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Return to work after traumatic injury or a long absence requires a strategy

Co-worker support, gradual re-entry can make return smoother

It's a common observation when the discussion is about return-to-work plans: "Every return to work plan is different because every employee/patient is different."

But what about cases that are *really* different — when the employee has been off work for five years, or is returning to work after a traumatic injury that not only affected the employee, but also the co-workers who witnessed it? In cases like these, neither the employees nor their workplaces are the same as they were before the employees went on leave.

"Successful return to work in these cases demands a combination of knowledge, experience, and creativity," says **Jeanne Griffin**, MS, CDMS, a disability management specialist and director of the Return to Work Center, a division of the Peoria, IL-based Institute of Physical Medicine and Rehabilitation. "When someone has been off work for years, or has had a catastrophic injury, each of those presents with its own set of problems."

A one-size-fits-all return to work approach doesn't work in general, she points out, and especially not when dealing with an employee whose biggest problems may not be just the injury or illness that put him or her on leave to begin with.

Issues beyond injury or illness

A clinician working with an employee who has been off work for years may find that the employee is reluctant to come to work, but not necessarily because he or she still is bothered by the initial injury.

"I recently worked with someone who had been off work for about five years," Griffin explains. "That was long enough that the employee was bored at home and really wanted to go back, but after that period of time, you aren't just looking at the injury anymore."

In cases in which employees are off work for years, they change, their health alters, and their job and workplace change.

Technological advances in the workplace may leave the employee feeling that he or she doesn't know the job any more; his or her supervisor might feel the same way.

Especially in the cases of employees who are near or in middle age,

intervening health problems can arise to cause problems that were not there at the time the employees went off work.

"What has this person being doing? Inactivity can have an effect on health," Griffin says. "Also, sometimes other conditions have developed in that time away from work.

"That makes it so important to identify all barriers to returning to work."

In the case of traumatic injuries, Griffin says the employee also is battling fears that stem from the event or its aftermath.

"Of course, they are worried about reinjury," she says. "Someone who has been in a serious motor vehicle accident may be very fearful about returning to work and driving a truck.

"What helps that situation are things like work hardening, work conditioning — a brief period where they have a neutral environment, when they can get confident, and with a brief oversight of that transition period [by a disability manager or nurse], you can get through that and smooth away the fear of reinjury, and reassure them that what they're doing at work is within their capabilities."

Education on all levels urged

When an employee is ready to go back to work after an extended leave, his immediate supervisor "can be a great help by letting the other workers know that this person will be back, and what his limitations are," says **Mary Patt Scanlon**, division chief in the Civilian Personnel Management Services, Injury/Unemployment Compensation, U.S. Department of Defense in Arlington, VA. "If the co-workers buy in — they may have to do some of this person's heavy lifting, for example — the return will go much more smoothly."

When the employee in question is someone who has been off work for a number of years, he or she might be coming back into a workplace that has changed; both the work and the co-workers might not be the same. Accordingly, other employees will be asked to make concessions for and assist a new worker they have no ties to.

"We get everybody on board, so everyone's working toward the same goal of getting a person back to work. That may mean some education for that first-line supervisor as to what this person can and cannot do, and for the [case manager] to act as a mediator to help in the transition."

When an employee who suffered a serious injury on the job comes back to work, not only is the occupational health manager faced with helping the worker overcome fears of being reinjured and the emotional and physical toll of regaining the comfort and proficiency of doing the job he or she was doing before the accident, but also the case manager finds other employees needing help, as well.

"The impact is on everyone at the workplace, especially those who witness a catastrophic injury," says Griffin. "It impacts the whole workplace, from preparation for the employee to come back, to how far this person is going to integrate back, to the emotions that they might be feeling."

Griffin says she once managed a worker who was seriously burned on the job. The employee's co-workers "never imagined he would be able to return to work, ever." When he did, "There wasn't a dry eye in the house." The tears were not just from happiness, Griffin says; the injured

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worker's experience brought home to his co-workers the realization that what happened to him could happen to them.

"The more that employers can understand that [an injured employee's] co-workers see how that person is treated while they are off, and how they are treated when they return, that's an opportunity for employers to raise their own awareness and to think of the things they can do to make transitions easier and make the environment safer for all their employees," she points out.

Same ideas, modified

Traditional tools for re-integrating an employee into the workplace — work hardening, work fit testing, modified or light work — are important components of getting a long-disabled employee, or a seriously injured one, back to work. The trick is using those tools in the right way.

"On-site work hardening, by itself, can be too costly. Modified work, by itself, does not advance the worker to the pre-injury job level," Griffin says. "There isn't just one solution."

Sometimes, it's easy.

"One of our goals is to change managers' attitudes," Scanlon says. "A lot of times, accommodating an injury can be simple. By removing one piece of a job description, the employee can do the rest of it. He may not be able to lift 50 pounds anymore, but he certainly can work."

Modified work can be a very good way to ease an employee back to his pre-injury levels. However, modified work can appear to be too simplistic to the experienced employee; if the employer has been forced to come up with "busy work" for the employee to do when he returns to work, the employee can feel guilty.

Griffin says that if the case manager can come on-site and oversee the employee's transition period — in as unobtrusive a way as possible — he or she can get an accurate picture of whether the modified work is enough to help harden the employee and foster his return to his previous work levels, or if it is so far behind what the employee is capable of that it actually sets his rehabilitation back.

"But there is something to remember about on-site supervision — it needs to be for as short a period and as nonintrusive as possible," she advises. "That person is going back as a whole person, and doesn't want to be identified as someone with special needs."

Devising a successful return to work plan must be done with input from the employee's physician

"You need to get them to write a prescription that really means something, not 'no use of right arm,' but something that really helps the employer understand the tasks the employee can do." **(For the American College of Occupational and Environmental Medicine's guidelines for making useful return-to-work recommendations, see box, above.)**

A mistake some case managers make on the employee's behalf is not giving the physician enough of the right information he or she needs to write a return-to-work prescription. The physician should be given detailed descriptions of the work — including, for example, what kinds of

Return to Work Recommendations

- ***Physical and functional limitations or restrictions:*** The employee's functional capabilities and vulnerabilities should be considered and matched against the demands of the job and working conditions.
- ***Limitations:*** Any existing constraints in the employee's physical or mental capability to perform tasks. A mild increase in symptoms with increased activity is appropriately viewed as a nonmedical issue. Patient self-report may not always be a reliable method of making this determination. Self-imposed limitations may be based on subjective perception or secondary gain. The physician is advised to rely on objectively determinable findings to the maximum extent possible.
- ***Specific restrictions:*** Any protective measures required to prevent injury or foster recovery. These should be specific — e.g., the exact weight and height for lifting restrictions; the amount of time per hour and per shift an activity can take place; postures to be avoided. Duration of restrictions should coincide with the expected increase in endurance associated with the increased activity of a graduated return to work.
- ***Social or environmental limitations or restrictions.***
- ***Schedule modifications:*** Should be noted when return to a normal schedule is medically appropriate.
- ***Medical aids, adaptive equipment, or personal protective equipment.***

Source: American College of Occupational and Environmental Physicians, Arlington Heights, IL.

hard labor are involved or what repetitive tasks are done. The physician also should evaluate what the patient is able to do at the time of the initial return to work.

The physician and case manager should be creative at times, to ensure that the return-to-work actually does prepare the employee to return safely to his or her former work. For example, an employee might need to be restricted to lifting 25 pounds; but if medically appropriate, the prescription could specify that the employee can lift more weight when the case manager is present. In that context, the employee and case manager can see what he is capable of, in a controlled setting.

"If you can do it in as nondisruptive way as possible, individual case management [on site] can get the employee back to work more quickly," Griffin says.

This on-site work hardening requires considerable communication among the worker, employer, physician, and case manager to obtain the desired results, authorization for compensation, and scheduling of site visits. Depending upon the workplace, there may be other considerations: safety equipment or special attire for the case manager, hours of supervision, and confidentiality issues for the worker.

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Do everyone a favor when you're sick: Stay home!

Presenteeism is a major thief of productivity

What's more contagious than the flu carried by the co-worker who comes in to work sick? Maybe the pressure to *be* at work even though sick.

American workers don't stay home enough when they're sick, and that's costing businesses millions in lost wages and unproductive workdays, report researchers at Cornell University.

The Cornell study is the first to include an employer's costs from unproductive days at work caused by health problems. **Ron Goetzel**, director of Cornell's Institute for Health and Productivity Studies in Washington, DC, says he and his colleagues looked at the costs associated with employees who came to work sick. The researchers determined that the practice of not staying home when sick costs about $255 per employee per year — perhaps more than absenteeism does, he adds.

Factors included lack of concentration due to sickness; work done more slowly and with more repeated tasks; and generally slowing down of productivity. The potential cost of infecting co-workers was not included in the Cornell findings.

Goetzel adds that expenses related to presenteeism are even exceeding the costs of absenteeism and medical and disability benefits, and part of the problem is that employers have not yet fully recognized the financial impact it can have on their business.

Why bring the misery to work?

A Dutch survey found that the reason workers tend to go to work rather than stay home and get well is due to "working under pressure," meaning, employees feel pressure from their workplace to be at their desks, day in and day out. Presenteeism was low among those working part-time (eight hours or fewer per week), and also among workers who are satisfied with their pay.[1]

Other factors include:

- male;
- young;
- having low or very high autonomy;
- having low job security;
- coping with financial concerns;
- dealing with uncertainty (e.g., a company merger);
- facilitating parental/family responsibilities.

"The question is not how much does it cost to keep employees healthy," says **Scott Sullivan**, president and CEO of the Scottsdale, AZ-based Institute for Health and Productivity Management. "The question is, 'What does it cost when they're not healthy?'"

Employers need to look at the total burden of illness, says Sullivan, which includes not only direct costs of medicine and physicians, but also the indirect costs of lost productivity, decreased

quality, and effects on co-workers and customers. Then employers should educate their employees about the wisdom of staying home when they are ill, and the long-term benefits of doing so.

Many of the illnesses that employees bring to work could be managed more quickly and with less ripple effect if the employee stayed home or received primary medical care. Common maladies such as the cold can be treated at home, with patients benefiting from rest rather than prolonging the illness by working. Others, such as migraines, can cause lost productivity but are easily treated and managed under a physician's care.

Not all causes of presenteeism are infectious. Psychological maladies, such as depression, are common causes of lost productivity.

A recent study published in the *American Journal of Psychiatry* draws a correlation between major depression and loss of focus and productivity, with the strongest depressive symptoms coming in the evening.[2]

Jeffrey P. Kahn, MD, clinical associate professor of psychiatry at Cornell University in New York City, says the study shows depression is associated with "a significant reduction in task focus" and productivity.

"[Researchers] calculated that the lost productivity from depression while at work was about 2.3 days per month, as compared to other studies reporting a typical loss of one day per month due to work absence," he points out.

"Together, these lost productivity causes resulted in an ongoing effective lost salary of $300 per month [other costs such as turnover, health care costs, and others were not included]. That would be enough to pay for a fair amount of treatment, and then some," he says.

Integrated strategy called for

Goetzel says making employees stay home is not really the solution. The answer, he says, is to focus on wellness so the employees don't get sick in the first place.

Combatting presenteeism requires an integrated approach, experts say. If employees are suffering from chronic illness or injury, occupational health professionals can work with the employee toward a solution, such as an ergonomic evaluation and changes to a workstation. In the case of chronic medical conditions, disease management techniques and employee wellness programs can be beneficial. If the problem is personal, workers can tap into their employers' employee assistance program for referrals or counseling.

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Creating, updating safety manual critical

This critical document often is neglected

Ask someone where a copy of his or her company's safety manual can be found, and there's a chance they won't know. Although a necessary part of a safety program, a safety manual is generally a tool nobody wants to assemble, keep up with, or update.

"Safety in the workplace has become complex, especially keeping up with the dos and don'ts," says **Swiki A. Anderson**, PhD, PE, president of Accu*Aire Controls in Bryan, TX. Anderson says he and a group of other safety professionals are trying to establish some methods for assembling — and importantly, continually updating — safety programs for the workplace.

The need for a manual that spells out a company's safety policy is obvious — a safety program is of little use if employees don't know what it is and cannot refer to it.

Experts told *Occupational Health Management* that some other reasons to have an up-to-date, truly useful written safety program are to:

• promote cooperation, raise morale, and increase productivity;

• increase the employees' responsibility for workplace safety;

• save money and reduce costs;

- reduce liability for OSHA violations;
- reduce employee absenteeism;
- maintain the company's reputation.

Why put it in writing?

Though often described as the book everyone's supposed to be familiar with but isn't, a company's safety manual is the center of its comprehensive safety program. According to the *Du Pont Resource Guide to Safety Services*, safety programs have helped many companies reduce accidents by 50%-70% in as little as two years.

In addition, many states' labor laws require employers to have, in writing, their company's safety program.

"You may want to put together a safety manual to give to employees at the time of hiring," says **Marvin Newsome**, safety officer with the Workers Compensation Board, Northwest Territories and Nunavut, in Canada's Northwest Territories. "When employees know from their first day that management puts great value on safety, they will be more likely to take precautions when working."

Besides being a good idea, a safety manual — while not required by OSHA — also can serve as a good tool against liability should an accident occur.

Who needs to be involved?

Developing a good manual starts with appointing someone with a broad knowledge of environmental health and safety to talk with those knowledgeable about the company, its operations, its people, and the hazards posed, says **Carter Ficklen**, CIH industrial hygienist, Mainthia Technologies Inc. and NASA LaRC Safety and Mission Assurance Support in Hampton, VA. "A safety program is not a word document that you buy on the Internet for $49.95, and then hit 'select/replace all' to include your company name."

Most mentioned the importance of getting all levels of employees involved in the development, maintenance, and use of the manual.

The most important resource you will need to initiate or improve your safety program is input from employees, contractors, and subcontractors. Their involvement is critical to the success of the program for several reasons, because it will:

- Increase their sense of ownership in the program. This will result in employee support for the program, which is necessary because many of them work in areas that will be most greatly affected by the safety program. They can offer valuable insight because of their skills and hands-on experience with hazardous work.
- Increase their knowledge of program objectives and requirements.
- Result in a higher level of worker compliance to program requirements.

Obtain employee, contractor, and subcontractor input by informing them of any plans related to the introduction of the safety program, inviting them to participate as often as possible, telling them how their input will be used, and then actually using their input; and giving them the finished products to use.

"A manual developed with common sense and practical environmental health and science knowledge, combined with management commitment and worker buy-in and involvement makes a solid program," says Ficklen.

James N. Gotay, QEP, CSP, of Matawan, NJ-based Skyline Environmental Inc., suggests beginning with an audit.

"Start with conducting a regulatory audit to identify the site-specific facility needs, then conduct a wrap-up meeting with site management to identify preferences and provide additional input on regulatory requirements," he advises. "A consensus of opinions should lead to a document with management support. Upper management sponsorship of the program will cause the functional staff to take notice."

Gotay says a safety and health manual consisting of generic, nonapplicable programs generated simply to attempt to comply with regulations "is going to sit on the counter and collect dust."

Every business in the United States has to comply with general industry standards that cover things like safety exits, ventilation, hazardous materials, personal protective equipment like goggles and gloves, sanitation, first aid, and fire safety.

Under OSHA, employers have a general duty to "maintain a safe workplace," which covers all situations for which there are published standards. OSHA's web site provides some tools to help companies start a health and safety program or update an existing one (www.osha.gov/SLTC/safetyhealth/index.html). OSHA and state safety organizations conduct safety consultation programs free of charge.

Experts say an early source to consult is the company's insurance carrier. Ask if an insurance company safety specialist can visit the site and make recommendations. Insurers typically are

happy agree, since the safer the business is, the fewer accident claims they will see.

After employee input, the most important resources are any materials, policies, procedures, or other means the company intends to use to promote safety. The safety manual should highlight and explain the specific dangers and hazards of the company's environment. To get the most comprehensive view, it should pool safety information from department managers, equipment and tool manufacturers (if applicable), and occupational safety and health experts. The safety manual should include information on startup and lockdown procedures, operational safety procedures, types of activities to avoid at work, and proper attire for operating equipment.

Some experts recommend putting the manual through a final review by an insurance professional, a government representative, and an attorney.

It's finished . . . now use it

Once the written version of a safety policy has been created, someone within the company should be charged with the responsibility carrying out the program and keeping the manual up to date. There should be a system — ideally, addressed in the manual itself — for ensuring that employees comply with safe and healthful work practices, and which includes disciplinary action as well as recognition of safe work habits.

Along with the manual, there should be put into place (if it doesn't already exist) a system for:

- communicating with employees about occupational safety and health, including encouragement to inform the employer of worksite hazards without fear of reprisal;
- identifying and evaluating workplace hazards, including scheduled periodic inspections;
- investigating an occupational injury or illness;
- correcting, in a timely manner, unsafe or unhealthful conditions or work practices;
- safety and health training for employees and supervisors;
- documenting scheduled, periodic inspections and employee safety and health training (OSHA requires these records be kept for three years).

"It's important to make your safety program accessible to everyone affected by the program by distributing copies of your safety program manual to each worksite and by making copies available to anyone who requests one," says Ficklen.

Keeping an up-to-date list of all employees, contractors, and subcontractors holding copies of the safety program materials will make distributing updates easier.

Some safety consultants recommend including a page in the manual that employees must sign, date, and return stating they have read and understood all the information in the manual and agree to abide by it.

Keep the manual current

Establishing a safety program and manual is one thing; keeping it current with technology, regulations, and changing facilities is another.

Anderson says he and his colleagues have studied various formats, in addition to a traditional print format, for documenting his company's safety program, but always come back to the question of which is going to be easiest to update on a regular basis.

"No matter which format we look at — print, electronic, database — it opens up another can of worms," he admits.

Suggestions for keeping the manual useful and current include a regular review and update of all aspects of the safety program, and simultaneous update of the manual. To ensure that everyone is on the same page, so to speak, experts recommend controlling the revision process from a central location, such as the company's headquarters, with any proposed changes and additions directed to a specific person at that location.

If a record is kept of all employees and contractors holding copies of the earlier version, use the list to make sure everyone gets a copy of any updates or supplements. Ask anyone receiving an updated copy to destroy to old copy, to avoid confusion.

Additional tips for developing health and safety programs and manuals can be found in *Guidelines for Developing Effective Health and Safety Programs,* a publication of the Workers Compensation Board, Northwest Territories and Nunavut. It is available on-line at: www.wcb.nt.ca/publications/Guidelines Developing.pdf.

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Work environment may hasten nurse retirement

Flexibility, accommodations would help

Work stress and dissatisfaction with the work environment may hasten the retirement of aging nurses, according to a study by the Center for American Nurses, an Austin, TX-based affiliate of the American Nurses Association.

Almost half (47%) of 4,000 nurses surveyed said the relationship with nursing management or administration caused them to think about leaving. Nurses also cited staffing concerns and "the effect of organizational shift from patient to finance or other [issues]" as reasons they might leave.

Yet nurses said they would consider postponing retirement if they could have flexible schedules or a phased retirement with shorter hours or fewer days worked. More than one-third (37%) of the nurses surveyed said they plan to retire between 2015 and 2020.

"Most nurses retire from the bedside at 52 and from the profession at 62," says **Claire Jordan**, RN, MSN, president of the Center for American Nurses, noting that the average age of nurses now is 46. "We are barely six years away from looking at 50% of the nurse work force leaving the bedside."

To retain nurses, hospitals need to alter the work environment to make it more suitable for older workers, she says. "Nurses have jokingly said to me, 'I guess we'll keep working if it'll pay for our total hips and our total knees,'" she adds. "The lifting issue is a big issue for nurses."

The need for accommodations came out in focus groups conducted by the Center for American Nurses. But most nurses said administration had not made any changes in scheduling or work environment to take into account the aging work force.

"Twelve-hour shifts in nurses over 52 just becomes almost impossible," Jordan points out.

Meanwhile, hospitals won't be able to fill their nursing needs just with new recruits, she cautions. "Obviously, one of the best ways to prepare for this shortage is to prolong the working life, to change the plans for retirement. We are trying to work up an agenda for all the acute-care employers [to retain nurses]."

The aging work force also has a major impact on nursing injuries and workers' compensation.

Here are three common ailments associated with aging — near-vision loss, arthritis, and back injuries — and examples of how hospitals can approach them:

1. Near-vision. Nurses need to see the fine print — on ID bracelets, orders, prescriptions, and labels. Yet as they age, near-vision suddenly may become a problem.

At Pitt County Memorial Hospital in Greenville, NC, nurses have a vision screening every year with their TB skin tests, bloodborne pathogen education, and immunization update.

In fact, the hospital is expanding the screenings into a health screen, offering glucose and cholesterol testing and a health risk appraisal.

Pitt County Memorial uses the Titmus Vision Screener to check near-vision, although a simple screen also could be accomplished with a Jaeger chart, says **Pat Dalton**, RN, COHN-S, occupational health project specialist.

"[The screens] do help us to identify people who are beginning to have problems. We are able to identify the near-vision problems that you begin to get with aging," she says.

The job duties determine the near-vision requirements, Dalton notes. At the first sign of decreased near-vision, employee health will simply ask the employee to check on it. If the problem is more significant, it may reach an action point. Employee health would alert the manager to make sure that the vision check occurred.

Meanwhile, a quality improvement team is reviewing the use of abbreviations, such as "qid." Some will be eliminated to prevent confusion, Dalton says. The use of computers to relay orders also has reduced the risk of miscommunication. "The reading is much more legible," she adds.

2. Arthritis. Chances are, many of your employees already suffer from arthritis. And as the work force ages, those numbers increase dramatically.

In 2002, some 43 million Americans had a diagnosis of arthritis, according to the Centers for Disease Control and Prevention (CDC). Another 23 million report chronic joint pain but don't have a diagnosis, says **Teresa J. Brady**, PhD, OT, senior behavioral scientist with CDC's arthritis program.

"Arthritis is already in the workplace; employers

don't need to wait for the aging of the population," she explains. "But we do predict that the problems related to arthritis are going to increase dramatically over the next 25 years."

That is especially true for nurses, with an average age of 46. Osteoarthritis commonly develops between the ages of 45 and 64. "The nursing population is aging themselves into the most common point of onset for degenerative, or osteoarthritis," Brady notes.

What can you do about it? Here are some basic steps, she advises:

• **Minimize repetitive bending or lifting.** Overuse of a joint, particularly after an injury, can increase the risk of osteoarthritis, she says. For example, repetitive knee-bending has been linked to osteoarthritis, she says.

• **Refer employees for evaluation if they have chronic joint pain.** Rheumatoid, or inflammatory, arthritis responds well to early, aggressive medical treatment.

• **Offer education on arthritis.** The Arthritis Foundation in Atlanta offers an Arthritis Self-Help Course at locations around the country — www.arthritis.org or (800) 283-7800. Contact the arthritis coordinator in your state health department, which has federal grant money for arthritis activities (www.cdc.gov/nccdphp/arthritis/states.htm).

• **Encourage weight control.** People who are overweight or obese have an increased risk of developing osteoarthritis.

3. Back injuries. When **JoAnn Shea**, MSN, ARNP, director of employee health and wellness at Tampa (FL) General Hospital, met with the senior management to ask for lift teams to reduce patient-handling injuries, she had a compelling argument. About half of the hospital's nurses are older than 40. The hospital's most severe injuries occurred among employees older than 45.

She presented four cases of patient-handling injuries, which cost the hospital between $350,000 and $500,000 each. Only one of the four was able to go back to work, and she had to take a non-nursing job. The others were totally disabled. All were older than 40.

The worst injury was to a nurse who was trying to move a 500-pound bariatric patient with the help of just one other employee. "It's sad, because she was a very good nurse," Shea adds. "She tried to get help but there wasn't enough help. She was moving the patient over to a stretcher." The nurse suffered a herniated disc, had three back surgeries, and remains disabled.

The administration approved the lift team. It costs about $200,000 in salaries and benefits per year, and Tampa General has spent about $750,000 on ergonomic equipment. The hospital has ceiling lifts in the rehab unit, skilled nursing facility, and half the rooms in the rest of the hospital.

But the investment has paid off. Workers' compensation costs declined 29% last year. In two years, patient-handling injuries dropped by 62%. "Our lost workdays went down, our restricted workdays went down," Shea says.

Tampa General also will be able to retain nurses who may have left because of the physical demands of the job. Shea surveyed nurses to see how they felt about the lift teams. "A lot of them said, 'I don't think I could continue to work without the lift team at my age. Now, my back doesn't hurt every day when I go home.'

"If you want to keep your experienced nurses in clinical nursing, which is where the shortages occur, then we have to provide the tools for them to be able to do their job safely," she adds. ■

CDC Q&A on national flu vaccine shortage

Live mist vaccine OK for most HCWs

In response to the national influenza vaccine shortage, the Centers for Disease Control and Prevention (CDC) is providing the answers to some of the most common questions by clinicians and the public.

Question: Who should be vaccinated?

Answer: The existing flu vaccine supplies should be given to protect people who are at greatest risk from serious complications from influenza disease. Everyone in this group should seek vaccination:

• adults 65 and older;

• children ages 6 months to 23 months;

• adults and children 2 years of age and older with chronic lung or heart disorders including heart disease and asthma;

• pregnant women;

• adults and children 2 years and older with chronic metabolic diseases (including diabetes), kidney diseases, blood disorders (such as sickle cell anemia), or weakened immune systems, including people with HIV/AIDS;

• children ages 6 months to 18, who take aspirin daily;

• residents of nursing homes and other chronic-care facilities;

• household members and out-of-home caregivers of infants younger than 6 months (children younger than 6 months cannot be vaccinated);

• health care workers who provide direct, hands-on care to patients.

Question: Who should go without vaccination?

Answer: Healthy people 2 to 64 years of age are asked to not get vaccinated this year at all or to wait to get their vaccine after people in priority groups in their area have had a chance to be vaccinated, so that available vaccine can go to protect those at greater risk for flu complications.

Question: What else can you do to prevent the spread of flu?

Answer: There are certain good health habits that can help prevent the spread of flu.

• Avoid close contact with people who are sick. When you are sick, keep your distance from others to protect them from getting sick too.

• Cover your nose and mouth with a tissue when you cough or sneeze — and dispose of the tissue afterward.

• If you don't have a tissue, cough or sneeze into your sleeve.

• Wash your hands after you cough or sneeze — with soap and warm water, or an alcohol-based hand cleaner.

• If you get the flu, stay home from work or school. You will help prevent others from catching your illness.

Question: What if you are in a high-risk group and your clinic has no vaccine?

Answer: Contact your local health department and ask your regular vaccine provider about other options for influenza vaccination. Health departments throughout the United States are trying to make sure that as many high-risk people as possible eventually will be able to go to either their regular vaccine provider or a flu shot clinic to get the vaccine. Some public vaccination clinics also may be posted at www.lungusa.org.

Question: How much flu vaccine will be available in the United States this season?

Answer: About 55 million flu shots will be available in the United States this season. About 1 million doses of live attenuated influenza vaccine (LAIV) will be available.

Question: Does CDC recommend using partial doses of influenza vaccine?

Answer: No. CDC does not advise using partial doses of recommended dosages of inactivated influenza vaccine (flu shot) either for people at high risk for complications from influenza or for healthy persons, including health care workers. There are no data on whether partial doses of the current 2004-05 vaccine would provide an adequate antibody response. Some studies have been done to assess the antibody response to one-half of the normal dose of inactivated influenza vaccine in healthy adults ages 18-49; however, the vaccine is not approved by the Food and Drug Administration for use at this reduced dose.

Question: What about using the new FluMist vaccine?

Answer: An alternative to the flu shot is the intranasally administered LAIV. If available, LAIV should be encouraged for use by healthy, nonpregnant people 5 to 49, including most health care workers, those who have contact with people in high-risk groups, such as those with lesser degrees of immunosuppression (e.g., people with diabetes, persons with asthma taking corticosteroids, people infected with HIV), and those caring for children younger than 6 months of age.

The only health care workers for whom inactivated vaccine (flu shot) is preferred are those who have contact with severely immunosuppressed patients, such as bone marrow transplant recipients, who are under treatment in special isolation units.

(Editor's note: For influenza updates, go to www.cdc.gov/flu.) ■

Counseling, support aid Alzheimer's caregivers

Relieving harmful stress and depression is the goal

A combination of counseling and support services may reduce the risk of depression in people caring for a spouse with Alzheimer's disease, a new study says.

The study, published in the May 1, 2004, issue of the *American Journal of Psychiatry,* also suggests that giving spousal support might help people who are not clinically depressed but who endure the chronic stress of caring for someone with the progressive brain disease. Other research suggests that chronic stress might damage the immune system and put caregivers at risk for diseases such as cancer.

The study began with the experiences of two elderly counselors who had started providing

informal help to spouses in the hallways of New York University's (NYU) Alzheimer's unit.

"We noticed that caregivers often looked very upset and bewildered," says NYU counselor **Emma Shulman**, who, at age 91, has plenty of life experience and a degree in social work to help her provide guidance to others. Shulman and her colleague, 84-year-old Gertrude Steinberg, began to offer advice to spouses who were caring for a partner with Alzheimer's disease.

Those hallway-counseling sessions seemed to help, but epidemiologist **Mary Mittelman**, DrPH, and her colleagues wanted to measure the benefit in a scientific study. The team recruited 406 people who cared for a spouse with Alzheimer's disease at home. Half were assigned to a normal Alzheimer's support group and typically did not get formal counseling. The other half received intensive counseling services: Shulman, Steinberg, or one of the other geriatric specialists at NYU sat down with the spouse of an Alzheimer's patient to assess the spouse's situation and recommend services that might provide some relief.

Counseling reduced depression

The interventions provided by the counselors included help in arranging respite care to give the caregiver a break, or helping a spouse work through the complicated financial problems that crop up when a partner can no longer pay the bills or balance the checkbook. Another individual session and four family meetings followed that first counseling session. The NYU staff got calls every day from spouses dealing with problems that ranged from the physical demands of caregiving to financial problems such as how to pay for home health care, a service typically not covered by Medicare.

The researchers gave the caregivers a test that measured symptoms of depression at the study's start and at intervals throughout the five-year study. They found that after one year, slightly less than 30% of people in the group that received the extra help had signs of depression, compared with 45% of the other spouses. The extra-help group also had fewer symptoms of depression overall. The positive effect lasted for more than three years after the initial counseling sessions. The benefit persisted even after a spouse died or had to enter a nursing home, according to the study.

Counselors can help caregivers minimize the behavioral difficulties caused by the disease. People with Alzheimer's can become aggressive and lash out at a family member. "This is a very difficult disease to live with," Mittelman says.

Alzheimer's disease can affect the entire family, but spouses can suffer the most, says **Sidney Stahl**, an Alzheimer's expert at the National Institute on Aging, which helped fund the study. He urges caregivers to seek help not just with day-to-day problems, but also with the emotional difficulty of watching the disease destroy their partner's mind.

"They're literally not the same person," he says. "That's got to be heartbreaking for the caregiver."

Tips for caregivers include:

- Learn all you can about the disease and caregiving techniques.
- Get help from family members, friends, and community services.
- Manage stress with relaxation techniques and time off.
- Get an annual physical and take care of yourself.
- Don't feel guilty if you can't do it all. ■

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

- The 7-Up safety program
- How to keep family leaves from hurting business
- Improve safety by bridging the communications gap
- Privacy issues unique to the on-site occ-health clinic

AAOHN revises ergo web site

The American Association of Occupational Health Nurses (AAOHN) is rolling out several additions to its ergonomics web site, www.ergo resources.org. The enhancements, which will make the site more user-friendly, include a new listserv, a new section containing downloadable templates and tools, and a more detailed list of links and other scholarly references.

"AAOHN developed this web site to provide occupational and environmental health nurses and other occupational health and safety professionals with the tools they need to address workplace musculoskeletal disorders," says AAOHN president **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN.

While there currently are many on-line ergonomics resources available, the philosophy behind AAOHN's site is to offer free, educational information, with an emphasis on a programmatic approach to ergonomics.

AAOHN developed the web site in 2003 as part of its alliance with OSHA. One of the areas of focus for the alliance is ergonomics. The others include workplace violence prevention and emergency preparedness. For more information about www.ergoresources.org, or about additional health and safety resources from AAOHN, call (800) 241-8014, ext. 0. ■

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.

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

21. When tailoring a return to work plan for an employee who has been off work for a period of years, which of the following should be considered?
A. Health issues that may have developed after the injury
B. Employee's self-doubt about returning to the workplace
C. Obtaining a detailed prescription from the employee's physician spelling out exactly what limits should be imposed on the employee's activities
D. All of the above

22. Cornell researchers did NOT consider which one of the following when studying the cost to employers of presenteeism:
A. Lack of concentration due to sickness
B. Work done more slowly and with more repeated tasks
C. Slowing of productivity
D. The potential cost of infecting co-workers

23. Enlisting upper management sponsorship of a safety manual/program helps encourage rank and file notice of the program.
A. True
B. False

24. Which of the following suggestions should people caring for loved ones with Alzheimer's consider helping prevent their own depression and reduce harmful stress levels?
A. Learn all you can about the disease and caregiving techniques.
B. Get help from family members, friends, and community services.
C. Don't feel guilty if you can't do it all.
D. All of the above

Answer: 21-D; 22-D; 23-A; 24-D.

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When looking for information on a specific topic, back issues of* Occupational Health Management, *published by Thomson American Health Consultants, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: custsomerservice@ahcpub.com.