Occupational Health Management™

A monthly advisory for occupational health programs

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INSIDE

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For those with depression, return to work positive, but flexibility, time necessary

Some can return quickly, while others need slower re-entry

Helping an employee return to work after a diagnosis of depression is similar in some ways to planning return to work after a physical injury, but depression demands a different consideration of limitations, timing, and clinical monitoring than most physical injuries or illnesses.

"Return to work is positive [for those suffering from depression]," says **Elayne Preston**, RN, DOHS, COHN(C), COHN-S/CM, occupational health consultant for Employee First Health and Safety Consulting in Surrey, British Columbia. "But often it needs to be a gradual work re-entry rather than a full return right away."

The occupational health nurse's role can begin before diagnosis, helping the employee or the employee's supervisor identify whether symptoms of depression might be present, as well as encouraging and supporting the employee in seeking the care of a physician.

Spotting the signs of depression

The occupational health nurse might spot signs of depression in an employee, but Preston says the employee's supervisor likely would notice changes first.

"What supervisors pick up on is declining work performance," she says. "They pick up on cognitive loss, memory loss, and concentration loss. Supervisors will pick up on that long before anyone else."

Rather than trying to spot symptoms of depression in employees, the occupational health nurse's role is more effective in educating supervisors and employees about what depression is and what the symptoms are.

"If you can identify [depression] early, they can get help faster," she says. "Depression develops over time, not overnight, so the signs are going to show up over time."

Symptoms that meet the diagnostic criteria for Major Depressive Disorder, according to the American Psychiatric Association, are:

- depressed mood most of the day, nearly every day;
- marked loss of interest or pleasure in all or almost all activities most of the day, nearly every day;
- significant weight loss or gain;
- sleep problems — getting too little or too much nearly every day;
- psychomotor agitation or retardation — the person is either on "fast-forward or slow motion," walking or talking very slowly or very rapidly, compared to previous habits;
- fatigue or loss of energy nearly every day;
- difficulty concentrating and making decisions nearly every day;
- feelings of worthlessness or excessive or inappropriate guilt nearly every day;
- recurrent thoughts of death or suicidal ideation or attempt.

The mnemonic "SIG E CAPS + Mood" (Sleep, Interests, Guilt, Energy, Concentration, Appetite, Psychomotor, and Suicide, plus depressed Mood) often is used as a checklist in diagnosing depression. The diagnosis is indicated in a person who experiences five of the nine symptoms in a two-week period; two of the symptoms must be depressed mood and loss of interest, and they must reflect a change from the person's normal condition.

"Sometimes, the person may not realize they're depressed, so occupational health nurses can help put the pieces together for them and encourage them to see their physician," Preston says. "We try to do prevention and encourage people to be diagnosed through their physicians.

"I think depression is different than an injury or illness of a physical nature. The limitations are different and the return to work is different," says Preston. "As occupational health nurses, we see depression that has not been diagnosed or treated, and then later, we help the walking wounded return to work."

Many employees continue to work with depression. But often, time off — as much as several weeks — is required for medication to take effect in restoring function.

"Once a diagnosis is made, whether the person is off work or not, the nurse's role is to encourage the person to continue treatment," she says.

Often, that encouragement needs to include educating and reassuring the employee about prescribed antidepressant medications.

"Sometimes they have thoughts about the medications — that they are addictive or have side effects that would render them incapable of working — that really aren't the case," says Preston. "So they resist taking the medications, and they aren't able to regain enough function to do the talk therapy, and that prolongs their recovery."

People trying to recover from depression should be reassured that their prescribed medications will improve functioning and speed recovery, she says.

"Occupational health nurses can make sure the employee receives the appropriate medical treatment by connecting with medical resources in their communities and finding resources for group therapy," she says. "Connecting the employee with the company's [employee assistance program], if one is

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available, would, of course, be important."

With moderate to severe depression, time off from work is followed by a return to work with substantial limitations.

"With severe depression, there are serious concentration, memory, and cognitive limits," explains Preston. "In the initial stages of treatment these limitations preclude the employee from working. Antidepressant medications require four to six weeks on average to be effective."

Determining how long that absence should be often falls to the occupational health nurse in conjunction with the treating physician, along with educating supervisors that the time off is needed and that it's OK for them to be out of the workplace temporarily, she says.

Working with the employee's physician, the occupational health nurse can help ensure the re-entry program is safe and reasonable and that the physician understands the true nature of the job.

"Sometimes you have to prompt doctors, or they have trouble articulating [their patient's] limits to me — that's not the case with a broken leg, but it seems to be when you're talking about depression," she points out.

Preston says she evaluates signs employees are regaining control of their emotional health prior to developing a return-to-work plan.

"I need to see that they have some better control over their emotions, that there are few crying spells," she says. "I also need to see that they have regained some ability to concentrate — that they are able to pay bills, can read an entire newspaper article, or watch an entire movie without losing concentration."

Other limits that can be important in re-entry for employees dealing with depression include:

- **The ability to tolerate distractions.** This might require providing alternate work duties or placing the employee in a less distracting, busy or noisy environment.
- **Stamina.** Some employees have more energy in the morning, so setting their work hours to fall in the morning, rather than in the afternoon, might be more productive.
- **Ability to multitask and stay focused.** "Especially for a manager, who has 15 balls in the air on a normal day, there might need to be some limits on tasks that require multitasking."
- **Interpersonal contact.** The employee can find dealing with the public or the possibility of confrontation difficult, and "that can be a huge limitation," Preston says. Alternate duties would be recommended initially in those cases to allow for a gradual return to those types of tasks.
- **Deadline pressures.** Preston recommends finding alternate tasks that don't carry stressful deadline pressures.
- **Medicine side effects.** While following the physician's prescription for medication is important for recovery, there are some side effects that can influence a return-to-work plan. For example, if the medication makes the person groggy in the morning, having him or her come in to work later in the morning or in the early afternoon would make sense.

"Depression is seen at different severities in different people," Preston points out. "So you have to look at each case individually when considering limitations and a re-entry to work, but if someone has been off work for a while, those are the limitations I generally anticipate."

Benefits to employer in treatment

More than 70% of people diagnosed with depression are employed, with depression resulting in 400 million lost workdays a year, according to a study by CIGNA Behavioral Health.

That's why employers have a huge stake in promoting treatment for depression, says **Keith Dixon**, PhD, president of CIGNA Behavioral Health.

"We need to convince company CEOs that the treatment of depression is good business strategy, and that begins by documenting the value of depression treatment beyond what exists today in academic and scientific journals," Dixon said.

In the private sector, Dixon notes, depressed employees use, on average, more than $4,000 per year in medical services vs. less than $1,000 per year used by employees without depression, making depression a driving force in health care costs. At the same time, employers bear many indirect costs of depression when it isn't treated, Dixon said.

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Expert supports mandated flu shots for all HCWs

Voluntary vaccination programs not enough

A senior epidemiologist and flu expert at Johns Hopkins University School of Medicine is calling for mandatory vaccination of all health care workers as the best means of protecting patients and hospital staff from widespread outbreaks of the viral illness. **Trish Perl**, MD, MSc, says studies by other U.S. researchers show that voluntary vaccination programs don't do the job, and that each year nearly 40,000 Americans die from influenza, many elderly or ill with weakened immune systems that cannot readily fend off the disease.

Perl, who published her conclusions in the online journal *Infection Control and Hospital Epidemiology* in November, concludes that mass vaccination policies are required to prevent patients from accidentally contracting the virus directly from an infected medical staff worker or indirectly from other patients or visitors via medical staff.

'Time to go the extra step'

Previous research from Johns Hopkins, Perl writes, showed that annual flu shots have been almost 88% effective at reducing the risk of flu infection and that they reduced by one-half the number of deaths among hospital patients from the disease. Research shows that despite free and ready access to the vaccine, only 40% of all health care workers actually get a flu shot.

"We have gone as far as possible with vaccination programs emphasizing education and health promotion," says Perl, an associate professor of medicine and pathology at Johns Hopkins University School of Medicine in Baltimore. "It's now time to go the extra step, requiring active declination or even making vaccination a mandatory part of the job linked to patient safety, along with such tasks as keeping hands clean and getting mandatory TB tests."

Neither state nor federal law requires workers to provide medical details when they call in sick, so it is difficult to precisely link seasonal hospital absenteeism and high rates of non-vaccination, she notes.

"We need to close the very serious gap between knowledge and behavior that exists among health care workers," Perl argues, and it can be done, she says. In 2003, her team, along with occupational health services at Hopkins, vaccinated more than 70% of the 10,000-member hospital staff. "But we can do better and, ideally, at Hopkins and other hospitals, our objective would be to consistently have more than 90% of staff vaccinated each year."

Lack of time cited for not getting shots

According to Perl, numerous staff surveys from other hospitals have shown that the most common reason cited for not getting a vaccination is lack of time (47%). Surprisingly, a remarkably high number of staff, more than 30%, believed they could catch influenza from the vaccine itself, which is false.

Perl also notes from surveys that relying on people's self-awareness is not sufficient to prevent the flu from spreading. "One-half of infected health care workers have no idea when they are infected with influenza, often having few, if any, signs and symptoms, and making it impossible to ask all staff to stay home when they are feeling ill to prevent other people from catching their infection," she says.

Still, other studies have found that education campaigns can be effective at increasing vaccination rates among health care workers by as much as 60%. And to the surprise of those conducting these surveys, the reason most likely to motivate health care workers to get the shot is that it benefits patients, not themselves.

However, in the editorial, Perl concludes, "Shifting the message from self-interest to altruism in protecting patients may improve vaccination rates, but it won't fix the problem. From a hospital policy standpoint, this is a real patient safety issue and vaccination can be viewed as a means of protecting patients from influenza exposure and the related mortality seen among vulnerable populations. Vaccination should be presented as such to both health care workers and every hospital's leadership."

Perl notes that even without mandatory vaccination policies, other potential barriers to widespread vaccination can be helpful and should be implemented nationwide. Among her recommendations are free shots for all staff, easy access to flu shot clinics on site, flexible vaccination hours, emphasis on patient safety aspects of the program, education to counter beliefs that the shots can make you sick, and encouragement from hospital leaders to get the vaccine.

The next step, Perl says, is for health care pro-

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Five key components of an effective flu shot program

SHEA outlines measures in recommendations

Health care-associated transmission of influenza has been documented in many different patient populations and clinical settings. In many of these outbreaks, infections occurred in non-vaccinated health care workers (HCWs), including workers who were linked epidemiologically to the transmission of influenza, the Society for Healthcare Epidemiology (SHEA) of America states in a new position paper.[1] Key SHEA observations and recommendations are summarized as follows:

• Health care-associated outbreaks of influenza may result in increased patient morbidity, mortality, length of hospitalization, and costs, and may disrupt the essential services of a health care facility during a season when patient census and worker absenteeism are high.

• Despite existing recommendations, overall influenza vaccination rates in HCWs remain unacceptably low, with only 40% of HCWs receiving influenza vaccination in 2003. It has been suggested that coverage of 80% of HCWs may be necessary to provide herd immunity to prevent health care-associated transmission of influenza.

An effective program to increase HCW vaccination rates must contain the following components:

1.) provide targeted education annually to all HCWs about the severity of influenza, particularly among high-risk patients, and about the safety of influenza vaccination;

2.) inform HCWs of the importance of influenza vaccination in promoting patient and employee safety;

3.) provide vaccine at no cost and at convenient locations and times;

4.) recommend that HCWs sign a declination each year if they refuse influenza vaccination after participating in an educational program or if they have medical contraindications to the vaccine;

5.) perform surveillance of rates of vaccine uptake by medical unit as well as identification of patients with health care-associated influenza to assess the impact of the vaccination program.

The educational component of any HCW vaccination program must explain the rationale for vaccination of HCWs and provide specific messages directed at dispelling myths about influenza vaccination, such as the perceived risk of post-vaccination influenza-like illness, which has not been substantiated by clinical trials. Vaccination should be convenient and easily accessible to minimize the impact on the daily activities and duties of HCWs.

Proven tools, such as mobile vaccination carts, continuous educational campaigns, visible vaccination of key leaders, off-hours clinics, incentives, and targeted vaccination at departmental or staff meetings, should all be considered as part of a facility's influenza vaccination program.

While the use of active declination to increase influenza vaccination rates has not been tested specifically, it is currently a component of HCW hepatitis B vaccination programs as required by the Occupational Safety and Health Administration's bloodborne pathogen standard. As a result of enhanced vaccination programs that include active declination and the implementation of standard precautions, HCW vaccination rates have increased and health care-associated hepatitis B infection rates in HCWs have declined by 98%.

A recommendation for active declination as part of influenza vaccination programs will result in increased workload and record keeping for infection control and occupational health staff. The annual nature of influenza vaccination campaigns, which occur within a few targeted weeks each fall, also provides additional challenges; however, other types of annual HCW screenings may be used as models for influenza vaccination campaigns for HCWs.

Health care facility administrators must provide ample financial support and human resources to ensure the success of their programs, which may require seasonal hires of information technology, secretarial, and nursing personnel to accommodate the demands of the annual vaccination campaign. In times of vaccine shortage, active declination programs should be directed only at those HCWs targeted to receive vaccine through the facility's allocation plan based on the intensity and duration of contact with patients.

Reference

1. Talbot TR, Bradley SF, Cosgrove SE. SHEA Position Paper: Influenza Vaccination of Healthcare Workers and Vaccine Allocation for Healthcare Workers During Vaccine Shortages. *Infect Control Hosp Epi* 2005: In press. ■

(Continued from p. 4)
fessional associations, such as the Infectious Disease Society of America and the Joint Commission on Accreditation of Healthcare Organizations, to endorse mandatory flu shots.

One group, the Alexandria, VA-based Society for Health Care Epidemiology (SHEA), last month endorsed such a plan. However, Perl acknowledges that current federal workers' rights prevent employers from making vaccinations a requirement.

Perl says her proposal is open to discussion at Hopkins. "Ultimately, we want to make vaccination as mandatory for workers as the law allows in order to effectively accomplish what we cannot enforce," she says.

Precaution vs. liability

What risks are there for hospitals whose employees become ill, and what legal standing do hospitals have to require immunizations and employees have to refuse vaccines?

As far as a hospital's responsibility to protect patients and other employees from contracting the flu from a sick worker, "I think the ethical implications are that ill employees must be tested with rapid flu nasal swab, and if they are negative they work, and if they're not [negative] they do not," says **James R. Hubler**, MD, JD, clinical assistant professor of surgery at the University of Illinois College of Medicine at Peoria.

"Even universal precautions in a high-risk population may not provide enough protection," he adds. "A clinic that does not protect its patients would be at risk for lawsuits, but it would be nearly impossible to prove that they contracted the disease from a health care provider and not [out in the community]."

There is little case law pertaining to institutions' responsibilities should employees become ill as a result of a facility-wide immunization process. In one case in Louisiana, *Guillory v. St. Jude Medical Center*, a hospital technician was ruled to be due workers' compensation when she developed encephalomyelitis triggered by a hepatitis vaccination administered by her employer, because the inoculation program was within the scope of her employment. In a related case in Texas, a firefighter who became incapacitated from a swine flu vaccination was awarded workers' compensation even though he received the vaccination voluntarily, because his job was considered critical to the community in the event of a swine flu epidemic and the city offered the vaccine from a desire to vaccinate critical employees. (For more information on the medical/legal implications of work-related immunizations, see *ED Legal Letter*, February 2003, p. 13-24.)

Lack of agreement on mandating vaccine

The Elk Grove Village, IL-based American College of Occupational and Environmental Medicine, in a new position statement, asserts that such vaccinations are not necessary and further opposes the use of declination statements (signed statements indicating the worker has opted not to have a vaccination) 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.

However, SHEA has come out with a position paper of its own that recommends HCWs who decline flu immunization *must* sign a declination statement. Published in the November 2005 issue of *Infection Control and Hospital Epidemiology*, the paper is available on SHEA's web site. In a nutshell, SHEA recommends all health care workers be immunized against the flu annually unless they have a contraindication to the vaccine or actively decline vaccination. (See SHEA recommendations for components of flu shot programs, p. 5.)

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Managing return to work after a heart attack

Understand, don't fear restrictions

Managing return to work for an employee who has had a heart attack not only involves determining worker's abilities and restrictions, but also can involve educating the worker about what precautions he or she should take, as well as what

he or she should not be afraid of.

According to the Dallas-based American Heart Association (AHA), most people who can perform routine activities requiring ordinary effort without being bothered by heart symptoms should be able to return to their previous jobs after recovering from a heart attack.

Because 45% of heart attacks occur in people younger than 65 and most people survive heart attacks, managing return to work after a heart attack is not an uncommon task for occupational health nurses. The vast majority of people who are not troubled by symptoms during normal activities requiring ordinary effort should be able to return to their previous jobs unless there are specific fitness requirements, according to AHA.

Job descriptions since the passage of the Americans with Disabilities Act (ADA) have become quite broad, but when working on a return-to-work plan for an employee who has suffered a heart attack, specifics are important, says **Maureen Thompson,** RN, COHN-S/CM, manager of employee health services for Toyota Financial Services in Maryland.

"The ADA makes job descriptions broad, but you need to get a detailed one for the physician," so that he or she can have an accurate picture of the physical demands the employee's job carries.

"Then, the occupational health nurse should meet with the employee's supervisor and the employee to go over the restrictions to make sure they both understand them," she says.

It's important that an employee understand what the restrictions are and what they are not. AHA recognizes that many people recovering from heart attacks are sometimes afraid that the rigors of everyday life might cause new heart symptoms, but fears of dying, of new pain, or of being unable to work are normal and should diminish with time and adherence to restrictions and a healthy lifestyle.

"You do have to make sure the employee understands the restrictions and that he or she must adhere to them, and that if they don't they'll have problems all over again," Thompson points out.

Rehab, monitoring contribute to re-entry

Before releasing a heart attack patient to return to work, the physician will evaluate his or her fitness and the heart's ability to respond to exercise. If the level of response is within acceptable limits, cardiac rehabilitation might be recommended.

Rehabilitation can aid in re-entry to work by addressing the patient's risk factors, treating symptoms, restoring physical fitness, relieving anxieties about the heart attack, and providing counseling to the patient and support to the family.

The occupational health nurse can not only help the employee understand the restrictions on his or her return to work, but also can help supervisors and co-workers understand the facts about heart attacks through general education.

"The occupational health nurse might also estimate the frequency of visits to the medical center, making sure that someone is medically watching the employee so that the physician can have an ongoing pattern to monitor," Thompson adds.

[For more information, contact:

- ***American Heart Association**, 7272 Greenville Avenue, Dallas, TX 75231-4596. "How Will I Recover From My Heart Attack?" available at http://www.americanheart.org/presenter.jhtml?identifier=3007458.*
- ***Maureen Thompson,** RN, COHN-S/CM, manager, employee health services, Toyota Financial Services. Phone: (410) 415-4420. E-mail: Maureen_thompson@toyota.com].* ■

Employees must be paid for time donning safety gear

Class-action suit filed by meat-packing workers

The U.S. Supreme Court has ruled that companies must pay plant workers for the time it takes to change into protective clothing and safety gear and walk to their workstations, a decision hailed as a safety victory for meat-packing, poultry, and food processing workers who typically must put on sanitary outer garments, boots, hardhats, aprons, and gloves.

The issue was one of two that the justices settled in a pair of unanimous decisions regarding the Fair Labor Standards Act. In a defeat for business, the court said that employers must pay wages for the donning of "integral" gear and the time it takes workers to then walk to the production area. The time spent putting on protective gear was not the focus of the ruling, because the Supreme Court held nearly 50 years ago that workers at a battery plant must be

compensated for time spent putting on special protective clothes. Instead, the dispute focused on the time employees spend walking from place to place. Justices had been told that workers sometimes have long waits after putting on their gear.

The ruling clears the way for 815 petitioning workers at a Tyson Fresh Meats Inc. packing plant to receive $7.3 million in a class-action suit filed more than seven years ago.

The case, *Alvarez v. IBP*, was filed by workers who claimed the company had violated federal and state law by not paying them for the time it took to dress in required protective clothing and walk to the production line. The workers argued it took them up to 30 minutes a day to "doff and don" the required metal mesh vests, aprons, leggings, and gloves, and said their workday should begin when they started dressing. The employer argued that a 1947 federal law required they start paying the workers only when they actually arrived at their workstations.

As a result of the ruling, an employer who requires employees to don special protective equipment prior to commencing work must compensate employees for time spent donning the protective equipment at the beginning of the shift, time spent removing the protective equipment at the end of the shift, and time spent walking between the changing area and the work site at the beginning and end of each shift.

The court rejected the employees' argument that they should be compensated for the time they spend waiting to don the first piece of safety gear at the beginning of the workday. ■

AAOHN, OSHA renew pact for education, research

Workplace violence one priority

The Occupational Safety and Health Administration (OSHA) and the American Association of Occupational Health Nurses (AAOHN) have renewed their 2003 alliance for another two years to continue targeting workplace violence, musculoskeletal disorders, and promoting the availability and use of automated external defibrillators in the workplace. Both OSHA and AAOHN say the first two years of the alliance provided important opportunities for education and outreach.

"AAOHN is pleased to renew our alliance with OSHA," says AAOHN President **Susan Randolph**. "We are committed to working together to promote safe and healthful work environments and preventing worker injury and illness."

This alliance provides AAOHN opportunities to collaborate with OSHA in training and education, outreach and communication, and promotion of the national dialogue on workplace safety and health. Through the alliance, an implementation team made up of representatives from OSHA and AAOHN will develop a plan of action, determine working procedures, and identify roles and responsibilities for both organizations. In addition, the organizations will meet at least three times each year to track and share information on activities and results in achieving the goals of the alliance.

"Our alliance with AAOHN has been very effective in working with frontline occupational safety and health professionals to improve safety and health in the workplace," according to acting Assistant Secretary of Labor for OSHA **Jonathan L. Snare**. "We look forward to furthering our joint efforts and achieving real improvements in workplace safety and health for occupational and environmental health nurses."

OSHA and AAOHN will continue to work together on specific goals of the alliance, including:

- disseminating health and safety information and guidance through meetings, conferences, and other events;
- encouraging AAOHN chapters to build relationships with OSHA's regional and area offices to address health and safety issues within the alliance's three key areas;
- encouraging AAOHN chapters to act as resources for OSHA's training institute and education centers to assist in the promotion and presentation of health and safety courses;
- raising awareness of and demonstrating a commitment to improving the health and safety of the work force;
- convening or participating in forums, roundtable discussions or stakeholder meetings about the three topical areas of the alliance; and
- encouraging AAOHN's members to act as industry liaisons and resources for OSHA's cooperative programs and compliance assistance specialists. ■

Study examines impact of health on bottom line

Costs of absenteeism and presenteeism researched

The American College of Occupational and Environmental Medicine (ACOEM) and the Integrated Benefits Institute (IBI) have launched a research study to assess the full costs of absenteeism and presenteeism on a company's productivity.

ACOEM and IBI, working with CorSolutions, Harvard Medical School, and the Midwest Business Group on Health (MBGH), will focus their "Health and Productivity as a Business Strategy" study on identifying leading chronic conditions that drive employer health care costs.

The goal of the research is to develop a greater understanding of the total impact of health on the financial bottom line for employers and contribute to industry advancement and the betterment of human health.

The study is designed to survey more than 100,000 employees using a Health and Work Performance Questionnaire (HPQ) to confidentially gather data. The HPQ is an on-line, validated productivity measurement survey tool developed by Ron Kessler, PhD, of Harvard Medical School, in conjunction with researchers from the World Health Organization.

Additionally, data analysis on health and pharmacy claims will be provided by CorSolutions and evaluated in conjunction with the HPQ to calculate health care expenditures and provide additional financial factors for calculating operations expenses.

ACOEM and IBI will work jointly on the study and production of a final publication.

The study seeks to involve partners in both the benefits and occupational health functions of five to 10 major corporations. The study will collect aggregate benefit program information from each corporation and will bring presenteeism into the "full-cost" framework so the impact of absence and ill health at work on productivity loss are understood compared to the employer's out-of-pocket expense.

The organizations participating in the study bring expertise in group health, workers' compensation, short-term disability, long-term disability, incidental absence, and family medical leave to help determine targeted cost/benefit analysis and plan modeling that may include disease management, employee assistance programs or wellness programs.

The study is scheduled to be complete by June.

Study outcomes featuring a validated third-party health and productivity snapshot report will be shared with participating employers to help quantify the effects of health problems on lost company productivity.

In addition, ACOEM and IBI plan to publish final results as well as share findings as part of public presentations. ■

BP assessed record fine for fatal Texas blast

OSHA cites 'egregious, willful' violations

In the wake of a disastrous explosion that killed 15 workers and injured more than 150 others, BP Products North America Inc. has been fined a record $21 million by the U.S. Occupational Health and Safety Administration (OSHA). The March 23 explosion, OSHA found, occurred due to management's lax attitudes toward safety.

BP has denied wrongdoing and placed the blame for the explosion on employees at its Texas City, TX, plant, some of whom were fired from their jobs and have responded with lawsuits claiming BP wrongly blamed them for the blast.

OSHA investigators ruled that the violations that led to the explosions had existed at the plant for years, despite OSHA inspections.

BP claimed the violations that led to the blast had existed for years and denied that OSHA had failed to properly inspect the plant over the years. According to OSHA, along with the $21 million in penalties, BP Products agreed to:

- abate all hazards for which it was cited;
- complete a review of the damaged unit to determine how it can be operated safely, and to notify OSHA if and when the company decides to start the unit back up;
- retain a process safety management consultant;
- hire an expert to assess and report on communication between management, supervisors, and employees;
- submit logs of occupational injuries every six months for three years;

• notify OSHA of any incident or injury at the facility that results in an employee losing one or more workdays during a three-year period.

OSHA cited BP for "egregious, willful violations" for operating faulty electrical equipment, failing to correct deficiencies in equipment related to the pressure relief system, failing to compile written process safety information for the unit, failing to evaluate the safety and health impact of a catastrophic blast near the unit, and failing to examine alarms and instruments for reliability. ■

Program helps members lose weight and stay fit

Goal to prevent and minimize chronic conditions

Based on the success of a weight management program targeted at already obese employees of a major Northwest corporation, Premera Blue Cross is offering a five-tier weight management program to eligible employer groups who want to help their employees lose weight or stay fit.

In 2004, the Mountlake Terrace, WA, health plan brought together an internal comprehensive obesity strategy team to address overweight and obesity issues in general and to develop strategies and implement programs for other employers.

The five-tier program the team developed ranges from basic tools and incentives to a comprehensive obesity benefit with nutritional, behavioral, medical, and surgical interventions.

The aim is to slow the trend of members into disease management programs by helping them avoid potential chronic conditions that are caused or exacerbated by obesity.

"Obesity can have a significant impact on the health of people with diabetes, congestive heart failure, coronary artery disease, and other conditions. We know that if people lose weight, they may be able to reduce medication they take for blood pressure, cholesterol management or diabetes," says Premera's director of quality, **Shelly Smith**, RN, MN, CPHQ.

The team started by identifying programs that already are part of the standards benefit package and are available at no additional cost to the employer.

"These benefits have been available, but they haven't been used much. We decided to promote them so that people who are already healthy would know that they could access information and benefits that will help them remain healthy," she says.

Programs included in Tier 1, the basic benefit, include a basic on-line health assessment tool; information about fitness, weight loss, and health issues through AHealthyAdvantage, an award-winning on-line health education resource; and discounts for weight loss programs and health club benefits.

"We started out by identifying programs that we weren't promoting but that could motivate people to lose weight. These programs are for people who want to take better care of themselves or who need to lose a few pounds," Smith says.

Tier 2 adds a health management benefit, which provides coverage for community wellness classes, such as smoking cessation and weight management.

Members eligible for Tiers 3 and 4 are identified through a comprehensive health risk assessment administered by Summex Health Management, an Indianapolis-based wellness management company.

The majority of employers choose the package that provides coaching for the 40% to 55% of employees who are identified as having the highest risk factors.

The program helps employers identify incentives that will help their employees reach their fitness and weight loss goals. Incentives may be cash, tuition credit or discounts on other benefit package components such as life insurance, disability insurance or medical coverage.

Members who are eligible for the program are mailed a letter offering them the services, as well as educational material on weight loss and fitness.

A health coach helps the members enrolled in the program identify what they are ready to change and what they want to work on first.

They call members at regular intervals, typically once a quarter, and are available to the member by telephone.

The health coach helps the members develop goals and choose steps and actions to take. For instance, the member may decide to walk three times a week or keep a journal and document everything he or she eats for a week, with the

long-term goal of losing 10 pounds.

Tier 4 targets members with a body mass index more than 30 and provides a more intensive level of management. The program provides a specialized assessment tool, followed by education and coaching.

The health coach contacts these members between 12 and 20 times a year and focuses only on obesity management, providing personal feedback and guidance to support their specific goals.

"At this level, we ask the members to document their goals in writing and to sign them. It includes a lot of education about what the member is eating and why," Smith says.

For instance, a participant may report being hungry after work and stopping by McDonald's for a snack before dinner. The health coach would work with the participant to keep snack crackers in the car to stave off hunger instead of stopping for a fast-food snack.

"The health coaches are looking for very specific behaviors. There is more frequent contact, more intensive goal setting, and more coaching around lifestyle changes," she says.

The health plan encourages members and employers to focus on Tiers 3 and 4 first, Smith says.

Tier 5 is a medical and surgical obesity benefit that can be customized to fit the needs of an employer's population.

The program provides physician-directed obesity and weight management, including medical visits, nutritional counseling, behavioral counseling, and other medical interventions, along with bariatric surgery benefits.

It's too soon for any definitive outcomes information for the program that Premera offers to all its employer groups, but the weight loss and corresponding improvement in health of participants are likely to be significant, Smith says.

"With our aging population, the potential for making a difference in disease management services is tremendous. When people lose weight, it can make a huge difference in their life." ■

Nursing homes dominate OSHA's hazard list

800 will receive comprehensive inspections

Twenty-eight hospitals and about 800 nursing homes will receive comprehensive inspections from the U.S. Occupational Health and Safety Administration (OSHA) because of high injury rates.

Nursing homes represent about 16% of the total high-hazard workplaces that have been selected for targeted inspection — and that is half of the number eligible for greater scrutiny. OSHA reduced the number of nursing home inspections by half because they would be overrepresented in the 5,000 inspections, explains **Tom Galassi**, MPH, CIH, deputy director of OSHA's Directorate of Enforcement Programs.

The high profile of nursing homes among high-hazard workplaces in the past is due to their overall number, says **Dave Schmidt**, chief of the division of data analysis. Some 17,000 of the 80,000 employers surveyed for the site-specific targeting program were nursing homes, he says.

But nursing homes also are hazardous because of resident handling injuries. To be on the primary inspection list, employers reported a rate of 12 or more injuries or illnesses that resulted in days away from work, restricted work activity, or job transfer (DART) for each of the 100 full-time workers.

The DART rate for nursing homes is 6.3, compared to 2.6 for the general industry. Sites on the targeted inspection list have a DART rate of 12 or higher or a "Days Away from Work [due to] Injury and Illness" rate of 9 or higher.

Since OSHA began using the general duty clause — which requires employers to maintain a workplace free of recognized hazards that could cause serious harm — as an ergonomics enforcement tool, the agency has issued 16 citations. Ten were given to nursing homes; no hospitals have received a citation.

But according to Galassi, the enforcement actions

COMING IN FUTURE MONTHS

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and the targeted inspections, along with patient handling guidelines geared toward nursing homes, have led employers to respond to the hazard.

"We think we're getting some buy-in from the industry and recognition and agreement that resident handling problems can be addressed through engineering controls and work practices," he adds. ■

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 **June** issue and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

1. A mnemonic for the symptoms required for a diagnosis of depression is:
   A. SIG E CAPS + Anxiety
   B. SIG E CAPS + Mood
   C. SIG E CAPS + Sleep disturbance
   D. SIG E CAPS + Fatigue
2. According to Perl et al. at Johns Hopkins, more than 30% of surveyed hospital personnel believed they could get the flu from the vaccine.
   A. True
   B. False
3. Regarding the donning of protective clothing and safety gear, the U.S. Supreme Court ruled that companies must pay plant workers for:
   A. the time it takes to change into protective clothing and safety gear and walk to workstations.
   B. the time it takes to wait in line for protective clothing when they arrive at the work site.
   C. both a and b
   D. neither a nor b
4. According to the Society for Healthcare Epidemiology of America, an effective program to increase HCW vaccination rates must contain which of the following components?
   A. provide targeted education annually to all HCWs about the severity of influenza, particularly among high-risk patients, and about the safety of influenza vaccination
   B. inform HCWs of the importance of flu vaccination in promoting patient and employee safety
   C. provide vaccine at no cost and at convenient locations and times
   D. all of the above

Answers: 1. B; 2. A; 3. A; 4; D.

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Dear *Occupational Health Management* Subscriber:

This issue of your newsletter marks the start of a new continuing education (CE) semester and provides us with an opportunity to review the procedures.

Occupational Health Management, **sponsored by Thomson American Health Consultants,** provides you with evidence-based information and best practices that help you make informed decisions concerning treatment options and administrative practices. Our intent is the same as yours — the best possible patient care.

The objectives of *Occupational Health Management* are 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.

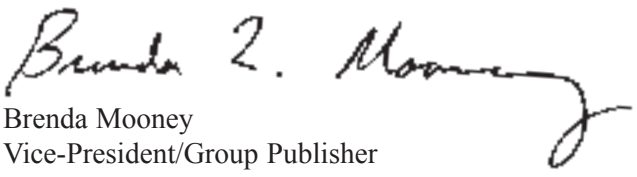
Each issue of your newsletter contains questions relating to the information provided in that issue. After reading the issue, answer the questions at the end of the issue to the best of your ability. You can then compare your answers against the correct answers provided in an answer key in the newsletter. If any of your answers were incorrect, please refer back to the source material to clarify any misunderstanding.

At the end of each semester you will receive an evaluation form to complete and return in an envelope we will provide. Please make sure you sign the attestation verifying that you have completed the activity as designed. Once we have received your completed evaluation form, we will mail you a letter of credit. This activity is valid 36 months from the date of publication. The target audience for this activity is intended for occupational nurses, occupational health managers and directors.

If you have any questions about the process, please call us at (800) 688-2421, or outside the U.S. at (404) 262-5476. You can also fax us at (800) 284-3291, or outside the U.S. at (404) 262-5525. You can also email us at: ahc.customerservice@thomson.com.

On behalf of Thomson American Health Consultants, we thank you for your trust and look forward to a continuing education partnership.

Sincerely,



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