# Occupational Health Management™

*A monthly advisory for occupational health programs*

THOMSON
AMERICAN HEALTH CONSULTANTS™

## IN THIS ISSUE



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# Malingering employee? It may be fear that keeps workers off the job

*Docs', employees' fear of pain or reinjury often slows return to work*

A customer service associate for a large company, whose days at work are spent taking customer calls at her desk, injures her back and is determined by her company's physician to be disabled. Six weeks later, she still has some back pain, so her physician does not clear her to return to work; however, she goes on vacation with her family, plays tennis, and swims.

Does this employee fit the definition of a malingerer — someone who is evading duty or work by pretending to be incapacitated? Not likely, says **Dave Hubbard**, RN, a disability case manager for Fort Dearborn Life, a BlueCross BlueShield subsidiary in Dallas. What is most often true in such cases, he says, is that a patient with some real — though not incapacitating — pain is afraid or unwilling to push his physician for a return-to-work (RTW) order; or the physician is not experienced enough in disability evaluation or not familiar enough with the employee's job description to determine that a little back pain will not harm the patient or affect her ability to return to work.

There are ways for occupational health practitioners to better serve both their employer companies and their injured workers, Hubbard says, and a lot of it boils down to motivation — motivating doctors to learn patients' job requirements, motivating patients to go back to work even if they are not at 100% of their previous ability, and motivating employers to want employees back at less than 100% ability at first.

### *Reasons for reluctance*

"I often think the term malingering is misused when in fact what is actually being referred to is an individual who is less than motivated to return to work and who, with minimal effort, knows that they can remain off work and continue to receive an income," says Hubbard.

Sometimes, the patient is motivated by the comfort of remaining off work while still drawing income. But often, there's more to it.

"Sure, they get more free time to spend on leisure activities, with the family, watching TV, surfing the net," he points out. "They also do not have to deal with a supervisor. It's often less stressful than work."

But perhaps more importantly, many injured employees believe they simply cannot go back to work.

"In the patient's mind is the worry the injury/illness will get worse if they return to work," says Hubbard. And the employee's physician and employer often share this misconception.

## What is 100%?

Many injured workers believe they are not obligated to return to their jobs until they are completely symptom-free, he notes.

"Quite honestly, it has to do with the physician and the employer," says Hubbard. "The employer often de-motivates the employee, saying the employee has to be 100% [recovered or healthy] before returning. I say, 'What's 100%?'"

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### Editorial Questions

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**R.H. Haralson III**, MD, MBA, FAADEP, president of the Chicago-based American Academy of Disability Evaluating Physicians (AADEP), contends that fear is a big factor in patients not returning from disability when it's actually in their best interest to get back to work.

"Workers who are injured are frightened. Some are frightened by the injury itself and the fact that they might not recover completely. If it is a back injury, some are frightened by the specter of paralysis, despite the fact that paralysis rarely occurs," he says. "They also are frightened by the specter of never recovering, since they all know someone with a back injury who remains totally disabled. They are worried about being able to earn a living for their family."

Haralson says employees sometimes have been told by co-workers that their companies are going to take advantage of them, or they are suspicious of the company doctor and wonder if he or she is siding with the employer and will rush the employee back to work too early.

"They are encouraged to act sick, for they are rewarded for being sick; and the sicker they are, the more they are rewarded," he says.

## Work: The best medicine

Studies are showing that with many injuries or other disabilities, returning to work can be a highly effective part of the recovery process, Hubbard says.

"People get better quicker, with less residual pain, when they return to work," he says. "Studies have shown that there is an eight times lower incidence of chronic pain when they go back to work than when they stay home, and at eight to 12 weeks [of an employee being off work on disability], the chance of that employee ever returning to work drop to 50%."

**James R. Garb**, MD, director of occupational health and safety for Baystate Health System based in Springfield, MA, says Baystate has a return-to-work philosophy for that very reason, saying, "Work is therapeutic for people who are injured."

Hubbard and others agree that returning to work does not always mean an immediate resumption of all the duties carried out before the employee went on disability. Some modifications may be necessary for a while, particularly when the employee's job requires lifting or repetitive motions or activities that would exacerbate the pain or injury that led to the disability in the first place.

An understanding of the employee's job is critical for any clinician making a determination of return-to-work eligibility, as is considering each employee individually in determining what 100% ability is for that person, he notes.

"My question is, are you talking about 100% [ability] of a 22-year-old, 6-foot-tall, 200-pound male, or his female co-worker who is 60 years old and overweight?" asks Hubbard. "There's often not a true standard, and lots of employees might use [applying the same standards to both types of the employees just described] as a reduction in force program, to get rid of employees they want to get rid of."

## All have roles

Getting an employee back to work takes motivation on the parts of the worker, his or her employer, and the evaluating physician, and each can have reasons to expedite or delay the return to work, experts say.

The employee might want to return to work, but fear that if he or she still has any remnant of pain, it's not safe to go back. On the other hand, he or she might be reluctant to give up the vacation-like conditions of staying home and drawing partial income.

The physician may rely too heavily on the patient's own evaluation of his or her pain, and without a clear understanding of the worker's job duties, might be reluctant to order him or her back to work when, in fact, it would be safe to do so.

The employer might place too much emphasis on having the employee be immediately at 100% ability upon return to work, when making some concessions for rest breaks or reduced physical activity would return the employee to some level of productivity and get him or her back to full productivity sooner.

If an employee is concerned about some remaining pain but is otherwise physically able to return to work — and, indeed, returning to work would speed recovery — the physician needs to step in, Hubbard says.

"Unless a physician sits down and says, 'Excuse me, this is going to take a few weeks, but you'll get over it and if you go back to work you'll get better faster,' then the patient won't know that the pain is normal and not a reason to not return to work," Hubbard points out.

On the other hand, sometimes it's the doctor who needs the push.

"Many physicians are not trained in the area of disability evaluation, don't understand the evidence-based medicine that's out there, and don't understand the necessity of returning to work in a timely fashion," he says. "AADEP is doing a lot to educate physicians and nurses in this area."

Some of the employers Hubbard deals with "would rather have nobody in a chair than have someone there who is missing an hour of work a day while they throw up or do some stretching," he says. "We need to be thinking of how we can accommodate these employees on the job. It takes very little, often, to bring them back to work, but the employer doesn't ask the doctor what that is, and if the doctor doesn't have a clear idea of the job requirements, he won't know what accommodations can be made."

Garb says that unless an employer tells the physician what a worker's job entails (e.g., heavy lifting, repetitive motion, or sedentary work), the physician only can rely on what the patient tells him or her.

Hubbard, the disability case manager, says he asks physicians what their understanding of patients' job requirements really are — sedentary, light, or medium work. "Many check off that they're unaware of what the requirements are, and they'll usually check off at least one grade higher [than the requirements actually are]," he says. "Unless they have experience evaluating disability, physicians don't ask what somebody does, and even if they do, it doesn't mean the patient is really going to be honest with them."

Besides checking on an employee's convalescence while he or she is out of work, the occ-health manager can monitor whether the patient is receiving all the care he or she needs.

"Professional athletes are given trainers and get back out there, but someone who is the sole support of their family is not given the training and support to bounce back as quickly as they should," Hubbard points out. "You have someone with a total knee replacement, who is told how to do physical therapy and then sent home with instructions to just do it, and doesn't do it as it should be done, has to go back in for manipulation and then back to physical therapy, and you lose eight more weeks of work."

Hubbard references a published study examined a random sample of adults living in 12 metropolitan cities in the United States who had acute and chronic conditions and preventive care, showed that those studied received only about 58% of recommended follow-up care.[1]

"If only that many receive recommended care,

what percentage of patients with claimed disabilities are likely to return to work in a reasonable period of time?" Hubbard asks.

### The true malingerer

The injured employee who decides he'd rather not go back to work — or worse, the employee who decided disability is a way to get out of work in the first place — poses a different challenge.

According to the American Psychiatric Association, malingering can be expressed in several forms, ranging from pure malingering, in which the employee falsifies all symptoms; to partial malingering, in which the person has true symptoms but exaggerates the impact the symptoms have on his or her ability to function; to falsifying symptoms of an injury or disease when the actual problem is something else, such as substance abuse.

Garb offers some examples of what he calls "problem claims" pertaining to injured workers, and some suggestions for minimizing problems.

Company occ-health or human resources personnel should contact injured workers regularly, in a nonthreatening manner, to ask how they are doing, he says. This lets the injured employee know that there is an expectation that he or she will return to work and that the employer wants them back.

According to Garb, more than two months out of work is a signal of potential delay in returning to work; he says he has encountered very few conditions that should keep an employee home that long.

Other indicators of possible true malingering include high absentee rates prior to the injury, reluctance to cooperate with treatment, inconsistent or nonorganic physical findings, two or more weeks of hospitalization, disability out of proportion to the injury, leaves that are extended just before the scheduled return to work, history of alcoholism or substance abuse, litigation pending, labor relations problems, and recent divorce or other family crisis, Garb states.

### Reference

1. McGlynn EA, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348:2,635-2,645.

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# NIOSH studies bullying in the U.S. workplace

*Most report employee vs. employee*

Anyone who, as a kid, was the victim of a bully can remember the sick feeling he or she felt on the way to school each morning. Any adult who is the victim of bullying in the workplace can tell you the feeling is no different.

A study by NIOSH reveals that workplace bullying — nonphysical belittling, intimidation, and rudeness — is commonplace, and suggests that management might not be aware of the extent of the problem.

The cost to workers is difficult to quantify, experts say, but at least costs time off from work, stress-related health problems, and depression, occupational health, and psychology researchers say.

**Paula Grubb**, PhD, a NIOSH research psychologist who reported the study findings, says about one-fourth of the 516 public and private companies surveyed reported some type of bullying.

A key component of the survey, she notes, is that the responses do not come from employees themselves — the survey questions were posed to key personnel, usually members of human resources management, so the results reflect only incidents of bullying that management knows about.

Most incidents of bullying in the workplace appear to be perpetuated by employees against one another, early findings from the studying suggest. Grubb said different survey methods might show different results, perhaps indicating more aggression between managers and employees.

"We were looking at a couple of different things, like outright violence, verbal threats, and incivility," Grubb says. "Incivility is just being rude in the workplace, but some researchers

think this type of behavior can spiral into more serious things."

Grubb says this survey is thought to be the first look at verbal bullying and aggression in a nationally representative sample of employers.

The findings suggest that efforts to make changes at the organizational level to prevent bullying in the workplace should include steps to improve relationships among co-workers, and should not strictly focus on improving supervisor-employee and customer-employee relationships, the researchers state in reporting the preliminary results.

The study points to further research that would be needed before researchers could offer definitive recommendations for preventing bullying as a potential factor for work-related stress.

"We don't have enough information to give recommendations at this point," Grubb says. "We were interested in getting information from the organizational level, about what dynamics might relate to bullying and other forms of psychological aggression.

"We got a sample of what's going on and what policies are in place, and later, we'll be doing some work where we'll ask the employees themselves to report on aggression in the workplace."

The findings were reported at the annual meeting of the American Psychological Association, held in July, as a progress report on the study.

## Groundwork for more study

Since the results are based on a survey of a representative but small sample of respondents, other studies involving larger numbers of respondents would be needed to confirm the findings, researchers say. In addition, more study would be needed in greater depth to identify the reasons for acts of bullying in the workplace, the circumstances in which bullying is most likely to occur, and specific measures for improving interpersonal relationships in the workplace.

"In this study, we started from a workplace violence background, with broad, general questions, about what type of violence is occurring and in what kind of numbers," Grubb explains. "We asked them if they have conflict resolution programs in place, written policies for workplace violence, grievance systems, that sort of thing."

Data reported from the survey indicate the following:

- 24.5% of the companies surveyed reported that some degree of bullying had occurred there during the preceding year.
- In the most recent incident that had occurred, 39.2% involved an employee as the aggressor, 24.5% involved a customer, and 14.7% involved a supervisor.
- In the most recent incident, 55.2% involved the employee as the victim, 10.5% the customer, and 7.7% the supervisor.

The organizations surveyed range in size from five employees to 20,000 employees each. Bullying was defined as repeated intimidation, slandering, social isolation, or humiliation by one or more persons against another. The study is part of NIOSH's research to identify factors associated with work-related stress and to recommend practical interventions.

Grubb says larger companies reported more bullying probably because there are more workers, more layers of management, and more opportunities for interaction.

## High cost of bullying

Grubb notes that bullying at work contributes to myriad problems, including depression, insomnia, and substance abuse. Productivity, motivation, and job satisfaction also are affected, she adds. Also linked to bullying are poor job security and a breakdown in trust between employees and management, even among employees who are not victims of the aggression.

According to **Gary Namie**, PhD, president of the Bellingham, WA-based Workplace Bullying & Trauma Institute, employers who allow workplace intimidation to go unchecked experience high turnover. His studies, available at www.bullyinginstitute.org, indicate that 82% of people targeted by bullies leave their workplaces: 38% cite health problems as their reason for leaving, while 44% say they left because they received performance evaluations that were skewed to show them as incompetent. Namie's studies, conducted through surveys of victims of workplace bullying, estimate the cost of replacing an employee at two to three times the employee's salary.

Health care costs also may rise for a company, as a bully's targets become affected by stress-related illnesses. According to Namie, 41% of bully targets become depressed, with 31% of targeted women and 21% of targeted men being diagnosed with stress disorders.

"Eventually, this will help us know which areas to focus on and research," says Grubb of the NIOSH study. "What are some of the

characteristics, what kinds of programs there are being used out there."

Most employers — 59% — report having programs in place to deal with aggression and conflict; what researchers hope to learn is how well the programs work and what might be done to prevent workplace aggression from happening in the first place.

"What can come out of this, once the results are published, is an awareness of the problem," says Grubb. "The first thing you do is put the information out there that shows this is going on, so people are aware that this is an issue in the workplace."

Grubb says that in other countries, bullying in the workplace is an issue that has been considered important for some time. The United States lags behind other countries in addressing the issue of workplace bullying, Grubb points out. An Internet search turns up several web sites addressing workplace aggression in Australia and the United Kingdom, for example, including information about government programs long in place to address the problem.

"What you hope for then is that it will encourage more research that is more systematic, and eventually, maybe finding out what some of the antecedents are and develop what can be used in the workplace and whether [the programs] are any good or not."

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*• **NIOSH web page on work stress**: www.cdc.gov/niosh/topics/stress/.*

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# Changes proposed to fed drug testing programs

*Alternative sampling flawed, critics claim*

A trade association representing the drug testing industry has lodged concerns with the U.S. Department of Health and Human Services (HHS) over flaws the trade group says are in proposed changes to federal drug testing programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA), part of HHS, is proposing a new rule that would allow federal agencies to use sweat, saliva, and hair in federal drug testing programs that now only test urine. The proposal would also allow selected specimen testing at the time and place it is collected — point-of-collection testing that would give immediate, preliminary results.

But during the comment period, which ended in July, DATIA, the Washington, DC- based Drug and Alcohol Testing Industry Association, submitted strenuous objections to portions of the proposed changes. DATIA executive director **Laura Shelton** wrote that while the association applauds the introduction of sweat, saliva, and hair as alternative samples for workplace drug testing, some of the requirements in the proposed guidelines "will negate the positive benefits of using these new technologies."

In addition, proposed changes that would permit employers more flexibility as to who performs the tests and where could have a negative impact on existing drug testing sites.

• **Testing hair, saliva, and sweat for drugs.** The SAMHSA proposal is predicated on scientific advances that will allow use of hair, saliva, and sweat specimens to be used with the same level of confidence that has been applied to the use of urine, according to SAMHSA spokeswoman **Leah Young**. The proposed rule spells out when these alternative specimens and testing devices may be used, the procedures that must be used in collecting samples, and the certification process for approving a laboratory to test these alternative specimens.

"These proposed rules will largely affect federal employees and job applicants in safety and security-related positions," SAMHSA administrator **Charles Curie** explains. "Hopefully, federal employees found to be using illegal drugs will seek treatment to allow them to attain a healthy life in the community. At the same time, we believe that drug testing provides a powerful deterrent to the destructive and dangerous conditions drug use creates."

About 400,000 federal workers in testing designated positions — those who have security clearances, carry firearms, deal with public safety or national security, or are presidential appointees — are drug tested when they apply for jobs. Some are subject to random drug testing during

their employment. Other federal employees are tested only if they are involved in a workplace accident or show signs of possible drug use.

• **Impact on private sector.** The proposed changes have farther-reaching implications, however; if adopted by the Department of Transportation for use in the trucking industry, the new testing procedures would affect private employers and workers, as well.

Under the proposed rule, federal agencies will choose whether to use the new tests. There is no requirement to test hair, saliva, or sweat. Agencies will consider their own needs and whether employees may consider these tests less intrusive and less invasive of privacy than collecting urine specimens.

The proposed rule would implement procedures to ensure that all federal agencies split every collected specimen, whether hair, oral fluid, sweat, or urine. This added safeguard benefits both the person tested and the agency, by providing a system that would permit the person tested to request an immediate double-check if a specimen comes back from the laboratory showing it is positive for drugs.

• **Shorter time for results.** The proposed new rule also will shorten the time for negative results to be reported to the federal agency by establishing criteria for a testing facility that will only perform initial tests and not confirmatory tests. The proposed rule also addresses point-of-collection tests or on-site testing kits, as well as people who do the testing. Positive results in the initial testing facility or in point-of-collection tests will still need to be confirmed by a certified laboratory.

Rapid results are an attractive feature, particularly if an employee in a sensitive job is suspected of being impaired, Young points out.

The new rules could pressure service providers to lower the prices they charge for laboratory tests, and give businesses greater flexibility in running their testing programs, a prospect that DATIA members don't like.

"The proposal for federal agencies to conduct semiannual inspections of collection sites that it uses will be an enormous burden and an unrealistic requirement," Shelton stated in a letter sent on behalf of DATIA. "What about collection sites that are set up temporarily on-site? How can they be inspected after the fact? Who will inspect the sites and what training will they have received?"

Young says that SAMHSA received "many, many comments, and not one-page comments; we received 50-page comments" about the proposed changes to the drug-testing law. While the rule was initially scheduled to become final in October, Young said there is no date now set for release of a final version of the regulation.

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# Testing 1, 2, 3: Help protect workers' hearing

*OSHA now tracking hearing loss*

According to the Arlington Heights, IL-based American College of Occupational and Environmental Medicine (ACOEM), hearing loss affects more than 28 million Americans, and the number is rising. Often, hearing loss is gradual; its effects are cumulative and the loss cannot be regained.

OSHA has taken steps to more closely monitor occupational hearing loss, and ACOEM has created a checklist to help employers and occupational health practitioners protect workers' hearing. **(See table, p. 116.)**

Noisy workplaces have been required to monitor employees' hearing when they are exposed to hazardous noise levels since the creation of OSHA in 1970. Exposed workers must be given a yearly hearing test, and work-related losses documented.

As of Jan. 1, any decrease in hearing of 10 decibels or more from an employee's previous level is required to be recorded. The rules require that the affected employee be referred for appropriate medical evaluation, as needed.

The previous criteria stated that employers would record hearing loss only after employees were exposed to levels of 26 decibels (dB) or more during a shift.

Employers, when recording hearing loss on the revised OSHA 300 form, which includes a column specifically for recording of hearing loss, are permitted to make adjustments for hearing loss due to age.

*(Continued on page 117)*

# Tips for Protecting Hearing in the Workplace

## General Workplace Environment

| Action Areas | Employers | Employees |
|---|---|---|
| **Inspections**<br>Identifying potential noise hazards and controlling/reducing noise at its source is the most effective way to protect worker hearing. | Perform regular safety inspections and assess hearing hazards, particularly in manufacturing/ industrial environments, using monitoring devices such as sound meters and dosimeters. | • Report noisy equipment, activities, and work areas.<br>• Participate in noise dosimetry testing. |
| **Noise Levels**<br>The Occupational Safety and Health Administration (OSHA) requires that employers monitor noise exposure levels and identify employees who are exposed to noise at or above 85 decibels (dB) averaged over 8 working hours. Continued exposure above 85 dB can cause hearing damage. | • Use engineering and/or administrative controls to reduce noise levels.<br>• Monitor employee hearing levels and notify them of the results of exposure monitoring (method of notification is left to the employers).<br>• Provide a quiet environment for breaks and lunch.<br>• Measure noise levels and control excessive noise. Make sure you are in compliance with OSHA regulations. | • Support the use of engineering controls that decrease noise levels.<br>• Observe monitoring procedures and make sure you are notified of the results.<br>• Get plenty of quiet time, especially between noise exposures. |
| **Hearing Protection Devices (HPDs)**<br>HDPs must be available to all workers exposed to 8-hour TWA noise levels of 85 dB or above. | • Evaluate the effectiveness of your hearing conservation program.<br>• Update your program on a constant basis or at least annually. Baseline audiometric testing should be done at the onset of a program with annual follow-up to measure changes.<br>• Consider offering hearing tests to those employees who are not exposed to hazardous noise on the job.<br>• Maintain records of noise-exposure levels, employees' hearing tests, background noise of audiometric testing room, employee education, and program evaluation. | • Take part in the programs offered at your facility. |
| **Education** | | |
| Intervention/Training | • Emphasize the importance of wearing protective hearing equipment and provide employees with proper training.<br>• Include information regarding hearing health in employee wellness education. | • Learn how to properly use protective hearing equipment.<br>• Read the information provided by your employer and apply it. |
| Hearing Exams | • Consider offering hearing exams as part of the health insurance program. | • Have regular hearing examinations. |
| Visual Reminders | • Place educational posters/information in key areas throughout your facility to remind workers about using HPDs and educate them on noise hazards. | • Take note of educational/ informative materials your employer provides. |
| **Lifestyle** | | |
| **Diet/Exercise/Stress/Smoking**<br>A healthy lifestyle — daily exercise, along with a healthy diet and reducing stress — can go a long way in protecting your hearing and treating tinnitus (ringing in the ears). | • Offer healthy food options in on-site dining facilities.<br>• Be proactive and alleviate stressful situations in the workplace.<br>• Provide exercise opportunities at work (lunchtime walking clubs, etc.).<br>• Ban smoking in the workplace. | • Choose healthy foods and limit your intake of caffeine.<br>• Work to reduce stress in your life whenever possible.<br>• Participate in employee-sponsored health activities.<br>• Stop smoking/don't start. |
| **Recreational Activities/Home** | • Include information regarding recreational noise in employee education.<br>• Provide appropriate personal hearing protection devices at any employee-sponsored recreational activity that involves loud noises. | • Turn down the volume or wear hearing protection when involved in certain recreational activities such as attending rock concerts, loud sporting events (car races, motor boating, etc.). Limit your exposure to excessive noise.<br>• Be a good role model by avoiding excessive noise and using hearing protection as needed — provide an appropriate variety of personal hearing protection devices for the whole family.<br>• Share information regarding prevention of noise-induced hearing loss with the entire family and teach children about the hazards of excessive noise and how to prevent noise-induced hearing loss. |

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If an employee's audiogram, or hearing test, shows a standard threshold shift (STS) in hearing in one or both ears, and the employee's total hearing level is 25 dB or more above audiometric zero (averaged at 2000, 3000, and 4000 Hz) in the same ear(s) as the STS, the patient's case must be recorded on the OSHA 300 log.

OSHA administrators say data collected on the new log will improve our knowledge of the extent of occupational hearing loss, and will help prioritize hearing loss prevention efforts.

"Hearing loss can result in serious disability and put employees at risk of being injured on the job," according to a statement from OSHA administrator **John Henshaw**. "This approach will help employers better protect their workers and help all of us improve our national injury and illness statistics and prevent future hearing loss among our nation's workers."

According to ACOEM, OSHA in 2001 issued 1,146 citations to companies that failed to adhere to rules on hearing protection. In 2001, OSHA issued 1,146 citations to American companies for failure to live up to the rules on hearing protection. In total, the proposed fines and penalties reached $611,000.

ACOEM has developed tips for monitoring hearing loss in the workplace as well as suggestions for protecting hearing at noisy work sites, at its web site (www.acoem.org).

Among the tips offered by ACOEM are to report overly noisy equipment or locations to a manager; provide employees with a quiet, restful spot in which to take breaks, and assess how well an employer's hearing conservation program is working. ■

# OSHA, JCAHO align to battle biohazards

*Alliance to provide education*

In the latest of alliances it has formed with other organizations, OSHA has paired with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Joint Commission Resources Inc. (JCR) to give health care workers a safer workplace.

The alliance, signed by OSHA, JCAHO, and JCR directors in August, primarily will allow the agencies to coordinate and maximize education and compliance assistance to health care organizations by providing information and access to training resources on biological and airborne hazard topics, in addition to emergency preparedness, ergonomics, and workplace violence.

"JCR's expertise in educational programming, combined with the safety know-how of OSHA and the Joint Commission, will provide a sound framework for disseminating information about opportunities to reduce employee injuries and illnesses in health care organizations," says **Karen Timmons**, CEO of JCR, an affiliate of JCAHO. Both JCR and JCAHO are headquartered in Oakbrook Terrace, IL.

The alliance among the three agencies is planned to be an education partnership agreement that will help health care organizations meet JCAHO accreditation expectations and comply with OSHA regulations. The educational aspect of the partnership is expected to improve efficiency and reduce duplication in oversight activities. JCAHO evaluates nearly 16,000 health care organizations and programs in the United States and accredits health plans, integrated delivery networks, and other managed care entities. JCR is a global, knowledge-based organization that provides tools and solutions to help health care organizations maintain accreditation standards and respond to issues impacting the health care industry.

OSHA's role is to assure the safety and health of America's workers by setting and enforcing standards; providing training, outreach, and education; establishing partnerships; and encouraging continual improvement in workplace safety and health. In recent years, OSHA has employed alliances as a means of encouraging voluntary change and compliance.

OSHA administrator **John Henshaw** says the OSHA/JCAHO/JCR alliance will focus on emerging occupational biological and airborne safety and health issues in the workplace, and will eliminate duplication of efforts by the agencies.

"By drawing on the expertise of JCAHO/JCR, together we can make positive strides in ensuring that health care workers are armed with the tools they need to stay safe and healthy at work," he announced in a press release at the time the alliance agreement was signed.

JCAHO president **Dennis O'Leary**, MD, says the alliance is a logical extension of the relationship between JCAHO and OSHA that dates back to 1996, when OSHA announced an educational partnership with JCAHO. The purpose of the

partnership was stated to be to help each agency "become more knowledgeable about each other's standards; to explore opportunities for reducing the number of health care workers' illnesses and injuries; and to improve compliance by health care organizations."

While OSHA, JCAHO, and JCR will work together to develop and communicate information on the recognition and prevention of workplace hazards, JCAHO surveyors, who document health care organizations' compliance with JCAHO requirements, will not turn into OSHA inspectors. Information will be shared among OSHA personnel and industry safety and health professionals regarding JCAHO/JCR, but the alliance is not intended to be, nor designed to be, a means for uncovering OSHA violations during JCAHO inspections.

OSHA and JCAHO/JCR will work together to develop training and education programs targeted to health care workers on topics including emergency preparedness, biological and airborne hazards, ergonomics, and workplace violence.

In addition, the agencies will provide each other expertise in the areas of safety and communications, each will provide speakers to the other for conferences, and will identify opportunities, as they arise, to expand upon the OSHA/JCAHO/JCR agreement.

OSHA has entered into several dozen alliances since the 1990s. According to Henshaw, alliances provide OSHA and its allies the opportunity to voluntarily cooperate with each other for purposes of training, education, outreach, communication, and the promotion of a national dialogue on workplace health and safety. An implementation team made up of representatives of each organization meets to develop a plan of action, determine working procedures, and identify the roles and responsibilities of the participants.

OSHA has identified three goals of alliances that typically are made explicit in formal alliance agreements:

- expand avenues for training and education;
- provide outreach and communication;
- promote the national dialogue on safety and health.

The OSHA/JCAHO/JCR agreement will remain in effect for two years, unless terminated by the director of any of the three allied agencies. Alliances differ from strategic partnerships. The crucial differences between the two kinds of relationships are that alliances are not based on a specific work site and have no enforcement component.

*[For more information, contact:*

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## ExxonMobil: No cell calls in company cars

ExxonMobil Corp. has been lauded by the National Safety Council safety leadership in enacting a ban on cell phone use by ExxonMobil employees and contractors while they are driving on company business.

"ExxonMobil has again demonstrated its safety leadership by recognizing a significant driving hazard and acting to reduce this hazard for their thousands of employees and contractors who operate motor vehicles and travel on company business," said **Alan C. McMillan**, president of the National Safety Council.

The new policy was developed after ExxonMobil commissioned an analysis of available science on cell phone use that concluded talking on a cell phone significantly degrades driving performance.

The ExxonMobil report analyzing cell phone research is available at www2.exxonmobil.com/corporate/files/corporate/Cell_Phone_Use_Study.pdf, or through the National Safety Council the National Safety Council web site, www.nsc.org.

The findings of negative effects of cell phone use on drivers, or "vehicle control degradation," cited in the ExxonMobil report include a delay in brake activation three times longer than the reaction deterioration found in drivers under the influence of alcohol; a fourfold increase in risk associated with the use of a cell phone while driving as compared to not using a cell phone; an increase in the relative risk of vehicle collisions similar to the hazard associated with driving with a blood alcohol level at the legal limit;

and a diversion of the driver's attention and situational awareness from driving environment and potential hazards that may unexpectedly impact safety during cell phone conversations.

"This action by ExxonMobil concurs with the policy of the National Safety Council that states that best practice is to not use a cell phone while driving," McMillan said. "The council's policy also recommends that employers assess whether to allow employees to use cell phones and other devices while driving; and if so, what sensible restrictions should be followed."

ExxonMobil's ban on cell phone use does not apply to commutes between a contractor's or employee's residence and work, even in a company car, or to calls made when the company car is parked in a safe location. ExxonMobil implemented the new policy in conjunction with the company's recognition of National Safety Month in June. ▼

# Asbestos exposure is catching up with us

Decades in which unprotected American workers were exposed to asbestos are catching up with us, a federal health expert says. Deaths from asbestos exposure have surged in the United States and are expected to keep rising in the next decade as more workers succumb to the lung disease.

The number of Americans who died of asbestosis, which is caused by inhalation of asbestos particles, jumped to 1,493 in 2000 from 77 in 1968, according to the Centers for Disease Control and Prevention in Atlanta. The incurable disease, marked by shortness of breath and persistent cough and linked to a higher risk of cancer, now is a bigger killer than silicosis and black lung and the deadliest of all work-related respiratory illnesses.

The CDC warned that the death toll likely will continue rising because of the lag — often as much as 45 years — between initial exposure to asbestos fibers and death. "What we're dealing with is a legacy of the past," says **Michael Attfield**, an epidemiologist at NIOSH and one of the study's authors.

Prized for its heat resistance and insulation properties, asbestos was mined for use in U.S. shipyards and construction sites after World War II. Its use declined sharply in the 1980s after warnings about health risks. Attfield warns that asbestos-tainted materials still are in some factories, workplaces, and other buildings across the nation, posing a continued risk of exposure to occupants. Coastal states such as Alaska, Washington, Mississippi, Virginia, Massachusetts, and Maine are among those with the highest rates of asbestosis mortality between 1982 and 2000, according to the CDC study, which analyzed data from death certificates.

The rise in asbestosis deaths has occurred amid a decline in mortality from other occupational lung diseases such as coal workers' pneumoconiosis, or black lung, and silicosis. The death rate from silicosis and other unspecified pneumoconioses was 70% lower in men between 1982 and 2000 than in the 1968-1981 period. Male mortality due to black lung fell 36% over the same time periods. ▼

## CE objectives

The CE objectives for *Occupational Health Management* are to help nurses and other occupational health professionals to:

- **develop** employee wellness and prevention programs to improve employee health and attendance;
- **implement** ergonomics and workplace safety programs to reduce and prevent employee injuries;
- **develop** effective return-to-work and stay-at-work programs;
- **identify** employee health trends and issues;
- **comply** with OSHA and other federal regulations regarding employee health and safety.

## COMING IN FUTURE MONTHS

- How good are small businesses at occupational health and safety?
- Professional development in occ-health: What's new, what's needed?
- HIPAA privacy rule compliance in the on-site clinic
- Keeping employees at work despite chronic pain

# NIOSH updates morbidity/ mortality reference

Cincinnati-based NIOSH has released an update of its 2000 reference, *Worker Health Chartbook.* The updated book, *Worker Health Chartbook 2004,* consolidates information from the network of injury and illness surveillance tracking systems in the United States, and is designed for agencies, organizations, employers, researchers, workers, and others who need to know about occupational injuries and illnesses. The document presents the data in an easy-to-read, visually compelling manner.

*Worker Health Chartbook 2004* is a descriptive epidemiologic reference on occupational morbidity and mortality in the United States. The chartbook includes more than 400 figures and tables describing the magnitude, distribution, and trends of the nation's occupational injuries, illnesses, and fatalities. The document is intended to fulfill the NIOSH strategic goals for preventing occupational injury and illness and to guide research and prevention efforts. The chartbook is available on-line in PDF format at www.cdc.gov/nio sh/docs/chartbook. ■



# CE *questions*

Nurses and other professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this semester's activity, you must complete the evaluation form provided in the **December** issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

13. OSHA requires that employers monitor noise exposure levels and identify employees who are exposed to noise at or above 85 dB averaged over:
A. Eight hours
B. One month
C. One year
D. One hour

14. Studies have shown that there is an eight times lower incidence of chronic pain when employees on disability go back to work than when they stay home, and at eight to 12 weeks (of an employee being off work on disability), the chance of that employee ever returning to work drops to:
A. 30%
B. 45%
C. 50%
D. 75%

15. The alliance of the JCAHO, JCR, and OSHA is intended to be an investigative and enforcement team.
A. True
B. False

16. According to the Workplace Bullying and Trauma Institute, what percentage of employees who are the victims of workplace aggression quit their jobs?
A. 0%
B. 20%
C. 55%
D. 82%

**Answer: 13-A; 14-C; 15-B; 16-D.**