Occupational Health Management™

A monthly advisory for occupational health programs

THOMSON
AMERICAN HEALTH CONSULTANTS

INSIDE

Statement of Financial Disclosure: Allison Mechem Weaver (Editor), Coles McKagen (Editorial Group Head), Jill Robbins (Managing Editor), and Deborah V. DiBenedetto (Nurse Planner) report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

DECEMBER 2005
VOL. 15, NO. 12 • (pages 133-144)

Sail the 'seven Cs' to go from good nurse to great occ-health nurse

It takes more than clinical skills to succeed in business

Any occupational health nurse knows that merely being a good nurse is not enough to succeed and excel in the demanding world of occupational health.

Donna C. Ferreira, RN-C, COHN-S, MS, a nurse practitioner at National Grid in Westborough, MA, found herself wondering what were the most important strengths and tools occupational health nurses should cultivate to be competent and confident, and came up with what she calls the "seven Cs."

"I wanted to give occupational health nurses an understanding that they can be strong in one area, but if they're not strong in other areas, it can negate the strengths they have," says Ferreira. "I tried to come up with a recipe for a strong, effective, efficient occupational health nurse."

The first C — Clinical

"If someone is going into occupational health, they should have a clinical background — for example, med-surg or emergency medicine experience," she says. "If they are going fresh from school into an occupational health setting, they don't bring strong clinical skills."

A clinical background gives a nurse not only knowledge but hands-on experience critical to making good decisions in the wide range of situations the occupational health nurse or nurse practitioner may come across, says Ferreira — it makes him or her a good nurse to start with.

"If they have that experience under their belt, they have the knowledge base to make sure they're doing the correct things — referring when it's appropriate, for example — and then they have the actual skills that they'll use when they have to take blood pressures, when nurse practitioners

EDITOR'S NOTE: This month, OHM *features the experiences of occupational health professionals whose companies have had success with innovative approaches to worker health and safety:*
-Award-winning occ-health program can be duplicated
-Use innovative approaches to make safety a priority

might be suturing injuries and dressing wounds, doing audiometry, phlebotomy. They'll have the hands-on skills."

The second C — Certification

Credentials run the gamut — COHN, COHN-S, spirometry, hearing conservation, cardiopulmonary resuscitation, phlebotomy, automated electronic defibrillation, safety and health, case management, first aid, advanced life saving, to name a few. But having credentials does more than add acronyms to your name, Ferreira says. They add weight to your opinions.

"Credentials can strengthen your recommendations if, for example, you're in a board meeting and discussing an addition to your wellness program or [the cause of] an injury," she says. "Credentials give you more clout."

Ferreira says when she lectures she tells nurses to use their certifications to underline their recommendations to give them more strength, but to refrain from using certification as a sledgehammer to prove their recommendations are better than someone else's.

The third C — Compliance

While the word "compliance" can carry ominous overtones when used in the workplace, conjuring images of visits by unhappy Occupational Safety and Health Administration (OSHA) inspectors, compliance can be a key tool for occupational health nurses as they strive to make their workplaces safer and healthier. Ferreira says if it can be demonstrated that some occupational health initiatives are necessary for compliance with federal, state or local safety and health requirements, employers are more likely to beef up their budgets to ensure the health and wellness of employees.

"Compliance is a key tool that occupational health nurses can use to help convince businesses to do particular programs," she says. "It's often the key to getting more resources, more money, and getting your ideas across the table," as well as bringing a workplace into compliance with OSHA, the Family and Medical Leave Act, Americans with Disabilities Act, Department of Transportation, workers' compensation, and state practice acts.

The fourth C — Confident presentation

You might be a terrific clinician with great ideas, but Ferreira suggests that if you cannot present your ideas and yourself in a confident and competent way "nobody will listen to you."

Confidence includes projecting a confident appearance — which may mean not dressing in traditional nurses' whites.

"Some occupational health nurses choose to dress in the traditional white uniform, and I think in that case sometimes people at higher levels treat you as 'just a nurse,' but if you go into a board meeting to represent your department, you might want to dress for success and the appropriate occasion," she says. "A business suit would probably be more appropriate for a high-level meeting."

Being an occupational health nurse means you're always "on," she points out.

"People watch what you're doing," she continues. "They watch what the nurse eats in the cafe-

Occupational Health Management™ (ISSN# 1082-5339) is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, Building Six, Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Occupational Health Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (ahc.customerservice@thomson.com). Hours: 8:30-6:00 M-Th; 8:30-4:30 F.

Subscription rates: U.S.A., one year (12 issues), $489. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $82 each. (GST registration number R128870672.)

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for 18 nursing contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

In order to reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, board members have reported the following relationships with companies having ties to this field of study. Dr. Patterson is a consultant for Hewlett-Packard Corp. Ms. Colby, Ms. DiBenedetto, Ms. Haag, and Dr. Prezzia report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

Editor: **Allison Mechem Weaver.**
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@thomson.com).
Senior Production Editor: **Nancy McCreary**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

For questions or comments, call **Jill Robbins** at (404) 262-5557.

teria. You are making an impression when you're on the phone, in elevators, in hallways, in one-on-one meetings, teaching, doing wellness programs, making training tapes, and in union arbitration."

Besides physical appearance, successful presentation encompasses your air of confidence, your trustworthiness, and how you come across in the first impression you make.

Communication and presentation skills can make or break a good idea, she points out. Body language and other non-verbal skills — firm handshakes, refraining from nodding at every comment made [and thereby sending a message you agree with everything said], making eye contact — are important to master.

"And your voice should be interesting, not meek or monotone," Ferreira suggests. To reduce anxiety prior to an important presentation, be well prepared, arrive early, and be cautious in the use of words, particularly clinical or technical words that if used incorrectly can cost you your credibility.

Other factors of confident presentation, Ferreira notes, include knowing the cultural differences in word choices and protocol if the company is foreign-based or does international business, and learning how to deal with difficult participants (whisperers; "showboaters," who ask questions to draw attention to their own knowledge or accomplishments; and "bullies" who try to make the speaker look bad).

The fifth C — Comprehend your business

An occupational health nurse who is a superb clinical nurse but has no comprehension of his or her employer's business is lacking a crucial tool.

"It is essential that the occupational health nurse comprehend the basis of economics, political forces, and economic trends that shape the business environment," she says. Occupational health nurses should be aware of events and conditions and how they influence the companies they work for. War, global shipping, and import/export conditions, the value of the dollar, and international trade agreements all can affect a business's bottom line, and therefore, its budget for employee health, wellness, and safety.

"I would suggest the occupational health nurse's role expands and contracts with the company's business cycle," Ferreira says. "In 17 years with my company, I have experienced downsizing with nurses offices in our field locations closing; after a while, those offices were reopened and staffed by nurse practitioners."

As companies expand across state lines, occupational health nurses might find themselves dealing with travel medicine issues, health education, immunizations, expanded case management duties, and psychological support programs.

"So an occupational health nurse, to comprehend the business of her company, needs to ask three questions: What is the mission of the company? Who are the company's customers? And who are the patients of the occupational health nurse?"

The sixth C — Correct etiquette

Building on the previous five Cs, Ferreira says a nurse can be a good clinician, with a good presentation and a head for business, but an etiquette gaffe can torpedo his or her reputation and credibility.

Among the business etiquette pearls Ferreira teaches are:

- when introducing two people, the person introduced first is shown the greatest respect and honor;
- when introducing yourself, take fewer than 10 seconds;
- "save" people who you've met but who obviously have forgotten your name; introduce yourself by saying, "I think we met last year…"
- use the name of the other person when you're talking one-on-one, but make sure you're using the right name;
- when doing business by phone never leave someone on hold longer than 20 seconds, answer within three rings and don't take calls while you're in meetings or with patients.

The seventh C — Connections

"You can have all the other Cs, but if you're not connected within the company and linked to strategic people in strategic places, you might still not have a strong enough voice within the company," Ferreira points out.

Having connections to people with the knowledge a nurse needs to make a successful occupational health program is imperative. Ferreira suggests cultivating relationships with people who can serve as resources in the following departments: human resources, labor, benefits, upper management, facilities, legal, security, safety, industrial hygiene, unions, trusted

employees, and a director in each department served by the occupational health program.

Connections need to extend outside the company, as well, to occupational health peers and associations such as the American Association of Occupational Health Nursing; OSHA and other federal and state agencies; and specialists in orthopedics, neurology, psychology, forensic psychology, workers' compensation, disability management, and, if applicable, outside occupational health vendors.

For more information on the seven Cs, contact Ferreira at donna.ferreira@us.grid.com. ■

Award-winning occ-health program can be duplicated

Adding nurse practitioner cuts absenteeism, costs

Community Memorial Hospital in Menomonee Falls, WI, had an occupational health and wellness program that had served its 1,500 employees quite well for many years. But the rocketing costs of health care benefits suddenly meant that Community Memorial's occ-health program had to do more.

"Our [human resources] department was having to make decisions on benefits and cost sharing, and the vice president of HR came to me and said, 'What can you do to help us with this?'" says **Shirley P. Rosien**, RN, BSN, COHN-S, director of occupational health and wellness at Community Memorial.

What Rosien and her colleagues in occ-health did was gather experts from throughout the hospital, from management to clinical, and create a strategic plan for delivery of better health care to employees at work by integrating a nurse practitioner component within the health and wellness program.

Sharing what works

Community Memorial and Rosien received several awards and recognition in 2005 for both the long-term success of the occ-health program at the hospital and the changes to the program that are providing better care to employees while containing benefit costs for the hospital.

She told *Occupational Health Management* that she and her co-workers are eager to share what they've learned, because the results can be duplicated not only in other hospitals but at any work site that can establish a relationship with a hospital or clinic.

Community Memorial received the American Association of Occupational Health Nurses (AAOHN) Business Recognition Award for its occupational and environmental health nursing services within the corporate structure for businesses with more than 750 employees. The award is considered highly prestigious in the occ-health industry, recognizing the work of the department over a five-year period.

Community Memorial and Rosien herself received the AAOHN Innovations in Occupational Health Award for 2005 for the creative implementation by nurse practitioners to improve the effectiveness of occupational health care services at the hospital.

While Rosien says the program developed at her hospital was tailored to fit the Community Memorial employee population, similar ideas have worked elsewhere and can work in other companies.

"We took a currently successful occupational health program with several certified occupational health nurses and capitalized on what they already do and then integrated an on-site option for health care for our employees," she explains.

Expanding on what a nurse can provide

When Community Memorial sat down to evaluate its program and the hospital's need to control health care benefit costs for its employees, Rosien says, they learned that one of the limitations of the existing employee health program was the restriction on what a nurse could provide in the way of care.

"As nurses, we can assess, triage, and provide some treatment, but there was always some stumbling block if the employee needed further diagnostic work to find out what the illness or injury was, or if they needed medicine to recover we weren't able to do that," she says. "Some programs opt to hire a physician, but when we looked at our philosophy and our practice, we saw that the nurse practitioner, in philosophy and practice, came out ahead from both the cost standpoint and how they treat the employees — holistically, focusing on prevention, treatment, and maintenance of health along the lifespan."

Employee acceptance was enthusiastic. What started out as a half-time position was increased

to full-time midway through the first year, and Rosien says she has just received approval to add another half-time nurse practitioner.

"The outcomes have been very positive, and customer satisfaction has been very positive," she says. "The nice thing is that [the satisfaction] is both on the employee side and the employer side."

Rosien admits she would love to see dramatic decreases in office visits and emergency room visits; the decreases are there, but aren't dramatic. However, the real benefit is the cost avoidance the employer is seeing in its health plan.

"The way we fashioned the plan, employees don't pay an office fee to see the nurse practitioner. In the past, office visits were out-of-plan, out-of-pocket costs," she says, which makes the nurse practitioner popular with employees for whom copays and office fees are consequential expenses.

"We have set up a tracking mechanism to track office calls [to the nurse practitioner] and set up a database to track what the cost would have been for a [physician] office visit," she says.

Employee response good, and surprising

While nurse practitioners at the work site is not a new idea, Rosien says the occ-health staff wasn't sure what the response would be to bringing in a nurse practitioner to provide care to health care workers — a population "not noted for their self-care."

But response has been terrific, she says, particularly among two patient populations. One was expected — those who have no extra income at the end of each pay period, who benefit from not having a copay.

The other high-end user group was a surprise, Rosien says.

"It is upper management, and they say the No. 1 reason for them [to use the nurse practitioner on site] is the time savings. They love the convenience," she says.

At the end of the first year, 50% of the health program clients were employees who said that if the nurse practitioner weren't there on site, they would not have sought medical care as early or wouldn't have been diligent in following up for tests.

"We are saving [physician] office calls and saving emergency room visits," she points out. "Instead of going to the emergency room with insulin shock, they're getting help sooner and not going into insulin shock."

Medication 'tryouts' another popular aspect

Community Memorial added another feature that enhances the nurse practitioner's ability to prescribe medications. Through an arrangement with a vendor of medication-dispensing machines, employees who receive a prescription from the nurse practitioner can, in many cases, also get a sample dose, so that they don't invest in a full prescription without knowing it will work for them.

The machine tracks the medicines used most frequently, benefiting the vendor when it comes to working on sales to the hospital pharmacy, as the core medicines used most frequently are identified.

And in the case of some conditions, including strep throat and pinkeye, they benefit very quickly from the loading dose of antibiotic, enabling the patient to walk out of the nurse practitioner's office with an initial dose already in them can reduce absenteeism and presenteeism by speeding recovery.

The availability of on-site care also cuts down absenteeism caused by several hours away from work for an off-site office visit. The typical visit to the Community Memorial health clinic is 30 minutes or less, and so employees usually return to work that day.

Community Memorial is working with other employers in the area to develop their own on-site programs.

"It can be duplicated in almost any setting," she says. "There are some things that we're able to access that expedite care in the hospital setting, with the labs and diagnostics readily available.

"What I'd recommend to people who aren't in a hospital is to set up a collaboration with a hospital or clinic so they can have ready, easy access to some of the diagnostics. Those are the costs to the employer in money and productivity."

For more information, email Rosien at srosien@communitymemorial.com. ■

Occ-health pros up safety with innovative approaches

Companies share exceptional results

Ingrain safety as a priority for employees from the moment they are hired. Have your 10,000-person workforce stop what they're doing and think about how safely they are working. Rather

than fear an inspection by the Occupational Health and Safety Administration (OSHA), ask for it and make OSHA your partner in making your work site safer.

These are just a few of the ideas used by occupational health departments that were recognized over the past year by industry and association groups as innovative ways to help workers stay healthy and productive.

The companies share some common traits: lost-time accident or injury rates are lower than their industries' averages; recognition from industry trade associations; and employee health programs that take traditional concepts of occupational health and safety to new levels of effectiveness.

Marathon Oil: Working with OSHA as partner

The Marathon Oil refinery in Robinson, OH, is in an elite group; fewer than 20 refineries have received the OSHA voluntary protection program designation, which recognizes employers that partner with OSHA to jointly work toward safe work sites.

"We work with OSHA instead of against them; we are not afraid of them coming in," says **Gail Sandiford**, environmental, safety and security manager at the Robinson facility. Marathon was another company named to *Occupational Hazards'* safest companies for 2005.

"Leadership is key," says Sandiford. "You have to have leaders in place who have the commitment that you put safety equal to everything else. It's not below production, not below quality. It's equal."

Sandiford concedes that not all corporate occupational health departments have the luxury of working with management that places such a high priority on safety.

"That's been a key thing for us, that to our management team and our top manager safety is extremely important," she says. "Of course, you have to put your money where your mouth is, and you have to invest."

Marathon invests several million dollars a year in safety upgrades, Sandiford says, something not every company can do.

"But some steps can be as simple as ergonomics — try to look at previous injuries and first aids, and analyze them to see what we can do to reduce the risk of them happening again," she says, pointing out some low-cost steps that can be taken by an occupational health program that would yield important results for little money.

"This year we're looking at strains and sprains. These are first-aid cases, not reportable to OSHA, but as our workforce ages we're getting more strains and sprains," she says. "In January, we started a voluntary stretching program, where before work starts, employees take five or 10 minutes for stretching exercises that are led in work groups throughout the company. In 10 months, we've seen strains and sprains reduced significantly."

Marathon also engages in behavior-based safety (BBS), which involves its hourly workforce in looking at why employees make conscious decisions that can put their health and safety at risk. Some examples include not wearing proper protection, or positioning the body in such a way that makes it more susceptible to injury. BBS encourages employees to focus on the choices and behaviors that could lead to injury and replace them with preventive behaviors.

"And we don't just work with our employees," she adds. "We have a tremendous relationship with our contractor workforce, and they're brought into it.

"We have a motto, 'I have the right and responsibility to go home uninjured,' and we want our contractors to have that, too."

Delta: Lowest workplace injury rates

Delta is the first airline to be named to *Occupational Hazards* magazine's list of "America's Safest Companies." It has the lowest OSHA recordable injury and illness rates of any Air Transport Association member and was the first commercial airline to be accepted into OSHA's voluntary protection program.

The airline was given the 2005 National Safety Council Green Cross for Excellence award, given to National Safety Council members with lost work day rates below the Bureau of Labor Statistics' national average, and the 2004 Georgia Department of Labor's Safety Excellence award, presented to Georgia locations that operated 250 days in the previous calendar year without a lost work day due to occupational injury or illness.

Behind those accolades, Delta says, is a dedication to safety that begins when an employee is first hired. Safety is listed as a responsibility in all Delta job descriptions, and management maintains an open-door policy for any safety-related concerns.

Westinghouse Savannah River relies on BBS

Behavioral-based safety is a major component in the safety environment at the Westinghouse Savannah River Company (WSRC) in Aiken, SC, a contractor for the U.S. Department of Energy that processes nuclear materials and provides services for the cleanup of the Savannah River Site following 50 years of nuclear materials production.

All employees are encouraged to participate in BBS either as trained observers or by volunteering to be observed.

"We believe all injuries can be prevented and expect that work is stopped rather than proceeding unsafely," says **Kevin Smith**, industrial safety manager for WSRC. "At the same time, we expect that all injuries are reported, no matter how insignificant they may seem. It is not unusual to have employees report to medical with a paper cut or small scratch."

Another tool WSRC uses to drive home the point that safety is a priority above production is the scheduled and unscheduled "stand down," when work stops and employees focus on performing work safely. Employees frequently are reminded of their responsibility to call a "time-out" when they feel uncomfortable about the safety of a work evolution. Work does not resume until all parties involved are satisfied the concern has been addressed. Time-outs are informal in nature to encourage employees to be quick to call them.

Subcontractors are not left to their own devices, either, when it comes to safety. Smith says WSRC uses a point-of-entry process that ensures all site subcontractors, visitors, and vendors are given a basic orientation of safety expectations, and also review job hazards with those groups so they will know what safety hazards they might encounter while on site. Subcontractors working in jobs that have been deemed high-risk are monitored to make sure they understand and comply with safety expectations.

"We conduct an annual safety conference each summer that is open to 500 employees from across the site," says Smith. "It is produced and led by employees, and involves 50 to 60 exhibits featuring interactive safety displays and four to five interactive, entertaining, and informative breakout sessions that address current safety issues."

Other local industries are invited to participate in the safety conference to encourage sharing ideas and best practices.

Within the last two years, WSRC has been the site of two National Safety Council perception surveys, and in both cases, results showed employee opinions relative to site safety programs were "strong to very strong" when compared to National Safety Council database participants.

"We perform high-hazard work, such as building demolition and facility deactivation in environmentally hostile settings like high radiation levels requiring additional [personal protective equipment], yet continue to successfully strive for continuous improvement relative to employee safety," says Smith. "Even in light of ongoing workforce restructuring and downsizing and other distractions, employees at the site [take] pride in their efforts to be their brothers' keepers when it comes to safety."

[For more information, contact:

- ***Gail Sandiford**, environmental, safety and security manager, Marathon Oil, Robinson, OH. Phone: (618) 544-2121.*
- ***Kevin Smith**, industrial safety manager, Westinghouse Savannah River Company, Aiken SC. Phone: (803) 952-9924. E-mail: kevin.smith@srs.gov.]* ■

Declination forms sticking point in flu vaccine debate

ACOEM says requiring forms could be coercive

The debate over whether health care workers with direct patient contact should be required to receive flu shots rages hotter and hotter as flu season draws closer and some concern that we are in danger of a pandemic grows. One component to that debate is whether workers who refuse the shot should be made to sign declination forms.

Those who oppose mandatory shots, favoring education and voluntary vaccinations, say requiring a declination form in lieu of a vigorous education program could turn what should be a positive health decision into one pitting employee against employer.

Those in favor of the forms say they are another tool in educating and encouraging

(Continued p. 141)

SAMPLE Consent/Declination for Influenza Vaccine 2005-2006

Influenza (flu)

Influenza is a highly infectious viral illness. It causes an estimated 114,000 excess hospitalizations and 36,000 deaths every year in the United States. Influenza-related complications for high-risk people are primary pneumonia, bacterial pneumonia or severe disease in elderly or pregnant women and immunocompromised people.

Symptoms of the flu may include fever, chills, dry cough, headaches, sore throats, and muscle aches. These symptoms may persist for several days.

The vaccine

Influenza vaccine is the primary method for preventing influenza and its severe complications.

Receiving the vaccine protects health care workers, their patients, and communities, and will improve prevention, patient safety, and reduce disease burden.

The inactivated (killed) influenza vaccine is made from highly purified egg-grown viruses that have been made non-infectious. The vaccine contains the three virus strains believed likely to circulate in the United States during the upcoming flu season. Protection develops about two weeks after the injection and may last up to a year. The 2005-2006 vaccine will give protection against the following strains:

- A/New Caledonia/20/99-like (H1N1);
- A/California/7/2004-like (H3N2); and
- B/Shanghai/361/2002-like antigens.

Possible risks from influenza vaccine

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm or death is extremely small. Almost all people who get the vaccine have no serious problem. *The viruses in the vaccine are killed, so you <u>cannot</u> get influenza from the vaccine.*

Mild problems:

- soreness, redness, or swelling where the shot was given
- fever
- aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

Severe problems:

- Life-threatening allergic reactions are very rare. If they do occur, it is within a few minutes to a few hours after the shot.

<u>Advise the nurse if you have any of the following conditions:</u>

- bleeding disorder
- fever or infection
- an immune deficiency (natural or due to cancer chemotherapy, radiation, or steroid therapy)
- infection with the human immunodeficiency virus
- Guillain-Barre syndrome or other neurological problems
- an unusual or allergic reaction to latex or rubber
- an unusual or allergic reaction to influenza virus vaccine, eggs, thimerosal, other medicines, foods, dyes or preservatives
- pregnant: women who are pregnant during the influenza season are recommended for vaccination at any stage of pregnancy

I have read and understand the above information:
<u>I consent to receive the vaccine:</u> DATE: _____ PRINT Name: _____ SIGN Name:_____

Date of Birth:_____ SS#: _____ DEPARTMENT NAME: _____
(must show badge or GDAHA card)
Site: ☐ L ☐ R Deltoid ☐ VIS Given Pub Date: 7-18-05
Lot#: _____ Exp. Date: _____ Person Administering: _____ Date: _____

<u>I DECLINE THE VACCINE:</u>

PRINT NAME: _____ SIGN NAME: _____ DATE: _____
DEPARTMENT NAME: _____ SS#: _____
☐ I have received the (check one):_____live nasal or _____ inactivated flu vaccine from another source.

Source: Grandview Hospital and Medical Center, Dayton, OH.

employees to get vaccinated and to protect the employer when workers choose not to have the shots.

"There are published studies showing that you can double flu vaccination rates with good interactive flu vaccine workshops where workers have a chance to have their questions answered and numerous myths dispelled," says **Bill Borwegen**, MPH, occupational health and safety director for SEIU.

And even among the best educated health professionals, there are misconceptions, he points out.

"I know that a recent study found that even [some] registered nurses think they can get the flu from the inactivated flu virus," he says. "I worry that requiring declination before prescribing a comprehensive educational campaign is putting the cart before the horse. That's why ACOEM [the American College of Occupational and Environmental Medicine] has come out against theses bureaucratic, time-consuming records." (See *Occupational Health Management*, November 2005.)

Forms can be viewed as coercive

The goal behind a declination form is to record that the employee was offered the flu vaccine (declination forms are used for other types of vaccines, as well, including hepatitis) and, after being informed of the risks to him or her, as well as others, declined it. (See sample form, p. 140.)

ACOEM, in a position statement on mandatory flu vaccines issued in the summer of 2005, doesn't argue the merits of employee-sponsored vaccination, but does come out against mandating flu shots.

"Ample reasons exist for employers to sponsor influenza vaccination programs for their employees and to vigorously pursue strategies to maximize participation," ACOEM stated. "However, the ACOEM believes that mandatory influenza vaccination for health care workers is 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."

Declination forms could be seen as part of a coercive program, ACOEM says.

"It has been suggested that health care organizations should require employees who refuse vaccination to sign declination forms," the ACOEM statement continues. "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."

More paperwork to deal with

As with any other new level of documentation, there's the paperwork question. Hospitals with a few thousand employees foresee hours of work to document and store the declination forms.

"Our space is limited, and to have these additional pages filed to every chart every year — not to mention the time required to sort and file them," says **Kristen L. Steivang**, RN, MSN, APRN-BC, APNP, an employee health services nurse practitioner at St. Mary's Hospital Medical Center in Madison, WI. "[It's a] great idea in theory, but have all the logistics been sorted out?"

ACOEM also views declination forms as an unnecessary burden on occupational health departments.

"There is no evidence to suggest that such programs will increase compliance, and the burden of requiring compliance from those who have already chosen not to participate would tax employee occupational health resources that could otherwise be devoted to positive reinforcement for compliance," ACOEM stated. ■

Sexes differ in reactions to burnout, depression

Burnout worse in women; depression worse in men

Men and women sometimes approach their jobs differently, and recent findings published by the American Psychological Association (APA) indicate they may burn out in those jobs differently, too.

Work-related burnout can lead to inflammatory processes that play key roles in the initiation and progression of cardiovascular disease and other diseases related to inflammation, but furthermore, according to the study's authors, men and women differ in their inflammatory reactions to work-related burnout and depression

Writing in the *Journal of Occupational and Health Psychology,* an APA journal, **Sharon Toker**, PhD, of Tel Aviv University, describes the first large-

scale study showing a physiological difference in how men and women react to emotional states. Toker and her colleagues examined micro-inflammation blood markers and levels of burnout, depression, and anxiety in 630 otherwise healthy, employed women and 933 otherwise healthy, employed men. According to Toker, the study aimed to determine which emotions are more likely to present more problems for each sex.

Women hit by burnout, men by depression

Blood levels of C-reactive protein (CRP) and fibrinogen concentrations were used to measure levels of micro-inflammation. Fibrinogen is a blood-clotting factor that responds to vascular and tissue injury, and CRP is a complex set of proteins produced when the body is dealing with a major infection or trauma. Women who experience job burnout and men who experience depression were found to have increased levels of fibrinogen and CRP. Both of these biomarkers have been associated in numerous studies with an increased risk of future cardiovascular disease and stroke over and above the conventional risk factors such as blood lipids and glucose.

Depression in the study is defined as a generalized distress encompassing all life domains and burnout is defined as a depletion of an individual's energetic resources at work. Anxiety is defined as a person experiencing "negatively toned arousal."

The women in the study who scored higher on burnout scores had a 1.6-fold risk of having an elevated level of CRP (>3) and elevated levels of fibrinogen compared with their non-burned-out counterparts (after controlling for their levels of depression and anxiety). The men in the study who scored higher on depression scores (controlling for their levels of burnout and anxiety) had a 3.15-fold risk of having an elevated level of CRP (>3) and elevated levels of fibrinogen compared to the non-depressed men.

These results suggest that the burned-out women and depressed men are at a greater risk for future inflammation-related diseases such as diabetes, heart disease, and stroke compared with their non-burned-out and non-depressed counterparts. All these links were obtained after taking into account a host of physiological factors known to be associated with CRP and fibrinogen levels.

Even though burnout and depression affect men and women differently, the health consequences end up being the same, according to Toker, who suggests that gender difference be included when comparing certain emotions and health risks.

"The findings also confirm that emotional states do indeed affect a person's risk for developing cardiovascular disease," says Toker. "This information can be used to help medical and mental health professionals design more appropriate stress management interventions for each sex and hopefully prevent long-lasting health consequences."

Toker and her colleagues discuss the complete results of their study in: Toker S, Shirom A, Sharpira I, et al. The association between burnout, depression, anxiety, and inflammation biomarkers: C-reactive protein and fibrinogen in men and women. *J Occ Health Psychol* 2005; 10. The article is also available on-line at www.apa.org/releases/TokerEtAl.pdf. ■

Ergonomic efforts move to the states

Texas first to require program

Texas has become the first state to require safe patient handling programs in hospitals. That milestone has captured national attention as other states consider their own versions of a safe patient handling mandate. The state's activity echoes the early days of the needle safety movement, which started in California and swept through state legislatures until it gained national momentum, resulting in a federal law. Could that happen again with patient handling?

"Obviously, we would love for that to occur," says **Sue Whittaker**, RN, MSN, associate director of state government relations for the American Nurses Association (ANA) in Silver Spring, MD.

ANA still would like to see a federal regulation, but that seems a distant hope. Both a Washington state and an Occupational Health and Safety Administration standard were rescinded, she notes. "For us, this was the way to go."

Texas may seem an unlikely state to be the standard bearer for a new worker safety requirement, but concern over nurses' injuries and the nursing shortage brought the Texas Nurses Association and the Texas Hospital Association together.

"We want to make sure hospitals and nursing homes are paying attention to the fact that it is important to retain the nurses we have," says

Jennifer Banda, JD, director of governmental affairs for the Texas Hospital Association in Austin, says, "Our nursing shortage in Texas is at a crisis level."

The nurses association previously had worked with the hospital association to lobby for more funding for nursing schools and nurse staffing.

That relationship made it easier to reach agreement on patient handling, says **James Willmann**, JD, general counsel and director of governmental affairs for the Texas Nurses Association, also in Austin.

"It wasn't going to be sufficient to just address the supply of nurses unless you addressed some of the work force issues they had," he says.

Hospital must assess risk of injury

Under the new law, as of Jan. 1, 2006, hospitals in Texas will be required "to identify, assess, and develop strategies to control risk of injury to patients and nurses associated with the lifting, transferring, repositioning, or movement of a patient."

The law actually doesn't require the use of equipment or the purchase of new equipment, but it says the hospital's policy must include "an evaluation of alternative ways to reduce risks associated with patient handling, including evaluation of equipment and the environment" and a "restriction, to the extent feasible with existing equipment and aids, of manual patient handling or movement of all or most of a patient's weight to emergency, life-threatening, or otherwise exceptional circumstances."

Hospitals must analyze risks to patients and nurses and educate nurses about the risks. They also must have "procedures for nurses to refuse to perform or be involved in patient handling or movement that the nurse believes in good faith will expose a patient or a nurse to an unacceptable risk of injury."

The law requires an annual report on patient handling activities to the nurse staffing committee and the hospital's governing body or quality assurance committee. Construction or remodeling of a hospital or nursing home also must involve consideration of patient handling equipment.

"We really do believe that if we can get the hospitals and nursing homes to seriously look at this issue — and the legislation forces them to look at it — it will translate into some results," Willmann says.

The Texas law reflects some political realities. It mentions only nurses, although its supporters hope and expect that hospitals will create a broader policy and program that include other health care workers.

It doesn't require the purchase of equipment. "We agreed we would not mandate that by some certain date we'd have to eliminate manual lifting," Willmann notes.

"You'd probably have to have an exception for small rural hospitals. They'd say, 'We'll just close our doors.' Well, that's not an option in rural Texas," he says.

Willmann points out that a bill in California requiring hospitals to use lift teams and equipment to reduce patient handling injuries was vetoed by the governor.

"We went into this believing that hospitals will operate in good faith," Willmann says. "If they're going to be required to develop policies, most of them are going to develop policies that make good sense."

Meanwhile, other states have fashioned legislation to promote safe patient handling. The New York legislature authorized a two-year study of safe patient handling programs. "Hopefully, it will raise awareness in health care institutions and elsewhere about how critical this issue is," Whittaker adds.

Ohio provided interest-free loans to long-term care facilities that implement a "no manual lift" program. The loans are targeted for equipment and employee training. Savings from the reduction in injuries could be used to repay the loans, she explains.

COMING IN FUTURE MONTHS

- Case managing depression
- Return to work for substance abuse
- Building a business case for wellness
- Implementing stop-smoking programs at work

California, Iowa, Massachusetts, Minnesota, New Jersey, and Washington also considered safe patient handling legislation this year.

The Texas Hospital Association has been promoting the new safe patient handling law, educating CEOs, and touting its benefits — not just for nurses, but for patients, too.

"Overall, we're getting a positive response," Banda continues. "Hospitals realize that we want to do something to have a positive impact on the work force in the hospitals. This is a very good first step in working with the nursing work force."

ANA has emphasized patient handling with its Handle with Care campaign. These new state laws are just a beginning, Whittaker points out.

"Until we can take nurses off the list as one of the higher professions being injured, then we have a lot of work to do," she explains. "We know what causes it, and we know what prevents it." ■

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. ■

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.

21. The 'seven Cs' of competent, confident occupational nursing do NOT include:
    A. correct etiquette
    B. confident presentation
    C. certification
    D. courtesy

22. When Community Memorial Hospital in Menomonee Falls, WI, added a nurse practitioner component to its employee health offerings, what two employee population groups became the highest end users?
    A. those on tight budgets and upper management
    B. those who have no insurance and those on tight budgets
    C. physicians and housekeeping staff
    D. no groups used the program more than others

23. The Toker study published in *Journal of Occupational and Health Psychology* suggests that women suffering from job burnout and men suffering from depression are at a greater risk for future inflammation-related diseases such as diabetes, heart disease, and stroke compared with their non-burned-out and non-depressed counterparts.
    A. True
    B. False

24. An approach to work site safety that encourages workers to focus on the choices and behaviors that could lead to injury and replace them with preventive behaviors is termed:
    A. behavior-based safety.
    B. choice-based safety.
    C. OSHA-driven safety.
    D. injury-avoidance safety.

Answers: 21. D; 22. A; 23. A; 24. A.

Occupational Health Management™
2005 Index