. 1."

Evelyn S. Miller, CPA, executive vice president-finance for Medway Health Inc. in Dallas, agrees. "You don't want it to look to your clients like you don't know what you're doing," she notes. "If they come into your clinic and sign a privacy agreement, then get referred to the hospital, which is owned by the same company [and get asked to sign another], they think you are clueless."

Miller has just such a situation. "We have two freestanding locations, each with three distinct treatment departments," she says. "It's helpful for us to know whether a patient has already signed an authorization form; it not only eliminates paperwork, but we are perceived as being more professional." Miller says this is one of the primary reasons she decided to integrate HIPAA GUARD with her STIX software.

There are other reasons managing HIPAA compliance with software can be beneficial. "We anticipate that whether you are a freestanding facility or a hospital, because the occ-med department is the department that routinely releases information to

the employer, this could potentially be a source of weakness in the whole system," notes Stroupe. "Plus, even though the law does not require authorization for purposes of workers' comp, it *does* require you to document and keep track of disclosures made for workers' comp. If you're a small operation, you can just pull out the chart and see it, but in a large one, where you have many disclosures in many different places, having no single place to keep track of all of them is a huge problem."

Miller sees other reasons for the electronic record keeping the software facilitates. "When we get audited, surveyors want to see your compliance with HIPAA and how you track it," she notes. "We are getting ready for our accreditation by CARF [the Commission on Accreditation of Rehabilitation Facilities], and they want to see how we are complying with HIPAA, as well as logs of where we have done the accounting, whether people are receiving proper notice, and so on."

Not a performance change

Both Stroupe and Miller agree that the new Privacy Standard may change the way certain processes are handled, but not the way care is given.

"The general thinking is that HIPAA allows health care providers to do things that in the past they couldn't do, but that's just not true," Stroupe asserts. "It requires providers to tell people what is happening. What I anticipate is this: in the past, patients haven't asked to see their records, and in most cases it probably never occurred to them to ask. Now they're being given a document that tells them there's a new law that says what their rights are. Soon, a certain percentage of people will start to request their records just because they can. This can cause real headaches, because the law requires you to reply to these requests within a certain amount of time. The software keeps track of when this has been done, what is pending, and so on. Even in the absence of any breach this is important."

"I agree," says Miller. "We've not yet seen any increase in the number of requests for medical records. We already had a response system in place; this is just making it more standardized. Basically, for us it's just creating more work to document what we already do."

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HIPAA a challenge for occ-med researchers

Take care with identifiers

The new HIPAA rules also present a challenge to medical researchers, who need to be able to identify individual patients in clinical studies and to track them over time. (Research plays a significant role in the occupational health profession, as experts seek to understand the connection between job tasks, the working environment, and injury and illness.)

"HIPAA regulations are a wake-up call for clinical researchers who now need to modernize their approach to managing private clinical information," says **Eran Bellin**, MD, a medical researcher who also is the head of New York City-based Montefiore Medical Center's HIPAA security subcommittee. HIPAA specifically requires hospitals to "implement a mechanism to encrypt and decrypt electronic protected health information."

Bellin, who could find no existing computer software to meet both privacy rules under HIPAA and his own research needs, built one. The innovative program encrypts *identifiers* (such as a Social Security number) on a clinical trial patient's electronic medical record. The key or code to the encryption system, and therefore access to the patient's medical record, is then stored in a separate database on another computer.

"The software is significant for Montefiore, because, as the university hospital and academic medical center for the Albert Einstein College of Medicine, we conduct trials involving hundreds of patients and tens of millions of dollars annually," says Bellin, who hopes that the software will become a national model for other medical centers. The software is believed to be the first of its kind.

Patient privacy can be further protected, notes Bellin, if the encryption key becomes the property of a research institution's institutional review board — generally composed of ethicists, researchers, and

community members who review and monitor clinical research and whose job it is to guard against access to patient records.

Researchers have historically been permitted to review patients' medical records and then physically lock up the information in a drawer, file or within a computer database. When research findings are released, the data are aggregated so no individual is identified. HIPAA restricts the ways in which researchers may use or disclose protected health information in a patient's medical record and this requires more modern methods to access and use the patient information.

The new software is called FieldEncrypt. Additional information is available at http://fieldencrypt.devguru.com. ■

AHA offers HIPAA guidelines

With the deadline for complying with the Health Insurance Portability and Accountability Act's (HIPAA) privacy rule upon us, the Chicago-based American Hospital Association is reminding members about a brochure it released in February that updates guidelines for releasing information on the condition of patients under HIPAA.

The brochure is designed to inform hospital staff about how and when hospitals can release information on a patient's condition to media, family members, and clergy. Members can download "Guidelines for Releasing Information on the Condition of Patients" at www.aha.org. Click on "HIPAA" under "Key Initiatives," then on "Updated Guidelines." Printed copies can be ordered by clicking on the "Order Guidelines" for the brochure at www.hospitalconnect.com. ■

Weight loss program helps shift workers

Customized eating plans are key

It's challenging enough for any employee to practice proper nutritional habits. But when they work the night shift, and breakfast time comes at 9 p.m., things can really get tough.

"Traditional breakfast, lunch, and dinner are hard to manage when your work hours are the opposite of your family and friends," notes **Suzanne Henson**, RD, director of the EatRight weight management program at the University of Alabama at Birmingham (UAB). "It's easy to fall into bad habits."

What are those bad habits? "Obviously, due to their schedule, a lot of these people say their nights and days are different from ours," Henson explains. "Yet many times they feel they have to have the same meal habits as eight-to-fivers. What happens frequently is they may get off work at 7 a.m. and rather than having 'dinner,' they may graze all morning, go to bed later, and never really adjust their eating schedules. When you're not getting balanced meals, you're eating snacks during the day and then just eating what is commonly found in vending machines during work, weight gain can be very common."

This can impact both health and productivity, says Henson. "One nurse with a cardiac problem was just not getting her weight off, and her supervisor told her she didn't have the energy needed to do the job properly," she recalls. "For a factory worker, being out of shape or overweight can also put you at risk for injury."

Henson is helping shift workers in the Birmingham area deal with the challenges of shift work with her program, whose 400 some-odd participants cover the gamut of UAB and other area employees. "We serve the general community as well as central Alabama," says Henson. "Our classes include everything from working professionals to stay-at-home moms, from late shift nurses who work in the UAB hospital to factory workers. They come into class right after they get off work."

Everyone is different

The program is designed to accommodate the diverse schedules of the area working population. "We have six classes each week at various locations, with staggered schedules to accommodate different lifestyles and areas of town," Henson notes. Each class is 90 minutes long, with anywhere from 10-20 people in a class. The program consists of one class a week for 12 weeks.

"This is a comprehensive weight loss program," says Henson. "We cover different lifestyle topics — not only the types of foods you eat."

EatRight Healthy Food Guide

Menu	Starch	Meat/Dairy	Fruit or Vegetable
Baked potato	Microwaved baked potato	Low-fat cheese	Leftover vegetable
Soft taco	Tortilla & canned fat-free refried beans	Low-fat cheese	Salsa
Mexican dish	Instant brown rice	Canned black beans	Canned stewed tomatoes
Pasta	Pasta	Parmesan cheese	Canned spaghetti sauce
Soup	Crackers	Canned soup	Canned fruit
Tuna	Crackers	Tuna	Canned pineapple
Peanut butter	Raisin bread	Peanut butter	Banana
Cereal	Cereal	Milk	Banana
Popcorn	Low-fat popcorn	Parmesan cheese	Vegetable juice
Cottage cheese	Crackers	Cottage cheese	Canned fruit
Beans & greens		Canned beans	Canned turnip greens

Source: EatRight Weight Loss Program, University of Alabama, Birmingham.

Shift workers are encouraged to think about their own unique work schedule and come up with an eating norm for that specific schedule. "For example, it may be hard for shift workers to get away to eat dinner or breakfast," says Henson. "For them, breakfast may be at 9 p.m., before they go to work at 11."

Food choices are stressed in the program — i.e., eating more fiber, drinking more water, and in general getting the most food for the fewest calories. "We talk about easy snacks that are healthy, too — a string cheese and melba toast pack, apple wedges with peanut butter, and so on," says Henson. "We also look for things that you can keep on you — even things like meal replacement bars. A lot of them are really candy bars, but some are healthy." **(See the EatRight healthy meals chart, above.)**

Every worker is different, she stresses. "You have to look at your own situation — what a nurse working the third shift may be able to do could be different from a factory worker," she explains. "For example, an ER nurse can't predict when she'll be able to take a break. I've encouraged them to keep things in their pockets so they can grab a snack when they have a free minute. For factory workers, it depends on whether and when they get a break."

Henson challenges the workers with questions like, "Is it a reality for you to have three main meals and one or two snacks?" That's typically what most people need, she says, but sometimes that's just not realistic. "You may need to have five or six mini-meals spaced out during your

day and night," she notes. "Just make sure they are not five or six large meals."

Henson is pleased with the success of the program. "At one point one of our insurance companies offered an incentive-based reimbursement program," she recalls. "People who attended 10 to 12 of our classes were much more successful."

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Heart-attack help you can carry in your pocket

Self-care in critical early minutes may save lives

A close friend's brush with death inspired the head of an employee health consulting firm to develop a product that has the potential to save thousands of lives. The product is called the Cardiac CareKit, and it can fit inside the employee's wallet or purse.

The kit's components include:

• a 16-page booklet containing information on recognizing heart attack warning signs, first aid, how to perform CPR, and a place for recording personal health information;

• two aspirin;

• a vinyl sleeve with two pockets and the worker's name prominently displayed.

Brush with death

"A good friend of mine, who is 52 and who did not have any of the risk factors for heart attack or cardiac disease, was working in his yard recently and started to feel chest pains and pain moving to his jaw and shoulders, typical symptoms of a heart attack," relates **Don R. Powell**, PhD, president of the Farmington Hills, MI-based American Institute for Preventive Medicine. "Most people ignore these symptoms, but the American Heart Association recommends getting treatment within an hour."

Fortunately for Powell's friend, he recognized the symptoms and knew to take an aspirin and call 911, and not to delay. An ambulance came and got him, and on the way to the hospital he had a heart attack — and survived. "The emergency personnel said that what saved his life were recognizing the symptoms, calling 911, and taking aspirin," says Powell. "When he told me this story, I wondered how many people knew to do this, and if there was any kind of kit for workers that covered this situation."

Powell did some calling around and couldn't find such a product. "You can certainly take aspirin and call 911 on your own, but having a reminder in your wallet or purse can be very helpful," he notes.

Such a kit is especially important if your work force averages age 45 or older, says Powell, but notes that employees of any age can benefit. "Each year, approximately 800,000 people suffer a heart attack, and nearly one in three don't survive, according to the American Heart Association," Powell observes. "More than half of these will die in one hour if they don't recognize the symptoms and receive the proper medical care."

Through his company's clients, Powell says he has the potential to provide about 20 million employees with the kit.

[For more information or to receive a sample kit, contact:

• ***American Institute for Preventive Medicine**, 30445 Northwestern Highway, Suite 350, Farmington Hills, MI 48334. Telephone: (248) 539-1800. Fax: (248) 539-1808. E-mail: aipm@healthy.net. Web site: www.HealthyLife.com.]* ■

Workplace occ-health issues go international

Countries agree on excellence criteria

Occupational safety and health officials from the United States, Mexico, and Canada have agreed on criteria to recognize excellence in workplace safety and health programs in all three nations. The group also reached consensus on key elements for establishing effective occupational safety and health management systems.

"Worker safety and health is a high priority for each of our nations and together we are addressing key issues and exchanging ideas in order to produce tangible results that will benefit all of our workers," said OSHA administrator **John Henshaw**, commenting on the March 10-12 meeting of one of the subgroups of the Tri-National Occupational Safety and Health Working Group, which met in El Paso, TX/Cuidad Juarez, Mexico

to discuss best practices, partnerships, voluntary programs, and occupational safety and health management systems. "An important part of our joint efforts includes recognizing excellence in workplace safety and health programs and sharing that information with workers and employers throughout North America."

Established under the auspices of the North American Free Trade Agreement's side accord on labor — the North American Agreement on Labor Cooperation (NAALC) — the Tri-National Occupational Safety and Health Working Group brings together technical experts from the three nations to advance cooperation and programs in key areas of occupational safety and health. The Working Group is headed by each nation's top occupational safety and health official.

During the technical workshop on Occupational Safety and Health (OSH) Management Systems and Voluntary Protection Programs, the group discussed best practices and lessons learned from all three countries on building cooperation and partnership with companies, and their experiences in implementing their voluntary programs and occupational safety and health management systems. The group also participated in site visits of medium-sized businesses in Cuidad Juarez and construction companies in El Paso.

The Occupational Safety and Health Working Group reached consensus on the following key elements of effective occupational safety and health management systems:

- management commitment and responsibility;
- employee involvement and responsibility;
- worksite analysis and approaches;
- hazard/risk prevention and control;
- training on criteria for recognizing excellence in workplace safety and health programs.

The subgroup also established criteria for recognizing best practices in excellence in workplace safety and health programs, including:

- application and evaluation processes;
- criteria to participate;
- a recognition strategy.

The subgroup was to meet again during the full working group meeting in April 2003 in Toronto to focus on specific applications of safety and health management systems. Topics that the subgroup is considering for future technical workshops include: Canada's OSH auditor certification process; programs aimed at construction and small businesses; OSH education for youth; issues specific to Hispanic workers; and the collection and reporting of injury and illness statistics.

For more information on meeting results, visit the Tri-National web page at www.osha.gov/TriNational/index.html. ■

Smallpox vaccination bill protecting hospitals passes

Congress has passed the Smallpox Emergency Personnel Protection Act of 2003. The legislation provides for changes in the government's voluntary smallpox program by allowing hospitals to provide vaccinations without fear of liability if someone they vaccinate should become ill. It also includes a compensation fund that pays up to $50,000 a year for those sustaining a disability after vaccination and a death benefit of $262,000, an important first step in providing a safety net for those few people who suffer an adverse reaction to the vaccine. Congress also approved $43 million to help fund the bill. ▼

Duke offers occupational medicine certification

Duke University Medical Center in Durham, NC, is planning its fourth annual certificate

COMING IN FUTURE MONTHS

- How to use benchmarking data to address return-to-work issues
- Functional assessment vs. pain assessment: The pros and cons
- Can self-management be effective in dealing with chronic pain?
- Health care facility seeks partners in addressing worker shortages
- Guidelines and regulations: Why they should be treated differently

program in Occupational and Environmental Medicine for physician assistants, nurse practitioners, and physicians, to be held Oct. 5-10, 2003. This on-campus program offers CME and graduate credit.

Total costs are $2,750, which includes tuition, private accommodations at the R. David Thomas Executive Conference Center, and all meals.

Complete information and a registration form are available on the web at http://pa.mc.duke.edu/oem.asp. Or contact program director, Patricia Dieter, at patricia.dieter@duke.edu, for a printed brochure and registration form. Registration deadline is June 1, 2003. ▼

First installment of HIPAA enforcement rule issued

The Department of Health and Human Services (HHS) has placed on display an interim final rule establishing procedures for the imposition of civil monetary penalties on entities that violate standards adopted under the administrative simplification provisions of the Health Insurance Portability and Accountability Act. The rule, published in the April 17 *Federal Register*, is the first installment of HHS' enforcement rule for the provisions and informs regulated entities of the agency's approach to enforcement. The rule is effective 30 days after publication and provides for a 60-day comment period. ▼

CDC software tracks vaccinated workers

The Atlanta-based Centers for Disease Control and Prevention (CDC) 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/. ▼

HHS proposes smallpox compensation for injured

Responding to concerns from health care workers, hospitals, and public health departments, the U.S. Department of Health and Human Services (HHS) is working with Congress to establish a limited compensation package for caregivers who are injured or die as a result of receiving the smallpox vaccine. The administration's proposal is based on a compensation package similar to that currently available to police officers and firefighters.

The Chicago-based American Hospital Association, which has been pushing HHS for better protection of hospital employees and patients, is reviewing the department's proposal to see how well it addresses the association's concerns. ■