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INSIDE

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Information gatekeepers: Occ-health nurses must ensure employee privacy

On-site caregivers are being called to do more than treat patients

If you provide medical services at a company's on-site clinic or occupational health office, you know the balancing act — organizing charts so they contain what they should but don't contain more than is necessary; having information readily available to those permitted access to it, but making sure privacy laws are observed.

"It's a real tricky area," agrees **Barbara Lucas**, RN, COHN-S, BS, CPC, an Arizona-based consultant who specializes in regulatory compliance, privacy, and Health Insurance Portability and Accountability Act (HIPAA) issues. "Insurance companies, medical reviewers, all want to see all the information in a patient's file. So does the occupational health nurse have discretion? Yes, and it comes down to organization of charts."

Who is entitled to access?

Lucas says that in many on-site clinics, the nurse maintains a running progress note, documenting each visit by an employee. This leads, in some cases, to lots of comingled information and could lead to a privacy breach.

"One of the significant issues in on-site clinics is the comingling of personal and work-related information that really should be segregated," she says.

OSHA inspectors can come into a workplace seeking surveillance data (data used to track occupational injuries, illnesses, hazards, and exposures, an integral part of NIOSH operations), and come away with more than they need or should have access to.

"They're just looking to make sure surveillance is taking place, so they should only be seeking surveillance information," Lucas points out. "We should not turn over [an employee's] whole record to OSHA; just the information they're seeking."

But the most common potential compromise to employee health records comes from within.

"The most challenging is human resources' [HR] and supervisors' access to medical information," Lucas says. "A lot of times, it's for valid work reasons or they genuinely want to know how someone is doing. But there is no HIPAA privacy requirement for a supervisor. A lot of times, you'll see

people sending out an e-mail — 'So-and-so had a heart attack last night' — and I just cringe."

The chain of command leading to the occ-health nurse can lead to some uncomfortable situations, too.

"Where you get into trouble with HR is that a lot of nurses report to HR, and HR supervisors feel entitled to see records; but the issue is why do they want to see them?" Lucas explains.

Right to know vs. need to know

The reason for confusion can be traced, in many cases, to what may appear to be a conflict between what's permitted by the Americans with Disabilities Act (ADA) and what's controlled by HIPAA privacy rules. The ADA allows for "reasonable accommodation" of employers to obtain information on employees' health issues.

"But does HR have the right to the entire record, or just to those [work-related health] issues?" Lucas asks.

She recalls being assigned temporarily to a company's on-site clinic and being visited by someone from HR who wanted medical information on an employee. The occupational health nurse working at the time refused and documented the request. Sometime later, that nurse was out and a temp nurse was filling in; the same HR employee came to the clinic and asked for the information, and again was refused, and again the request was documented.

"Finally, when another temp was filling in, the HR employee came in, asked again for the medical information, and when the temp nurse pulled the chart and saw the documentation of the two previous requests, she said, 'If the other two nurses wouldn't give it to you, what makes you think I would?'"

Lucas says requests from supervisors who merely want information out of concern for the employee also pose privacy challenges.

"It's a touchy situation for the nurse to explain that an employee has, say, certain restrictions to doing his or her work but without saying why," she explains. "It's very touchy when you have someone with a chronic health condition that could cause a life-threatening emergency in the workplace; it's in the employee's best interest for a supervisor to know about it, but the nurse would get in trouble for disclosing that information to a supervisor because it violates HIPAA."

Lucas says she encourages such employees to discuss their health conditions with the supervisor; she sometimes is present, to provide medical information within the confines of the privacy restrictions.

The occ-health professional charged with maintaining employee health records has to learn his or her state's privacy laws as well as HIPAA privacy laws and how they dovetail or differ.

"You have to separate out workers' comp from personal and private information, and know what's OK to release under subpoena under the workers' comp system," Lucas advises. "Be very familiar with state laws. HIPAA is very specific that workers' comp and disability are not covered under HIPAA, but that the state laws and workers' comp laws would still apply. You can't just give the charts to whoever asks."

Occ-health nurses must exercise caution, even when an employee's medical condition appears

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to be common knowledge among coworkers.

"Just because HR knows what the medical condition is, the nurse still can't discuss the condition," says Lucas. "Even if the employee has told her supervisor, the nurse is still restricted only to discussing what the restrictions are, and not the 'why' of the restrictions."

Some companies have a practice of doctors' notes regarding work restrictions being given directly to the supervisor, but Lucas says her recommendation to companies she consults with is that physicians' notes need to be handed to the occ-health professional, and the nurse then sends the supervisor a form that details only the work restrictions.

"You have to remember that there is company liability at stake, and possibly personal liability, as well," she points out.

While it is necessary to keep adequate documentation to support any nursing support given to a worker, it is not necessary — or even wise — to document and record everything, says Lucas.

"If an employee comes in with an upset stomach, then pours out her soul about emotional issues, that information is confidential," she says. "The nurse should probably not document everything, but for the record would document the basic information — stomach pain, emotionally upset, stress, problems at home — no need to document that her husband was arrested for embezzlement."

More routine information should also be kept separate from the job-related information. Blood pressure checks are one example. Lucas recommends blood pressure checks be kept in a separate log, unless it becomes linked to work.

What about finding out information that has nothing to do with job performance or injury? Lucas says discoveries need to be handled on a case-by-case basis.

"Say you're in a hospital setting, and a patient contracts [tuberculosis]," she says. "You're required to report that. So what generally occurs is that you attempt to maintain confidentiality, but management has to identify who has worked with that person. Under the circumstances, it would be considered an incidental disclosure because [the co-workers] would be required to undertake TB testing."

What if, during the course of taking a patient's history for a musculoskeletal injury, among the medications he is taking is the anti-HIV drug azidothymidine. His HIV status does not affect his job or the safety of his co-workers; should that information be documented at all?

No, says **Lydell Anderson**, MD, an occupational health physician in Long Beach, CA.

"Until there is 100% assurance that an employee with HIV or a pacemaker will not be discriminated against, we must act in the best interests of our patients," he says. "Any other choice will eventually undermine their trust and prevent us from obtaining this very important information in the first place."

An employee who is visibly angry and upset could pose a potential for violence in the workplace. "That would be the most difficult scenario I could identify," says Lucas.

"If a company has an EAP [employee assistance program], then it's an easier course to take," she continues. "If not, there is an obligation to report and provide protection."

Another example given by Lucas is the employee who takes warfarin following a heart attack. She advises that the employee discuss the fact that he or she is taking the blood thinner, so that if anything happens at work, someone will be able to alert medical personnel.

Lucas says cases like these illustrate one important reason companies are hiring occupational health nurses — it's not always to treat ill or injured employees.

"Companies are hiring occupational health nurses, in part, to protect the privacy of their employees and those medical records," she says. "And it's been my experience that most occupational health nurses are doing a very good job."

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Should flu vaccine be forced on workers?

Rights, shortage lead some to say no

The severe nationwide shortage of killed flu vaccine has put a stop, at least temporarily, to initiatives in some places that would force health care workers to be vaccinated or risk their jobs,

but some health care experts warn that the solution advocated by at least one state — that health care workers forego the vaccine entirely so that more is available for higher-risk groups — could be dangerous to the very people it aims to protect.

The CDC, in recommendations updated after the news that the nation's supplies of flu vaccine would fall far short of need, advises that among the population groups that should be vaccinated against the flu are "health care workers who take care of patients."

The reasons that health care workers who are in contact with patients should be vaccinated, according to the CDC's Advisory Committee for Immunization Practices (ACIP), which drew up the vaccination recommendations, are that the health care workers are at higher risk of getting sick themselves, and because they are in contact with patients with influenza, are at a high risk of spreading the virus.

"Vaccinating a nurse or physician who is in contact with patients has a much greater effect than just the vaccination of that one individual. You don't just protect that health care worker, you protect everyone that health care worker comes in contact with. It has a very broad effect," says **Jane Siegel**, MD, a University of Texas Southwestern Medical School professor specializing in pediatric infectious diseases and an advisory member of ACIP and the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC).

'A very disappointing thing'

But the Minnesota Department of Health has determined that vaccinating healthy health care workers is not the best way to utilize the limited resources of vaccine available and has recommended that all health care workers forego the flu vaccine until the shortage is eased.

"The goal of vaccination is to prevent severe complications in those patients at the highest risk, and we didn't have enough vaccine to reach those high-risk groups and to vaccinate health care workers," says **Kristen R. Ehresmann**, RN, MPH, section chief in the Immunization, Tuberculosis, and International Health Section of the Minnesota Department of Health. "The state had to step in because the facilities that had [received their full supplies of] vaccine weren't looking at sharing to ensure that as many high-risk patients as possible were covered."

Ehresmann says the state has encountered resistance from hospitals who had vaccine and wanted to vaccinate their clinical staff.

"But we in public health had to advocate for the public health in general, not just the health of health care workers," she says.

Siegel says the approach taken by Minnesota and other areas and facilities that are not vaccinating clinicians "is a very disappointing thing."

"I don't think that was at all the intent of the CDC," she says. "It's not appropriate to encourage health care workers to not take the vaccine."

Ehresmann and Siegel agree that health care workers — such as any healthy adults younger than 50 who aren't in contact with immunocompromised patients or relatives — are good candidates for use of the inhaled vaccine FluMist.

"Use of FluMist is an alternative for anyone not working in a high-risk population, such as bone marrow transplant patients, and still preserves the killed vaccine," Siegel agrees.

Minnesota is encouraging health care workers who can take the FluMist vaccine to do so.

"And as we get more flu vaccine, as we hope to do, we'll vaccinate health care workers," Ehresmann says. "We are hoping we're asking them to merely defer getting the vaccine, not forego it entirely."

Making sick patients sicker

Unvaccinated nurses and other health care workers often are the source of influenza for their patients in health care settings. Nurses working in hospitals already strapped for manpower frequently continue to work when suffering with influenza, in an effort to not burden their co-workers.

"Health care professionals have a responsibility to receive the vaccine," says **Herman I. Abromowitz**, MD, a member of the American Medical Association board of trustees. "Health care professionals run a high risk of exposure and can transmit the virus to patients. The risks are great to ourselves, our families, and our patients."

Hospital-acquired influenza can be deadly for patients admitted with severe health problems; and in acute care hospitals, studies have shown the median mortality rate for hospital-acquired influenza is about 16%.

"Especially disheartening is the mortality reports of patients with nosocomial influenza as a result of refusal by health care personnel to have their annual required influenza immunization,"

says **Nancy Bjerke**, BSN, RN, MPH, CIC, a consultant with Infection Control Associates in San Antonio. "Some would classify this occurrence as a Sentinel Event due to willful noncompliance."

Abromowitz cites studies that indicate vaccination of health care workers in nursing homes has been associated with fewer deaths from influenza in the nursing home populations studied. For this reason, he says, "even healthy people, if they come into contact with those vulnerable [to serious flu-related complications] should receive the vaccine."

A risk secondary to transmitting the disease is the staffing burden worsened by staff who must stay home with the flu.

Because health care workers with the flu are advised to stay home when sick, the result can be added stresses to noninfected staff. The manpower shortage translates to reduced delivery of health care, and staffing shortages have been linked to poor patient outcome, Siegel says.

A just-as-unappealing alternative is that health care workers whose facilities already are shorthanded will take over-the-counter medications to ease their symptoms, and will come to work sick, risking infecting more co-workers and patients.

There currently are no states that require health care workers to be vaccinated against influenza. Massachusetts is among several states that are pushing for mass immunization of health care professionals. The NFID earlier this year issued a call for greater immunization rates among health care professionals, and the Massachusetts Department of Public Health is exploring the idea of making the flu vaccine mandatory for doctors in the state.

But even in years when the flu vaccine has been plentiful, the nationwide vaccination rate among health care workers has averaged about 38%. The reasons for the low compliance rate are the same as for the general population — from apathy, to fear of contracting the virus from the vaccine, to fear of other side effects.

Because there are no universal mandatory regulations for immunizing clinicians against the flu, mandating vaccinations has not been easy for facilities that have attempted it. While the CDC has long included health care workers on its list of those who should be immunized each year, obstacles include the individual rights of the clinicians, and questions about what happens when a the vaccine is not an option because the clinician has an allergy to eggs (flu vaccine is grown in egg media), has a history of Guillain-Barré syndrome, or is running a fever.

The vaccine shortage came along just in time to derail, at least temporarily, a fight brewing in Seattle that started when Virginia Mason Medical Center attempted to become the first hospital in the country to make flu shots mandatory for its staff and volunteers.

In eligible employees (those for whom the vaccination was indicated), compliance with the vaccination was linked to continued employment. The state nurses' union reacted swiftly, filing suit in federal court seeking to stop the vaccination program.

Virginia Mason administrators said the mandated vaccines were merely good medicine — that by requiring the vaccine, it would boost the hospital's overall vaccination rate from 55% of workers to 100%, protecting more patients.

"This new policy will save lives," **Robert M. Rakita**, MD, Virginia Mason Infectious Disease Section Head, announced in a press release in early October.

But Virginia Mason received only about one-fourth of the amount of vaccine needed, and Rakita and the hospital were forced to put their staff vaccination program on hold.

"Virginia Mason places a high value on patient safety and believes a medical center staff flu vaccination requirement can save lives," says Rakita. "But because the U.S. flu vaccine supply has been cut in half, we will not implement our 100% staff flu immunization program this year."

Precaution vs. liability

What risks are there for hospitals whose employees become ill, and what legal standing do hospitals have to require immunizations and employees have to refuse vaccines?

As far as a hospital's responsibility to protect patients and other employees from contracting the flu from a sick worker, "I think the ethical implications are that ill employees must be tested with rapid flu nasal swab, and if they are negative they work, and if they're not [negative] they do not," says **James R. Hubler**, MD, JD, clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria.

"Even universal precautions in a high-risk population may not provide enough protection," he adds. "A clinic that does not protect its patients would be at risk for lawsuits, but it would be nearly impossible to prove that they contracted the disease from a health care provider and not [out in the community]."

There is some scant case law pertaining to institutions' responsibilities should employees become ill as a result of a facilitywide immunization

process. In one case in Louisiana, *Guillory v. St. Jude Medical Center*, a hospital technician was ruled to be due worker's compensation when she developed encephalomyelitis triggered by a hepatitis vaccination administered by her employer, because the inoculation program was within the scope of her employment. In a related case in Texas, a firefighter who became incapacitated from a swine flu vaccination was awarded workers' compensation even though he received the vaccination voluntarily because his job was considered critical to the community in the event of a swine flu epidemic and the city offered the vaccine from a desire to vaccinate "critical" employees.[1]

In the case of the Virginia Mason mandatory vaccination plan, a spokeswoman for the nurses' union that represents the 600 nurses at Virginia Mason says that while nurses support the idea of vaccinations, the issue in this case is one of workers' rights.

"Federal and state law requires that if you're going to change a working condition, which requiring this vaccination is, the employer must bargain with the union," says **Barbara Frye**, BSN, RN, director of labor relations for the Washington State Nurses Association.

The CDC plans to focus attention on the health care community prior to the next flu season, in hopes education will prompt a greater number of workers who come in contact with patients to voluntarily be immunized.

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Dallas program slashes presenteeism rates

Losses to musculoskeletal disorders drop 62%

Presenteeism can seem an almost insurmountable cost of doing business, but a two-year study and project by the Federal Reserve Bank of Dallas (FRBD) shows that reducing the direct and indirect costs of a major cause of lost productivity is possible — in a big way.

The goal of the study and project, "Managing the Costs of Human Capital — Health and Produc-tivity in the Workplace," was to address the costs of presenteeism and the impact work site disease management programs could have on it. The results were impressive — a 62% reduction in the cost and effects of presenteeism in two departments of the FRBD.

The project was undertaken by the FRBD, Dallas/Fort Worth Business Group on Health, the Institute for Health and Productivity Management, and was sponsored in part by Pharmacia Corp.

"I feel that this project, more than anything, was an effort to determine the impact of presenteeism due to musculoskeletal disorders [MSDs], rather than an effort to demonstrate outcomes due to disease management," says **Bob Queyrouze**, CEBS, CCP, SPHR, manager of compensation/benefits for the FRBD. "Our initial goals were to identify the economic impact of musculoskeletal disorders among employees in two pilot departments, improve health or management of musculoskeletal disorders, and improve employee productivity."

The stated goals of the project were to improve employee understanding of presenteeism, increase healthy behaviors, and improve employee/physician communication, with the underlying message that presenteeism costs employers more than absenteeism.

The study cited national studies that have

estimated the cost of absenteeism nationally at 2.5 billion days and $234 billion each year in lost productivity.

Because MSDs top the list of the seven most common conditions impacting work and productivity (the other six are respiratory disorders, migraines, hearing problems, vision problems, diabetes, and depression), the Federal Reserve project chose as its goal to identify the economic impact of musculoskeletal disorders at the FRBD, and to improve the health of its employees with MSDs.

The Federal Reserve is the nation's central bank, and the Dallas office employs 1,000 people. The FRBD study targeted two of its departments — the cash department, with 49 employees, and the payment services (checks) department, which has 266 employees.

Beginning with calculations of the baseline impact of MSDs on the two departments, the findings were sobering. Lost productivity costs to the two departments amounted to an estimated $532,338 for the year 2000 (not counting direct medical costs), equal to 6% of the departments' payroll, and a per-employee cost of $2,572 per year. **(See Table 1 for a breakdown of costs before the study, right.)**

TABLE 1: Economic Impact of MSDs on FRBD Departments (For Year 2000)

Direct Impact

Medical claims	$19,812
Medication claims	$14,019
Workers' comp	$98,421
Total	$132,252 (more than 1% of total payroll)

Indirect Impact

Payments department	50% of employees	$474,918 in lost productivity
Cash department	26% of employees	$57,419 in lost productivity

Source: Federal Reserve Bank of Dallas.

TABLE 2: Effectiveness of Initiatives

	Productivity loss pre-program	Productivity loss post-program
Cash department	3.9%	1.7%
Payments department	9.4%	3.5%
Totals	8.3%	3.0%

Source: Federal Reserve Bank of Dallas.

The study used a questionnaire designed by the Health Institute of the New England Medical Center at Tufts University in Boston. The questionnaire measured employees' health, how it affected their ability to go to work, and how it affected their job performance. Employees were given the option of registering responses via paper questionnaire, voice response, or on-line; 87% chose the on-line route.

Once the baseline data were in, the second phase of the project aimed to design and implement interventions to address the problems. The interventions included addressing the health needs of both high-risk and low-risk employees; encouraging and facilitating healthy behaviors, educating employees about MSDs, and improving communications between employees and their health care providers.

Phase three consisted of follow-up interview and assessment of the effectiveness of the intervention.

Follow-up assessment of the employees who participated in the program indicate the project had profound effects on loss of productivity due to MSDs. **(See Table 2, above.)** The two departments went from a combined productivity loss of 8.3% to a combined productivity loss of 3%; costs of lost

productivity went from $532,388 to $201,550.

"I believe we were successful in achieving all three of our goals as a demonstration project to support other disease management efforts we wanted to engage," Queyrouze says. "We clearly had an impact on presenteeism because we reduced its impact by 62%, documented through our resurvey effort at the end of the project.

"While we have no direct measures of improved employee health and management of musculoskeletal disorders, the follow-up presenteeism survey documented increased productivity. This was a three-year project and, unfortunately, during that period of time the largest department — checks — underwent significant changes in structuring and staffing, which has led to difficulty with continuing the work we began."

Some of the behavior modifications employees reported using to improve their musculoskeletal health are exercise, stretching, relaxation, seating and workspace modifications, and improved communications with their medical providers.

"Since the completion of this project, we have engaged three additional chronic diseases through programs in the workplace — weight management, diabetes, and metabolic syndrome," says Queyrouze. "All of these programs are supported through bank subsidies in one way or another — weight management through subsidy of Weight Watchers at Work, diabetes through free diabetic meds and supplies and on-site diabetic educator meetings, metabolic syndrome through a subsidized, on-site, six-week program called the Game of Health.

"All of these programs are performance based. Employees are required to meet specific requirements to qualify for subsidies or meds and supplies."

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Eating at your desk? Disinfectant is in order

Desk areas have more germs than toilets

Employees might save some time during the workday by having lunch at their desks, but they could pay for it by making themselves sick. According to a study released by the University of Arizona, the typical office desktop has more germs per square inch than the average toilet seat.

"We don't think twice about eating at our desks, even though the average desk has 100 times more bacteria than a kitchen table and 400 times more bacteria than the average toilet," says **Charles Gerba**, PhD, an environmental virologist with the University of Arizona. "Without cleaning, a small area on your desk or phone can sustain millions of bacteria that could potentially cause illness."

Talking dirty

The worst offender on the typical desk is the telephone, the Arizona team found. According to the study, the typical desktop had 20,961 germs per square inch. Phones have up to 25,127 germs per square inch; keyboards can contain 3,295 germs per square inch; and computer mice 1,676 per square inch.

The average toilet seat, surprisingly, is more germ-free, averaging 49 germs per square inch.

"Desks are really bacteria cafeterias," says Gerba.

His study, funded by cleaning giant The Clorox Co. in Oakland, CA, examined typical office sites in locations across the country. Each office included cubicles, open spaces, and private offices. One common feature was that cleaning routines were often limited to vacuuming and emptying trash and cleaning bathrooms (hence the relative cleanliness of the toilet seats), with little or no attention to desks.

During the three-month study, one group of office workers at each location was asked to clean their desks with disinfecting wipes. The other group left theirs alone. Bacterial samples were taken several times a day from just about every surface, handle, and knob.

Employees could be saved sick time by merely keeping a disinfecting cleaner nearby. Gerba's study showed that the desks that were cleaned daily with disinfecting cleaner saw a 99.9% decrease in germs. In work areas where cleaning wasn't performed, bacteria levels increased 19%-31% every day.

Gerba says the study indicates benefits of companies paying for individual desk cleanings, or at least supplying employees with disinfecting cleaners and instruction on the benefits of using them — and cold and flu season is a good time to start.

"When someone is infected with a cold or flu bug, the surfaces they touch during the day become germ transfer points because some cold and flu viruses can survive on surfaces for up to 72 hours," Gerba points out.

Cleaning up desk spaces doesn't appear to be a common habit among office workers, according to the Washington, DC-based Soap and Detergent Association (SDA), which conducts periodic surveys about cleaning habits. According to the SDA, 46% of Americans surveyed said they do not clean their desks before eating there; women are more likely to clean their desks before eating than are men.

So how can you help the people you work with lessen the likelihood that their desks will make them sick? The SDA offers theses suggestions:

- Consider providing each of your employees (or each floor or section) with personal cleaning supplies such as wipes, sprays, and disinfectants to keep their personal environments clean and healthy.
- Post signs encouraging frequent hand washing. A 2001 SDA survey found nearly three-quarters of offices and customer service facilities do not post signs reminding their employees to wash their hands.
- Send an officewide e-mail encouraging hygienic activities at work and at home, to help prevent sickness for themselves and others.
- Always ensure restrooms and kitchen areas are supplied with enough and proper cleaning products for hands and surfaces, including disinfectants and multisurface cleaners.

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Reducing Hispanic on-job death rate

Construction industry rallies

It's the kind of story the U.S. Department of Labor (DOL) realizes is told too often, but advances in the past year brings hope that it's a story that will become less familiar.

Juan Calixtro, a 27-year-old man from central Mexico, was hoping to earn money so he could support his elderly mother and someday get married. He traveled from his rural village to find work in the United States. He quickly found a job at a residential construction site in Texas. Much of his $7-an-hour salary was sent home to his mother. Four months later, in late 2004, he was killed when a forklift he was working near toppled.

Calixtro's case illustrates a statistic the DOL hopes to reduce: the number of foreign-born Latino workers who die or are injured while working in the United States. Limited education, poor English skills, and sometimes-illegal immigration status conspire to put these workers at risk, according to Bureau of Labor Statistics (BLS) studies.

According to the BLS, from 1997 to 2002, total fatalities in the construction industry rose by slightly more than 1%. During this same period, the number of Hispanic fatalities in the industry shot up by almost 50%. Foreign-born Hispanic workers are more likely to die than Hispanics born in this country.

Feds, business taking steps

The Hispanic death rate on the job has at least slowed. **John Miles**, OSHA regional administrator in Dallas attributes a dip in the last year, along with a 15% decrease in the number of all work-related deaths in Texas and its four surrounding states so far this year, to its aggressive outreach to Hispanic workers.

The DOL and OSHA, in conjunction with Latin American consulates and other community, faith-based, and governmental organizations, launched the Justice and Equality in the Workplace Program in 2001, to educate workers on their rights and responsibilities, as well as provide an avenue for non-English speakers to report violations of laws enforced by OSHA, Wage and Hour Division, and Office of Federal Contract Compliance.

"Recently, 13,000 construction workers at the $3 billion expansion of the Dallas-Fort Worth International Airport completed a 40-hour health and safety course," Miles says. "Some of [the training] was tougher than what OSHA requires."

To reach the 7,000 Hispanic employees who don't speak English and often can't even read or write in Spanish, the course training relied heavily on pictures and hands-on training, he adds.

The injury rate at the DFW airport is 70% below a typical construction job of that size, he

points out, and employers at the site have saved about $5 million in state workers' comp claims.

U.S. Secretary of Labor Elaine L. Chao and Secretary for Foreign Affairs of Mexico Luis Ernesto Derbez in mid-2004 signed a joint declaration of commitment to improve compliance with and awareness of workplace laws and regulations protecting Mexican workers in the United States.

One of the priorities of the DOL's Wage and Hour Division is to increase worker protections in the low-wage industries that often employ high numbers of Hispanic workers.

"Through the end of the first half of the fiscal year [2004], the Wage and Hour Division collected just over $18.3 million in back wages for nearly 31,000 workers in key low-wage industries that typically employ large numbers of Hispanic workers," according to **Victoria A. Lipnic**, Assistant Secretary for DOL's Employment Standards Administration.

OSHA has more than 140 Spanish-speaking employees, including Hispanic coordinators in each of its 10 regional offices and has created a Hispanic Taskforce. The agency has also established partnerships or working relationships with the Hispanic Contractors of America, the National Safety Council, the Mexican consulates, the Mexican government, and many other organizations to work together on outreach, education and assistance. The agency offers a toll-free help line [(800) 321-OSHA] that provides assistance in English and Spanish; a Spanish web page that is continually updated; and many documents and publications available in Spanish. For more information, you can contact the DOL, Employment Standards Administration, at (866) 4-USA-DOL or visit the web site at www.dol.gov/esa.

The program already has begun to pay dividends. The Houston Justice and Equality in the Workplace Program, which was created in July 2001, has already aided the Wage and Hour Division to recover over $1.3 million in back wages for 1,900 workers as the result of investigations initiated by referrals from the partnership. Nearly 70% of all calls at the Houston program were referred to the Department of Labor.

"Our overall goal is a 15% reduction of all fatalities [for all workers] over the next five years," says Miles. "With the immigrant worker population representing a quarter of that number, this will make a big difference."

The American Society of Safety Engineers Los Angeles Chapter, along with the newly formed Safety Professionals and Latinos in the Workplace, convened the first "Safety for Latinos in the Workplace" conference in November, aimed at offering practical insight and tips into the Latino work force, including safety problems and ways to communicate information to this population, the latest resources available to the Latino work force, and up-to-date information from OSHA and the National Institute of Occupational Safety and Health.

Speak the workers' language

According to OSHA's interpretation of regulation 1910.1200(h), when employers have a training requirement, they must provide it in a language the worker can understand. Teaching in the appropriate language, however, is only the beginning. Successful training of Latino workers must be sensitive to differences in culture and education that distinguish Latinos from other workers — and that even divide Latinos among themselves. But to truly affect workers' behavior and attitudes requires more than mere fluency in the language.

"We recruit instructors who are from the ethnic groups we are training," explains **Joseph Halcarz**, president of BEST Institute, the Texas company that developed the training program for DFW airport workers. Instructors and curriculum developers are bilingual, and many have worked in construction themselves.

And the efforts are not only centered in the Southwest, the region with the largest concentration of foreign-born Hispanic workers.

Patricia Clark, OSHA's regional administrator in Buffalo, NY, says her office has allied with HUB Inc., a nonprofit corporation providing bilingual, bicultural assistance to Hispanic residents in that area.

"We will reach out to build trust, raise awareness, and educate employers and workers about safety and health," promises Clark. "We recognize the value of a collaborative relationship in achieving these goals."

[For more information, contact:

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*• **Joseph Halcarz**, President, BEST Institute Inc., Garland, TX. Phone: (972) 926-9390.*

*• **John Miles**, Regional Administrator, Occupational Safety and Health Administration-Dallas, TX, 8344 E. RL Thornton Freeway, Suite 420, Dallas, TX 75228. Phone: (214) 320-2400.]* ■

Safety management certification offered

Got safety duties? Get certification

Occupational health nurses who spend a large part of their workday dealing with safety activities soon can be certified in safety management, to demonstrate competence in the field of safety and promote career development for certified occupational health nurses in an expanded role.

The new certification was announced recently following three years of study and development by the American Board for Occupational Health Nurses (ABOHN) and the Board of Certified Safety Professionals (BCSP), and becomes available in 2005. The examination that resulted from the study is designed to test the significant knowledge, skills, and abilities of occ-health nurses with safety responsibilities.

The certification carries the designation of COHN-S/SM or COHN/SM, or if the ABOHN case management credential also is held, COHN/CM/SM or COHN-S/CM/SM.

ABOHN executive director **Mary C. Amann**, RN, MS, COHN-S/CM, FAAOHN, says the new certification "will be of great value to occupational health nurses in industries such as health care, manufacturing, and others where they have assumed responsibility for safety due to blending of departments and roles."

The computer-based examination, which consists of 200 multiple-choice questions, will be available starting in April, and will be administered at Thomson Prometric testing centers throughout the United States and internationally.

To be eligible for the new certification, the candidate must have a COHN or COHN-S core credential; be in a professional position that includes at least 25% safety activities; have 50 contact hours of safety-related continuing education; and have 1,000 hours of experience in the most recent five years.

A self-assessment test and reference list became available in December. Application for the safety management exam may be made directly to ABOHN, and is available on-line at www.abohn.org after Jan. 31.

ABOHN's goal in development of this credential is to provide evidence of competency for certified occupational health nurses in a safety role and to promote career opportunities and professional advancement in health and safety, according to Amann.

"Occupational health nurses bring a strong health-related perspective to the role of safety management, resulting in a very holistic approach to workplace health and safety," she adds.

The new credential may provide a career path to the Certified Safety Professional (CSP) credential. ABOHN Safety Management specialty credential allows those who apply for and pursue the CSP to achieve a waiver of BCSP's Safety Fundamentals examination. Applicants for the CSP must meet all other requirements for earning the CSP credential.

CSP is a title or designation awarded by the

COMING IN FUTURE MONTHS

- Helping employees work through chronic pain
- Keeping moms fit
- Diagnosis and management of occupational asthma
- Partnering to reduce strokes and heart attacks

BCSP to individuals who meet the standards for a safety professional established by BCSP and continue to meet annual renewal and recertification requirements.

[For more information, contact:

*• **Mary C. Amann**, RN, MS, COHN-S/CM, FAAOHN, Executive Director, American Board for Occupational Health Nursing. Phone: (630) 789-5799. Web site: www.abohn.org.*

*• **Board of Certified Safety Professionals** (BCSP), 208 Burwash Ave., Savoy, IL 61874. Phone: (217) 359-9263. Web site: www.bcsp.org/bcsp/index.php.]* ■

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.

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 **June** 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.

1. In facilities where the supply of killed flu vaccine is inadequate to cover high-risk patients and healthy employees, those healthy employees who are younger than 50 years and are not in contact with immunocompromised patients or relatives should consider FluMist as an alternative.

A. True
B. False

2. A study and intervention program conducted at the Federal Reserve Bank of Dallas resulted in a 62% reduction in presenteeism costs for employees who suffer from:

A. Migraines
B. Respiratory diseases
C. Musculoskeletal disorders
D. Diabetes

3. In Gerba's study of germs in the office, he showed that desks that are cleaned daily with disinfecting cleaner see a 99.9% decrease in germs, while work areas where cleaning isn't performed, bacteria levels increase 19%-31% every day.

A. True
B. False

4. From 1997 to 2002, total fatalities in the construction industry rose by slightly more than 1%. During this same period, the number of Hispanic fatalities in the industry shot up by almost:

A. 20%
B. 30%
C. 40%
D. 50%

Answers: 1-A; 2-C; 3-A; 4-D.