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INSIDE

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Mutual recognition erases state boundaries on nursing licenses

Enables telenursing, practice in other states

Imagine the inconvenience of having a driver's license that was good only in your state of residence. If you wanted to drive the roads of a neighboring state, you'd have to arrange to get a second license. That is something like the situation in which many occupational health nurses and nursing professionals in other specialty areas found themselves until recently.

Historically, nursing licenses, like medical and other professional licenses, have permitted nurses to practice in their states of residence where the licenses are issued — not very convenient for an occupational health nurse employed by a company that has locations in six states.

But a growing number of states — 18 so far, with another dozen or so contemplating legislation — have passed laws permitting nurses to practice in states in addition to their states of residence under a mutual recognition model, the nurse licensure compact (NLC). **(See chart, p. 51, for list of states that already have passed NLC legislation.)**

Go where work leads

The compact allows for ease in getting nurses where they're needed in times of emergency — after hurricanes and other natural disasters, or in the wake of man-made disasters. But more frequently, it will allow nurses to practice their profession in areas that once were off-limits, according to **Don Bollmer**, director of business affairs for the American Association of Occupational Health Nurses (AAOHN).

AAOHN has been a supporter of the NLC, urging passage of the compact so nurses residing in compact states would be able to practice in other compact states without applying for separate licenses.

"We have a member in Texas who works for a refinery that has facilities in Alaska," he explains. "She has had to be licensed in Alaska and in Texas, but what she is finding is that technically she can't really practice in Alaska because she's not a resident."

According to information supplied by the National Council of State Boards of Nursing (NCSBN), the mutual recognition model of nurse licensure allows a nurse to have one license in his or her state of residency, and to

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practice in other states (both physically and electronically), subject to each state's practice laws and regulations. Under mutual recognition, a nurse may practice across state lines unless otherwise restricted.

"Mutual recognition of a license increases nurse mobility and facilitates delivery of health care by innovative communication practices, such as telenursing," says **Katherine A. Thomas**, MN, RN, executive director of the Texas Board of Nurse Examiners. Texas enacted the NLC in 2000. "Additionally, it will better promote the public health and safety by encouraging cooperative efforts among the party states in nurse licensing and regulation.

For a nurse to take advantage of mutual recognition, each state in which he or she wants to practice must enact legislation authorizing the NLC. States entering the compact also adopt administrative rules and regulations for implementation of the compact. The nurse also must apply to the nonresident state for recognition of his or her license.

Once the compact is enacted, each compact state designates an NLC administrator to facilitate the exchange of information between the states.

Since 1998, the NLC has included RNs and licensed practical or vocational nurses (LPN/VNs). In 2002, the NCSBN Delegate Assembly approved the adoption of model language for a licensure compact for advanced practice registered nurses (APRNs), which may be implemented only by the states that have adopted the RN and LPN/VN NLC. In 2004, Utah became the first state to enter the APRN compact.

The legislation makes all licensed nurses in the compact states eligible to practice in other compact states, with employers responsible for verifying their licensure status through their home states and/or the basic licensure information and disciplinary history provided through NCSBN at www.ncsbn.org.

Some nursing specialties always have had a need to move between states, but occupational health nursing is relatively new to that world, Bollmer says.

"Occupational health nurses once were very facility based, and now they're not," he says. For example, in addition to providing telehealth and case management services across state lines for their employers, nurses who operate as consultants likewise want the freedom to move across state lines, he points out.

Questions about licenses

The NCSBN began the process of creating a nurse licensure compact in 1996 at its national assembly, when delegates voted to investigate different mutual recognition models and report their findings. That was followed a year later by a unanimous endorsement for pursuing mutual recognition on a state-by-state basis.

Understandably, nurses and state nursing boards have questioned the implementation and effect of the NLC on the way licenses are granted and recognized, and how states will handle violations and disciplinary actions.

According to information provided by NLC spokeswoman **Dawn M. Kappel**, questions have arisen regarding:

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Editorial Questions

For questions or comments, call **Alison Allen** at (404) 262-5431.

• **What is the effect on licensure requirement?** Even if a state enacts the NLC, it retains complete authority to determine its licensing requirements and disciplinary actions according to its Nurse Practice Act;

• **Which state's practice laws apply?** A nurse who practices in compact states is required to comply with the nurse practice laws where he or she is treating a patient, just as a driver licensed in one state is required to follow traffic laws in any state in which he or she drives.

• **How are violations handled?** Complaints against nurses are handled in the state in which the violation allegedly took place, and are reported to the states that issue their licenses. According to the NCSBN, many compact states investigate complaints in the state where the alleged violations occur, and then transfer the information to the state board that licensed the nurse (his or her state of residence), so that disciplinary action is taken only once.

However, the Nurse Practice Acts of most states (including non-NLC states) authorize nursing boards to take action based upon action taken in another state, meaning that a nurse who has his or her license disciplined in one state is likely to also face action in all other states of licensure, just as under the traditional system of single state licensure.

A coordinated licensure information system has been developed to enable the sharing of information between compact states; all information involving any action is accessible to all NLC states, and some of it is available to noncompact states.

• **Is a nurse's license automatically recognized by compact states if his or her state adopts the NLC?** No. The licensing authority in a compact state where an application is made may choose not to issue a license to an out-of-state nurse if the applicant does not meet that state's qualifications for granting a license.

States that have enacted RN and LPN/VN NLC (as of February 2005)

State	Date Implemented
Arizona	7/2002
Arkansas	7/2000
Delaware	7/2000
Idaho	7/2001
Iowa	7/2000
Maine	7/2001
Maryland	7/1999
Mississippi	7/2001
Nebraska	1/2001
New Mexico	1/2004
North Carolina	7/2000
North Dakota	1/2004
South Dakota	1/2000
Tennessee	7/2003
Texas	1/2000
Utah	1/2000
Virginia	1/2005
Wisconsin	1/2000

(Note: New Jersey has enacted the NLC, but at press time had not yet implemented the compact.)

Source: National Council of State Boards of Nursing, Chicago.

More states targeted

About 13 states are debating whether to adopt mutual recognition legislation. AAOHN, along with state boards and other nursing associations, is urging them along.

"We have targeted three states, where we have large, active membership numbers but where there was not licensure compact legislation, and where we thought [AAOHN] members would be traveling across state lines regularly," Bollmer points out.

The states AAOHN is concentrating efforts in are Georgia, Illinois, and Michigan.

Georgia will not introduce compact legislation this year, Bollmer notes, so efforts are going toward persuading Georgia legislators of the benefits of mutual recognition.

The state has two boards of nursing — one for registered nurses, and one for licensed practical nurses, and the two boards share one "very overworked" staff, he explains.

"We are working with the boards of nursing as well as with our members and leadership in other interested organizations to educate the board members about what this is and why it's necessary to

get their blessing before moving on to the legislature," Bollmer says.

Illinois has legislation on the licensure compact on its way to committee. Michigan, like Georgia, is still a year or so away from introducing legislation, he estimates. "All in all, it's progressing nicely."

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More evidence shows wellness cost benefits

Save $16 per $1 spent

Yet another study — this one from Brigham Young University (BYU) in Provo, UT — gives more ammunition to occupational health and wellness managers who seek to prove their programs' value to employers.

The study, led by **Steven Aldana**, PhD, BYU health promotions director, indicates that employers can save nearly $16 for every dollar spent on wellness and health promotion at the workplace.

"This is just another reason companies should offer and encourage participation in wellness programs," he says. "Many corporations use health promotion programs as a reactionary effort to curtail ever-increasing, employee-related expenses of health care and lost productivity. This new information provides additional evidence why companies should help employees have healthy lifestyles."

The BYU study was published in the March issue of *Preventive Medicine,* but it comes as no surprise to those working in the employee wellness world. They say the data are getting stronger and stronger with each new study.

"We've done considerable research, maybe more than anyone in the world, on the issue, and our data continues to be positive," says **David Anderson**, PhD, vice president of program strategy for St. Paul, MN-based StayWell Health Management.

"There have been several new studies that are even better than what we've seen in the past, [showing] as much as $450 savings per employee in a company that is just two years into [a wellness] program," he adds.

Todd A. Cipriani, MS, president of the board of the Wellness Council of Rhode Island, points out that employers are learning that to reap the benefits of a healthy work force doesn't always mean a big budgetary layout.

"It doesn't always take a big front-end investment; you don't need a shotgun approach," Cipriani says. "More and more companies are getting that message and becoming true believers. They are tracking the data and seeing the financial benefits."

The BYU researchers determined that depending on a company's size, between 2.5 % and 4.5% of the money spent on salaries goes to absent employees. By implementing wellness programs, Aldana estimates that companies can save millions of dollars annually.

The study examined the health claims costs and absenteeism of 6,246 employees and retirees from the Washoe County School District in Reno, NV, during a six-year period. Employees' participation in the school district's wellness program was associated with an estimated savings of more than $3 million in absenteeism costs when compared with nonparticipants.

"Findings like these are important because, although investment in health promotion is not large, it has a large payback for organizations," according to Cipriani.

Anderson says that as employers embrace the idea that spending money on health promotion is a good investment, wellness programs are evolving.

"Today's programs are much better than they were five or 10 years ago," he says. "They are showing uniformly very good results, assuming they're well implemented and include the building blocks of a good, solid program."

The rise of wellness and health promotion is the natural result of employers "having tried everything on the health care plan side, as far as managing the supply of health care," Anderson points out.

Despite the use of pharmacy benefits managers, managed care, and utilization control, costs keep increasing, and employers look for more ways to keep their employees healthy and costs down.

"What we've seen in the last three years is the real rapid adoption of the idea that we need to

shift our focus from producers of care to consumers of care," he says.

This is resulting in three main approaches, according to Anderson:

- proliferation of disease management programs, through which employers focus on chronic diseases and management of clinical issues related to chronic disease;
- consumer-driven health concepts, such as health spending accounts, in an attempt to get employees to act like consumers who are shopping for good health with their own money;
- more strategic and comprehensive health management strategies that are targeted and well-managed, rather than "scattershot" programs of a class here and a meeting there.

"If we can get people to adopt a healthy lifestyle, their health will improve and they will live longer. Death can be postponed by 10 to 20 years," says Aldana.

"They will lose weight, experience less diabetes, dramatically lower their risk for cancer, and considerably improve the quality of their lives," he continues.

Duke University in Durham, NC, has operated its Live For Life health fitness program for more than 15 years, and has depended on hard data to keep it going and focused on what works, according to program manager **Julie Joyner.**

"Our Pathways to Change program is targeting people at risk for high blood pressure, and they work with a leader for a year," she says.

"In a year, we've seen 85% if participants decrease their risk, and 15% come completely out of risk. It's only been going two years, so we'll need to look at it over time, but we're pleased," Joyner explains.

Life For Life services 24,000 people in the six-mile radius of Duke's campus. The program achieves its 54% participation rate by not waiting on employees to come to the program.

"We are set up with a truck to travel to the employees," Joyner says. "We get them in their breakrooms, we wait outside operating rooms in the medical center and catch the staff as they are coming out.

"That gets us over the barrier of getting them to come to us — we go to them. So our biggest challenge is just the size of the population we serve."

As for cost savings from the Pathways to Change program alone, Duke invested $28,175, or $175 per participant. The estimated savings, before costs, was $38,477, or $353 per participant, for a net savings of $10,302.

Cipriani, who works as vice president for professional services at Newport (RI) Hospital, is quick to say that employers are not merely driven by money.

"The financial stuff helps them get started, but the financial reason is not why most companies do wellness promotion," he says. "They have to get [the initial cost] off their plate as a disadvantage, but the driver is good leaders running good companies, who know that it's a good thing to do."

A captive audience

The workplace is a natural place for promoting wellness, since that's where the people are, adds Cipriani.

"A good percentage of people want a healthful environment; they don't need to be convinced," he says. "They don't want to smoke, or be overweight. So if the employer provides a culture and facilities and an environment that encourages that, they don't have to worry about changing employees' behavior, because that will come later."

Joyner says Duke's philosophy of making wellness as convenient as possible has paid off in the rate of participation by employees.

"We put ourselves where people naturally gather, and during orientation we let people know who to find us so they know how to tap into those resources," she says.

As many components as possible are made available on-line, so they are not hindered by 9-to-5 hours, Joyner adds. The smoking cessation program offers five different options, from phone to on-line to live components, so smokers who want to quit can get started whenever and wherever they decide they're ready.

Anderson says while it took American employers a while to truly warm up to the idea of health promotion as a means of saving money and lives, the growth of programs has escalated rapidly in recent years.

"It is happening very quickly and, in fact, over the next 24 months I would say virtually every Fortune 1000 company is in the process of implementing a program, enhancing an existing program, or are in the planning stages of a new program," he says. "So we are seeing a huge amount of movement in the markets, lots of growth and interest.

"With all this change, I suspect the data will keep getting better and employers will recognize that keeping people healthy has lots of benefits," Anderson notes.

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Lack of occ-clinic access means emphasis on nurses

High-poverty areas far from specialty clinics

High-poverty counties in the southeastern United States have limited access to physicians and clinics specializing in occupational and environmental medicine, according to recent research, making the role of the occupational health nurse at workplaces in those areas all the more important.

"Access is always difficult in rural areas," says **Susan A. Randolph,** MSN, RN, COHN-S, FAAOHN, president of American Association of Occupational Health Nurses (AAOHN) in Atlanta. "There just aren't as many resources in those areas."

A study conducted by researchers at Morehouse School of Medicine in Atlanta looked at access to physicians and clinics specializing in occupational and environmental medicine (OEM) in the "cotton belt" region of South Carolina, Georgia, Alabama, and Mississippi, and the coal mining counties of eastern Kentucky.

What the researchers, including **Lee S. Caplan**, MD, MPH, PhD, found was that most minority and low-income workers in impoverished areas in the region studied are more than 100 miles from the nearest occupational medicine specialty clinic.

At the same time, many workers in these areas are working in the high-risk agricultural and manufacturing industries. "What the study showed is a significant shortage of board-certified OEM physicians and OEM clinics for disadvantaged populations in some areas," according to Caplan.

He points out that his team's research, published in the March issue of *Journal of Occupational and Environmental Medicine*, shows that 95% of the population of counties in which at least 15% of residents are below the poverty level live more than 100 miles from the nearest Association of Occupational and Environmental Clinics (AOEC) clinic. AOEC is a network of NIOSH-funded clinics; the nearest clinics to the area studied are in Durham, NC; Nashville, TN; and Atlanta.

In addition from having limited access to specialized OEM clinics, only 17% of the counties studied had one board-certified OEM physician.

Caplan notes that census maps used for his team's study suggested remnants of two historically important industries in the southeastern United States: cotton and coal mining. The areas with the highest concentrations of poverty and African-American population cut a path from the Mississippi Delta across central Alabama, Georgia, and South Carolina. In eastern Kentucky, similarly high poverty rates were noted in a region of high white population, reflecting the influence of the coal mining industry.

Both the agricultural cotton industry and the coal mining industry have been left behind as service industries and educated workers migrated toward urban industries, and it is there that more health care resource options — of all specialties — are easily found.

Randolph and **Tee L. Guidotti**, MD, vice president of the American College of Occupational and Environmental Medicine (ACOEM) and former president of the AOEC, say that part of the problem is supply and distribution.

"The fundamental issue, from the [ACOEM] view, is getting enough specialists out there who have the expertise to help," Guidotti says. "The southeast has been difficult for university programs, and clinics tend to locate in urban areas."

Randolph says that while the number of nurses in occupational health settings has grown overall in recent years, more are being outsourced through temp agencies rather than employed in-house, and that may be reflected in studies like the Morehouse paper.

"What this points to is the need to promote the specialty of occupational and environmental health, and ongoing education about what is an occupational health professional and when do you utilize those particular services," Randolph states.

In regions where access to specialized occupational health clinics is limited, she says, the value of an employer having an occupational health nurse on hand is clear.

"That's where you will see the value of the occupational health nurse," Randolph points out. "The nurse may treat on site and use a physician with an occupational health specialty in the community. Or perhaps some of those illnesses and injuries can be treated on-site if the company has someone with those skills either on staff or with a temp agency."

And even if an OEM clinic is at a distance, because occupational health is an interdisciplinary specialty, an occ-health nurse is going to know where to refer a patient for advanced care.

"We tie into physicians because we are interdisciplinary and because there are some things beyond the RN's scope of practice, so we need to have a relationship with physicians in the community," Randolph says. "It's great if you can get someone who is board certified in occupational medicine, but in rural areas you're not always going to have those kinds of resources."

And, she adds, "100 miles to a specialty clinic — that's a couple of hours — is still a reasonable distance."

Researchers at Morehouse suggest medical schools cultivate more residency programs to train qualified OEM physicians, along with programs and incentives to place OEM physicians and clinics in underserved areas.

Guidotti says ACOEM has been concerned about the distribution of occupational health resources in the United States for some time.

"The most dangerous occupations in the U.S. seem to be progressively concentrated in most disadvantaged population," he states. "These people are getting less than they need, and the College has called for a more equitably distributed and increased supply of OEM physicians for years."

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How a little snooping can go a long way

Detective work can help ID cause of illness

When an employee who works in a shop where strong chemical fumes are present comes to the company nurse complaining of respiratory problems, an exposure history that identifies the chemicals he works around is likely to uncover the source of the health complaint.

But when the symptoms don't fit the job — and sometimes, even when they do, it takes a careful history and sometimes a bit of detective work to find out what's making the employee sick or what caused an injury, and whether it was a work exposure.

"Sometimes it's pretty straightforward, but other times, it's not so obvious," says **Rosemary Klein**, MS, C-ANP, COHN-S, a nurse practitioner and occupational health nurse who acts as clinic coordinator at the Central New York Occupational Health Clinical Center and a faculty member in the Department of Family Medicine at the State University of New York Health Science Center at Syracuse.

Even when the cause of an injury or illness seems evident, Klein advises taking the time to complete an extensive history before ruling occupational exposure in or out. "Ask not only what is happening at this job, but ask about previous jobs, and what exposures there might be at home, or working on a hobby or other activity," she suggests.

When asking about the employee's job, take time to find out what his or her work really entails, not just what the job title is. A worker's job title might sound like it would be strictly office work, for example, when he or she actually might be moving throughout a worksite and in and out of potentially hazardous areas during the day.

"Sometimes job names are opaque," Klein says, meaning that the title doesn't really reveal what the person does all day. "You should find out what the process is that is being accomplished at the job, and not only what kinds of

chemicals the employee is using, but what chemicals are being used by other people who he might be in the vicinity of."

Another factor that can shed light on a possible occupational exposure is the ventilation — or lack of it — in the areas where the employee works. Important to note is not only whether the area is ventilated, but whether seasonal conditions affect the ventilation — are the doors and windows open in the summer, but closed tight during cold months?

Even if an employee has been doing the same job for years in the same way, with the same materials, and without complication, an occupational injury can't be ruled out.

Klein explains that even a seemingly insignificant change can create symptoms where before there were none.

"I was working with a [patient] who has welded for 25 years with no problems, until he used a different welding rod on one job," she says. "It turns out his symptoms were consistent with manganism [manganese poisoning, also known as 'Parkinson's syndrome' because its symptoms closely resemble those of Parkinson's disease], and his manganese level quite elevated. We're trying to find out what was different about this rod or this situation that caused him to develop symptoms."

Granted, manganism symptoms in a welder are not unlikely — another name for manganism is "welder's disease." Some complaints, however, may seem unlikely for people working in some jobs, but a thorough history and additional research can turn up surprising links, Klein says.

Occupational illnesses and injuries and hazardous exposures have long been part of the manufacturing, construction, and agricultural sectors, but in recent years have become more and more common in the service sector. A significant proportion of occupational illnesses are related to building conditions, such as inadequate fresh-air ventilation, low humidity, and the presence of cigarette smoke, volatile organic compounds and fibers, molds, or other microbiologic materials, says Klein.

An office employee might complain of upper airway and eye irritation, and possibly fatigue and difficulty concentrating. Could these be symptoms of asthma, or seasonal allergies brought on by being outdoors? Possibly — but if others in the office or building complain of similar symptoms, and they report clearing of the symptoms when they leave the workplace, the signs could point to poor indoor air quality, and further follow-up is indicated, according to Klein.

Furthermore, the workers report rapid clearing of the symptoms when they leave the workplace. Other illnesses, including asthma, hypersensitivity pneumonitis and respiratory infections, also have been linked to specific building-related exposures.

The timing of symptoms in relation to work often is crucial in the assessment of a potential occupational illness, Klein stresses. For example, a patient with asthma may report that her symptoms appear soon after she gets to work, and then go away when she leaves and on weekends. Establishing the timing of the symptoms may allow the nurse to pinpoint a specific substance, process, or recent change that could be causing the symptom flare-ups.

Klein notes that if a workplace illness progresses, it may be difficult to establish the temporality, because the symptoms may no longer abate after the patient leaves work.

"It's easy to have your mind fixed on one idea and so miss another, so you have to try to not drop the ball by assuming something came from the workplace," she says. "The [patient's] chart is a work in progress, so there's a totality to it you're building on, and sometimes missing something is just a matter of not thinking about it."

Klein says the initial interview with an employee who might have suffered an exposure needs to be a long one. "The first visit takes a while, and requires lots of follow-up after," she admits.

Every patient's chart should include a self-administered occupational history form that the patient fills out. This should be a simple form on which the employee lists jobs he or she has held, the dates of employment, job title, specific duties, any exposures (e.g., dust, chemicals, noise, repetitive motion, stress, etc.), and protective equipment used.

The history taken by the occupational health nurse should include a standardized set of questions asked of every patient — Klein says this is the single most important method of recognizing the link between illness and occupation. Besides aiding in the establishment or exclusion of an occupational exposure in the patient being seen, a standard questionnaire will point out similarities among symptoms seen in more than one employee, should other complaints arise.

The key screening questions include:

- What type of work do you do?
- Do you think your health problems might be related to your work?

• Are your symptoms different at work and at home?

• Are you currently exposed to chemicals, dusts, metals, radiation, noise, or repetitive work? Have you been exposed to chemicals, dusts, metals, radiation, noise, or repetitive work in the past?

• Are any of your co-workers experiencing similar symptoms?

Answers to these questions that suggest the employee's symptoms might be job-related or the result of a hazardous exposure should trigger a comprehensive occupational history, Klein says.

HHS' Agency for Toxic Substances and Disease Registry (ATSDR) offers a thorough exposure history form, and provides it on-line at www.atsdr.cdc.gov/HEC/CSEM/exphistory/pdffiles/exposure_form.pdf.

An early step, if an employee reports an exposure, is getting his or her permission to request the employer submit material safety data sheets (MSDS), required by OSHA for identifying hazardous ingredients and health risks of the substances. This gives the nurse full information about the substances the employee works with, including materials the employee might not be aware he or she works with.

"We try to get those, but sometimes it's difficult to find them, because not all employers are as up to date as they are supposed to be," she says. "Sometimes they're wary about turning those over, but we just tell them that we are not an enforcement agency — we're just looking for information."

Asking for the right MSDS can hinge on getting an accurate job description from the employee. "I had one fellow who said his job required him to work in one area, but when we got him to explain in detail where he was, we found he was all over the place, and was exposed to all sorts of things," she recalls.

Once the MSDS is in hand, the employee's symptoms can be compared against the known effects of the material to see if there is a match.

According to the ATSDR, the numbers of toxins and how they can affect different organ systems are countless. For example:

• More than 100 toxicants cause asthma, and many more can exacerbate it.

• Symptoms of liver disease due to toxic exposure can mimic viral hepatitis.

• Organic solvents and heavy metals are known to adversely affect renal function.

• Many chemicals cause mild central nervous system depression that may be misdiagnosed as intoxication and, if undetected, can progress to psychoses or dementia.

• Cardiovascular changes, as well as exacerbation of preexisting cardiovascular conditions, can result from exposure to noise and to chemicals such as carbon monoxide and tobacco smoke.

• Benzene can cause bone marrow changes leading to aplastic anemia, acute leukemia, and chronic myelogenous leukemia.

Effects can be long-lasting, leading to symptoms that don't match up with the employee's current working or living environment.

"I saw one man who was four years removed from a job in a foundry, where he'd handled lead as part of a brass process," Klein recalls. "He worked there for 50 years, retired, but four years later had elevated lead levels. We very carefully tried to determine whether he had other sources of lead contamination — in his home, in dietary supplements, eating off pottery with a lead glaze. We couldn't find anything, so we sent the typical letter to the employer [seeking MSDS information], and instead of sending us the information, the employer replied that they hadn't used lead in their processes for a very long time."

Off-work activities may also contribute to illness, and should be assessed as part of the comprehensive history, she says. Smoking and excessive alcohol use contribute to a variety of diseases and may interact with occupational exposures to increase the risk of adverse health effects. Recreational activities, hobbies, and drug use are other potential sources of hazardous exposure. For example, a miner may be exposed to noise both at work and at home, or a construction painter may be exposed to lead during bridgework and while scraping and repainting his own house. A complete history allows the evaluation of the relative contribution of on- and off-job exposures to an illness.

Klein and her colleagues use the team approach when working on exposure cases, calling in industrial hygienists, occupational medicine physicians and nurses, nurse practitioners, and social workers to discuss cases and make sure stones aren't left unturned.

The Internet has revolutionized the research component, and Klein says as a result, her network's traditional library is beginning to age.

The ATSDR, one of the resources Klein says has proven very useful to her practice, notes at its Web site (www.atsdr.cdc.gov) that the introduction of new chemicals and other materials has far outpaced general knowledge of their potential toxicity. The MSDS often is limited, however.

Since many substances remain unstudied and their toxic effects are unknown, they have not been deemed harmful by OSHA. As a result, they are not covered in MSDS materials.

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An old foe still is costly to employers

Prevention efforts save money

Advocates say alcoholism is chronic disease despite the tremendous amount of education delivered to Americans at home, school, and work, according to a George Washington University center devoted to studying and promoting solutions to alcohol abuse, alcohol use continues to take a tremendous toll on the work force, and employers can do a better job of providing help.

More than 7% of workers in the United States have a problem with alcohol, according to the HHS' Substance Abuse and Mental Health Services Administration, including those who are dependent or suffer from alcoholism, and others who drink in ways that are risky to health and safety.

"Not many companies track the cost of alcohol problems or the savings they can realize from treatment, but ones that do, even smaller ones, have seen that treatment unmistakably saves money," says **Eric Goplerud**, PhD, director of the Ensuring Solutions to Alcohol Problems (ESAP) program at The George Washington University in Washington, DC.

"Alcohol problems take a tremendous toll on the workplace, and it's in the interest of every workplace to confront the problem and encourage treatment. Treatment works — it saves companies money, and it saves people's lives."

One of the efforts of ESAP is to promote, among businesses and insurance providers, the idea that alcohol treatment should not be viewed any differently from treating other serious chronic diseases.

"You can't run an industrial health program without focusing on diabetes or asthma, and the treatment success for alcohol is as good or better," says Goplerud. "For the pre-diabetic, there are interventions and lifestyle changes that can be made that area cheaper than treating Type II diabetes, and it's no different for alcohol."

Goplerud says the main difference between treatment for problem drinking and treatment for asthma or diabetes is that health insurance doesn't cover treatment for alcohol the same as it does other diseases. "It is treated differently, and not in a way that promotes health or even a good bottom line for businesses," he says.

Treating alcohol abuse early can reduce health care costs right from the start, with especially noticeable savings among younger drinkers, ESAP figures show. The program even devised a calculator that can be adapted to fit a company's size and type of business and show what the costs associated with alcohol problems might be (www.alcohol costcalculator.org). The calculator looks at obvious costs, such as health care and time away from work, but also adds in related social costs.

"It translates it in a way a corporate medical director or occupational health nurse can see it's relevance to their own company," Goplerud says.

ESAP has created a list of seven steps employers and employee health managers can take to reduce the cost, in dollars and health, exacted by alcohol abuse. They are:

1. Offer comprehensive health insurance. A 2002 ESAP report found that there are significant gaps in alcohol coverage in many health plans. Nonetheless, it also found that some companies can and do purchase insurance that covers the range of needed alcohol services.

2. Monitor and maintain standards of care. Coordination of EAP, behavioral, and medical services benefits both employer and employee, and ensures that a patient's care is coordinated and, therefore, more cost-effective.

3. Enact treatment-oriented workplace policies. Strong, clear workplace policies can reduce alcohol problems and reduce legal liability, but

COMING IN FUTURE MONTHS

■ Workplace stroke prevention that works

■ Do you have enough malpractice insurance?

■ Developing an outcomes management program

■ When an employee resists your RTW plan

Has assistance for problem drinking been left behind?

When it comes to addressing the problem of alcohol abuse, are employee assistance programs (EAPs) keeping up with the needs of workers' busy lives, or have they lost sight of the purpose that led to the boom in EAPs over the last 20 years?

It's a debatable question, admits **Eric Goplerud**, PhD, who directs The George Washington University's Ensuring Solutions to Alcohol Problems (ESAP) in Washington, DC. "One of concerns we have, working with big companies on improving their EAPs, is that we're finding that while EAPs have their genetic roots in the old industrial alcohol programs, they're not identifying many people with substance abuse problems [today]," he notes.

As EAPs evolved from their 1940s-era beginnings of supervisor referrals for alcohol abuse to today's self-referrals for a wide range of personal and family concerns, Goplerud says too little attention may be going toward the problems of chemical abuse.

"Typically, EAPs see between 2% and 5% of employees annually, but we know that 7.5% of employees, on average, have a diagnosable alcohol or drug problem, so we're only getting maybe one in 20, and the consequences are that employers and coworkers are bearing an extra cost," Goplerud states.

But **D. Scott Richardson**, associate vice president for human resources at Grand Valley State University in Allendale, MI, says the evolution of EAPs is necessary to serve the broader needs of employees and their families. "The focus and the function of an EAP has changed markedly in the last 20 years, and is currently under an evolution that will have a larger and more immediate impact than the industry has seen before," he adds.

"The days of only offering crisis services and support to the 'troubled few' are ending. The scope of service from an EAP now needs to encompass a much larger spectrum of employee, family, and work-life needs," Richardson continues.

Goplerud contends that today's EAPs are not adequately asking employees about alcohol problems. "Part of the reason is that people who are trained in mental health generally have very little training in how to treat alcohol problems," he asserts.

ESAP describes EAP follow-up to treatment for alcohol abuse as having two primary goals:

1. to help the employee maintain work continuity during treatment (if the employee is staying on the job while receiving outpatient treatment) and after treatment;
2. to ensure that the employee adheres to the continuing care component of his or her treatment plan, and, in case of a failure to comply with company policy (i.e., a positive drug or alcohol test), continued monitoring.

Goplerud says research shows that sometimes, even a little intervention can make a big difference when an employee is engaging in risky drinking behaviors.

"Some research-based literature says interventions can be as brief as 15-20 minutes and can have a tremendous effect on risky drinking — people who drink and drive, or who binge on weekends," he says. "For alcoholics, brief interventions won't be as effective."

Goplerud says a recent national survey of the memberships of the Employee Assistance Professionals Association and the Employee Assistance Society of North America identified 15 common types of EAP services — including financial and legal consultation, job placement, career testing and counseling, and executive coaching — that fall outside the scope of traditional EAP programs and require completely different knowledge and skills.

The demand for these services by self-referred employees, in conjunction with frequent lack of addiction training, have left the new breed of employee assistance professional with less time to deal with alcohol problems, he adds.

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should be nonpunitive and encourage employees to seek treatment.

4. Intensify health education. Goplerud says studies on the impact of education programs on employees' alcohol use have found that employees where such programs are in place reported lower alcohol consumption and lower incidences of negative work performance related to alcohol use.

5. Promote confidential screening. When screened for alcohol problems, one in five men and one in 10 women who visit their primary care providers meet the criteria for at-risk drinking, problem drinking, or alcohol dependence, adds Goplerud. Confidential screening often opens the door for intervention and treatment.

6. Offer/expand EAPs. An effective EAP includes confidential screening and counseling, worksite awareness programs, web-based resources and referrals to treatment, recovery support for those in treatment, and training to

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help supervisors spot productivity problems that may be alcohol- or drug-related.

7. Manage employees' time off and return to work. Employers can take an active role in managing employees who are temporarily off the job while receiving treatment for alcohol problems By making reasonable accommodations and by easing the return through flexible scheduling, allowing for time to go to medical appointments, the company can retain trained employees and avoid the high turnover costs sometimes seen in industries plagued by high rates of alcohol use.

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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 to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

17. In states that enact nursing licensure compacts, the licenses of nurses in those states are automatically recognized in other states.
    A. True
    B. False

18. A Brigham Young University study indicates that employers can save how much for every dollar spent on wellness and health promotion at the workplace?
    A. Nearly $8
    B. Nearly $12
    C. Nearly $16
    D. Nearly $20

19. Workers in the Morehouse study on rural access to occupational health clinics and providers typically work in which industries:
    A. Agricultural
    B. Manufacturing
    C. Mining
    D. All of the above

20. Which of the following statements about occupational exposures is NOT true?
    A. If a worker has been doing the same job, with the same materials, in the same place, and in the same way for years, his or her symptoms can be assume to not be job-related.
    B. Off-work hobbies should be looked at as a source of symptoms.
    C. Whether or not co-workers have experienced similar symptoms is pertinent.
    D. Ventilation, or lack of it, can be a factor in exposure symptoms.

Answers: 17. A; 18. C; 19. D; 20. A.