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Occ-health psychology looks at mental health needs of workers

Well established in Europe, OHP gaining notice in United States

It has been 17 years since the National Institute for Occupational Safety and Health (NIOSH) formally recognized psychological disorders as a leading occupational health risk, but getting American businesses to accept the benefits offered by occupational health psychology (OHP) may take longer than that.

Through the initial efforts of NIOSH and the American Psychological Association (APA), graduate psychology programs at a dozen U.S. schools now offer concentrations in OHP. The term "occupational health psychology" is becoming more familiar in the workplace, but because the benefits don't show up on earnings reports right away, U.S. business is warming slowly to the notion that preventive workplace mental health can pay off.

"The ultimate goal of occupational health psychology is a healthy workplace, and a healthy workplace guarantees a high-performance organization," says **Peter Y. Chen**, PhD, industrial/organizational (I/O) psychologist and associate professor at Colorado State University's department of psychology in Fort Collins.

Promoting the mind/body/bottom-line connection

In 1990, two years after NIOSH formally recognized psychological disorders as occupational health risks, APA and NIOSH formed a partnership to promote the new discipline of OHP. This was followed in 1994 with a joint funding of seven postdoctoral positions in occupational psychology at Duke University Medical Center, Wayne State University, and Johns Hopkins University, and in 1998 with funding for 12 universities to develop and implement OHP curricula for graduate students.

The idea, new to the United States, is well established in Europe, where "work psychology" is as common a term there as "workers' comp" is here. Interest in the field in the United States grew along with the workplace, according to **James A. McCubbin**, PhD, professor and chair of the psychology department at Clemson (SC) University.

"Occupational health psychology is an interdisciplinary field that has developed from overlapping interests — industrial-organizational, personnel

psychology, and clinical psychology," he explains. "Part of what has stimulated interest and market demand [for occupational health psychology] has been the evolution of the workplace over the past 30 years."

McCubbin cites changes such as the role of women in combat support roles in the military, growth in gender and minority diversity, and demands of the work environment as fuel for increased psychological demands on workers and, consequently, efforts by occupational health and psychology communities to help.

Ronald G. Downey, PhD, psychology professor at Kansas State University, says his school established its certificate program in OHP in 2000, but only in the past year has it developed a market.

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"It's a new program [at KSU] in a new field, and so it takes some time," he says.

Not just stress

Corporate downsizing and organizational changes in most workplaces have created new sources of psychological stress for workers, but OHP is not just about stress.

"It's a variety of health-related issues in the workplace, ranging from substance abuse to enhancing employee assistance programs, anticipating and dealing with mental health issues," McCubbin says. "It's about the effects of psychological and organizational factors on physical health."

NIOSH, in pushing for the creation of the OHP concentration of studies, was responding to psychologists who argued that the psychology field needs to take a more active role in research and practice to prevent occupational stress, illness, and injury. Research and practice in OHP may cover a wide range of topics, but NIOSH has urged that the relatively new field give special attention to the primary prevention of organizational risk factors for stress, illness, and injury at work.

This viewpoint is expressed in the NIOSH-proposed definition of OHP: "OHP concerns the application of psychology to improving the quality of work life, and to protecting and promoting the safety, health and well-being of workers." The notion of health "protection" in this definition refers to intervention in the work environment to reduce worker exposures to workplace hazards, while health "promotion" refers to individual-level interventions to equip workers with knowledge and resources to improve their health and thereby resist hazards in the work environment.

Although both of these types of interventions can be defined as primary prevention, the NIOSH-proposed definition places priority on health protection, Chen says.

OHP addresses both prevention and psychological issues as they arise, but Chen says the most common U.S. specialist in OHP is trained in I/O psychology, and would therefore be more concerned with intervention and prevention.

"We would not go into tertiary counseling therapy or hospital treatment," he says. "That would belong to the clinical psychologists."

Some OHP graduate programs are imbedded in universities' clinical psychology programs, however, and so treatment would be more of a factor with those specialists, Chen notes.

"Occupational health psychology is especially concerned with the dramatic transformation of work and employment that has been under way in industrial economies since the 1980s, and how changing organizational structures and processes are influencing the health and well-being of workers and their families," McCubbin says.

"All these change in the work environment have created a number of sources of occupational stress, and we're coming to widely appreciate that these types of psychological factors can have a palpable effect on workplace productivity, from absenteeism due to health reasons to diminished performance and capacity to effectively carry out one's job mission."

Prevention and maintenance

While occupational health nurses and physicians tend to the physical aspects of workplace injury and illness, psychologists trained in OHP can deal with the related issues of compliance, rehabilitation, and the effects of chronic pain.

"Occupational health psychology covers a lot of areas relating to safety procedures and compliance — how to get people to follow directions and use safety procedures," says McCubbin. "It also covers reintegration into the workplace after an illness. People are living longer and staying in the workplace longer, so there are issues relating to chronic illnesses, like blood pressure and glucose control."

Helping workers cope with psychological issues relating to chronic pain is a major focus of OHP. The depression and stress that can accompany chronic physical pain is a serious cause of health-related productivity loss, McCubbin adds.

"Lower back pain is a great cost to employers, and it's an area psychology has a lot to say about."

But he agrees with Chen that OHP's greatest impact is probably on prevention.

"As insurance and actuarial figures come in on that, it supports the role of workplace wellness and how it can provide significant savings in the long run," he says. "Educating employees about why they should follow safety rules, and dealing with the psychological factors that influence them to follow those rules, saves a lot more than waiting until something happens and dealing with it then."

But business being business, both Chen and McCubbin say workplace psychology can be a hard sell to business owners.

"Human beings are the assets of any organizations, and if you have lot of unhealthy people, physically or psychologically, you won't create a high-performance organization in the long run," says Chen. "But the benefits [of OHP] can't be seen in the short range. They can't be seen from accounting immediately, within a year or two. It's a long-term process."

Chen says employers in areas that require high degrees of safety consciousness — construction, for example — are more aware of the benefits of preventive occupational psychology.

"But I am not quite positive that they belong to the majority," he says.

Career choices

OHP concentrations minors, or majors are offered at Bowling Green State University, Clemson University, Colorado State University, Kansas State University, Portland State University, Tulane University, University of California at Los Angeles, University of Connecticut, University of Houston, University of Minnesota, University of South Florida, and University of Texas at Austin.

The programs range from graduate minors as part of existing I/O and clinical psychology programs; concentrations within master degree programs; and full interdisciplinary master of science and PhD degrees.

The core curricula in these training programs usually include course work covering a survey of occupational safety and health; job stress theory and mechanisms; organizational risk factors for occupational stress, injury, and illness; health implications of stressful work, including physical and psychological, health, and economic outcomes; organizational interventions (e.g., work redesign) and programs (employee assistance programs, work-family programs, etc.) for reduction of occupational stress, injury, and illness; and research methods and practices in public and occupational health and epidemiology.

Other themes that are included in some programs include the macroergonomics of hazard management and musculoskeletal disorders, gender discrimination and workplace civility, rest break schedules during computer-mediated work, health psychophysiology of work teams, and utility analyses for OSH programs.

But what do graduates do with all this new, cutting-edge knowledge?

"That's really hard to answer," says McCubbin. "We envision there's a need, that there has to be a parallel evolution in the job market. What's happening in this market is that this specialty is

being brought into the traditional I/O career paths as an additional area of expertise, and expands [graduates'] effectiveness."

While work psychology is a full specialty in Europe, OHP still is a subspecialty of clinical, social, or I/O psychology in the United States, he says. "My belief is that if our I/O grads, as they enter the job market because they have this OHP training in additional to traditional I/O psychology training, will be viewed favorably in the job market."

Downey said the students who pursue the graduate certificate at KSU, offered as a distance learning program, are either already established in their careers or are in graduate programs in psychology or counseling, and want to build on that.

"One of our students has a masters in counseling and is using [his OHP training] in terms of vocational counseling and advice to clients about health issues in the workplace," Downey says. "Another student is a lieutenant commander in the Navy and is doing the program to help her understand and establish policies and procedures on health issues for the Navy."

Some programs steer their graduates into academia.

"Our program is new and we have not had any graduates yet, [but] research universities like this one are most interested in graduates becoming academic researchers, and that is certainly a goal," says **Charles J. Holahan**, PhD, professor in the University of Texas at Austin's psychology department. "I envision that some students will also go into applied work either as independent consultants [e.g., stress management] or within larger occupational settings [e.g., wellness programs]."

Chen says the addition of OHP studies broadens the career horizon for Colorado State I/O psychology graduates.

Besides slow acceptance within the business community, OHP met with some early resistance from the traditional I/O discipline.

"There is some inertia in the disciplinary fields, some natural inertia that must be overcome as this field matures," McCubbin says. "At this point, [OHP] is really interdisciplinary, and not encapsulated on its own as much as it is bringing another layer of expertise to the I/O discipline."

For information and links to the OHP programs offered at U.S. universities, visit the NIOSH web site at www.cdc.gov/niosh/ohp.html.

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Smoking among nurses is a workplace issue

One group wants to help nurses kick the habit

Nurses sometimes fail to intercede with patients about cigarette smoking because they haven't been trained in how to effectively do so; or, they may not intercede because they themselves are smokers unable to break the habit.

The Tobacco-Free Nurses Initiative (TFNI) is providing nurses tools to address both problems, and research has provided much new information on women and tobacco use, according to **Linda Sarna**, RN, DNSC, FAAN, lead investigator for TFNI and a professor at the University of California-Los Angeles (UCLA) School of Nursing.

"Nurses describe becoming addicted when they were very young," she says. "Then, coming into schools of nursing and going on to employment, quitting was very difficult and they didn't have support available to them to help them quit."

Much of what Sarna has learned about nurses and smoking came from a study she and other researchers from UCLA's Jonsson Cancer Center conducted, in which they talked with smokers, nonsmokers, and former smokers in the nursing profession.

What they found was that smoking is a workplace issue, not just an individual behavior.

Smoke breaks, or no breaks

Sarna said that in the sometimes grueling schedule of a hospital nurse, the only available excuse to leave the floor for a break was to satisfy a craving for nicotine.

"Smoking among nurses was described as an integral part of their work routine, affecting management of patient care and timing of breaks," the study states. "The perception that smokers take more and longer breaks and were less available for patient care was an important theme in discussions with both smokers and former smokers, and clearly created conflict in the work environment."

Sarna said some nurses told her that the only breaks they get are smoking breaks. "One critical care nurse, a nonsmoker, told us that she never gets a break, that only the smokers got a break because they needed it," she said.

This line of thinking leads in some cases to "war between smokers and nonsmokers," Sarna said, because it causes a perception that the smokers, because they take breaks, are less involved in patient care. The smokers, however, contend that they get just as much work done and are more organized because they don't want anything to interfere with their smoke breaks.

Smoking among nurses affects interactions with patients, Sarna says. Nurses who smoke are less likely to intervene with patients who smoke, and they experience a high degree of shame and guilt about their smoking, taking steps to try to hide the evidence of their smoking, such as repeated brushing of teeth, frequent hand washing, and wearing cologne.

The study shows the need to develop work-based strategies and programs to support cessation efforts.

"The benefits of supporting smoking cessation in the worksite could have an immediate positive impact on nurses' health, and might result in other positive outcomes (e.g., reduced sick time)," the study concludes. "The benefit to patients must also be emphasized, as nonsmoking clinicians are more likely to provide cessation interventions than their smoking counterparts."

Research leads to on-line help site

While the majority of nurses do not smoke, Sarna said, about 16% of the 2.3 million nurses in the United States do smoke, the highest rate among all health care professionals.

Compounding the problem is the lack of support for cessation programs. Nurses are often too embarrassed to admit their smoking habits, so do not seek out cessation programs if they are offered at the workplace.

What Sarna and the other Jonsson researchers found led to the creation of a web site, www.tobaccofreenurses.org, a resource for cessation programs, evidence-based facts about smoking and cessation, and 24-hour support for nurses wanting to quit the habit.

"Nurses are working in a very stressful environment, and that makes it even more difficult to quit," says Sarna.

Armed with evidence that nurses provide their peers with the best support in efforts to quit smoking, tobaccofreenurses.org provides facts, downloadable brochures, and a link to Nurses QuitNet, a site affiliated with Boston University School of Public Health that provides on-line support and community for nurses who want to quit smoking. The free service allows nurses to create their own quit smoking plan, get advice from experts, and peer support from other nurses who are quitting or have quit.

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Do things right, and return to work won't go wrong

Employers can take steps to avoid mistakes

When an employee is out of work for an extended period with an injury or illness, his or her absence creates a physical and emotional void. The work needs to be done, and coworkers and supervisors look forward to the employee's return. That is, unless the employee isn't really wanted back.

While a boss might think that preventing an employee from returning from leave is a convenient way to terminate employment, it could be the first steep step into a lawsuit, according to **Jeffrey M. Tanenbaum**, JD, a San Francisco-based

attorney specializing in employment law and occupational safety and health administration law.

Tanenbaum says his clients — employers — encounter problems not because they want to get rid of employees because of their injuries or illnesses, but because of performance problems that existed before the worker went on leave.

"When you have someone who simply has not been a good performer, forgetting about the injury or illness, the employer needs to deal with [the poor performance]," he explains. "And the best way to deal with it is to have documented it before the employee ever went out on leave."

Otherwise, if the employee comes back and the employer chooses that point to tell the employee that his or her performance is not working out, "the timing looks suspicious to the employee and to any judge who might hear the complaint," Tanenbaum pointed out. "Even if the employer's intentions are good, you can get into trouble if you haven't documented."

Reasons to complain

Employees terminated during a leave, or who feel their right to return is not being honored, can lodge a grievance for several possible causes, including:

- The Americans with Disabilities Act prohibits adverse action against an employee who is able to perform the essential functions of his or her job "with reasonable accommodation," which can include a reorganized work station, reduced hours, or a flexible break schedule.
- The Family and Medical Leave Act prohibits employers' interfering with guaranteed family or medical leave, and prohibits retaliation against employees who take advantage of leave.
- An employee who files a workers compensation claim cannot be terminated because of that claim. The penalties for such termination can be costly.
- Violation of the implied contract in the employer's internal policies.
- Violation of a written contract or collective bargaining agreement.

An offer the employee can't refuse?

An option an employer can use is to provide a severance package to the employee, in exchange for release of all claims against the employer, Tanenbaum says.

On the one hand, an attractive severance package gives the employee the opportunity to find a new job while drawing a salary — "an extended vacation, if that's how they want to view it," he says.

"The downside is the moment you start talking about severance, in their mind, they no longer have a job. They might very well start thinking about a lawsuit because they're not being provided with their rights to return under the law."

Disputes over wrongful termination relating to employee leave are common, but they commonly are settled before ever going to trial. Proactive steps, which Tanenbaum says "are just good HR [human resources]," and can avoid disputes later on.

When the job or worker has changed

Another issue that can arise when it's time for an employee to return to work is when there's no job to come back to.

"What do you do when the workplace has changed while the employee has been off? For the most part, the law gives employers additional discretion if the job the employee left has been eliminated as part of a layoff," said Tanenbaum. "However, the employer will still be scrutinized for a nook job that person could fill."

In other cases, it's the employee who has changed.

"I recently had a case in which a senior executive was in a car accident and sustained a severe head injury," Tanenbaum recalls. "When he returned, his ability to concentrate was limited, his cognitive abilities were severely impacted, and he was no longer capable of serving in an executive capacity."

This person was fortunate — his company found another position for him and is supportive as he struggles with memory lapses that cause him to forget he's no longer a senior executive.

A situation like this could prove to be a hardship for some employers, but Tanenbaum says the law expects it to be.

"It's a cost-shifting set of laws," he says. "They simply put the burden on the employer to bear that, and with more than 10 or 20 employees, it's hard to show that it's a hardship. Certainly, with larger employees — 100 or 200 employees — it would be incredibly hard to show hardship."

Employers inadvertently can give employees a wrongful discharge claim by making certain promises in their return to work policies and then violate them.

"They have written extensive policies that go beyond the legal requirements, and then they don't follow their own policies," Tanenbaum says. "Handbook policies are as enforceable as some statutes."

He says employee policies, whether they address human resources issues or safety, should be written as required by law.

"And if you add any extras, you'd best do what you say you are going to do," Tanenbaum says.

Another fairly common mistake employers make that can come back to haunt them when an employee goes on leave is neglecting to include a cutoff date for certain types of leave. Workers' compensation is not subject to preset cutoff dates, but other types of leave — maternity leave, for example — should have cutoff dates specified.

"Sometimes the policy is not written well enough for employers to say, 'You have no more leave,' and you can't get them back to work; it's like the reverse of return to work," Tanenbaum says.

Another hot-button issue for employees and employers in return to work situations is when employers are required to make "reasonable accommodations" to allow the employee to resume his or her job.

"The Americans with Disabilities Act or state law will say you must accommodate that employee, whether it is a change in the work station to accommodate a disability, a computer with dexterity assistance, aids for vision or hearing loss," Tanenbaum explains.

When faced with making accommodations for an employee's return to work, employers need to "engage in an interactive process to determine what a reasonable accommodation would be," he says. "There are a lot of reasonable accommodations readily available, and they are affordable — many cost less than $1,000. It's hard for an employer to say that's a hardship."

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HIPAA not always is applicable to occ-health

Know what's protected

[In the January issue, Occupational Health Management *presented some of the privacy issues that can arise when dealing with employee health records.* OHM *editorial advisory board member **Deborah V. DiBenedetto**, MBA, BSN, COHN-S/CM, ABDA, FAAOHN, past president of the American Association of Occupational Health Nurses and a nationally recognized consultant on occupational health issues, provides more information on the relationship between the Health Insurance Portability and Accountability Act (HIPAA), employee health records, and the occupational health nurse.]*

HIPAA's privacy requirements, which went into effect in their current form in late 2002, can present challenges to the occ-health professional, because while HIPAA does not regulate employers or employment-related health or occupational health records, it does regulate the employer's health benefit plan, according to **DiBenedetto**, a Michigan consultant.

"While workers' compensation, occupational injury or illness evaluation, and employment-related medical records are exempt from HIPAA, there continues to be great concern about managing occupational health and related injury, since many physicians are refusing to release medical information, stating that HIPAA does not allow the release of protected health information [PHI]," she explains. "There are numerous reports of occupational health nurses and case managers who say they just cannot get the necessary medical information from doctors in their community, and they are spending inordinate amounts of time trying to navigate this issue."

HIPAA authorization important

DiBenedetto points out that a key tool for the occupational health professional who deals in employees' PHI is a HIPAA-compliant authorization, which allows the exchange of medical information between an employee, his or her medical provider, and the occupational health professional. **(See form, p. 32.)**

According to DiBenedetto, employers are entitled to know employees' fitness for duty, their need for accommodation or restricted work, and what those restrictions are. The Americans with Disabilities Act (ADA) and

(Continued on page 33)

Sample HIPAA Compliant Authorization

Employee Authorization for Disclosure of Protected Health Information

ABC Corporation

I, (Print Employee Name)_____ hereby authorize the use or disclosure of my health information as described in this authorization.

1. I authorize the following person, professional, organization and/or class of individuals to provide the information:

_____

2. Specific person/organization/or class of persons authorized to receive and use the provided information:
Name/Title: _____
Address: _____
City/State:_____ Zip:_____ Telephone:_____

3. Information to be released:
- ❑ Pre-Placement Medical Exam Results
- ❑ Drug Testing Results
- ❑ Driver Qualification Medical Exam Results
- ❑ Fitness for Duty Exam Results
- ❑ Medical Records Relating to one or more of the following benefits:
  - ❑ FMLA ❑ STD ❑ LTD ❑ ADA ❑ Medical/Health Surveillance ❑ Other Benefit
- ❑ All medical records including results of exams, laboratory tests, imaging, etc.
- ❑ All medical information, exam and lab results pursuant to a work-related/occupational injury or illness/workers' compensation claim. Date of injury: _____
- ❑ Other _____

4. Purpose of the request: ❑ To determine fitness-for-duty ❑ Benefit determination ❑ Regulatory compliance
- ❑ At the request of the individual ❑ Determine current medical status and/or return-to-work capability
- ❑ Other_____

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying ABC Corporation in writing at: _____ to the attention of _____ . I understand that the revocation is only effective after it is received and logged by ABC Corporation and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive ABC Corporation benefits affected by this revocation (Optional Statement in Italics)

6. I understand that after this information is disclosed, federal law may not protect it, and the recipient may redisclose it.

7. I understand that my initial and continued employment and position are subject to my agreement to this authorization and any additional authorization ABC Corporation requests. (Optional statement)

8. I understand I am entitled to a copy of this authorization.
I am requesting a copy of this authorization ❑ *Yes* ❑ *No - If Yes, I have received a copy*_____ *(initial)*

9. I understand this authorization will expire when my employment with ABC Corporation terminates.

Signature of Employee _____ Date _____

Personal Representative Section:
If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of _____

Source: Sample HIPAA Compliant Authorization, DVDiBenedetto & Associates Ltd./DVD Associates LLC.

Transferring personal health information

Under HIPAA, a transaction of information between two parties for the purpose of carrying out financial or administrative activities related to health care can include the following types of transmission:

- health care claims or equivalent encounter information;
- health care payment and remittance advice;
- coordination of benefits;
- health care claim status;
- enrollment and disenrollment in a health plan;
- eligibility for a health plan;
- health plan premium payments;
- referral certification and authorization;
- first report of injury;*
- health claims attachments;*
- other transactions that may be prescribed by regulation.

*Currently, HIPAA has stayed, or delayed implementation of, first reports of injury and health care claim attachments as covered HIPAA transactions. *Note:* Although an occupational health nurse may fax or electronically transmit a first report of injury, doing so does not make him or her a "covered entity" under HIPAA. This transmission generally is related to the physician's first report of injury for which the physician will receive payment for services rendered. ■

the Family and Medical Leave Act (FMLA) require that medical information be kept separate from an employee's personnel file. Medical information also is to be kept confidential, and not used for other employment reasons or actions.

DiBenedetto explains that the ADA does allow medical information to be shared in three specific situations: Supervisors may be informed regarding necessary restrictions on the work or duties of an employee and necessary accommodations; first aid and safety personnel may be informed (when appropriate) if the employee's physical or medical condition might require emergency treatment; and government officials investigating compliance with FMLA (or other pertinent law) shall be provided relevant information upon request.

HIPAA primarily impacts health care plans, health care clearinghouses, any health care provider who transmits any health information in electronic form (computer-to-computer transmission) in connection with a standard transaction as defined by HIPAA, and plan sponsors such as self-insured employers. The HIPAA standards apply to all individually identifiable health information — electronic or otherwise — for covered entities. DiBenedetto says occupational health professionals should remember that HIPAA does not protect their conversations with employers, supervisors, or anyone else unless the occ-health service is conducting HIPAA transactions. *Transaction* means the transmission of information between two parties to carry out financial or administrative activities related to health care. **(See table, left, for HIPAA-covered types of information transactions.)**

The patient/individual may stipulate restrictions on uses and disclosures on the authorization form they sign. HIPAA requires providers and health plans to explain how employees' PHI will be used, shared, and maintained. While the health plans may own the physical medical or health record, the individual owns his or her own PHI contained in the records — records maintained or transmitted in any format — paper, electronic, or any other media.

PHI and the occ-health professional

The treatment of employment related medical records was address by HHS in the Aug. 14, 2003, *Federal Register* at 67 *FR* 53,192 (www.gpoaccess.gov/fr/index.html). HIPAA does not apply to medical records maintained by employers in the employment capacity. HIPAA does not apply to return to work notes; medical information provided to substantiate requests for employee benefits such as short-term disability, long-term disability, FMLA requirements, job accommodation requests, or medical information for compliance with ADA.

However, in the case of FMLA and ADA compliance, those laws mandate that medical information received by an employer for FMLA and ADA requests must be kept confidential, maintained separate and apart from employment or personnel files. Some employers have the occupational health service maintain ADA and FMLA medical information; otherwise, these records must be maintained in separate files, apart from the human resource record.

Third-party occupational health providers must determine if they meet the definition of a covered entity and should modify their polices and procedures to comply with HIPAA as appropriate.

However, if a provider does not conduct HIPAA

standard transactions, he or she will generally not be under HIPAA's compliance umbrella.

Many occupational health professionals may also administer employer-based programs in which they handle, request, or exchange PHI in the course of their work activities. If the occupational health professional is part of the employer's health plan or benefits staff, his or her activities will be regulated by HIPAA, and therefore must be firewalled off from the employer side so that the PHI is not disclosed to the employer without an employee authorization allowing the use of this information for nonplan purposes.

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CDC backing off NIOSH reorganization — for now

Stakeholders not convinced of institute's future

Occupational health leaders are guardedly optimistic about the Centers for Disease Control and Prevention's (CDC) abandonment — at least for now — of reorganization plans that would have changed the organization of NIOSH.

But one industry association that opposed the reorganization, which would have made NIOSH a subgroup of an umbrella center for environmental and occupational health and safety, does not believe the independence of NIOSH is secure, and is planning to ask Congress to make NIOSH part of the National Institutes for Health (NIH).

CDC director Julie Gerberding announced nearly a year ago that she would reorganize CDC's programs into four coordinating centers. Under the plan, NIOSH — along with the National Center for Environmental Health, the Agency for Toxic Substances and Disease Registry, and the National Center for Injury Prevention and Control — would be part of the coordinating center for environmental health, injury prevention, and occupational health.

Criticism began immediately about moving NIOSH deeper into CDC's bureaucracy, with industry leaders fearing the change would mean a loss of emphasis on occupational health research and, consequently, reduced spending on NIOSH.

"NIOSH is the only federal agency that deals with occupational health research, and that's why it's important," says **Aaron Trippler**, director of government affairs for the American Industrial Hygiene Association (AIHA). AIHA has openly expressed concerns about what the proposed reorganization would mean to NIOSH.

Because NIOSH is involved with research, education, and training on a national level, Trippler says, its individuality and independence is important.

AIHA and other stakeholders in NIOSH also were unhappy that they were not consulted about the reorganization plans before Gerberding announced them.

The CDC has taken some initial steps toward consolidating overlapping CDC and NIOSH operations, including moving NIOSH budgeting functions from NIOSH offices to CDC headquarters last October. But in late November, following the issuance of strongly worded directions from Congress, included in the fiscal year 2005 budget, instructing the CDC to make no changes to the organization of NIOSH, the CDC changed course.

Congressional appropriators attached report language to the 2005 appropriations bill directing the CDC "to make no changes to NIOSH's current operating procedures and organizational structure and ensure that no funds or personnel will be transferred from NIOSH to other components of CDC by means other than traditional reprogramming of funds."

In response, the CDC announced it would comply with the Congressional direction and not tamper with the status quo.

NIOSH future still questionable

"If you take a look at what Congress said, there is a lot of ambiguity to what happened," Trippler says, when asked if the Congressional direction and CDC reaction mean things would not change with NIOSH. "Some personnel, like communications

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and printing personnel, had already been shifted to the CDC from NIOSH, and I am not sure they have been sent back."

Of concern to AIHA and other stakeholders is that NIOSH retain its budget for use in occupational health research.

"The CDC has a lot of authority over the budget at NIOSH," Trippler says. "They can maintain status quo, but can still maintain control over the budget. There is going to be a lot of interest in what will take place with NIOSH down the road."

He reports that AIHA will be drafting a letter asking Congress to move NIOSH and align it with another agency, such as the Department of Labor or — preferably, as far as AIHA is concerned — the NIH.

"The research focus of NIH would be an excellent complement to NIOSH's research efforts," he says. "We're asking Congress to request a [General Accounting Office] study, to find out if NIOSH should be moved; and if so, where?"

Trippler says the current controversy over the CDC reorganization's effect on NIOSH makes now the perfect time to assess NIOSH.

"Since 1970, NIOSH has been in the CDC, but things change," he points out. "The CDC is now more devoted to public health, rather than occupational health."

Changes in leadership of the Department of Health and Human Services (HHS), OSHA, and NIOSH also could be factors, industry leaders say.

Not only will a new HHS secretary have an influence on where NIOSH lands, but there are concerns that there could be a change in leadership within NIOSH. Current NIOSH director, John Howard, MD, is considered a candidate to helm OSHA.

"There are lots of reasons we're all going to be watching what happens with a great deal of interest," says Trippler.

[For more information, contact:

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• ***Aaron Trippler**, Director, Government Affairs, American Industrial Hygiene Association. Phone: (703) 846-0730. E-mail: atrippler@aiha.org.]* ■

Federal agencies must report worker injuries

Now held to same standard as private employers

Starting at the first of this year, federal employers and agencies are required to adopt the same worker safety and health record-keeping and reporting requirements that have been in effect for the private sector. Federal agencies had been exempt from the reporting requirements until this year.

The regulation became effective Jan. 1, but notices of violations will not be issued during the first year as long as agencies are making a reasonable effort to comply with the requirements. OSHA has launched a comprehensive outreach and compliance assistance effort to educate and train federal agencies on the new recording requirements.

The change means federal employers, like those in the private sector now, will be required to post summaries of the total number of job-related injuries and illnesses that occurred in the prior year each February. Federal employers will begin posting the summary, OSHA Form 300A, Feb. 1, 2006. Employers with more than 10 employees, except for employers specifically exempted by OSHA, must post the form in a common area wherever notices to employees are usually posted. ■

AAOHN readies for first independent conference

The Atlanta-based American Association of Occupational Health Nurses Inc. (AAOHN) will convene its first independent annual conference next month in Minneapolis. The weeklong AAOHN 2005 Symposium & Expo, April 29-May 6, is open to AAOHN members and nonmember occupational health and safety professionals.

Until this year, AAOHN co-hosted the annual American Occupational Health Conference (AOHC) with the American College of Occupational and Environmental Medicine (ACOEM). The decision to host an independent conference

came after careful study and input from members and attendees, according to AAOHN president **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN.

The symposium and expo will include a symposium with educational sessions, networking opportunities, business and section meetings; and an exposition featuring an exhibit showroom, poster presentations, and networking and social events. For information on the symposium and expo, or to register, visit www.aaohn.org. ■

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.

9. Specialists in occupational health psychology are trained to help employees deal with which of the following health conditions and job stresses?
A. Helping employees comply with safety procedures.
B. Reintegrating into the workplace after an injury or illness.
C. Maintaining good health while dealing with chronic illnesses such as high blood pressure or chronic pain.
D. All of the above

10. If an employer does not want a problem employee to return to work after an accident or illness, a safe way to accomplish this is to avoid making reasonable accommodations, as defined by the Americans with Disabilities Act, to facilitate the employee's return.
A. True B. False

11. The Tobacco-Free Nurses Initiative study on nurses and smoking found that smoking by nurses is:
A. a workplace issue, not just a personal behavioral issue.
B. a source of friction between some smoking and nonsmoking nurses.
C. not an impediment to nurse-patient interaction.
D. Both A and B

12. In language inserted in the fiscal year 2005 budget, Congress instructed the Centers for Disease Control and Prevention to:
A. immediately cease all reorganization efforts.
B. preserve the status quo regarding the organization of NIOSH.
C. turn over coordination of NIOSH to the National Institutes for Health.
D. proceed with plans to fold NIOSH into a new "coordinating center."

Answers: 9-D; 10-B; 11-D; 12-B.