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Ongoing diversity training can yield happier, healthier workers

Cultural differences can cause physical, mental health problems

The issue of cultural diversity has had a front-of-mind status in much of corporate America for several years now, and many companies recognize the value of respecting the differences within an employee population. However, paying attention to those differences has a special significance for occupational health professionals. In fact, ignoring them can lead to myriad problems both for individual employees and for the worker population at large.

"The workplace has become more and more diverse and heterogeneous," asserts **Donna L. Goldstein**, EdD, a cross-cultural psychologist and managing director of Development Associates International in Hollywood, FL. "People have been used to making assumptions that everyone was like them, but now, in any workplace, you can have people from different parts of the world, with different values that can cause them to make very different choices and have very different priorities. If management does not understand that, they can make bad decisions."

Even the simplest decision can lead to greater stress for some employees, she notes. "Say you want to reward your employees, and you want to have an event on a Monday night," Goldstein poses. "If the employee is single, it might be a good thing; but if employees are married or single parents, or if they are Haitian, Caribbean, or Latin — where family is very important in their culture — it would not be a good thing to go out with fellow employees on a weeknight."

The employee is then caught in the middle; if he does not go, he may anger his boss. If he does go, he could anger his family. "So the situation causes stress one way or the other," Goldstein says. "In such a case, it might be more appropriate to go at lunchtime."

Goldstein's reference to married couples or single parents points out an important consideration when it comes to diversity: The occupational health professional needs to be aware of employee differences that go beyond ethnicity.

"I look at populations at special risk in the workplace," says **Pamela F. Levin**, PhD, RN, associate professor at the college of nursing at Rush University in Chicago. Most programs in the workplace are centered around ethnicity, she asserts. "But culture is also age and gender."

"We need to have a broad definition to include socioeconomic factors as well," Levin continues. "Certain industries hire more low-income workers, who are less likely to have insurance. Also, they tend to work in more risky jobs. Diversity also brings in issues like disability and lifestyle [e.g., sexual preference]."

It's also important, says Goldstein, for occ-health professionals to recognize the difference between cross-cultural considerations and diversity issues. "Diversity usually focuses on recognizing prejudice and discrimination, and developing strategies for understanding each other in a domestic setting," she explains. "Cross-cultural training is required outside of a domestic setting — for example, a hospital in Japan seeking to do work in Brazil."

The issue of diversity is much more than a theoretical problem for occ-med professionals; it plays out in real-world health problems every day. "There are a lot of people from different ethnic backgrounds who are afraid to use the health care system for a variety of reasons involving fears, including anything from losing their job for reporting that they hurt themselves to not being understood and in some way being discriminated against," says **Lewis Schiffman**, president of Atlanta Health Systems.

"Additionally, many of them are used to receiving services from health care systems that operate differently, and they don't understand our system. So what is often easier for them, rather than feeling awkward or embarrassed, is to try to treat things on their own or with methods traditional to their own culture."

Such differences can cause both physical and mental health problems, says Levin. "Health practices and health beliefs vary across cultures, ethnicities, and ages," she observes. "For example, those workers who are in their 20s are quite different from baby boomers. For one thing, they grew up with managed care.

"With gender, we know that women use the health care system differently than men; they are more preventive-oriented," she continues. "Also, health services have been designed to appeal more to men, and although this is changing, it has not trickled down to the workplace yet. And men have a disproportionate number of injuries [compared to women]."

Workers from other cultures, Levin notes, may not know how to access or understand the health care system, including dealing with insurance issues. "Also, our health care system is predominantly Western in style," she says. "This raises issues such as CAM [complimentary alternative medicine], which is not often incorporated into a traditional occupational health assessment."

Mental health issues also can be significant, Levin notes. "There is no training outside the workplace in terms of how to respect people who are different from you. We teach self-esteem, but not how to respect others in the workplace, which will be very different from their smaller community at home," she says.

"If there is racial or ethnic tension or misunderstanding, it creates a much more stressful work environment," adds Schiffman. "This adversely affects everyone's health and will also increase the number of injuries and workers' comp claims."

"There is a lot of interesting evidence that turnover is more likely if workers do not feel

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accepted or part of a group," says Goldstein. "Employees who are gay, for example, may be made to feel uncomfortable if they are not allowed to have a picture of their sweetheart on their desk. You could expect their morale and productivity to go down, they will become more introverted, less willing to interact with their colleagues, and less likely to fulfill their potential as workers. The more open you can be with them, the more likely you will be to resolve their problems."

Small differences, big issues

Even seemingly small cultural differences can have a large impact on how employees interact with you and with the health care system, says Goldstein. "Even things like the perception of mental and physical illnesses are significant," she notes. "In some cultures, it's OK to say you are going to a psychiatrist; in others, it's taboo to admit weakness. In some, you may not believe you are sick because of germs, but because of some sort of spirit. If you have a different perception of what makes you ill, you will have a different perception of what will heal you."

This, Goldstein says, impacts how the health care professional will treat the employee. "You must be cognizant of the fact, for example, that while you may want to just give them medicine, they may also go for spiritual [treatment]," she explains.

A similar problem can arise with a death in the family, she notes. "In some cultures, it is a terrible thing. In others, they believe you are going to a better place," Goldstein says. "So, how do you comfort a co-worker?"

Even such simple things as how close we stand to each other can become large issues, says Goldstein. "In a number of instances, cultural miscommunication is seen as sexual harassment," she explains. "In some cultures, people touch each other when they talk, but the British, for example, stand particularly far apart and almost never touch except when they shake hands. Mexicans, however, touch maybe 70%-80% of the time. Then, overlay [these differences with] the appropriate concern in the U.S. for sexual harassment, and you can have a lot of miscommunication."

The same may be true with nonverbal communication, such as eye contact. "In some cultures, it is considered a sign of respect for authority to not make eye contact," Goldstein explains. "But if a worker did that to an American boss, that boss might think he was lying."

Winning strategies

Despite the daunting list of challenges presented by employee differences, there are a number of techniques occupational health professionals can use to address these differences.

"The first thing is, finding out about the cultural norms of the group or groups you work with and what their traditional beliefs are in health care," Schiffman recommends.

"Second, learn a few words of their language. Making an effort to communicate with them in their language, even if you are not fluent, demonstrates respect and is perceived as a desire to create alignment.

"Third, make a lot of eye contact and try to observe their nonverbal responses. Many health care providers will focus more on the interpreter rather than the patient, and this is often perceived as disrespectful and builds distrust."

Levin agrees. "It's on the very basic level of the health professional that you treat everyone with respect," she says. "Ask what it is that they do in terms of helping for their health. If you have that dynamic of equal respect, you don't have to know *everything* about all the different cultures."

Also, be aware that while cultural sensitivity may make you cognizant of general trends. "When you get down to the individual level they may not represent that population at all," says Levin. "They may have a Spanish surname, but they may have grown up in America and do not identify with Hispanic culture at all."

It's also important to take a look at the tools used within the health center, she adds. "Do your health and history forms take into account issues broad enough to capture the diverse health issues of the population?" she poses.

Diversity training needed

Goldstein recommends using a Cross-Cultural Adaptability Inventory. Basically, this indicates how well workers are likely to do with people different than themselves. "If the score is low in flexibility and openness, you might have to have a [training] series," she says, noting that she's had employees complain about things as seemingly minor as the smell of curry in the break room.

Unfortunately, says Goldstein, the emphasis on

diversity training seems to have waned. "A lot companies are saying, 'We've already done that,'" she complains. "They've had a day or two of training, and they think they're done."

However, this is an ongoing process, Goldstein says, partly because our definition of diversity continues to evolve, and partly because employee populations themselves continue to evolve. "What if 10 years ago, 5% of your workers were Hispanic, and now it's 40%? What if you now have a boss who's gay?" she poses.

Any training that occurs must be strongly supported by management, adds Levin. "Unless you evaluate your people on those behaviors or skills, there is no repercussion," she asserts.

While it is true that in most companies the human resources manager hires the diversity trainer, the role of the occupational health professional is no less critical, says Schiffman. "I would encourage the occupational health professional to be an advocate and an educator, to teach all people to make better use of the health care system," he says. "It should be brought up as an organizational health and performance issue for any number of reasons. If people are reluctant to come in for care in a timely manner, it increases the risk for more costly claims — and that impacts everybody."

Even if the human resources department has instated a diversity training program, says Goldstein, it may be up to the occ-health professional to remind them there is an ongoing need for such training. "I would think it should be done once a year," she recommends.

Finally, says Levin, even if the organization at large is not proactively dealing with diversity, that doesn't mean you can't make changes within your department. "You certainly can, although it will be more challenging if the environment outside your department is that different," she says. "On the other hand, the occupational health professional can also be instrumental in *changing* an organizational culture."

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GUEST COLUMN

Psychological treatment complex, but critical

Problems could impact return to work

By Pamela A. Warren, PhD
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Mental health issues often are factors in occupational medicine and are essential to treat since they interfere with physical recovery. A recent study by Dersh, et al. (2002) reported that 64% of all occupational medicine patients experience at least one psychological disorder, compared to the 15% prevalence rate of the general population.[1] Therefore, it is crucial that occupational physicians and clinicians are aware of the high occurrence of psychological disorders in their patients. It is equally important to utilize mental health professionals who practice in occupational psychology or psychiatry to assess and stabilize the individual in order to facilitate a full recovery and a return to work.

Of note, the National Institute of Occupational Safety and Health recently reported that the lost productivity and absenteeism occurring from all mental health concerns resulted in approximately $312 billion dollars annually.[2] This high cost negatively impacts overall health care costs. As a clinical psychologist who practices in occupational psychology and disability management, I regularly observe numerous issues and make several recommendations to assist the occupational medicine professional in navigating the psychological treatment process effectively in an occupational medicine setting.

Here are a few recommended guidelines:

• **Determine if an appropriate psychological diagnosis has been made.** Stress, anxiety, and depression are the most common psychological diagnoses observed in file reviews or disability evaluations. However, stress is not a true psychological diagnosis. It is important to examine what stress is, vs. what stress is not. Stress is a normal, inherent part of life. It comprises both positive and negative components. Examples of positive stress are birthdays, marriages, or packing to get

ready for vacation. Examples of negative stress are death of a loved one, losing one's job, or diagnosis of a life-threatening illness. Stress is subjective and dependent on the individual's repertoire of coping techniques, internal beliefs, and ability to view stress as temporary vs. permanent (individual resiliency).

Stress is not permanent, but is cyclic in nature. It is not impairment, since it is a part of everyday life; nor is it a disability. Therefore, stress is not a reason to apply or to file a disability claim. If a diagnosis of stress is provided by the employee or by other treating providers, it is an important clue that a potential psychological concern is occurring that hasn't been appropriately identified according to professional psychological criteria.

• **Define the actual psychological diagnosis.** Specifically, it is essential to determine the factual reasons that the employee believes s/he cannot work or complete one's defined workplace duties. This information must be objective, not subjective. An example of subjective information that is commonly seen is: "My patient cannot work at all because of workplace issues." Most insurance companies and employers do not ask for objective information on their applications. Therefore, it isn't supplied by the applicant or to the treating health professional.

The occupational health professional should examine the clinical data received. Look for objective data versus subjective opinions. For example, is the employee anxious or depressed? This is a psychological diagnosis and therefore determines what type of information needs to be gathered from the employee and from the treating occupational medicine professional.

• **Obtain a written copy of the actual workplace duties for the employee.** It is the employer's responsibility to define the actual workplace duties the employee completes so that duties match the written job description. Ideally, a written job description is completed for each paid position to define specific workplace duties. After it is signed and dated by the employee, it should be kept on file at the workplace. In the application for disability process, a copy of the signed job description should be sent to the occupational medicine professional in order to understand what actual workplace duties are required of the employee. By utilizing this information, issues of functional impairment can be determined in a factual manner.

• **Obtain appropriate documentation from employers and insurance companies.** Most employers and insurance companies do not generally have forms that allow health professionals to provide factual general or mental health information. For example, it is rare to see insurance forms that ask the health professional to provide the *Diagnostic and Statistical Manual of Mental Disorders* multiaxial diagnosis (e.g., Axis I-V). Yet, these are the professional criteria that all mental health professionals employ to make a diagnosis. Lack of appropriate documentation leads to health professionals relying on subjective information from the employee. This creates a miscommunication cycle about the appropriate questions to ask, as well as understanding what objective professional documentation is necessary to assess a claim.

• **In the majority of cases, a diagnosis of Anxiety or Depression is not permanent.** It is essential for the occupational medicine professional to express in objective terms why a short-term leave is necessary and what evidence-based treatment should occur in order to return the employee to work. Unfortunately, this is rarely the case when mental health or nonoccupational concerns arise during occupational medicine treatment. Frequently, employees are placed open-ended, long-term leave because of the individual indicates s/he isn't "better yet." Therefore, occupational medicine professionals, insurance companies, and employers must ask for regular documentation of an evidenced-based treatment plan, coupled with clinical evidence of objective progress made. The evidenced-based treatment plan must have specific goals to return the individual to work. With a short-term leave from work, a graduated plan for return to work should be a part of the treatment plan.

• **It is essential to ensure that the employee is receiving treatment and is complying with treatment recommendations.** The occupational medicine professional, insurance company and employer must ensure that the employee/applicant is actually receiving and complying with treatment. It is startling how frequently in file reviews the applicant is not receiving regular, appropriate treatment and/or is not complying with treatment recommendations.

If a disability leave is approved, then the employee has a responsibility to follow the stated requirements for the leave. For example, if an individual is depressed and has an approved leave, then, it is important for occupational medicine professionals, insurance companies and employers to indicate in the application process that the

employee is responsible for obtaining treatment and for providing regular documentation of treatment in order to maintain a leave. For an acute mental health diagnosis, there needs to a reasonable evidence-based treatment plan being utilized, such as clinical appointments one to two times a week or inpatient hospitalization if the symptoms are severe, to ensure that the employee is becoming stabilized and improving. Once-a-month appointments denote a lesser degree of professional care. If improvement is not occurring, then it is important to ask why not and obtain a second opinion.

• **Ask other treating health professionals to provide objective evidence to support a psychological diagnosis.** Ask what standardized psychological tests have been given to assess the severity of the employee's stated concerns. It is inappropriate to make a diagnosis on the basis of an evaluation alone or on psychological tests alone. The professional standard is to complete both to reduce bias.

• **Obtain training or work closely with an occupational mental health professional to become educated regarding current standards of treatment.** It is crucial for occupational medicine professionals, insurance companies, and employers to familiarize themselves with current standards of treatment in order to accurately assess mental health claims. Otherwise, arbitrary decisions can and are made all too frequently which end up making mental health claims extremely expensive and antagonistic for all involved parties.

In closing, it is important to be aware that not all physicians are comfortable diagnosing or treating mental health concerns and therefore, only with pressing, will render a diagnosis. It is also essential to realize that mental health professionals do not receive professional training in disability management regarding the application of the clinical evaluation data and development of a reasonable treatment plan to assist employees in returning to work.

Therefore, it is imperative to first find a mental health professional with actual training and is practicing in the disability field to facilitate appropriate treatment and to return the employee to work. These professionals are rare.

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Disabled may soon get a ticket to work

Early claims assessment encouraged

A new integrated disability program to close long-term disability (LTD) and Social Security Disability Income (SSDI) claims was developed by the federal government and a public/private partnership.

Called Ticket to Work, the program targets two areas: existing/maintenance claims and early intervention claims. It is based in the Social Security Administration (SSA) but research is being undertaken by the San Diego-based Disability Management Employer Coalition (DMEC). DMEC, formed in 1992, has 19 chapters nationwide and about 1,300 paying members (employers and vendors that serve employers).

"It's not unusual for employers to be self-insured for STD [short-term disability] but insured for LTD [long-term disability]," says **Peter Mead**, chair of the DMEC Supported Employment Committee (SECom). "Also, in workers' comp, there's no such thing as short-term and long-term disability; it's all workers' comp. So as a management tool, claims are triaged and some are put on a quick return-to-work track and some on a slow track."

It's not unusual, he continues, for some employers to say it does not make sense with nonoccupational injuries to spend too much money on aggressive triage up front to identify potential LTD claims and begin treating them even before they are LTD claims, because often it is the insurance company's responsibility to do that. "It's only natural that employers will be hesitant to invest in STD claims until it is very clear they will be LTD claims," he notes.

In other words, if an injury is treated as if it is relatively simple, it may not be until six, eight, or 10 weeks have passed that it becomes clear the worker is not progressing as he or she should. "At that point, you could say there may be other factors involved, such as psychosocial factors," says Mead. "It's possible that Ticket to Work may

encourage organizations to do an earlier claim assessment and ask themselves up front if it will become an SSDI case. The program may create enough resources and incentives to do that."

Where things stand

The first phase of Ticket to Work focuses on the existing 9 million SSDI and SSI claims, providing new resources to help close them. Ticket to Work's program for existing claims can be described as a new federal integrated disability management program. It provides medical care, disability benefits, vocational rehab, and associated case management, as well as incentives to win buy-in from employers and claimants, Mead explains. However, Mead adds, it is struggling because "SSA doesn't know how to sell Ticket to Work to its disability beneficiaries, and the other challenges that can be addressed through improved intake."

However, he notes, DMEC's may have a solution to these problems. DMEC currently is involved in research to develop an efficient model for using Ticket to Work to help LTD/SSDI claimants return to employment and to test this model based on outcomes. The model is aimed at addressing marketing and intake needs.

"We have the benefit of some software we will use as part of the process that will help us standardize our data gathering," says Mead. "It was developed by a consultant to SSA, a disability researcher named Dave Vandergoot. He played a key role in developing such a program for Pepsico."

The Pepsico program, he notes, involves early triage. "It's not so much that they're looking for fraud, but rather at how the incentives are lined up," Mead explains. "In other words, 'Is this person lined up in such a way that he does not have incentives to try hard to get back to work?'"

The program being developed for DMEC will have some similarities to the Pepsico program, but differences as well, Mead notes. "Although we will continue to fine-tune the model, it is now robust enough to begin seeking research partners for tests."

DMEC currently is talking with employers, carriers and third-party administrators (TPAs) about putting the model to the test to help close their claims. "As a result of the research, we want to gather good robust database to answer question, 'Does Ticket to Work pencil out for insurers, employers, and TPAs?'" Mead poses. "We anticipate that within two years we should have enough data to begin to get a halfway reliable answer to that question."

The SSA also is doing research to explore another phase, which they call early intervention. It would provide new resources to help prevent significant claims from going to SSDI by helping people find alternate careers. However, says Mead, any real progress still is years away.

"Perhaps we will have a national demonstration in early 2005," he says.

"The SSA has only committed to research the possibility [of such a program]," says Mead. "If the research shows that early intervention can reduce SSA disability costs by preventing claims, the Ticket program sends a favorable report to Congress, which presumably would be eager to pass a law authorizing and funding such a program. The early intervention research is a nationwide demonstration to gather 5,000 claims for a conclusive test. If all goes well, this could become a permanent program, and our very best opportunity for changing one of the very worst features of SSDI — the ghastly application process."

From an altruistic perspective, says Mead, the goal is to help people with disabilities become self-sufficient and achieve their potential. "Also, from the perspective of SSA, they need to learn how to prevent or minimize claims," he adds. "Their disability trust fund continues to require new funds, and to some degree we should at least wonder, "Are we helping people with disabilities or *creating* them?'"

A total of about 9 million people currently receive benefits from the SSA; 5.5 million of whom receive SSDI benefits, notes Mead, so the current research projects "could cast a long shadow and affect the way many claims are handled."

[DMEC still is looking for research partners. For more information, visit the web site, www.yourticket towork.com, or contact:

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UV system helps protect workers against TB

Lab used to test control of airborne disease

The test lab in the engineering department at the University of Colorado in Boulder looks very

much like a hospital room, complete with a patient hooked up to a hanging IV drip. However, the patient is a mannequin being used to study the effectiveness of ultraviolet light to reduce health care employees' exposure to tuberculosis.

The six year study was funded by the National Institute for Occupational Safety and Health (NIOSH).

"The CDC issued new guidelines for preventing TB in health care facilities in 1994," recalls **Shelley Miller**, PhD, assistant professor in the mechanical engineering department and lead researcher on the NIOSH TB study. "In that guideline, they suggested ways to use engineering controls to protect health care workers from getting TB, particularly when they work in TB isolation rooms. However, they noticed they didn't have a lot of data on ultraviolet light (UV), so they decided to put out an RFP [request for proposals] for more data on UV." The existing data at the time were sparse, she says, "so they wanted a detailed, controlled study."

Honing in on UVGI

Currently, many facilities use ultraviolet germicidal irradiation, referred to as UVGI, as an auxiliary control measure when their ventilation systems in hospital rooms are unable to provide air exchange rates recommended by the CDC. In addition, UVGI is used for air disinfection in other areas such as waiting rooms. The UVGI lamps are suspended from or located near the ceiling or are placed in ventilation ducts.

However, while it was known that UV light renders bacteria inactive, thereby limiting their ability to grow and multiply when inhaled, most of the experimental data that led to the development of UVGI systems are decades old. Aside from anecdotal observations, little subsequent information existed about the actual performance of these systems in hospital rooms.

The results of the new research would give employers, employees, and facilities managers better data for answering key questions such as: Is a combination of ventilation and UVGI reliable for controlling TB transmission in a given facility? Would an employer need to invest in potentially more costly, time-consuming upgrades to the ventilation system to be safe? Is UV irradiation effective only above a specific intensity?

The study took place between 1997 and 2002. The research team looked at environmental factors that could either enhance or diminish the effectiveness of UVGI, such as high vs. low levels of relative humidity, high vs. moderate ventilation in the room, and air-mixing effects, as well as the actual UV levels coming from the UVGI lamps. They also examined UVGI effectiveness when the lamps were placed at different locations within the room. They used newly designed, commercially available UVGI fixtures consisting of five lamps. Four of the lamps were mounted in each corner of the room. The fifth was mounted from the center of the ceiling.

The mannequin in the test chamber (called "Manny" by the staff) was heated to approximate human body temperature. Heat from the body is one of the subtle factors that influence the movement of air near a person inside a room, affecting the amount of tiny particles such as bacteria that come into the person's breathing zone.

"The lab was probably roughly the same scale and volume, with a ventilation system similar to that in many hospitals," says Miller.

"Temperature and relative humidity were controlled just like a hospital room would be. We also had HEPA filters on our ventilation system because we really needed to keep the test chamber clean," she says.

Examining the results

Findings from the study include:

- Increasing the irradiance level of the UVGI lamps increased the effectiveness of inactivating the TB-like bacteria. The relationship was linear up to a certain level. Further increasing the irradiance above this high level resulted in little increase in the inactivation of the airborne TB-like bacteria.
- High relative humidity above 75% lowered the effectiveness of UVGI to inactivate the TB-like bacteria.

Mostly, ventilation and UVGI worked together to remove or inactivate the airborne TB-like bacteria at a greater rate than either system working alone. Low to moderate levels of ventilation in the room did not negatively affect UVGI effectiveness.

The study clearly demonstrated that the air in a room must be mixed for UVGI to effectively inactive the TB-like bacteria. When warm air entered the room via a duct close to the ceiling (which may occur in the winter when the heating system is turned on), the warm air simply rested on the much cooler air below and the efficacy of the UVGI system was dramatically diminished. No mixing fans were on during this experiment but moderate ventilation was present.

The findings of the NIOSH-funded study

provided new data to help scientists in future research projects to evaluate a novel three-dimensional measurement approach to measuring UV radiation.

This last finding is particularly interesting and may lead to significant new developments in the future. "One of the more important variables is the actual irradiance level the lamps put out into the room," Miller explains. "I suspect that many times hospitals just hang them and do not measure irradiance, but it is that [irradiance] level that enables you to kill the bugs."

Because the lamps the researchers used were hanging all over the room, they had to measure irradiance from all directions. "So, we tested a new method for getting the levels," says Miller.

Miller concedes, however, that more research needs to be done on measuring irradiance in a room. "The way we did it in our project is just too time-consuming and cumbersome for health and safety officers in hospitals," Miller says. "We are working on developing a way for staff to do it easily."

She also is interested in testing UV systems against viruses. "It's a big concern, especially with the recent SARS outbreak," she notes. Her team is currently developing the protocols for new research, but they have not yet identified a target virus.

Findings generalizable

As for the research that has been completed, Miller is convinced that UV systems offer added protection against TB. "The data definitely showed that," she asserts.

In addition, NIOSH says that while the study used a hospital room as a model, the findings are also applicable to other workplaces such as correctional facilities, homeless shelters, residential care facilities, and nursing homes. "The findings are pretty generalizable to other high-risk environments where you have someone who has TB but doesn't know it, and there are other susceptible people in that environment," Miller concludes.

[Editor's note: The recently published article on this study, titled "Efficacy of Ultraviolet Germicidal Irradiation of Upper-Room Air in Inactivating Airborne Bacterial Spores and Mycobacteria in Full Scale Studies," by Xu, et al., appeared in the journal Atmospheric Environment *(2003; 37:405-419).*

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AAOHN, AOHP seeking new respirator standard

Aim: Meet unique needs of health care workers

The Atlanta-based American Association of Occupational Health Nurses Inc. (AAOHN), and the Association of Occupational Health Professionals (AOHP) in Reston, VA, have jointly called for a new respirator standard that takes into account the unique needs of employees in the health care industry. The associations submitted their joint recommendation in response to the Occupational Safety and Health Administration's (OSHA) recent notice of proposed rulemaking and call for comments on 29 CFR Part 1910.

The existing respirator standard, 1910.134, is appropriate for general industry, note the associations, but does not necessarily translate well into health care settings; airborne exposures are more likely to involve infectious microbes. The trend toward the emergence of newer, more virulent strains of infectious diseases such as SARS underscores this need, they say.

"As employee health professionals, our primary concern is the health and safety of the health care worker," says AOHP executive vice president **MaryAnn Gruden**, MSN, CRNP, COHNS/CM. "Our care needs to be based on the best scientific data available. Often, in hospital settings, there may be several hundred to several thousand employees who require an annual fit test under the existing standard," she says. "This would make it not only challenging, but close to impossible, for employee health professionals to be in compliance."

"The requirement for annual fit testing in health care has raised tremendous anxiety; compliance with the requirements would be very difficult for a hospital to handle," adds **Lori Schaumleffel**, RN COHN-S, a regional director for AAOHN in Folsom, CA.

Highlights of the response to OSHA from the two associations include recommendations for the agency to:

- rename Sec. 1910.139, "Respiratory Protection for *M. Tuberculosis"* to "Respiratory Protection for Airborne Infectious Diseases";
- determine respiratory protection requirements for health care workers based on the size of the infectious microbe;
- clearly define surveillance procedures under

the standard in a way that promotes the protection of workers' health and safety, but in a way that is both practical and efficient. For example, conduct fit testing upon hire and then use annual surveys thereafter to determine any physical changes that affect the fit of the respirator.

Precedent already is set

OSHA already has set a precedent for recognizing unique situations when it comes to respirators, notes Gruden. "Tuberculosis as an airborne disease has been addressed separately; there is no need for annual fit testing," she notes. "But right now, it only covers TB; all other airborne diseases would be under the current standard. Because of the logistics of trying to implement annual fit testing, we feel you should put like hazards under one standard."

At the time that SARS became a concern, notes Schaumleffel, that double standard was in place. "OSHA has had a general respirator standard and a separate tuberculosis standard," she notes. "So, when OSHA came out with recommendations regarding SARS, they used the general respiratory guidelines, since the TB standard was written just for TB, but not for any other airborne disease."

"OSHA has already considered the logistical challenges and safety issues [of airborne diseases], and the result was the creation of the tuberculosis exemption standard, 29 CFR 139," Gruden reemphasizes. "We believe OSHA should apply this same thinking and publish a more comprehensive rule that acknowledges the unique characteristics of the health care setting."

Partnering makes sense

It makes perfect sense for AOHP and AAOHN to team up in this effort, says Gruden. "Both organizations primarily comprise occupational health nurses," she notes. "AAOHN membership includes them in a variety of settings including health care, while AOHP is primarily in health care settings. So, we look for areas where there are common grounds and common concerns."

"Obviously, we have many nurses in AAOHN who work in the health care environment, and they [AOHP] are specifically in that environment, so we have a crossover," adds Schaumleffel. "This is an issue that is not something that needs to be addressed in general industry, so it obviously made sense for us to partner."

Will partnerships like this become more common in the future? "Absolutely," says Schaumleffel. "We are trying to expand our efforts in this area. You have more power in numbers, and there are often multiple organizations that focus on the same things. We all have limited resources, so to work together and maximize those resources is a good idea."

"I do see more of this happening," adds Gruden. "This is the second time we have partnered [the first was during the OSHA ergonomic standard process]." The benefits of partnering, she notes, include demonstrating the fact that your organization is not the only voice on your side of the issue, that there is support for your position and added concern about it.

"Numbers have strength, and AAOHN is a larger organization than we are," she notes. "We were really founded because occupational health nurses had very special needs. We are trying to address airborne pathogens, and seeking to build our name recognition so we will be seen as experts in this area."

For a complete copy of the AAOHN/AOHP comments, visit the AAOHN web site at www.aaohn.org, or the AOHP web site at www.aohp.org.

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Retirement plans recruit, retain

Hospitals and health systems facing a workforce shortage see retirement benefits as a key factor in employee recruitment and retention, suggests a new survey from the American Hospital Association and Diversified Investment Advisors.

The survey of more than 300 U.S. hospitals and

health systems focused on respondents' defined contribution plan characteristics and associated challenges. It found retirement benefits are frequently used as a recruitment and retention tool, and that plan sponsors are providing more investment advice, education and ancillary services, and new and more precisely focused investment options, said **Chris Cumming**, business leader for defined contribution plans at Diversified Investment Advisors.

For example, most plans are liberalizing age and service requirements and immediately vesting employees in employer contributions to attract and retain workers, the survey indicates. The survey also suggests that the mix of investment options has changed to include a greater number of bond, real estate, and emerging product category funds in response to recent volatility in the equity market.

The survey report, "Retirement Plan Trends in Today's Healthcare Market — 2003," can be purchased at www.ahaonlinestore.com. ▼

Labor urged to exempt health care professionals

Warning that it could exacerbate an already dangerous shortage of nurses in the United States, 10 leading nursing associations have urged the U.S. Department of Labor to exempt health care professionals from a proposed regulation that could result in a large number of registered nurses losing access to overtime pay.

The regulation, "Defining and Delimiting the Exemptions for Executive, Administrative, Professional, Outside Sales and Computer Employees," could create situations where "a cluster of nurses over the salary threshold will not receive payment for their overtime; whereas others in the same unit, who are paid less, will receive payment for their overtime. If this occurs, these situations will create extreme dissatisfaction, likely resulting in the loss of more experienced nurses from the health care system," the groups warned.

"Changes in the longstanding practice of paid overtime for nurses will create job dissatisfaction in the nurse work force and many more early retirements and career changes will result," predicted **Gail Kincaide**, executive director of the Association of Women's Health, Obstetric, and Neonatal Nurses, one of the 10 organizations. ▼

Schedules, pay matter to nurses

But those cheesy T-shirts don't

What matters to your nurses? The ability to schedule their jobs around their lives, according to a survey of 811 RNs. Conducted by Bernard Hodes Group and Nursing Spectrum, the survey asked questions about perceptions of employers before they were hired, how the reality related to those perceptions, and even what RNs look for in an employment ad.

Here are some of the results:

• Surveyed RNs selected work schedules, growth opportunities and commuting distance as the primary reasons for choosing their present employer.

• Overall, RN satisfaction centers on work schedules, coworkers, and opportunities to learn; dissatisfaction is fueled by a lack of being valued, inadequate communications, and insufficient compensation.

• If empowered as upper management, RNs surveyed indicated that the key areas they would address are: compensation, performance incentives, and the addition of benefits and flexible schedules.

• Local newspapers, typically consulted on a weekly basis, are seen by RNs as a good source of job leads, as are Internet-appropriate employment sites and job boards.

• Respondents appear to be equally divided

COMING IN FUTURE MONTHS

- ■ It's raining men? Not when it comes to the nursing profession!
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- ■ Making a difference: How occ-med pros can engender culture change

between brochures and web sites as a preferred medium for researching prospective employers.

• The vast majority of RNs would or have referred job candidates to their current employer, and feel that bonuses or prizes are effective motivators for such referrals.

Random comments

When asked what one thing should be changed about nursing to attract more people to the profession nurses answered:

• "We need to cut the cutesy nurse crap, which is so offensive — all the T-shirts like 'Nurses Call the Shots' and 'Nurses Have the Courage to Care.' All the teddy bears and angels really have to go. By promoting this girly image, we provoke others to patronize us."

• "Many older nurses forget they were not born nurses. Preceptorship is learning and teaching, not having the new nurse do the work for you and being overly critical."

• "Fire any manager who invents a new form to fill out."

• "It has never made sense to me why executives of a hospital feel it is more appropriate to invest millions of dollars in fancy new buildings than to adequately staff the ones they already have."

The entire survey is available at the Bernard Hodes Group web site: www.hodes.com/hc recruiting/index.html?hc_nursingpulse.asp. ■

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Occupational Health Management™

A monthly advisory for occupational health programs

Salary increases slightly lower, but more opportunities exist

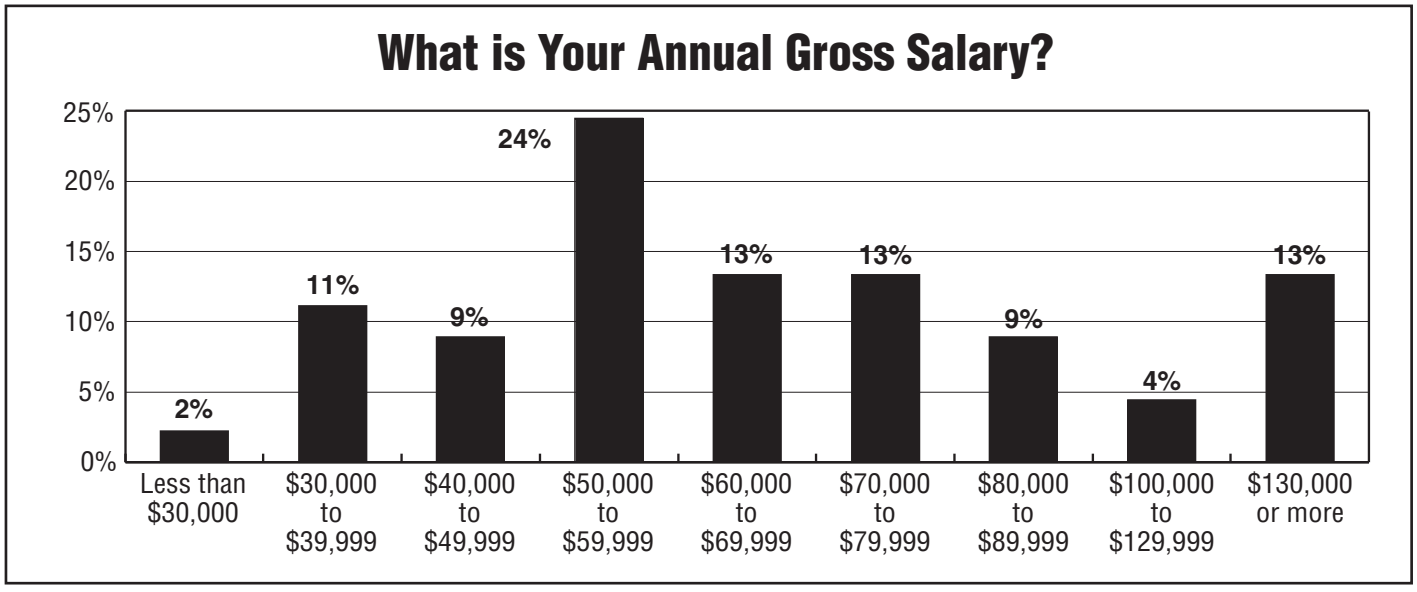
Occ-health nurses have more options

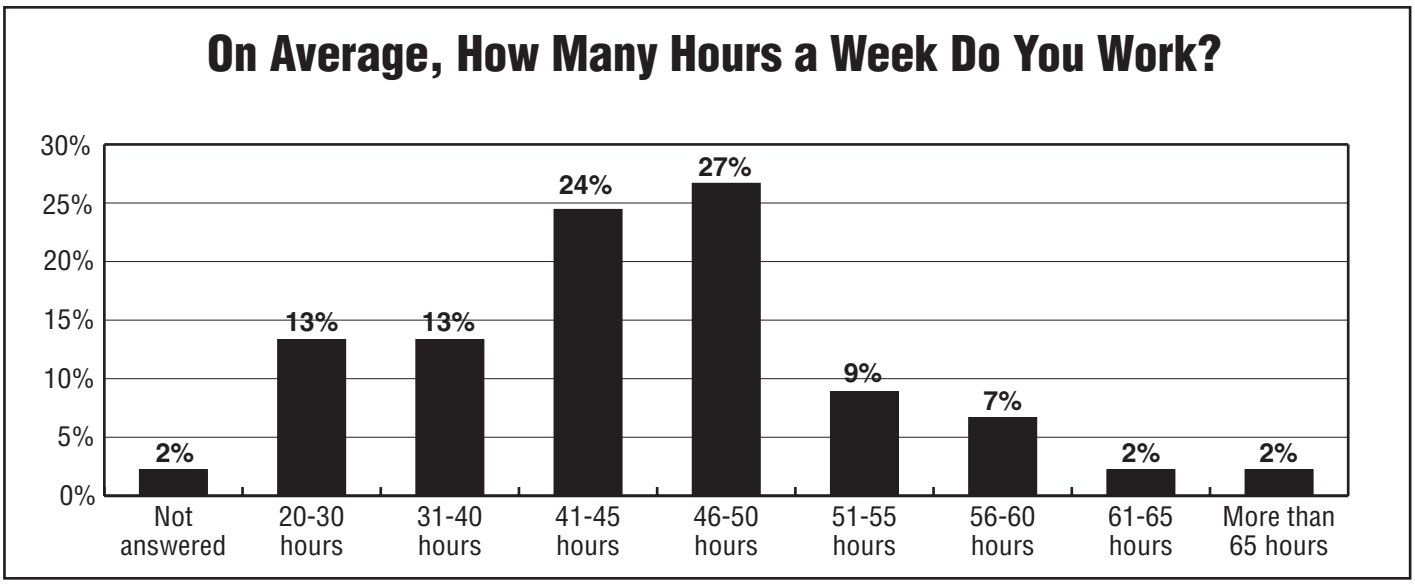
Following a significant decrease in the average raise reported by occupational health professionals between 2001 and 2002, average salary increases were only slightly lower this year, according to the 2003 *Occupational Health Management* salary survey. In addition, both private corporations and public employers are finding newer, more creative ways to sweeten the overall compensation package of their occ-health professionals.

OHM is pleased to provide our readers with the results of this year's survey. Our exclusive report illustrates some of the key factors that may influence salaries and benefits among occupational health professionals. The survey was conducted in the summer. Survey responses were tallied, analyzed and reported by Thomson American Health Consultants, publisher of *OHM*. We trust you will find the survey of value in helping you gain insight into the leading salary and compensation trends in this dynamic industry.

Raises off slightly

Responses from occupational health professionals indicate that salary increases this year were almost — but not quite — the same as last year. In the 2003 survey, 68.89% of respondents reported an increase of between 1% and 6%, compared





with a total of 69.56% of 2002 respondents who received an increase of between 1% and 6%.

A further breakdown of the numbers shows that in the 2002 survey, 41.30% of the respondents reported increases of between 1% and 3%, and 28.26% indicated increases of between 4% and 6%. In 2003, 42.2% reported increases of between 1% and 3%, while 26.67% reported increased of between 4% and 6%, indicating a slight but definite shift toward more modest increases.

"That seems about right from what I've heard, and given the state of where [the health care] business is," says **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN, president of the Atlanta-based American Association of Occupational Health Nurses (AAOHN). "Some people are thankful to have jobs."

When you look at occupational health nurses with more advanced education, however, the picture brightens, according to **Mary Amann**, RN, MS, COHN-S/CM, FAAOHN, executive director of the American Board of Occupational Health Nurses, Chicago.

"In the certified community [those nurses with the COHN and COHN-S core certifications, and the subspecialty in case management] in 2002, the average salaries for certified occupational health nurses showed about a 4% increase over 2001," she reports. "I do think that is a good increase given the economy, and, after all, that takes into account many companies where there are no increases — or even decreases."

Occupational health nurses appear better prepared than others in the nursing field to roll with the punches when it comes to downsizing, say the experts. For while they are not immune to the onset of longer hours or smaller support staffs, their training in a wide variety of disciplines gives them the flexibility to succeed in entirely new and different positions should their current position be eliminated. In fact, one such alternative, consulting, has become a lucrative option, indeed.

Of course, salaries as well as increases can vary by position. The *OHM* survey showed 6.67% of respondents reporting a 7%-10% increase, and 2.22% reporting an 11%-15% increase. A total of 15.56% reported no change.

The highest paid occupational health professionals, making $130,000 or more, held the title of medical director. In the $100,000-$129,999 range were directors of occ-health and staff physician. However, directors of occ-health reported salaries of anywhere from $50,000 to $129,999, and occ-health nurses ranged from $30,000 to $89,999. **(See table, p. 1.)**

One additional job title that could fall in the higher ranges is consultant, says Amann. "Many occupational health nurses are now in the position of consulting, either internally or externally, and we find the consultants very often are in the much higher price range — up there with the corporate directors," she says.

"It sounds to me like you have some clinicians doing very well, too; and my guess is they are nurse practitioners," she continues. "That is also very desirable, because in many cases where there is a shortage of physicians the nurse practitioner is a valued, multitalented person to have on staff."

Creative compensation

While salaries may not be rising at a dramatic pace, Randolph says occupational health professionals are being rewarded in other ways, such as

Salary by Title

Income	Director Occ-Health	Injury Prev. Coordinator	Occ-Health Nurse	Manager/ Coordinator	Employee Health Nurse	Administrator	Staff Physician	Medical Director
Less than $30,000	1%	0%	0%	0%	0%	0%	0%	0%
$30,000 to $39,999	0%	4%	4%	8%	0%	0%	0%	0%
$40,000 to $49,999	0%	0%	0%	4%	8%	0%	0%	0%
$50,000 to $59,999	4%	0%	7%	11%	0%	0%	0%	0%
$60,000 to $69,999	8%	0%	0%	4%	0%	0%	0%	0%
$70,000 to $79,000	4%	0%	0%	7%	0%	1%	0%	0%
$80,000 to $89,999	7%	0%	2%	0%	0%	0%	0%	0%
$100,000 to $129,999	2%	0%	0%	0%	0%	0%	2%	0%
$130,000 or more	4%	0%	0%	0%	0%	0%	0%	8%

additional paid time off.

"In the state of North Carolina, for instance, instead of giving a specific percentage increase, they approved a flat fee across the board — say, for example, $500 — and then a certain number of paid days off," she says.

If you provide a lump sum payment, that benefits people on the lower end of the income scale more than a percentage increase would, Randolph notes.

"It can definitely help people who are not making as much money," she notes, while adding that there is an element of cynicism on the part of the employer. "The state figures, 'Who will use that paid time off?' This is true in corporations, too. With fewer people doing the work and working harder, how can they take that extra week of vacation?" she asks.

Speaking of longer working hours, the *OHM* survey showed 26.67% of respondents reporting an average week of 46-50 hours, and 24.44% reporting and average of 41-45 hours. Randolph notes, however, that this doesn't tell the whole story.

"Yes, you can say people are working 50 hours a week — or, you can say, 'Whatever it takes.' With today's technology, you not only work while you're at work, but you take work home and work on your computer, and if you have a cell phone or a pager, how much are you truly out of touch?" she poses.

"This naturally affects your work/life balance, and some people would rather make less money and have a better quality of life."

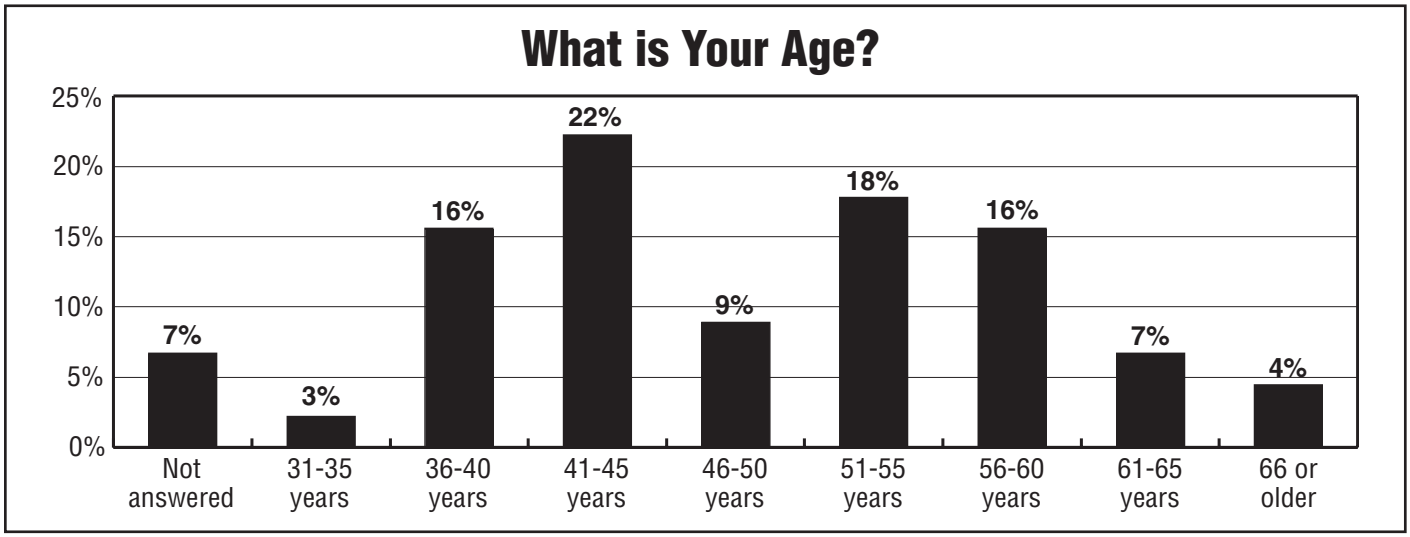
Does shortage have impact?

The nursing shortage, at least for now, continues unabated, but it's not having quite the impact you might expect when it comes to occupational health nurses.

"I think that there is a demand for occ-health nurses, especially for certified occupational health nurses," says Amann. "In general, occ-health nurses are multitalented. They can manage many different aspects of an occupational health and safety program, and that's one of the reasons why the market for them remains good."

That's not to say there aren't companies eliminating occ-health positions. "As companies lay off workers, or move operations to other countries, that also translates into the loss of occ-health nursing jobs," says Randolph. "However, while that might shut the door on that particular setting, it could certainly provide opportunities for other types of positions in small businesses, or in consulting."

Amann agrees. "In some cases, the role of the occupational health nurse has expanded, ironically enough, because of the collapsing of [their original] roles," she says. "Many times, because they are skilled in many areas, they are required to take on many different roles. They may end up working in an expanded role with, say, the HR team, or with the safety team. But all of that is good for occ-health nurses, because it affords them many



opportunities to expand their interests."

Meanwhile, efforts continue to fight the demography gap in occ-health nursing, where the field is dominated by nurses with many years of experience, and there are too few younger nurses entering the field. **(See above chart.)** "Certainly we are looking at ways to promote nursing as a viable profession," says Randolph. "But it has to be promoted as a career when people are very young — even in high school."

Last year, for example, the North Carolina chapter of the Brownies came out with an "Exploring Nursing" patch, says Randolph, who is herself a troop leader. "I started thinking about that, and felt an obligation to do it with my troop," she says. "We need to educate young people about the fact that nursing is more than just being in the hospital, that it is for all ages, and that it has something for everyone. There needs be a strong grass-roots effort to make the profession look enticing."

Amann believes these and other efforts already are succeeding. "I think they are working. I know it's a slow process, but we are starting to see the average age [of nurses] go down for a number of reasons," she says. "Certainly part of that is due to attrition, as the older nurses are leaving, but also because we are making an effort to reach people and introduce them to occ-health nursing when they are in undergraduate school."

This is a change from the past, Amann says. "The belief had been that you needed vast experience in other areas [to be an occ-health nurse]," she notes. "That is no longer the belief. We bring in younger people, who will then get more on-the-job experience. Also, we are increasing the visibility of the occ-health nurse as viable — before people graduate from college."

Still, those efforts may not keep pace with larger demographic trends, says Randolph. "As the population gets older, we will have a need for more nurses," she notes. "If the shortage continues, then salaries just might have to go up."

They might go up in any event, adds Amann. "As occupational health nurses achieve more skills and bring more value to their organizations, I hope that the salaries will increase in a similar manner," she concludes. ■