Occupational Health Management™

A monthly advisory for occupational health programs

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INSIDE

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Lessons from Katrina: Be prepared, know your site's post-disaster risks

Occ health nurses should help with pre-planning and recovery

The devastation left in the wake of Hurricane Katrina gives occupational health professionals cause to consider what effects natural disasters can have on worker safety and health, both when disasters strike workers' homes and jobs and when disasters are far away.

Floods, tornadoes, earthquakes, and hurricanes wreak obvious damage at the time they occur, but even after cleanup, people returning to work face residual hazards that are less obvious, yet still serious.

While rescue and recovery workers are exposed to the immediate hazards of a natural disaster, their training affords them some protection that non-emergency workers don't have. Those who are not trained in disaster work but who volunteer or people who venture into disaster recovery sites after the immediate threat is over are exposed to injury, illness, and stress that can come from not preparing for or taking precautions against what they are going to encounter.

There are a couple of ways to look at how large- and small-scale disasters can affect the occupational health professional, according to **Susan Randolph**, MSN, RN, COHN-S, FAAOHN, president of the Atlanta-based American Association of Occupational Health Nurses.

"You have nurses who might be responding themselves and treating people at the scene and people doing search and rescue, and getting injured while they're doing that," she says. "And then you have nurses who may have employees there, or have employees who have family or friends [caught in the disaster], and they're trying to help them with the concern and stress. Or, you may work for a company that has a location [at the disaster site], and you're wondering what you can do to help the folks at that site."

Don't neglect occ health, safety

If Hurricane Katrina has any legacy for occupational safety and health professionals, it is that even organizations that have disaster plans might not be adequately prepared, according to **Bruce Lippy**, PhD, CIH, CSP, director of the National Clearinghouse for Worker Safety and Health Training in Washington, DC.

And, says **Tee Guidotti**, MD, vice president of the American College of Occupational and Environmental Health and a George Washington University professor of environmental and occupational health, "the big lesson is don't neglect occupational health and safety when something does happen."

Anyone, from professional rescuers to everyday workers, gets into trouble when they ignore plans and protocols in the heat of a crisis, Guidotti says.

The United States has never seen destruction from a natural disaster like that caused by Katrina. That means that even the most well-thought-out disaster plans probably could not stand up to the flooding and loss of electricity, shelter, food, and portable water.

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Emergency and rescue workers are trained to deal with the hazards posed by flooding, contamination, and other conditions that result from natural disasters, experts point out. It's when untrained volunteers — or people returning to their damaged homes and work sites — go in to contaminated or damaged areas that injuries and illnesses become greater concerns.

"In past hurricanes, it's the accidents from chainsaws and axes that occurred during debris cleanup that jump out at you," says Lippy. "You have volunteers and small companies [contracted to help clean up], and they're not adequately trained, and you get lots of physical injuries. That was a major issue with Hurricane Andrew [in 1992], and [Hurricane Katrina] is beyond any scope we've dealt with in the recent past."

Loose and leaking chemical tanks and underground tanks, downed electrical wires, infectious agents in the water, toxic molds, and unstable surfaces are just a few of the hazards that can be left behind after a serious storm or flood, Lippy says, and ignoring well-established occupational safety procedures in the drive to get cleanup or recovery under way can have serious consequences.

"We are urging people to try to work from a staging area and to train people before they go in" to disaster-stricken areas, Lippy continues. "There is a course, a two-day course created by [the Occupational Safety and Health Administration (OSHA) and National Institute for Environmental Health and Safety (NIEHS)] for people who are not emergency responders but who come into an area afterward."

Lippy says this training (information available at www.niehs.nih.gov) gives participants a crash course in following an incident command system, and is important for occupational health nurses who come to a work site returning to assist recovery workers and workers.

Effects just as dangerous, more subtle

While recovery after some disasters can begin immediately with few residual hazards that is not always true with many disasters. Even after the New Orleans area is drained of water and debris is cleared, the health threats left behind will last for years, some experts predict. Guidotti says the area hit by Katrina "is like one big Superfund site," and the precautions and cleanup required will be comparable to cleanup at a toxic waste site.

Michael Harbut, MD, MPH, FCCP, chief of the Center for Occupational and Environmental

Medicine at the Karmanos Cancer Institute at Wayne State University and a leading expert on environmental health and toxins, says while disease and injury are obvious risks right now for recovery workers in the areas hit by Katrina, long-term effects could be just as deadly, though much more subtle.

Carcinogens, mutagens, molds, lead, and organic solvents will be present long after the risk of infectious disease is gone from the flooded areas, Harbut points out.

"The main problems will be subtle and long term, for a long period of time," he explains. "There will be carcinogens left on surfaces that people will come in contact with, so there will most likely be an increased risk of cancer in people there.

"There's not going to be some enormous epidemic of cancer. Carcinogens sneak up on you, and that's my big concern," he explains.

Additionally, it's hard to tell how much lead contamination can be left behind after a flood.

"If I were in charge of ensuring a healthy work site for people to come back to after it had been flooded, I would contract with an environmental testing company to test for residual levels of hazardous substances," he says.

Expect respiratory ailments

Following a flood, respiratory ailments take a sharp upturn, experts say. In any flooded-out area, molds become a real problem, air quality can be difficult to ensure, and improperly remediated plaster can result in airborne plaster and construction dust, exacerbating respiratory complaints.

Guidotti says flooding can cause "explosive" mold contamination as waters recede, creating serious health problems.

"The initial dangers merge into environmental concerns, including groundwater contamination, contaminated soil, overgrowth of mold, pathogens that can be stirred up in the soil or imbedded in building materials," he says. "In New Orleans, we're in for a very, very long haul."

Julie Anderson, PhD, RN, CCRC, a professor at the University of North Dakota in Grand Forks, was living in Grand Forks in 1997 when a catastrophic flood forced evacuation of the city's 60,000 residents. Flooding was followed by years of recovery, and Anderson says the city is a changed place — one with markedly increased numbers of respiratory ailments.

"What I found was that asthma increased significantly in certain populations," she says. "Some people just didn't feel comfortable returning to the city, and those who did felt their asthma was much worse, that things seemed to trigger their asthma that didn't before, and some of them had to move away."

She says occupational health nurses working in areas that are recovering from flooding should monitor respiratory complaints among workers.

Another health risk that nurses at recovering work sites should guard against is carbon monoxide (CO) poisoning, Anderson emphasizes. Following the Grand Forks flood, she and other health care providers began noticing more cases of CO poisoning, and quickly broadcast public service announcements and distributed pamphlets warning against the dangers of CO poisoning after floods.

According to the Centers for Disease Control and Prevention (CDC) in Atlanta, 33 laboratory-confirmed cases of CO poisoning were identified following the Grand Forks flood, and all involved the use of gasoline-powered pressure washers — a ubiquitous cleanup tool following a flood — being used in basements.

For that reason, the CDC now warns that CO poisoning must be considered a potential hazard after major floods. Work sites where cleanup is going on in closed spaces should be closely monitored for ventilation and buildup of CO.

Lippy says occupational health and safety workers should have learned another respiration-related lesson from the Sept. 11, 2001, terror attacks on the World Trade Center. Safety supervisors involved in recovery and cleanup did a bad job of enforcing respirator use during operation of heavy machinery, he says, and the clouds of dust from the cleanup resulted in workers who now suffer from chronic lung diseases.

Lippy urges companies to bring OSHA in whenever a disaster affects a work site, because the resources available to help in cleanup and safety are extensive. Plus, he says, during the immediate period after a disaster, OSHA "is not in enforcement mode." But once recovery and cleanup begins, OSHA will start enforcing its requirements, so getting input early on can help avoid citations later and ensure safety for workers.

Watch for signs of stress

As workers return to their homes and work after a disaster, occupational health nurses should be attuned to the toll stress and — if lives were lost — grief can take.

"You need to move into critical incident stress management," says Lippy. "There can be a lot of issues about traumatic stress."

During cleanup at the World Trade site in 2001, Lippy says he watched as heavy machine operators who were clearing the rubble "got that thousand-mile stare."

"You could see these people drifting away, and it's a real concern. Who's watching out for those people? There have been suicides from the people at the [World Trade Center] site. They saw things people shouldn't have to see, and the same thing has happened in Louisiana."

Randolph says occupational health nurses need to keep in mind that if they are victims of natural disasters, they need to make sure they take care of themselves, too. While helping the people they work with, nurses might be wondering how their own lives will regain normalcy, she points out.

Anderson, who studied the Grand Forks flood, says clinic visits for depression and drug and alcohol abuse increased significantly after the flood.

Martha Starr, MS, BCETS, a crisis management expert and faculty member at the University of Alabama at Birmingham's department of education, says health care workers, particularly those who work in rescue operations, operate "on autopilot" during the crisis, but then may be debilitated by the stress that follows.

Symptoms of stress that nurses should make workers aware of include poor concentration, anxiety, depression, irritability, chest pains, and headaches.

"These are normal reactions to an abnormal event, but if the symptoms increase to where they remain over time, they may develop post-traumatic stress," Starr explains. "Health care and emergency workers have this little gene that makes them take care of everyone else but themselves, and they need to make sure they practice what they preach in terms of getting enough rest, food, water, and in terms of talking to someone they trust about what they're going through."

One on-site occupational health nurse will be hard-pressed to monitor the emotional well-being of a plant full of people coping with the aftermath of a disaster, Starr acknowledges. The nurse can help beef up the support system by encouraging a "buddy tree" — one person calls to check on another person he or she feels close to, another friend or co-worker is keeping tabs on the first, and so on.

Following a disaster in which homes, lives, and jobs are lost, survivors' buddy trees should probably go on for several months, she says.

Anyone whose life and work has been disrupted by a natural disaster will be anxious to restore things to the way they used to be, but Starr cautions that health care providers must emphasize to people in their care that recovery from a disaster is not a short-term proposition.

"It's going to go on for months, and if they burn the candle at both ends, they will wear out," says Starr. "They need to have a goal in mind, and to take care of themselves while they work to achieve it. The occupational health nurse can help by setting a good example and saying 'this is how you survive one of these things.'"

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Physicians specialized in occ may not meet demand

Med school program cuts taking toll

Just when the business world is coming back around to the idea of on-site corporate medical offices, the supply of physicians specializing in occupational health may be choking itself out.

Much on-site health care once handled by teams of physicians and nurses gradually has became the responsibility of occupational health nurses, according to **Tee Guidotti**, MD, vice president of the American College of Environmental and Occupational Medicine (ACOEM). Now that employers are seeing the benefits of expanding

the health services offered at work sites, the occupational medicine doctors might not be there to fill the demand.

While Guidotti says some of his colleagues in ACOEM fret that jobs once held by occupational and environmental medicine physicians are now in the hands of occupational health nurses, "it's not a question of choosing a nurse over a doctor."

Economics, he says, has shaped the fortunes of occupational medicine physicians, both in positive and negative ways. ***(For up-to-date feedback on the state of occupational health nursing, see the insert in this issue.)***

The company doctor is (back) in

When companies started downsizing in earnest about 20 years ago, middle management positions were among the most commonly cut. Guidotti says those middle managers, by and large, influenced decisions about corporate medical department staffing. What disappeared with those positions, he theorizes, "were a lot of people who appreciated what occupational medicine could do for them."

In the ensuing years, decisions on employee health were based on economics. When deciding whether to keep some health care presence at the site or completely do away with on-site medical care, Guidotti says employers opted to cut costs by hiring occupational health nurses, thus providing care for employees without the cost of maintaining a clinic or occupational medicine team.

However, the current generation of managers has shown growing interest in the long-term value of occupational medicine and the benefits of offering physician services at the workplace, in addition to occupational nursing.

"We're finally getting some arguments about how occupational physicians enhance productivity and reduce risk and liability," he says.

Guidotti says ACOEM has noticed a reawakening of the corporate medical office — just as the supply pipeline of new occupational and environmental medicine physicians appears in danger of choking itself.

Supply may not meet demand

Occupational medicine can be viewed as a supply-driven specialty, Guidotti says, because the greater the presence of occupational medicine physicians, the more demand there is for their services. "Employers see we're adding value, and they say, 'I want that.'"

But Guidotti says his single biggest concern for his specialty is that although residents are getting good jobs, the market is favorable, and indicators are that the job market is favorable for occupational medicine physicians for the first time in a while, the discontinuation of training programs is threatening the supply.

"There is a constant pressure [for schools] to close small programs, and occupational medicine programs tend to be relatively small," he says.

"Accreditation agencies have a strong preference for large programs in fields like surgery, because large programs are preferable in some specialties, but if you apply that across the board and say that means small programs are substandard, then that hurts small programs."

While private occupational medicine practices can be lucrative, programs in large medical centers often suffer from lack of funding, he says, because they're not seen as large revenue generators.

To make inroads in the workplace, occupational health practitioners in all fields need to demonstrate their value, suggests Giudotti.

"Physicians and nurses need to take care of the fundamentals, show the value we add, and demonstrate our utility," he says. "There's no magic marketing or ad campaign. We just need to understand our ability and demonstrate our ability to take care of the workforce."

Susan Randolph, president of the American Association of Occupational Health Nurses, says polls taken by the group show that occupational health programs make the most positive impact when the occupational health professional understands the employer's needs and expectations.

"By knowing the executive management team's goals and perspectives, the occupational health staff will ultimately be better equipped to prove their true value and benefit within the workplace," she says.

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Taking care of loved ones at home need not derail job

OHNs need to keep juggle home, work demands

An employee with an aging, sick parent or a chronically sick child may do a good job of juggling the responsibilities of caregiving and working, but there almost always comes a time when the burden is overwhelming. Employers are getting better at helping those workers out during those times of crisis, abandoning the old rule of "leave your home life at home."

"It's how we work; we work 24/7," says **Kay Campbell**, EdD, United States manager for employee health support and resilience at pharmaceutical giant GlaxoSmithKline. "Where does work begin and home life end? There is an integratedness between work life and the rest of life."

While it's been part of the cost of doing business to bring work problems home with us, there's historically been less acceptance of bringing home problems to work. But in recent decades, with the advent of employee assistance programs and recognition of the wellness of the "whole" worker, crises such as the stress of facing the death of a loved one is considered something that can, and should, be dealt with at work as well as off duty.

Keeping balance while 'juggling'

"That need is understood today and is being addressed," says **Sandi Thomson**, OHN, occupational health nurse and safety coordinator for Largo, FL-based Cox Target Media**.** "The occupational health nurse brings a level that goes even a little beyond just providing a caring work environment, because we can do so much — one-on-one, in the home — that might be above and beyond."

MetLife insurance's Mature Market Institute has looked extensively at the challenges faced by caregivers who also are managing careers. In its 1999 study, "The MetLife Juggling Act Study" (www.caregiving.org/data/jugglingstudy.pdf), MetLife surveyed more than 1,500 caregivers and found that at the time they became caregivers to a sick or dying loved one, most underestimated the time that would be required of them and the impact of that obligation on their work.

Most of the caregivers surveyed started out providing a small amount of care, gradually taking on more and more responsibility.

Respondents expecting care to last six months or less actually spent more than a year providing care. Similarly, a majority of those anticipating one or two years of caregiving actually spent four or more years providing care.

Work schedules are compromised, with responsibilities at home possibly costing the employee promotions, business travel, and training. Overall, 40% of the MetLife survey respondents reported that caregiving affected their ability to advance in their job, and more than one in 10 said that their work was "greatly affected."

"Think about how trying to be present on your job and be productive when other things are pulling at you can be difficult," says Campbell. "So a lot of times, the occupational health nurse will be who the person seeks out as the confidential advisor about what resources are available."

While the employee might be reluctant to step forward and address the outside stressors affecting his or her work, his or her manager, and sometimes the occupational health nurse, are usually able to pick up on problems.

"A lot of times, the managers know employees are struggling, because they know the people," says Campbell. "So managers will come to the nurse, who will act as an advisor for the manager, to help them know what to say and do, and will give the manager information to help him or her work with that person."

Even when employees realize that caregiving responsibilities are affecting their job performance, they may have difficulty making time in their already overloaded schedules to seek out support for themselves.

That's another opportunity for the occupational nurse to help. While referral to a company employee assistance plan is an assumed step, the employee might not take advantage of it due to time constraints. So the occupational nurse might have to go off the formal path and on to something that works better for that particular employee.

"What we have found in recent times is that it's hard for people to get away from work for lunch programs, especially in caregiving situations, so providing programs where it fits into their day — during a lunch break, or through a teleconference that the employee can watch at his or her convenience — can work well for those people," says Campbell.

Sometimes, she says, employees who are in

caregiver situations find each other. Informal support groups need not be directed by the company, but can be welcomed and encouraged.

Helping employees take care of themselves while they're taking care of loved ones at home seems to make financial sense. MetLife says that one worker in 10 reports that their work is "greatly affected" by their caregiver responsibilities, and estimates that U.S. businesses lose $11.4 billion to $29 billion per year due to caregiving, absenteeism or presenteeism (at work, but not doing their job as usual), early retirement, frequent job turnover, and lost productivity.

FMLA can help if it's used

So long as the person being cared for is a direct relative of the employee, the Family Medical Leave Act (FMLA) can apply and be a boon to the caregiver, providing them up to 12 weeks of job protection should they need a leave of absence due to injury or illness. But the FMLA is of less use when the person being cared for is not a direct relative.

And sometimes, even when the FMLA could save the employee a lot of stress and juggling of time, it's not taken advantage of.

"I find I have to encourage them to take FMLA," says Thompson. The same applies to employee assistance programs — the employee, focusing on the person he or she is caring for, may be unable to see himself or herself as in need of help.

GlaxoSmithKline has been teaching employees how to be more resilient, even those who are not facing a demanding caregiving situation.

"It's based on the premise that all of us are stressed," says Campbell. "We teach them how to juggle better, how to be flexible optimists, and how to manage themselves."

Caregiving responsibilities often take a toll on the health of the caregiver. Almost three-quarters of those responding to the MetLife survey said caregiving had a negative impact on their health, with more than 20% reporting significant health problems.

"The key to helping employees keep themselves well in these situations is establishing a rapport with them, so they see you as someone who cares and is there for them no matter what their crisis is, and then they'll come," says Thompson.

Campbell says the occupational health nurse will frequently find himself or herself acting as a health care advocate, answering questions about the employee's health care benefits and about the health care system, which some employees find mystifying.

"[Helping employees who are facing end-of-life and other lengthy caregiving situations with loved ones] is something we are going to see more and more of," says Campbell. "It's not only because we have an aging population, but more so because people are seeing that the workplace is a major part of our lives, and it's the place — or one place — where you should be addressing these things."

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Debate against mandatory flu vaccines in HCWs grows

Professional organizations oppose requiring shots

Mandatory influenza vaccination for health care workers is not justified says the American College of Occupational and Environmental Medicine (ACOEM) in a new position statement. The college further opposes the use of declination statements noting that there is "no evidence to suggest that such programs will increase compliance." The statement — *Influenza Control Programs for Healthcare Workers* — applies to seasonal influenza and is not necessarily appropriate during a major antigenic shift in the virus resulting in a pandemic situation.

Influenza continues to be a major cause of death and disease, readily spread by respiratory droplets both in the community and in the hospital environment.

While ample reasons exist for employers to sponsor influenza vaccination programs for their employees and to pursue strategies to maximize participation, the college noted that mandatory flu shots are not justified for several reasons — the vaccine itself is variably effective; vaccination does not preclude the need for other controls; and a coercive program has the potential to harm the employer–employee relationship. In addition, the college points out that "given the ubiquitous nature of influenza in the community, patients will continue to be exposed to influenza through family members and friends regardless of the vaccination status of their health care workers, with whom they have much less intimate contact."

CDC issues tiered priorities for vaccinations

Given the uncertainties in doses and distribution, the Atlanta-based Centers for Disease Control and Prevention (CDC) recommends that the following priority groups receive trivalent inactive vaccines until Oct. 24, 2005:

- persons 65 years or older with comorbid conditions
- residents of long-term care facilities
- persons ages 2-64 years with comorbid conditions
- persons 65 years or older without comorbid conditions
- children age 6-23 months
- pregnant women
- health care personnel who provide direct patient care
- household contacts and out-of-home caregivers of children younger than 6 months

As of Oct. 24, 2005, all persons are eligible for vaccination, according to CDC guidelines. The tiered use of prioritization is not recommended for live attenuated influenza vaccine (LAIV) administration. LAIV may be administered at any time for vaccination of nonpregnant healthy persons age 5-49 years, including most health care personnel, others in close contact with groups at high risk for influenza-related complications, and others desiring protection against influenza. Additional information is available at http://www.cdc.gov/flu.

Vaccination only one part of control

"Vaccination is only one prong in a multifaceted approach to infection control," says **William Buchta**, MD, MPH, FACOEM, chair of the college's Medical Center Occupational Health Section and author of the paper. "Health care workers must also appropriately use hand washing and personal protective equipment and they should consider self-removal from work when experiencing symptoms of a communicable illness."

Buchta also notes that reliance on employee vaccinations alone for prevention and control of influenza in the health care environment offers a false sense of security and ignores some of the more practical, but also effective, means of minimizing nosocomial transmission.

While ACOEM endorses a multifaceted influenza control program in all health care facilities and strongly encourages health care organizations to facilitate participation by providing influenza vaccine and/or prophylactic medication at no expense to the employee, the college discourages generalized policies requiring mandatory compliance with employee vaccination or prophylactic medication, noting that such policies have already been successfully challenged in Canada.

The American Nurses Association (ANA), likewise, urges health care workers to be vaccinated, but "could not support mandatory vaccinations [because we] believe it is a nurse's personal decision," ANA spokeswoman **Carole Cook** says.

"Making people sign a statement that they have declined to receive a flu shot not only impacts the employer–employee relationship in a negative way, but diverts resources from activities known to increase compliance and devotes them to enforcement of a policy with no proven benefit," says Buchta. "Influenza control can be successful with creative programs that employ the 'carrot' rather than the 'stick,' while still respecting the rights of both patients and employees."

There currently are no states that require health care workers to be vaccinated against influenza. But even in years when the flu vaccine has been plentiful, the nationwide vaccination rate among health care workers has averaged only about 38%. Those involved with professional associations say the reasons for the low compliance rate are the same as in the general population — from apathy, to fear of contracting the virus from the vaccine, to fear of other side effects.

Influenza Control Programs for Healthcare Workers was approved by the ACOEM board on July 30. It is available on-line at www.acoem.org.

CDC guidelines and continually updated flu information are available at www.cdc.gov/flu.

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Mutual recognition eases nurses' work across states

Requires license in home state and compliance in others

New Hampshire has become the 20th state to join the Nurse Licensure Compact (NLC), a mutual recognition model of nurse licensure that allows nurses to have one license in their state of residency and to practice across state lines. Under mutual recognition, a nurse licensed in one NLC state may practice in another NLC state unless otherwise restricted.

According to the National Council of State Boards of Nursing (NCSBN), New Hampshire plans to implement compact in 2006.

Compact eases work restrictions

"The ready access of nurses across state lines will assist our board's mission to respond to state emergency-care needs and allow nurses greater work flexibility," according to **Margaret Walker,** MBA, BSN, RN, executive director of the New Hampshire Board of Nursing.

NCSBN developed the NLC with its member boards in 1997. Under the NLC, nurses hold a license in their state of residency and are able to practice in another NLC state, provided that they follow the laws and regulations in the state of their current practice (similar to laws governing drivers' licenses in the United States). All NLC states participate in a coordinated licensure database, Nur*sys*, which shares information on nurses' license status in their home states and in states where they may practice.

The goal of mutual recognition is to simplify government processes and remove regulatory barriers in order to increase access to safe nursing care. This regulatory initiative responds to the rapidly evolving health care environment by addressing new practice modalities and technology (such as telenursing) for nurses who practice across state lines in a variety of health care settings.

The American Association of Occupational Health Nurses (AAOHN) supports the compact.

"The NLC provides an extremely valuable service in today's constantly changing health care delivery system," says **Kathy Apple**, MS, RN, NCSBN executive director. "The streamlined process in the mutual recognition model allows nurses greater mobility without ever compromising public safety or welfare."

The NLC is managed by the Nurse Licensure Compact Administrators (NLCA), which functions as a separate incorporated body made up of the participating state-designated NLC administrators. Chicago-based NCSBN serves as the secretariat for the NLCA.

In addition to New Hampshire, states that have joined the NLC are Arizona, Arkansas, Delaware, Idaho, Iowa, Maine, Maryland, Mississippi, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

For more information on the compact, contact the NCSBN at (312) 525-3600, or visit the web site at www.ncsbn.org. ■

Fewer companies offering health insurance benefits

Smallest employers least likely to offer benefits

The percentage of businesses offering health insurance to their workers has declined steadily over the last five years, as the cost of providing coverage continues to outpace inflation and wage growth, according to a study by the Kaiser Family Foundation.

About 60% of companies nationwide offer health benefits to their employees, down from 69% in 2000, according to a survey by the Menlo Park, CA-based Kaiser Foundation, a non-profit, private foundation that amasses and distributes information and analysis of health care issues. It is not associated with Kaiser Permanente or Kaiser Industries.

Most of the companies that eliminated health benefits have fewer than 200 employees — those most likely to be hurt by the loss or unavailability

of benefits. The Kaiser study showed the drop stems almost entirely from fewer small businesses offering health benefits, as nearly all businesses (98%) with 200 or more workers offer such benefits.

"It is low-wage workers who are being hurt the most by the steady drip, drip, drip of coverage draining out of the employer-based health insurance system," says Kaiser Family Foundation President and CEO **Drew E. Altman**, PhD.

Premium increases outpace earnings growth

The 2005 Annual Employer Health Benefits Survey (available on-line at www.kff.org/insurance) reflects that health insurance premiums in 2005 are still up sharply, though not at the double-digit increase seen a year earlier.

Premiums increased an average of 9.2% in 2005, down from the 11.2% average seen in 2004. The 2005 increase ended four consecutive years of double-digit increases, but the rate of growth is still more than three times the growth in workers' earnings (2.7%) and 2.5 times the rate of inflation (3.5%). Since 2000, premiums have gone up 73%.

The annual premiums for family coverage reached $10,880 in 2005, more than the gross earnings for a full-time minimum-wage worker ($10,712). The average worker paid $2,713 toward premiums for family coverage in 2005, or 26% of the total health premium.

High-deductible health plans

The Kaiser Foundation found that one-fifth of employers that offer coverage are providing high-deductible options, plans that have deductibles of at least $1,000 for single coverage and $2,000 for family coverage. Among employers who offer a high-deductible plan, relatively few (19.5%, or 3.9% of all offering employers) also make a contribution to a health reimbursement arrangement (HRA), offer a plan that would permit an enrollee to establish a health savings account (HSA), or do both.

HRAs and HSAs may play a role in employees' interest in wellness. They are tax-favored accounts that employees can use to pay for medical expenses, and often are described as consumer-driven because patients pay for a greater share of their health care out of pocket, and so may have a financial incentive to reduce their health care spending by being proactive in making good choices when it comes to diet, exercise, and monitoring of potential health problems.

Cost determines benefits offered

The majority of firms that do not offer health benefits to their workers cite cost as a key factor, with nearly three in four (73%) saying high premiums were very important in their decision. In comparison, just over half (52%) said their firm's small size determined their decision not to offer benefits, and one in three (33%) said the fact that their workers had access to other coverage was an important consideration.

According to Kaiser, about 1% of firms say they are "very likely" to drop health coverage entirely in the near future. More than 40% of large firms (200 or more workers) offering health benefits say they are "very likely" to ask employees to pay more in premiums next year.

[For more information contact:

• Kaiser Family Foundation, 2400 Sand Hill Road, Menlo Park, CA 94025. Phone: (650) 854-9400. Web site: www.kff.org.] ■

CSTE says work-related fatalities up in 2004

Special concern for immigrant workers

More than 5,700 work-related fatalities were recorded in the United States in 2004, up 2% from the year before, according to the Council on State and Territorial Epidemiologists (CSTE).

U.S. Department of Labor's Bureau of Labor

COMING IN FUTURE MONTHS

- Incentives to get employees into wellness
- Return to work after heart attack or heart surgery
- Is it occupational asthma?
- Environmental conditions that affect productivity

Statistics reports that in 2004, logging workers, aircraft pilots and flight engineers, fishers and related fishing workers, and structural iron and steel workers were among the occupations with the highest fatality rates.

The CSTE reports that not all the news is bad. Through careful benchmarking and research, many occupational fatalities are preventable. A report released by the CSTE and the National Institute for Occupational Safety and Health (NIOSH) draws on 19 occupational health indicators to provide a snapshot of the health of workers in 13 states, while providing a model for other states to do the same.

According to the CSTE president-elect, **Robert Harrison,** MD, the collaboration of the 13 states and the information provided through the occupational health indicators establish benchmarks for worker safety and health in the United States.

"Not only will strong information gathering protect the individual worker and the public at large, but the information from these health indicators can help workers and businesses find solutions that can reduce the number and cost of work-related diseases and injuries," says Harrison.

Jobs with high work fatality rates for 2004 include:

- Logging workers (92.4 per 100,000 workers, 85 fatalities)
- Aircraft pilots and flight engineers (92.4 per 100,000, 109 fatalities)
- Fishers and related fishing workers (86.4 per 100,000, 38 fatalities)
- Structural iron and steel workers (47.0 per 100,000, 31 fatalities)
- Refuse and recycle material collectors (43.2 per 100,000, 35 fatalities)
- Farmers and ranchers (37.5 per 100,000, 307 fatalities)
- Roofers (34.9 per 100,000, 94 fatalities)
- Electrical power-line installers and repairers (30.0 per 100,000, 36 fatalities)
- Driver/sales workers and truck drivers (27.6 per 100,000, 905 fatalities)
- Taxi drivers and chauffeurs (24.2 per 100,000, 67 fatalities)

Fatalities among those 10 occupations accounted for nearly 30% of all work fatalities in 2004.

Occupational health and labor advocates are especially concerned by the proportion of immigrant workers who die or are injured on

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 **December** 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.

17. According to Michael Harbut, MD, flooding such as in Louisiana after Hurricane Katrina can immediately result in injury and infectious disease. However, which of the following can threaten people who come in contact with them even long after the flood?

A. Organic solvents
B. Molds
C. Lead
D. All of the above

18. What is perceived as a hindrance in the recent resurgence of interest in corporate-occupational medicine physicians in the workplace, according to Tee Guidotti, MD, of the ACOEM?

A. A preference for occupational health nurses
B. Lack of interest among employers
C. Short supply of physicians due to cuts to occupational medicine programs
D. Continued downsizing

19. The number of companies nationwide offering health benefits to their employees has declined to about 60%, a Kaiser Family Foundation study says. The drop is seen mostly in:

A. the biggest employers, who are cutting benefits to their employees.
B. smaller companies that employ fewer than 200 workers and do not offer any health benefits.
C. bigger employers who are raising premiums, forcing workers to drop coverage.
D. both big and small companies equally.

20. Professional medical organizations oppose making flu shots mandatory because, among other reasons, the vaccine is variably effective, vaccination does not preclude the need for other controls, and a coercive program can harm the employer–employee relationship.

A. True
B. False

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

the job. According to a report released in August by the AFL-CIO, workplace fatalities among foreign-born workers increased by 46% between 1992 and 2002. Fatalities among Hispanic workers increased by 58% over the same period.

AFL-CIO report finds that while employment of foreign-born workers increased by 22% from 1996 to 2000, their share of fatal occupational injuries increased by 43%. Fatal work injuries in six states — California, Florida, Illinois, New Jersey, New York, and Texas — accounted for 64% of all fatalities for foreign-born workers during that period.

For the full AFL-CIO report, "Immigrant Workers at Risk: The Urgent Need for Improved Workplace Safety and Health Policies and Programs," visit www.aflcio.org. For more information on CSTE, go to www.cste.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 productivity.
- **Identify** employee health trends and issues.
- **Comply** with OSHA and other federal regulations regarding employee health and safety. ■

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PS Form **3526**, September 1999 *(Reverse)*

Occupational Health Management™

A monthly advisory for occupational health programs

Growth slow overall, but more men entering field

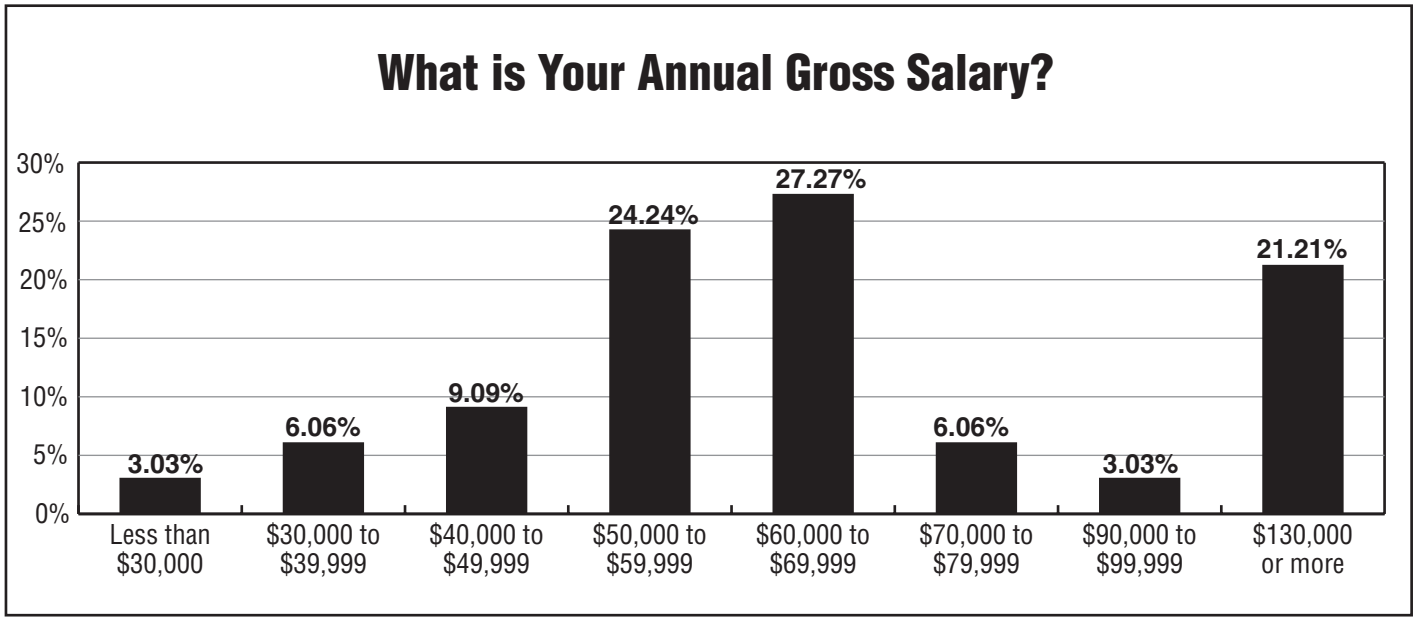
Advanced degrees and more training in safety programming and tracking becoming a trend

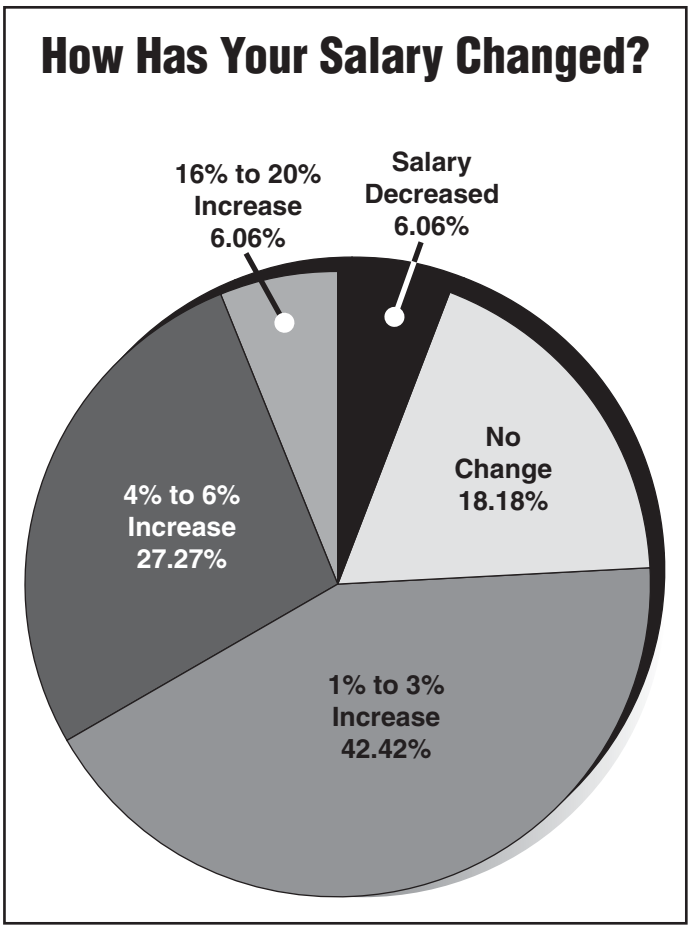
Following what appeared to be a growth year in the occupational health field, readers of *Occupational Health Management* report that they saw fewer new nurses coming to work for their employers in the past year. The field, however, did see a slight increase in the number of men.

These were two of the findings from the 2005 *Occupational Health Management* salary survey. The survey, which was administered in August and tallied, analyzed, and reported by Thomson American Health Consultants, publisher of *OHM*, illustrates some of the key factors that may influence salaries and benefits among occupational health professionals.

Income remains steady

Salaries continue to increase steadily. In gains similar to those reported in the 2004 survey, 42% say they received raises of 1% to 3%, and 27% say their raises were in the 4% to 6% range.





Though there were increases, it seems salaries were actually lower than those reported last year. In 2005, just over 57% say they earn between $50,000 and $80,000; in 2004, 63% reported they were in that salary range.

However, a larger percentage of respondents this year reported earning more than $130,000 — 21% in 2005 vs. only 12% in 2004.

Respondents were predominantly occupational health care managers, coordinators, and directors. Nurses with bachelor's degrees made up 35% of those responding, and 3.5% are master's level nurses. Occupational medicine physicians were 20% of our respondents, and readers holding MBAs made up 3.5%.

The greatest percentage of responses came from occupational health professionals working in hospitals — 72%. Just over 17% work in clinics, 3% for health departments, and almost 7% are in private practice. Only 1% report that they work as independent occupational health consultants.

Branching out into safety

Susan A. Randolph, MSN, RN, COHN-S, FAAOHN, a clinical instructor in occupational health at the University of North Carolina at Chapel Hill and president of the American Association of Occupational Health Nurses (AAOHN), discussed the survey findings with *OHM*, and suggests that continued training, advanced degrees, and branching out into safety are trends that likely will be seen in the field of occupational health.

"One change or trend that we've noticed seems to be that more occupational health nurses are having some safety responsibilities," she observes. "They are asked to take over safety as well as nursing, and to some extent, those go hand-in-hand. If someone gets injured, you want to know how it happened and how to prevent it happening again, and there may be some safety issues involved."

Tee L. Guidotti, MD, vice president of ACOEM, says today's generation of corporate managers is showing reinvigorated interest in what occupational health and safety can bring to their companies. "I think there is a growing interest in our long-term, strategic value," he says. "I am hearing some arguments [among corporate managers] about occupational medicine enhancing productivity and reducing risk and liability."

Guidotti observes that the traditional areas of corporate medicine seem to be making a comeback. "There seems to be an increasing number of corporate medical departments restaffing, and we think that has to do with a learning curve about what occupational medicine can bring to the workplace."

Randolph says the new interest in occupational health nurses taking on safety responsibilities is reflected in the new certification offered this year by the American Board of Occupational Health Nursing (ABOHN), the Safety Management credential (COHN-S/SM or COHN/SM). Eligibility for the safety credential includes the COHN or COHN-S core credential, work responsibilities consisting of at least 25% safety activities, 50 contact hours of safety-related continuing education, and 1,000 hours of experience in the preceding five years.

Is growth of field stalled?

Both Guidotti and Randolph say their observations indicate the field of occupational health is burgeoning, with new interest in the value of services occupational nurses and physicians can offer, as well as expanding capabilities within the professions. But readers who responded to the *OHM* survey seem to say growth in the field coasted a bit in the past year.

In 2004, 62% of respondents said the occupational health staff at their workplaces had grown, but this year, only 36% saw gains in positions within their departments; half of those responding said there had been no change, up or down, in their departments. As with last year's survey, 12% reported job losses within their departments.

Randolph says even in times when companies are looking for ways to tighten spending, "there always will be a need for someone focusing on health and safety of the workplace, whether that will be as an employee of that organization or through a contract position."

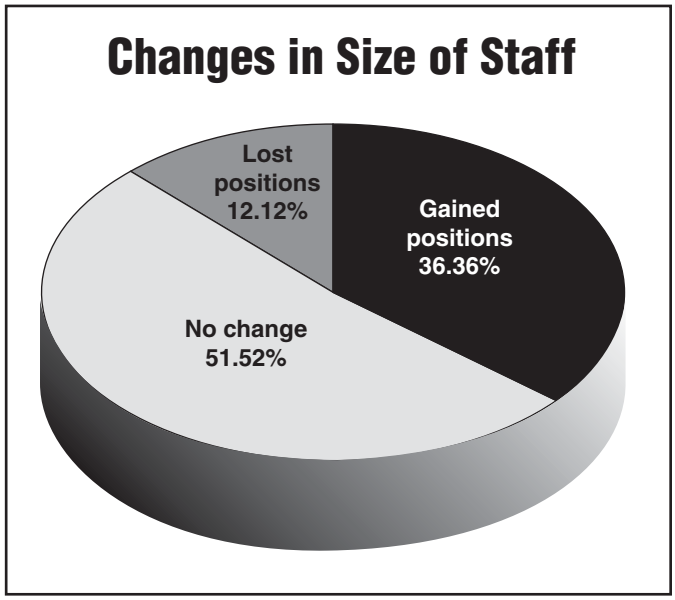
The aging of America's workforce – reflected also in the ages of our survey respondents – creates health and safety issues that will continue to put occupational health on employers' priority lists, she says.

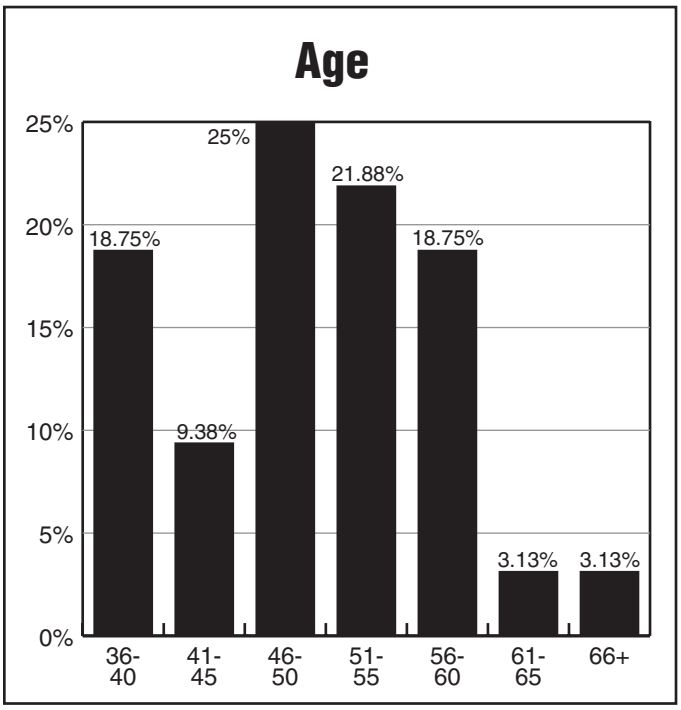
"As the health care costs associated with aging are escalating, employers are starting to look at [the value of workplace health and safety] more closely," Randolph continues.

Guidotti says it's important for all occupational health professionals to sell employers on the value they add to the company.

They may be getting the message: In a survey AAOHN conducted earlier in 2005, when asked about the value they place on occupational health nurses in the workplace, nearly 60% of employers surveyed described their occupational health nurses as "invaluable" to their company.

"The way for all of us in the occupational fields to recover and get back the influence we historically had is to take care of the fundamentals," Guidotti says. "We need to show the value we add and demonstrate our utility."



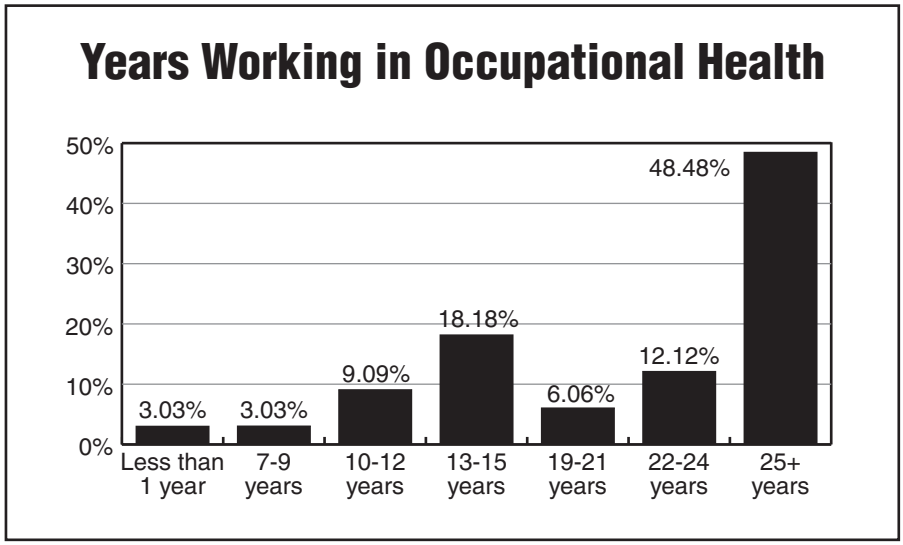


A job for the experienced

As in previous years, the respondents to the *OHM* survey are a mature lot. In 2004, 12% of those who answered were younger than 40. This year, none of the responses were from anyone younger than 36.

This finding is in keeping with the fact that occupational health has traditionally been viewed as a field into which nurses move after they have earned experience in other specialty areas.

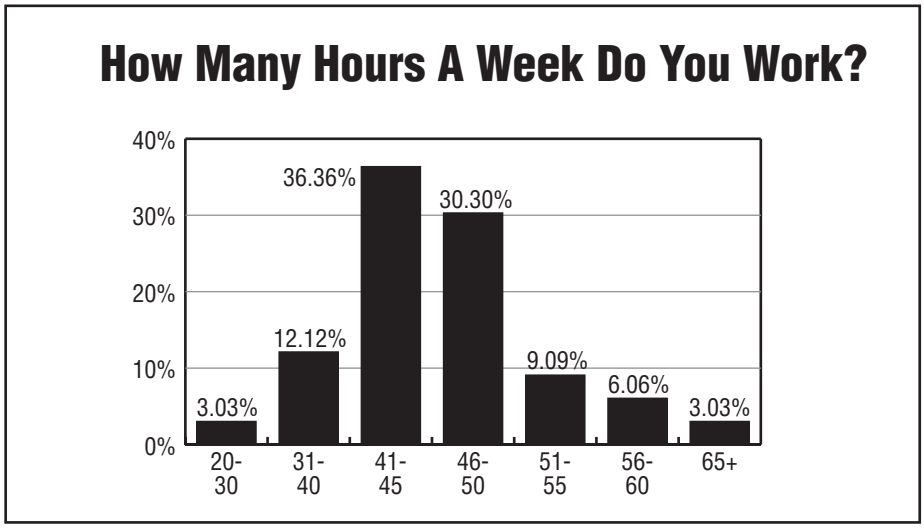
This year, almost half — 48.5% — of respondents have been in health care for more than 25 years; however,



only 12% have been in occupational health care for that long. The majority say they have been in occupational health fewer than 15 years.

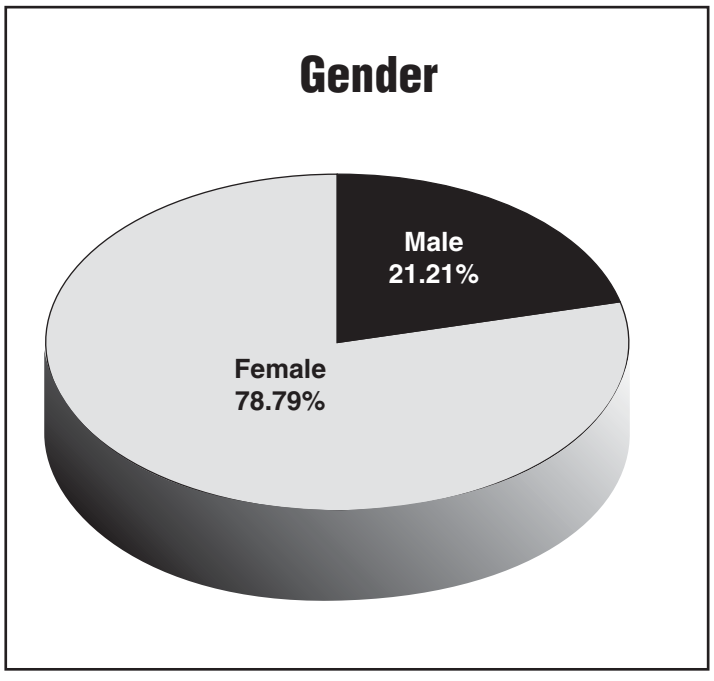
People apparently do not choose occupational health because of shorter working hours. Again this year, survey participants say the notion of a 40-hour week does not emerge in their workdays.

Eighty-five percent say they work more than 40 hours per week, with 17% working more than 50 hours per week.



Still working to bridge gender gap

Again this year, the *OHM* survey reflects a huge disparity between the number of women in the field and the number of men. While men make up the majority of occupational medicine physicians, the majority of occupational health nurses — and nurses in all fields — are women.



Daniel J. Pesut, RN, PhD, CS, FAAN, president and chair of Sigma Theta Tau International honor society of nursing, says men are slowly making inroads into the traditionally female bastion of nursing.

"There have been increases in men who are entering the field; I think [the honor society's] latest data show nationally men making up 9% of the nursing work force," Pesut says. "It used to be 6%."

In the nursing honor society in the last two years, Pesut says, there has been a 1% increase in membership to 127,000.

"Men have many choices in terms of specialty areas," he explains. "The literature suggests most men gravitate to areas like the emergency room, critical care, anesthesia, and psychiatric mental health, as well as nursing administration and teaching." ■