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INSIDE

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Employer ultimatum: Get off cigarettes or get out resumes

Michigan employer takes hard line on smoking

Is it concern for employees' health or worry about the bottom line? Discrimination or concern for workers' welfare? A Michigan medical benefits company has kicked up a firestorm over its zero-tolerance policy toward tobacco use. Employees at Weyco Inc. in Okemos, MI, are not just barred from using tobacco products at work — they're banned from using them at all. And if they do — or refuse to be tested for tobacco use — they lose their jobs.

Weyco founder and CEO **Howard Weyers** says his company created the smoking ban out of a desire to contain rising health care costs and to protect employees from paying a price in higher deductibles because they smoke. He says he also wants his employees to be healthy; and smoking, Weyers adds, doesn't fit in with that plan.

"Weyco's mission is to help businesses improve employee health and cut costs with innovative benefit plans," he points out. "Weyco decided to take the lead by phasing in a tobacco-free employee policy over 15 months, with company-paid smoking-cessation assistance."

After that — the deadline was January — employees who still smoked on or off company time would be terminated.

"It's not about what people do at home," says Weyers. "It's about the acceptance of personal responsibility by people we choose to employ."

Groundwork laid over period of years

Though Weyco employees were given 15 months to quit tobacco or find work elsewhere, the company started laying the groundwork for the smoking ban three years ago.

The tobacco-free policy has been an ongoing program — and part of the Lifestyle Challenge Program at Weyco Inc. — since 2003. In early 2003, Weyco stopped hiring anyone who admitted to using tobacco. The company offered assistance to employees, including smoking-cessation classes, acupuncture, and medication. In late 2003, smoking by employees was banned on company property. In 2004, employees who smoked were charged a $50 monthly "tobacco assessment" if they didn't go to a smoking cessation class.

Employees were given 15 months, until January 2005, to quit smoking or quit working for Weyco. Of the 200 people employed by the company, Weyers says, 20 quit smoking, one resigned, and four were fired.

Weyers says the groundwork supporting his decision to enact the ban is there as well.

"There's no longer any question about the devastating effects of tobacco use on our society, or why it must be eliminated," Weyer explains. "Tobacco is a major killer and drain on health care resources. Michigan's smoking-related health care costs amount to $2.65 billion a year."

And the cost to businesses, Weyers adds, is further justification.

"Any private Michigan business organization has the right to protect itself from the enormous financial damage that tobacco users inflict upon society by destroying their own health," he says.

Controversial, but legal

Civil rights advocates don't like Weyco's hard line on smoking, saying it intrudes on employees' privacy by dictating that they cannot engage in a legal activity outside business hours and off company property.

But no legal challenge is expected to stand, according to a statement by the American Civil Liberties Union of Michigan, because Michigan's laws protect employers' rights to hire and fire for behaviors that are not specifically deemed protected from discrimination.

Michigan is among 21 states that have no "smoker's rights" law, protecting smokers from discrimination. Michigan also is one of many states in which employers may hire and fire at will, for any reason not excluded by anti-discrimination laws, employment contracts, or union contracts.

In other words, Weyco could fire employees who smoke, ride motorcycles, or have red hair. Under federal law, employees cannot be fired or discriminated against due to religion, race, gender, marital status, or age. Michigan includes weight and height in that list, while other states do not deem weight, smoking, or other lifestyle issues grounds for discrimination.

"Smoking is not a civil right," says Weyers. "It's just a poor personal choice. Employment is not a right, either."

Weyco is not the first company in the United States to use lifestyle choices as grounds for hiring or firing decisions. Airlines until recently enforced weight limits on flight attendants; other companies have dictated hairstyles or facial hair, limited at-work expression of certain political leanings, and dictated smoking and other behaviors on company property. Kimball Physics, a scientific instrument manufacturer in New Hampshire, has a policy of banning anyone who smells of tobacco from company grounds.

"Although the announcement of this policy by Weyco has generated a great deal of controversy, it's far from the only company to single out smokers," says **John F. Banzhaf III**, JD, executive director and chief counsel of Washington, DC-based anti-smoking organization Action on Smoking and Health.

"Alaska Airlines asks prospective workers to pass a nicotine test. Union Pacific Railroad questions applicants about smoking. Kalamazoo

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Valley Community College as of this year isn't hiring smokers anymore. CNN under Ted Turner had the policy, and many fire departments haven't hired smokers for many years."

Michigan state Sen. Virg Bernero, responding to negative backlash following the Weyco firings, announced he plans to introduce a bill that would ban employers in his state from firing or refusing to hire workers for legal activities employees engage in on their own time that don't interfere with their work.

Insurance savings for employers

Weyers says while insurance costs are not the primary reason for the smoking ban at his company, the rising cost of health insurance was one factor.

"[Insurance] is darned expensive," he comments. Weyers charges that one reason for the increases in health insurance costs to employers is "self-destructive behavior by a small percentage of employees."

Typically, health insurance premiums are higher for smokers than they are for nonsmokers; how much higher depends on the policy, the insured person's age and health, and other factors.

Of the 15-20 Weyco employees who used tobacco before the no-smoking policy was announced, "about a dozen" have stopped using tobacco, Weyers reports.

"It's not just about saving money," he says. "It's about saving lives."

Weyco's no-smoking policy is available at the company's web site, www.weyco.com.

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NIH tailors RTW program specifically for nurses

Clinical duty not out of the question

Nurses are among the highest risk professions for back injury, and when a nurse is injured, devising their return to work in an environment that demands physical tasks — lifting patients, pushing gurneys, etc. — can be a challenge.

Add to the fact that not only are nurses at high risk for musculoskeletal injury, lots of them actually do get injured. In fact, OSHA estimates that nearly half of all health care workers, including nurses, will experience at least one work-related musculoskeletal disorder during their working lives.

"Getting nurses back to work is particularly difficult because of the work nurses do," says **Pamela Koviack**, RN, nursing consultant for the National Institute of Health's (NIH) Warren Grant Magnuson Clinical Center (Clinical Center), the NIH's clinical research facility in Bethesda, MD. "It's difficult to place them back into direct care."

But a program that she helped get off the ground in 1999 — when she herself was an endoscopic nurse on light duty from an injury — is getting nurses back to work, even back into direct patient care roles.

"We put the program in place to ensure we were using consistent practices in handling staff who have functional limitations," says Koviack, who now serves as coordinator of the medical and reasonable accommodation program (MRAP).

The program was developed with input from the NIH's office of workers' compensation, the Equal Employment Opportunity office, legal counsel, human resources, employee assistance representatives, and occupational medical services, all of whom made up a task force "to see what we could do better" when one of the clinical center's 660 nurses is injured, she says.

"When you realize that the average age of a nurse in the U.S. is 46, you realize that because of our age and the type of work we do, we're susceptible to injury," she says. Those injuries can occur on or off the job, so the MRAP at the Clinical Center does not discriminate based on where the injury occurred.

"We will accommodate anyone, so long as their limitations are not so severe that they can't do work," she says.

Start with an assessment

When an injured nurse is ready to return to work, the first step is to have the nurse complete a self-reporting assessment of his or her limitations. That report, backed up by documentation from the nurse's physician, is followed by a skills

checklist that the nurse fills out, indicating what work he or she is comfortable doing.

"Computer programs, interviewing patients — we have a large skills checklist, and we match those skills and functions against the jobs we need to have done," Koviack explains. **(See checklist, p. 41.)**

The program is part of the Clinical Center's Nursing and Patient Care Services Department, but other departments are called on to fill their vacancies with limited-duty nurses.

"We can support other departments, such as research physicians who need assistance with research projects, or radiology, who needs them to monitor patients," Koviack says. "They may be out of the direct care arena, but still they are supplying needed resources in other areas of the clinic."

Limited duty assignments are maintained and assigned by the hospital's central staffing department. Departments or administrators with the need for help or with absent staff are matched with the available limited-duty nurses.

At any one time, there are usually six to eight people in the MRAP program, Koviack reports.

When a member of the nursing staff requires accommodation for an injury or illness, the nurse requests entry into the program through his or her supervisor. The supervisor of record remains the employee's supervisor. The employee's schedule usually is changed to a Monday through Friday day shift unless the temporary work assignment requires rotation to other shifts.

Finding a fit

The MRAP can accommodate a nurse for about six months, says Koviack. At that point, she meets with the employee to assess where they go from there.

"We get a prognosis for their return to full duty," she says. "In the rare case they might never be able to go back to their routine direct care responsibilities — and that happens rarely, thank goodness. [When it does], we will help by circulating their resume. [NIH] is a big organization, and we are usually able to find a good fit quickly."

Nurses on MRAP limited duty reassignment remain at their regular pay level and reap the much-proven benefits of returning to work sooner, rather than later.

"We value their abilities, and just because they can't work at a patient's bedside doesn't mean they can't support the organization," she says. "If they're home on workers' comp, we're paying them anyway. This way, they're filling jobs we need to have done, and that saves the organization from having to hire temp help.

"Plus, it benefits the employees by not making them use up their sick leave, keeping them gainfully employed, still covering their insurance. And statistics show that when you get an employee back to work sooner, they come back to full duty much quicker."

She says she finds that rather than take advantage of the break from the heavy-duty routine work of patient care, most nurses in the program are anxious to return to full duty. Sixty percent of nurses who enter the program are in it for fewer than 30 days.

"I haven't found any malingering problem, or people wanting to stay in limited capacity so they don't have to work so hard," she says. "People are nurses because they like what they do."

Participants' feedback tailors program

Feedback from participants in the MRAP has been used to tailor the program over its five years in operation, and one of the biggest changes has been to allow some nurses in the program to work modified clinical assignments.

"Employees were asking to go to direct patient care, and before, we did not put them where they could incur further injury," she says. "But we looked into it and found that possibly a modified clinical assignment would work for some nurses, and we have made that change."

Nurses on modified clinical duty might find themselves taking vital signs, doing admissions and patient interviews, administering medicines, and starting IVs.

Koviack says the MRAP program in the nursing services division has led other departments to pattern similar programs.

"There is a need for this no matter what department you're in — dietary, housekeeping, whatever. Other departments have been doing it, but I think we're just more systematic about keeping the data and being consistent for fairness and EEO purposes," she points out.

Since Clinical Center's MRAP was launched, nurses in the program have filled 25,382 hours, or 3,171 eight-hour shifts, in temporary work assignments. Koviack says her department's research shows that using accommodated staff to fulfill the needs of the nursing services department

(Continued on page 42)

Nursing and Patient Care Services
Medical and Reasonable Accommodation Program (MRAP)
Self-Assessment of Skills and Experience

Name: _____ Date: _____

Unit: _____ Unit Phone: _____ Nurse Manager: _____

The purpose of this self-assessment is to identify what competencies and skills you have experience with in order to provide you with a temporary work assignment that will best meet the needs of the organization.

1. Which of the following skills/activities do you feel competent to perform? (check all that apply)

- ❑ Typing
- ❑ Filing
- ❑ Distributing mail
- ❑ Xeroxing
- ❑ Word processing
- ❑ Telephone
- ❑ Developing clinical maps
- ❑ Interpreting for foreign-speaking patients

Indicate languages: _____

- ❑ Effective communication
- ❑ Writing
- ❑ Scheduling
- ❑ Ordering supplies
- ❑ Data entry
- ❑ Providing tours of the Clinical Center
- ❑ Preparing research specimens for mailing
- ❑ Processing specimens (e.g., spinning blood)

2. Which of the following programs do you feel competent to perform (check all that apply)?

- ❑ MS Word
- ❑ Making labels
- ❑ Formatting documents
- ❑ Mail merges
- ❑ Excel
- ❑ PowerPoint
- ❑ Access
- ❑ Other _____

3. Which of the following equipment do you have experience with? (check all that apply)

- ❑ PC
- ❑ MAC
- ❑ Copying machine
- ❑ Fax machine
- ❑ Slide projector
- ❑ Overhead projector

4. Are there any other skills and abilities you possess, not mentioned above, that would assist us in placing you in a temporary work assignment?

_____

_____

_____

Source: National Institutes of Health, Nursing and Patient Care Services Medical and Reasonable Accommodation Program, Bethesda, MD.

potentially saved the center $731,763 in the first three years of the program in potential overtime and agency expenses.

Of the 147 staff who were accommodated during the first three years of the program, 61 employees were enrolled due to work-related injury. Allowing them to continue to work in an accommodated status saved the organization an estimated $270,000 in workers' compensation claims.

The MRAP program seeks to place every qualified employee seeking accommodated assignments, but placement is not guaranteed. When an assignment match cannot be made, the employee still can request sick leave, leave without pay, or other disability leave options available at the Clinical Center.

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Integrated disability management a slow sell

Pays off in savings on lost time, expert says

Though research and anecdotal evidence seem to show that integrating disability and health care programs for all injuries and illnesses — whether suffered on the job or off — can get employees back to work more quickly, prevent absences, and lower total benefit costs, most employers are slow to warm up to the idea.

"We're probably 10 years into integrated disability management, and there still aren't as many companies doing it as all of us on the delivery side think there should be," says **Janet R. Douglas**, managing director for Marsh Mercer Inc., a global risk and insurance services firm. "For the companies that are, the results have been extremely encouraging in terms of reducing medical costs and lost time by applying best practices across the board, regardless of whether it's a work-related or nonwork-related injury."

Integrated disability management is a tool by which occupational and nonoccupational disabilities are approached consistently. Traditionally, injuries have been treated (with regard to benefits administration) differently, based on whether they occurred at work or at home.

"There have been huge variances in the amount of medical treatment and time lost from work, not based on the severity of the injury or illness, but based on the payment mechanism used," Douglas says. "Integrating your disability management takes a consistent protocol or approach to return to work; and applies it across the board, regardless of how or where the injury happened."

Evidence indicates benefits

A study released in 2004 by Philadelphia-based CIGNA employee benefits company examined claims from 60,000 employees in 156 companies, and compared return to work times for employees whose benefits were integrated against employees whose benefits were not. The study showed that short-term disability ended sooner and employees returned to full-time work more quickly when they had integrated disability and health care programs. **(See *Occupational Health Management*, June 2004, p. 66.)**

Integrated disability management had its genesis with three large employers — General Electric, Ameritech, and General Motors — that looked at costs, saw that they were doing all they could to manage workers' comp and disability costs, and wondered why their health care costs continued to increase.

"They started working with industry thought leaders, and the question evolved: 'Why do we have this divide between occupational and nonoccupational disability?'" Douglas says. "Why not take the best practices from both and combine them, get the best treatments that are cost-effective and timely and that get the doctor reimbursed, and get the employee back in workplace as timely as possible and as strong and healthy as possible?"

She says while employers can agree that the idea is good — according to her, no large employer who has integrated its disability programs has failed to realize savings — the effort and investment required to make the change from an established benefits system is daunting.

"It's a huge effort," Douglas conceded. "It requires commitment and it requires investment and it requires someone high up enough to say, 'Let's do what's best for the company.'"

The larger the employer, the more likely it is to have an integrated disability management program. According to Watson Wyatt Worldwide, the number of employers in its annual survey that had integrated disability management programs

increased from 26% in 1997 to 43% in 2001, and was almost 50% in 2004. The larger the company, Watson Wyatt reports, the more likely it is to have integrated disability management programs, also known as total absence management and health and productivity management.

According to Marsh Mercer's annual survey of employers about their time off and disability programs, lots of companies are integrating at least some parts of their disability programs.

The 2004 survey report showed that 62% of the 485 companies that participated in the survey use consistent occupational and nonoccupational return to work programs (up from 32% in 2000); 51% have integrated short-term disability and long-term disability coverage with one third-party administrator or carrier (up from 39% in 2000); and 42% use a single, centralized occupational and nonoccupational claim intake approach (up from 32% in 2001). The Fourth Annual Marsh Mercer Survey of Employers' Time-Off & Disability Programs is available on-line at www.marshriskconsulting.com.

Douglas says tighter controls on workers' comp over the last 20 years, plus more scrutiny on Medicare, has led to elimination of costly tests and interventions that, in the long run, has resulted in longer recovery time and more lost work time.

"There is an assumption on the part of some doctors that lost time doesn't cost anything, which is erroneous, of course," she says.

Getting employers — even ones who agree that integrating disability programs is a good idea in theory — to consider actually putting it into use within their own companies "represents a huge paradigm shift," according to Douglas. "Employers and workers are used to return to work for workers' comp, but not for short-term disability.

"They usually have workers' comp and disability managed internally through different groups and reporting through different avenues: workers' comp usually goes through risk management and finance, while disability goes to human resources."

When a changes as sweeping as integration of disability management programs is introduced, Douglas says she often sees a "push-back" from in-house medical departments.

"Any time you mess with someone's reporting systems, there will be some resistance," she says.

To demonstrate how an integrated system could save time and effort on everyone's part, and save money for the employer, Douglas suggests starting by measuring the number of lost work days — a huge cost to employers, but one that is not always well-tracked.

"Measure workers' comp and short-term disability costs," she says. "We find one of the biggest challenges is tracking short-term disability, so an employer doesn't always know what they're spending in the first place. So in that scenario, tracking that information helps employers know what they have spent so they can have that benchmark going forward."

Medical costs associated with workers' comp also should be examined.

"There's a learning curve, and you'll run into some issues around HIPAA," Douglas says. "People aren't used to being asked questions about nonoccupational injuries, so you have to do a lot of caretaking, making sure people's privacy is not invaded.

"People don't always understand why there's a difference in the way [disabilities] are reimbursed and why the paperwork involved is different. With integrated programs, there's a big increase in efficiency in the administration of the program."

And success stories are beneficial learning tools, too, Douglas says. According to the Integrated Benefits Institute (IBI) in San Francisco, Pitney Bowes Inc. reduced lost time by 42% in the first two years after it integrated its benefits programs and reduced medical costs by 25%. The company reported "virtually zero impact" on employee deductibles, copays, or other costs, according to IBI.

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Some chronic pain may be easy to treat

Pain costs workers time and money

The office manager who is certain she has carpal tunnel syndrome, and the grocery store checkout clerk who is convinced he has a pinched nerve might be correct; but it may be more likely that they are suffering musculoskeletal pain that is both easier to treat and less likely to be chronic,

given correct diagnosis and treatment.

"The first thing to do is to try to help patient understand source of his or her pain, what's causing it," says **David Hubbard**, MD, medical director for Rosemont, IL-based CorSolutions, consultants on disease management of chronic illnesses.

Once they know where their pain is coming from, they are better prepared to work on the cause. Sometimes, he says, what they learn can surprise them.

While patients with chronic pain often believe their pain is nerve- or joint-related, such as a pinched nerve or carpal tunnel syndrome, it is far more apt to be muscular pain, says Hubbard.

"Over 85% of pain conditions are of muscular origin, with nerve and joint pain and headache accounting for most of the remainder," he reports. "Not understanding the source of the pain can lead to costly and inappropriate treatment, including surgery."

Muscles major sources of pain

Muscle pain is the most common form of chronic pain, and can result from overexertion, repetitive use, or continuous stress on the muscle. Often mistaken for a pinched nerve, muscle pain is easily dealt with by sometimes minor adjustments to motion and position, Hubbard says.

"Five percent of the time, it's a pinched nerve; and for those 5%, surgery is required," he says. "But the other people, the single largest category, what they need is a combination of slow stretches, to work on what is probably a pinching component aggravated by muscle tension."

One of the most common workplace muscle injuries is repetitive strain injury, or cumulative trauma, which can be mistaken for carpal tunnel syndrome because pain is felt in the wrists and hands. Hubbard says the pain is actually coming from the forearm and shoulder, and often is caused by keyboarding in an awkward position.

Other sources of chronic pain include:

- **Nerve compression.** Typically, nerve compression is due to inflammation and edema in surrounding tendons and ligaments caused by overactivity. Disc herniation and carpal tunnel syndrome are typical examples of nerve compression.
- **Nerve damage.** Peripheral nerve damage is caused by either diabetes or trauma; nerve damage, Hubbard says, is the only source of chronic pain that is incurable. Medications can help manage the pain, but neither surgery nor physical therapy will cure it. Root damage is typically caused by prolonged root compression from a disc protrusion or damage during decompression surgery.
- **Joint/tendon conditions.** These conditions generally involve some degree of inflammation of synovia, tendon insertions, or ligament attachments. Inflammation can arise from trauma or over time from repetitive, awkward motions.
- **Migraines.** Migraines are severe episodes of throbbing head pain, light sensitivity, nausea, and vomiting that last from an hour to several days.
- **Complex regional pain syndrome (CRPS).** The hallmark of CRPS is when a light touch on an extremity, most commonly the hand, is perceived as painful. Typically, the patient's distress and disability are dramatically out of proportion to the objective findings.
- **Fibromyalgia.** The predominant symptom in fibromyalgia is widespread aching pain, involving much of the body, especially the neck, back, and proximal extremities. Associated symptoms are fatigue, sleep disturbance, lack of energy, and depressed mood.

Tension and stress add to pain

Awkward working positions — either from keyboards positioned incorrectly, workstations not ergonomically arranged, or other often easily remedied condition — contribute to chronic muscle pain. But stress if often found to be prolonging and exacerbating the pain, says Hubbard.

"Almost always, in addition to the awkwardness, is a tension component," he says. "So I tell them to look for source of their tension.

"It can be a pulling between the shoulder blades when they are angry, or feeling they're being treated unfairly at work. You can teach people to notice that situation and take action — take a break, get out of the situation, do something proactive."

Sometimes, the stress might not be obvious. Hubbard says he worked with an employee who believed she was headed for surgery for carpal tunnel syndrome, when she realized there was a pattern to the occurrences of her pain. Her desk was located next to the office copy machine, and when co-workers used the copier, they put their paperwork on the corner of her desk.

"She'd see people putting their stuff on her desk, and she could feel the tension; and two hours later, she'd start having pain," he says. "So we recognized that this minor pattern was

causing the tension and aggravating her pain, so she rearranged the top of her desk so people couldn't put their stuff there. That hugely eliminated the problem."

While some of the things that cause chronic pain are minor, more than 60 million Americans have conditions such as heart disease, hypertension, cancer, arthritis, diabetes, and mental illnesses that can be both life- and work-threatening.

According to Partnership for Solutions, a national policy research program funded by the Robert Wood Johnson Foundation and based at Johns Hopkins University, more than 125 million Americans live with at least one chronic health condition. By 2020, that figure is expected to grow to 157 million, fueled by the aging of the baby boomers and medical advances that are increasing life spans.

The Glenview, IL-based American Pain Society (APS) also attributes the increase, in part, to poor diagnosis and care of pain-related conditions, and cost shifting from group health plans.

Chronic pain is the second leading cause of medically related work absenteeism, resulting in more than 50 million lost workdays each year, according to the APS, and it is the leading cause of disability in the working-age population.

In its 2004 survey of 800 people who suffer from chronic pain, the APS found that 51% of survey participants who are employed said their pain adversely affects their productivity at work, and 41% said it affects their ability to put in a full day's work.

One in six (16%) said their chronic pain has adversely affected their opportunities to advance in their careers, and 45% said it has had a negative effect on personal relationships with spouses/partners, children, grandchildren, and friends.

According to the Joint Commission on Accreditation of Healthcare Organizations, pain costs the United States an estimated $100 billion each year and causes more than 50 million lost workdays per year.

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Monograph, "Pain: Current Understanding of Assessment, Management, and Treatments," is available online at www.jcaho.org.] ■

Define the product, know the market

Newcomers to occ-med need a marketing plan

When it comes to letting people know about their services, health care professionals have historically had the "If we build it, they will come" mentality, according to one consultant.

"But that mentality has reached extinction," says **Christine M. Kalina**, MBA, MS, RN, COHN-S/CM, FAAOHN. "A marketing plan is very, very important to an occupational health service."

Kalina, a Chicago-based global consultant in occupational health, advises clients to first decide what it is they are selling before they take their first marketing steps.

Know your product

Occupational health providers, like most other specialists in health care, often have not studied business extensively, so when it comes to launching or building on a service they might overlook some basic elements — like knowing just what it is they want people to come to them for.

"There are some very important steps to take when you're building a program, and the first one is to define what your product is," Kalina says. "Just what is it that you are marketing?"

Health care providers, she says, commonly "think they have to be the be-all and everything to everybody," but that approach usually is not successful.

"You've heard the saying that if you're good at everything, you're really good at nothing?" Kalina asks. "It's very important to make sure you have your product defined. Know what you're marketing before you start marketing."

She often meets occupational health providers who tell her they are busy marketing their businesses; when she asks what they are doing, they tell her they have mailed fliers or purchased advertising.

"If someone says, 'I sent out fliers saying my occupational health service is open from 2 to 4 p.m.,' I tell them that the real marketing question is

why is the service open from 2 to 4 p.m." Kalina says. "You have to understand what your strategy is, what targeted programs you're going to plan, and how to launch them."

While health care providers are usually far more interested in the service they're offering to patients, she says marketing has to be part of the strategic plan for the overall occupational health service. Advertising is just one part of the marketing plan.

There are Four P's — product, place, promotion, and price — that a new or growing occupational health service should incorporate into its marketing strategy, she suggested:

- **Product** — define what it is the service will provide;
- **Place** — where the program or product will be delivered. Will you take your services to the employee's work site, or will you have the employee come to you?
- **Promotion** — how the service will be promoted: word of mouth, fliers, and advertising are some promotional tools;
- **Price** — how the service is priced depends on what financial structure the occupational health program uses. Will employers pay for the service? Will employees be charged, under the theory that if someone pays for a service, there is more vested interest in its success?

As part of the promotion aspect of the plan, sitting down with customers to find out what they want is a valuable step, Kalina says. Find out what they want, and then decide how you can give it to them.

"Emerson says, 'If you build a better mousetrap, the world will beat a path to your door,'" she says. "If you define your product, create something unique, then there you have it. If everyone is selling the same thing, they're not being competitive."

The aggressiveness of a marketing strategy depends in part on where the service is located. If a service is coming into a market already bustling with competitors, marketing will need to be precise and aggressive; if it is the only occupational health provider in town, the need for marketing is much less.

Marketing can be an expensive proposition if a service calls on consultants to handle the process. On the other hand, a savvy manager can do the marketing if he or she knows the product, the market, and how to promote, Kalina says.

"Budgets drive operating expenses, so you have to step back, define what your objectives are for your marketing plan — what you want it to accomplish, and how much you have to spend to obtain those objectives," she says. "It goes back to your strategic business plan."

Benchmarking and competitive analysis are two tools that can help determine expenses and strategy, but one is easier to use than the other.

Benchmarking involves comparing what your business or service does, via what processes, and how best to implement those processes, based on how other businesses conduct similar processes. But it's not always comparing apples to apples.

For example, Kalina says a drug testing company can benchmark against a pizza company — both take multiple ingredients that must be processed to deliver a top-quality result quickly. Farfetched as it may sound, Kalina once conducted such a benchmark study.

"We benchmarked a pizza company for a drug testing company, and it was not comparing products — it was comparing processes," she recalls. "How do you take all these ingredients in a drug test and get it done faster?"

Competitive analysis provides information that's good to know, but hard to come by. It involves finding out what your direct competitors do and how they do it.

"And they're not going to share that with you that unless they're really, really stupid," Kalina says.

Whether an occupational health service devises a marketing plan that's complex or very simple, high-priced or inexpensive, it is a process that is sorely needed, she says.

"Marketing is something that occupational health care providers, in my experience, need to explore and implement more."

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AAOHN policy platform pushes healthy lifestyle

Employer incentives, nurse safety on list

Wellness and disease prevention remain at the top of the list of areas of emphasis and concern for occupational health nurses, as reflected by the American Association of Occupational Health Nurses' (AAOHN) 2005 public policy platform.

But the efforts of occupational health nurses shouldn't just be on wellness and disease prevention in the workplace, says AAOHN president **Susan A. Randolph**, MSN, RN, COHN-S, FAAOHN. Employees' lifestyles have direct impact on their wellness and ability to work, so AAOHN is urging its members to help employees with lifestyle issues that become workplace issues.

Smoking, obesity, and other nonwork-related lifestyle issues can play big roles in an employee's wellness at work, and in deciding on the areas the association should emphasize this year, AAOHN directors included lifestyle education and screenings.

Because monitoring of and education about health issues such diabetes, cardiovascular disease, asthma, smoking, stress, and fitness have been shown to improve health, increase workers' productivity, and yield significant return on employers' investments, AAOHN is urging national policy that directs more attention to health promotion, disease prevention, and lifestyle improvement programs as means of reducing health care costs.

"One of our major goals is to help secure legislation that will reward employers for implementing employee health and wellness programs," says Randolph. "In doing so, we are addressing some of the most critical issues facing the workplace — the need to improve employee health and therefore reduce health care costs.

"[Occupational health nurses] have always taken a lead role in managing this challenge, so we hope to heighten visibility and awareness for these issues in a public policy context."

Reward employers, attract nurses

AAOHN also is focusing its public policy efforts on the nation's nursing shortage.

"Many of the current efforts surrounding the nursing shortage involve a pipeline approach of addressing salaries, funding, training, and education to recruit more people to the profession," Randolph stated. "While AAOHN supports this approach, we also recognize that much of the current problem is rooted in retaining nurses once they're employed. To do this effectively, we have to provide for a healthier, safer work environment in hospitals, clinics, or any place where nurses and other health care professionals are employed."

According to a 2003 report by the Institute of Medicine, better nursing staff levels result in safer client care; but according to the AAOHN policy statement, health and safety risks to nurses are key factors in the nursing shortage.

Occupational health professionals always are going to be concerned with patient confidentiality, Randolph says, and that is reflected in the 2005 policy platform.

Most laws pertaining to privacy of workers' health information are state-based, so AAOHN is calling for comprehensive federal legislation to provide universal security standards and safeguards that protect the integrity and confidentiality of personal health information.

Workplace violence prevention is a policy platform carried over from last year. Randolph says there remains a need for education and training in the workplace, as AAOHN studies indicate a majority of the workforce can't recognize the warning signs of workplace violence. Occupational health nurses, the association says, are in a prime position to conduct organizational risk assessments and develop and implement violence prevention programs in the workplace.

Likewise, those in occupational health should play critical roles in helping employers and communities plan for and respond to large-scale hazards, whether they be epidemics of communicable diseases, or natural or man-made disasters.

Occupational health nurses are trained in emergency planning, injury prevention, loss control, health surveillance, safety awareness, post-accident reviews, evaluation of protective equipment and machinery, and delivery of services — all of which, Randolph says, are critical needs before, during, and after a disaster.

Because some occupational health nurses, as well as nurses in other specialty areas, find it necessary to practice in more than one state, whether in person or via electronic communication, AAOHN is throwing its support behind the Nurse Licensure Compact, a mutual recognition model by which a nurse's state of residence issues his or her nursing

COMING IN FUTURE MONTHS

- Mobile health — Taking wellness and diagnostic services to the work site
- Developing an outcomes management plan
- Hepatitis A at work
- RTW after cardiac events

license, which is then recognized by other states that have entered into an interstate compact with the state of residence. Nurses residing in compact states would be able to practice in other compact states without applying for separate licenses.

AAOHN drafts its annual policy platform based on past years' platforms and feedback from association members.

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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.

13. Which of the following practices is considered discriminatory in ALL states?
A. Hiring or firing based on tobacco use
B. Hiring or firing based on weight
C. Hiring or firing based on gender
D. Hiring or firing based on height

14. According to OSHA, a health care worker is at risk of sustaining how many work-related musculoskeletal disorders during a career?
A. At least 1
B. 2-3
C. 4 or more
D. None

15. In devising a marketing strategy, the occupational health professional should consider the "four P's," which include:
A. Product
B. Promotion
C. Price
D. All of the above

16. A nurse licensure compact does which of the following?
A. Guarantees a nurse licensed in one state will be granted a license in other states
B. Allows a nurse's license from one state to be recognized in another state that has entered into a compact with the nurse's state of residence
C. Grants lifetime licensure to nurses
D. None of the above

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