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VISIONS

Workplace Fatalities, Disabling Injuries Trigger Personal, Regulatory Response

“Better a thousand times careful than once dead.”
— A Proverb

By Karen O’Hara

Sometimes a tragic loss results in a calling. When Shawn Boone, 33, died in 2003 of burns suffered in an aluminum dust explosion at his workplace in Indiana, his sister, Tammy Miser, took a crash course in



work-related fatality investigations. “In my struggle to obtain information, it became clear to me there was a need for a centralized resource for families experiencing a workplace death,” she said. “You assume there is a process, but you don’t know what it is or what the regulations are, because you never expect something like this to happen.”

Ms. Miser made it her mission to establish the United Support Memorial for Workplace Fatalities



(USMWF), a non-profit organization that assists families and others affected by workplace deaths. USMWF advocates on behalf of victims’ rights, lobbies for occupational health and safety protections, and provides a broad range of resources to survivors, including an online memorial page with photos and tributes.

“Part of my motivation was that I wanted to understand our family’s legal rights and what we were entitled to know,” she explained. “There are some people with whom you are so close – like my brother was to me – and when you suddenly lose them, you need to know exactly what happened.”

Ms. Miser estimates about one-third of reported work-related fatalities in the U.S. find their way onto the USMWF website (www.usmwf.org) from a variety of sources. Regardless of the cause of death, if it happens at work, USMWF will post it. The organization’s motto is: “...Because going to work shouldn’t be a grave mistake!”

Fatalities Mount

Despite efforts to protect them, people die on the job, and each work-related death represents incalculable loss in terms of human suffering.

In 2008, the most recent year from which comprehensive data are available, 5,214

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EDUCATION

NAOHP Board Holds Spring Conference Call



To: NAOHP Members
Re: Spring Quarter Conference Call
From: Rachel Stengel, NAOHP Member Services Coordinator

The NAOHP Board held its quarterly meeting via conference call on May 3. Executive Director Frank Leone and staff members Karen O'Hara and Rachel Stengel were also in attendance.

Bi-Annual National Survey:

Mr. Leone reported that the NAOHP's bi-annual survey allows the NAOHP to create benchmarks and track changes in the marketplace. The 2010-2011 survey will be fielded electronically this summer. Board Members were invited to review the draft survey instrument and submit questions. Mike Schmidt suggested adding wellness-related questions, noting the growing interest on the part of employers. Ms. O'Hara suggested data on the use of electronic medical records be incorporated.

Member Recruitment and Renewals:

Mr. Schmidt encouraged board members to send reminder emails to NAOHP members who have not renewed their membership for 2010. Ms. Stengel reported positive renewal rates in all membership categories. She also invited the board to suggest prospective new vendor members. Ms. Stengel reported success with the NAOHP's first online Vendor Fair and said recruitment for the live 2010 Vendor Exhibit at RYAN Associates' National Conference is on track for the fall.

Staff and Clinician Relationships:

Ms. Merckling said team building is a major focus of the board's Staff/

Clinician Relationships Committee. She proposed a session on team building during the 2010 national conference (which has since been incorporated into the curriculum). Ms. O'Hara noted plans to offer pre-conference Medical Review Officer certification and OSHA recordkeeping courses in conjunction with the American College of Occupational (ACOEM) and Environmental Medicine for the first time this year.

In related activity, Ms. O'Hara reported on the recent American Association of Occupational Health Nurses (AAOHN) conference and the potential for an expanded relationship between the NAOHP and AAOHN, with both parties complementing each other's educational programs.

Information Management:

Board Member Michelle McGuire reported continued efforts to interview Joint Commission-certified programs for a future *VISIONS* article. Ms. Merckling reported on her investigation into translation software companies and plans to develop a list of compatibilities between practice management vendors and e-signature devices.

Publications:

Ms. O'Hara reiterated plans to launch an NAOHP blog this summer. As proposed, the blog would feature content similar to that of current publications but written in a commentator format. The goal of the blog is to promote active discussion of current occupational health-related issues.

Member Education and Services:

Ms. O'Hara announced plans to finalize the 2010 national conference agenda by mid-May and asked the board to review the agenda and respond with feedback. Board Member Denia Lash reported interest in case management, wellness, personal health care costs and topics related to national health care

reform. Mr. Rankin suggested offering a course on on-site services. Mr. Schmidt and Ms. McGuire proposed electronic medical record interfaces as a topic.

Member Benchmarking:

Mr. Leone reported the NAOHP has submitted an RFP to Press Ganey and Picker as part of an ongoing patient satisfaction benchmarking project.

Promoting National Visibility:

Mr. Leone reported continued discussions with ACOEM regarding joint efforts, noting pre-conference offerings for both 2010 and 2011 national conferences. He also gave an update on his involvement in a UCLA study on occupational medicine physicians' time on task. Mr. Rankin reported on continued efforts to forge relationships with substance abuse professionals' groups.

The next board conference call is scheduled for Aug. 18.

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MEMBER MENTIONS



Tim Ross, right, regional administrative director of WorkingWell, accepts the program's ISO 9001:2008 Certification from auditor Rich Shelhamer of Perry Johnson Registrars, Inc.

NAOHP member organization **WorkingWell**, a division of Sisters of St. Francis Health Services in Indiana, is the first occupational health provider ever to receive ISO 9001:2008 Certification, the program announced June 15.

ISO certification was a logical next step following NAOHP Quality-Certification in late 2008, said Tim Ross, regional administrative director. (Refer to Trendsetters in *VISIONS*, Vol. 19, No. 4, January/February 2009.) The NAOHP seal of approval is based on compliance with performance standards in six categories: administration, operational framework, staffing, quality assurance, product line development and sales/marketing.

ISO – the International Organization for Standardization – is the world's largest developer and publisher of international standards. Its standards are implemented in 162 countries under the supervision of the Central Secretariat, Geneva, Switzerland. ISO requires that certain standards be applied to all key business processes. While it has been an international leader in quality certifications for the steel and manufacturing industries for more than 63 years, ISO 9001:2008 requirements are generic and are intended to be applicable to all organizations, regardless of the type, size and product provided.

According to Mr. Ross, ISO certifica-

tion has many benefits in the health care industry. It is also something ISO-certified employers can appreciate. "The quality-management system provides a foundation of best practices, resulting in the highest quality health care, improved outcomes and reduced errors for patients," he said. "ISO 9001:2008 ensures the effectiveness of all documented processes, and commitment to their use for every patient. By following ISO standards for quality management, we are demonstrating a proactive approach that prevents errors and increases patient safety and satisfaction."

"Through the achievement of ISO 9001 Certification, WorkingWell has made a serious commitment to a high-quality standard of excellence and intends to exceed the expectations of their customers and the community," said Chris Vanni, regional manager of performance improvement, Sisters of St. Francis Health Services.

Mr. Ross and Ms. Vanni will speak on the process at RYAN Associates' National Conference, Oct. 11-13 in Boston.

Any business seeking ISO Certification must go through a rigorous audit of its quality management system. Quality goals are set and monitored for a continuously improving quality system. The WorkingWell ISO audit was conducted by Dale Kramer of Perry Johnson Registrars, Inc.

"WorkingWell is the top of the line! Overall, a nice system – very classy and sophisticated." said Mr. Kramer. "The best I have ever seen."

WorkingWell has five locations serving employers in northwest Indiana,

southwest Michigan and southeast Chicago. It also has two locations in the Indianapolis metropolitan area. The Sisters of St. Francis Health Services operates a network of eight hospitals on 12 campuses in Indiana and northeast Illinois.



ACOEM Installs New President

Natalie P. Hartenbaum, M.D., M.P.H., is the new president of the American College of Occupational and Environmental Medicine (ACOEM). Dr. Hartenbaum, an expert on transportation medicine, assumed office May 4. She has spoken at numerous RYAN Associates' conferences over the years.

Dr. Hartenbaum is Chief Medical Officer of OccuMedix, Inc., Dresher, Pa., and Adjunct Assistant Professor of Emergency Medicine at the University of Pennsylvania. She is also Medical Director of the Federal Reserve Bank of Philadelphia and Chief Medical Review Officer of FirstLab in North Wales, Pa.



In Memoriam

ACOEM members paid tribute to the late **Elizabeth Genovese, M.D.**, 53, at its annual conference in May. Dr. Genovese died April 19 of complications relating to a rare form of cancer. She was Medical Director of IMX Medical Management Services, Bala Cynwyd, Pa., and last year's recipient of the college's Robert A. Kehoe Award of Merit. The award is presented to individuals who have shown distinction in and made significant contributions to OEM. Dr. Genovese was acknowledged for her commitment to the principles of evidence-based medicine as exemplified through her work on ACOEM's *Occupational Medicine Practice Guidelines*, specifically as a lead author of a revised chronic pain chapter and a member of the spine panel.

workers were killed on the job – an average of 14 a day – and an estimated 50,000 more died from occupational diseases, according to U.S. government statistics.

In April of this year, 29 men died in a blast at Massey Energy Co.’s mine in West Virginia. The BP oil rig explosion in the Gulf of Mexico killed 11 men, and seven more workers suffered fatal injuries in a fire at the Tesoro refinery in Anacortes, Wash.

These types of disasters garner national media attention and serve as a wakeup call. Singular fatalities get far less publicity, but they have a profound cumulative effect.

In the last eight days of April alone, nine other fatalities and one incident involving multiple hospitalizations were reported to the federal Occupational Safety and Health Administration (OSHA).⁽¹⁾ Several of the fatalities that occurred between April 23-30 involved pressurized equipment failures. A deputy was shot; a plumber slipped while loading a truck; a man working in a corn storage bin suffocated when he was engulfed by grain; a track maintenance supervisor was electrocuted by a high-voltage rail; a slate roofer fell 18 feet onto a porch; and a man was crushed while cutting a bundle of pipe.

Weekly Toll: Death in the Workplace, a blog to which Ms. Miser and other USMWF volunteers contribute, suggests additional fatalities occurred during the last week of April that were not reported to OSHA. For example, USMWF bloggers posted the following: two police officers killed in separate vehicle-related incidents; two miners who died when a roof fell; a construction worker killed when a trench collapsed; a train conductor who fell and was struck by a locomotive; and a sewage treatment facility explosion that killed one worker.

The discrepancy between OSHA statistics and blog entries may be attributed, in part, to ongoing investigations about work-relatedness, timing lapses and varying information sources, Ms. Miser said.

Injury Rates

In addition to fatalities, approximately 4.6 million occupational injuries were reported in 2008.

On a positive note, non-fatal work-

place injuries and illnesses among private industry employers in 2008 occurred at a rate of 3.9 cases per 100 equivalent full-time workers, a decline from 4.2 cases in 2007, the Bureau of Labor Statistics reports. The total recordable injury and illness incidence rate among private industry employers has declined significantly each year since 2003, when estimates from the national Survey of Occupational Injuries and Illnesses were first published using the 2002 North American Industry Classification System.

However, government officials and labor leaders believe the actual number of injuries that occur annually is considerably higher than what is reported. In the 2010 edition of *Death on the Job: The Toll of Neglect*, the AFL-CIO cites estimates ranging from 9 to 14 million work-related injuries a year, with associated direct and indirect costs of \$156-\$312 billion.⁽²⁾

According to OSHA, more than half of reported cases require a job transfer, work restrictions or time off. Meanwhile, approximately 9,000 workers are treated daily in hospital emergency departments; about 200 of them are hospitalized.

Loss is Costly

To quantify the monetary cost of accidents, injuries and fatalities, the National Safety Council (NSC), a non-profit organization focused on injury and fatality prevention, estimates both dollars spent and income lost.⁽³⁾ Estimates are approximate, because so many factors can come into play. For example, calculable costs of work-related motor-vehicle crashes include wage and productivity losses, medical and administrative expenses, vehicle and property damage, and employers’ uninsured costs.

In **Table 1**, total per-death costs are estimated using averages based on



respective injury/death ratios. Multiplying the number of deaths by these average costs provides an estimate of the economic loss associated with both deaths and injuries in these categories.

In terms of death rates by industry, the agriculture, forestry, fishing and hunting industries topped the list in 2008, with 29 fatalities per 100,000 workers, surpassing mining with 21, transportation and warehousing with 13, and construction with nine per 100,000 workers.

While statistics show that some occupations are inherently dangerous, others involve risks that are not as readily apparent. For instance, scientists at the National Institute for Occupational Safety and Health (NIOSH) recently reported that the wholesale and retail trades sector accounts for a disproportionately high percentage of work-related injuries and illnesses in private industry. In a study, they found that overexertion and contact with objects/equipment are the leading causes of injury or illness in that sector, accounting for 57 percent of incidents.⁽⁴⁾

Table 1: Average Economic Cost of Fatal and Non-fatal Injuries by Class of Injury, 2008

Home injuries (fatal and non-fatal) per death	\$3,300,000
Public non-motor vehicle injuries (fatal and non-fatal) per death	\$4,600,000
Work injuries (fatal and non-fatal) per death	
• without employers’ uninsured costs	\$39,600,000
• with employers’ uninsured costs	\$42,500,000

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OSHA Director on Safety Incentives: It's Not About Pizza



In a recent online dialogue on *What to do About Safety Incentives*,⁽¹⁾ Dr. David Michaels, assistant secretary of labor, Occupational

Safety and Health Administration, (OSHA) told more than 1,000 listeners why he considers the link between accurate injury tracking and appropriate workplace safety incentives to be of paramount importance.

In his remarks, he discussed challenges the agency faces in identifying appropriate incentives and invited occupational health and safety professionals to submit comments and research on proven safety programs as well as incentives that fail to produce desired results.

During the hour-long call, Dr. Michaels also discussed concerns about under-reporting, citing a Michigan State University (MSU) study on work-related amputations as an example. In the study, the Department of Labor recorded 160 official employer reports of traumatic amputations in 2007. MSU researchers counted an additional 251 amputations on workers' compensation claims and 597 in emergency department records. The researchers concluded that official statistics based on employer reporting undercounted the true number of work-related amputations by 77 percent. (Of the 708 total amputations, 95 percent involved fingers; the leading cause was power saws).⁽²⁾

"We know we're missing recordable injuries," Dr. Michaels said. "The question is, why are we missing these injuries? What's happening to them?"

In response, OSHA has launched a national emphasis program on record-keeping to assess the accuracy of injury and illness data recorded by employers. The project involves inspecting records prepared by businesses and enforcing regulatory requirements when employers are found to be under-recording injuries and illnesses.

Excerpts from the session sponsored by the American Society of Safety Engineers follow:

"OSHA encourages employers to

have safety programs. Many of these programs include incentives and disincentives. We understand that. The difficulty we – and you – face is distinguishing between the programs that truly encourage safe work from the ones that discourage injury reporting.

"Effective safety programs rely on accurate injury reporting. Unfortunately, it appears there are some employers, particularly in high-hazard industries, that have implemented programs inadvertently, or by design, that discourage injury reporting. If accurate injury records are not compiled because workers believe they will not be required to report an injury, or supervisors fear they will lose their bonuses, or even their jobs, if workers report injuries, real safety is not being achieved.

"Depending on the environment, workers may fear being fired if they report an injury or they may feel pressured by co-workers not to report in order to avoid jeopardizing a group reward (such as a pizza party for an injury-free work week). The result is that certain employers appear to be safer. That may or may not be true, and it certainly puts other employers who don't have safety incentive programs at a competitive disadvantage.

"Furthermore, nothing can be learned from the injury itself. That's important because we know that much can be learned from injury investigations conducted by employers, workers, OSHA and safety professionals. Also, if an injury is not reported, the injured worker is denied access to workers' compensation benefits he or she should rightfully receive. Inaccurate statistics also impact OSHA, misdirecting our inspections away from high-risk employers.

"Why do I think this is a major problem? There are a tremendous amount of injuries that OSHA is not aware of that are not being recorded in the rates that are collected by the Labor Department. Every year, according to the Bureau of Labor Statistics, the injury rate in the U.S. goes down or remains relatively flat. At the same time, there are some indications in studies done by academic researchers that we are missing a significant portion of those injuries. The question is, how much are we actually missing?

"One thing we (recently) announced is a new initiative to move toward

electronic injury and illness record-keeping and recording. Right now for most employers our requirement is to fill out the OSHA log on paper and keep it in on hand in a top drawer. We don't collect it. Many employers already do this electronically. We want to implement a system where employers will have to provide this information electronically. We may or may not require them to send it to us.

"I don't know the answers. We are very much wrestling with these issues and we are looking for your help. We are committed to working with our stakeholders, especially safety and health professionals who are working in the field. We are eager to know more."

References

1. What To Do About Safety Incentives; <http://eventcenter.commpartners.com/se/Meetings/Playback.aspx?meeting.id=504812>.
2. Work-related Amputations in Michigan, 2007; Michigan State University and Michigan Department of Community Health; Dec. 2009; www.oem.msu.edu/userfiles/file/AnnualReports/Amputations.



OSHA Gains Momentum Under New Leadership

The federal Occupational Safety and Health Administration (OSHA) appears to be emerging from a period of the regulatory doldrums, industry observers say.

"It doesn't mean things were always bad in the past, but I do believe recent activity has increased the credibility of the agency, and that's a very positive thing," said Aaron Trippler, director of government affairs for the American Industrial Hygiene Association (AIHA). "The prior two-year session of Congress is the first time I can recall where not one issue was enacted dealing with occupational health and safety...Let's hope we see some action as we move forward."

Mr. Trippler made his observations during a recent web-based conference sponsored by *Occupational Healthy & Safety* magazine and *OHS Online*.

Co-presenter Dave Heidorn, manager of government affairs and policy for the American Society of Safety Engineers (ASSE), added: "Our members participate very heavily in the voluntary consensus process. They look at that process and ask, 'Why can't we do that at the federal level?' It's not easy, but we hope with the approach the current administration is taking in the leadership they picked for OSHA that we can find ways to move standards forward."

Both noted that health care reform, other "mega-concerns" such as immigration and finance reform, and the death of Sen. Edward Kennedy, a strong occupational safety and health proponent, have all contributed to pushing regulatory issues to the back burner this year. Hearings held this year on at least one major piece of proposed legislation—the Protecting America's Workers Act—are not expected to result in a final vote this term. As proposed, the act would amend the Occupational Safety and Health Act of 1970 to expand whistleblower protections and increase civil and criminal penalties for certain violators, they said.

In the 2010 edition of *Death on the Job: The Toll of Neglect*, the AFL-CIO reports that "eight years of neglect and inaction by the Bush administration seriously eroded safety and health protections." The labor organization goes on to say: "The Obama administration is returning OSHA and the Mine Safety and Health Administration (MSHA) to their mission to protect workers' safety and health." The report cites the appointments of Dr. David Michaels at OSHA and Joe Main at MSHA as positive steps toward a renewed focus on safety and health protections and regulatory enforcement.

On April 28, when the nation marked Workers Memorial Day, events highlighted the 40th anniversary of enactment of the OSH Act of 1970 and the 39th anniversary of the creation of the National Institute for Occupational Safety and Health (NIOSH) in the U.S. Department of Health and Human Services and OSHA in the U.S. Department of Labor.

According to labor and industry groups, many OSHA standards are out of date, and others need to be created. For example, there is ongoing discussion about ways to control ergonomic hazards and regulate exposures to silica, coal dust, combustible dust, infectious diseases, and risks associated with construction and the use of cranes and derricks.

The Department of Labor requested \$573 million for OSHA in FY 2011, which is \$14 million more than the agency received in FY 2010. Some of the funds will be used to beef up enforcement.

"You are going to see about a 100-person increase in enforcement," Mr. Trippler predicted. "This is big news, because that is the one area where they are going to be shifting dollars."

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Disabling Injuries

Even though a community generally will not be able to estimate the number of disabling injuries that occur in work, home and public non-motor-vehicle situations in any given year, it is useful to understand the approximate economic loss per death and per disabling injury in these three classes of accidents, NSC officials say. **Table 2** from the NSC shows the per-case average cost of wage and productivity losses, and medical and administrative expenses. The figures do not include any estimate of property damage or non-disabling injury costs and is not intended to be used to estimate total economic loss to a community from these kinds of injuries.

Table 2: Average Economic Cost by Class and Severity, 2008

	Death	Disabling Injury
Home injuries	\$1,030,000	\$8,100
Public injuries	\$1,030,000	\$9,500
Work injuries		
• Without employer costs	\$1,290,000	\$44,000
• With employer costs	\$1,310,000	\$48,000

According to the *Liberty Mutual Safety Index*, 2009, which is based on 2007 data compiled by Liberty Mutual, a leading workers' compensation insurer, the U.S. Bureau of Labor Statistics and the National Academy of Social Insurance (NASI), a non-profit organization, more than \$52 billion in direct U.S. workers' compensation costs are attributed annually to disabling work-related injuries and illnesses. (5) Overexertion is the leading cause of these injuries, followed by falls.

In August 2009, the NASI released a study on U.S. workers' compensation payments for medical care and cash benefits for workers injured on the job: Payments increased 2 percent to \$55.4 billion in 2007, the most recent year with complete data. The grand total includes \$27.2 billion for medical care (an increase of 3 percent compared to the prior year) and \$28.3 billion in wage replacement benefits for injured workers (an increase of 0.8 percent).

"The costs to employers for workers' compensation are what they pay each year. For employers who buy insurance, costs are premiums they pay to insurance companies plus benefits they pay under deductible arrangements in their insurance policies," the NASI reports. "For employers who insure their own workers, costs are the benefits they pay plus administrative costs. In 2007, employers paid a total of \$85 billion nationwide for workers' compensation."

Federal Response

Workers Memorial Day, marked annually on April 28, honors men and women who have suf-

ferred job-related injuries, illnesses and death. Acknowledging the day, John Howard, M.D., NIOSH director, said:

“The challenges and opportunities that we face as occupational health and safety professionals are clear:

1. We must work to eliminate, once and for all, the hazards that still persist in the industries on which our economy is built. No one should suffer a job-related injury or illness.
2. We must anticipate and engage the health and safety needs of the changing workplace. A rising generation of strong, capable workers is vital for America’s economic recovery and prosperity.
3. We must develop and use new technologies and methodologies that will shape more rapid, more effective workplace interventions.

“Scientific research is a fundamental driver of progress. NIOSH is honored to lead the strategic efforts that contribute to better recognition and understanding of occupational hazards, development and application of new preventive measures, and evaluation of those measures. We are committed to working with our diverse partners in those endeavors as wisely and as diligently as we can. In memory of the men and women who are honored on Workers Memorial Day 2010, we can do no less.”

(Editor’s Note: Dr. Howard will be the keynote speaker at RYAN Associates’ National Conference, Oct. 11-13 in Boston. Watch for details in the next edition of VISIONS.)

On the same occasion, Labor Secretary Hilda Solis noted: “In April, our nation’s consciousness was jarred by the loss of workers in the Upper Big Branch Mine disaster in West Virginia, an oil rig explosion south of Louisiana and a refinery fire in Washington state.

“The pain brought on by each of these tragedies is beyond comparison, and we should not think of the incidents as isolated. The fact is they all involve worker safety issues, which merit national attention and point to a disturbing pattern of deadly neglect that our country can no longer tolerate.

“...The mission of the Department of Labor’s worker safety and health protection agencies is clearer than ever. And, our effort to save lives through enhanced enforcement, a forward-looking and progressive regulatory agenda,

expanded outreach and a relentless commitment to enforcing the law has never been more necessary.”

OSHA Activity

OSHA is among federal agencies placing a renewed emphasis on workplace safety. For example, the agency plans to use a fiscal 2011 budget boost to significantly increase its regulatory enforcement efforts, which diminished when the Bush administration emphasized voluntary compliance and protection programs.

In recent testimony before the Senate Health, Education, Labor and Pensions Committee, Dr. David Michaels, an occupational and environmental health professor who recently took over the helm at OSHA, made several suggestions:

- Make violations of the Occupational Safety and Health (OSH) Act that result in a death or serious bodily injury felony offenses.
- Require employers to abate serious, willful and repeat hazards after a citation is issued, regardless of whether the case is contested. Currently, abatement is not required during the contest period, which can extend for years. Dr. Michaels said OSHA has identified at least 30 workers who died on the job between 1999 and 2009 during the contest period triggered by a citation. “The only situation worse than a worker being injured or killed on the job by a senseless and preventable hazard is having a second worker needlessly felled by the same hazard,” he said in prepared remarks.
- Trenching fatalities and serious injuries should result in presumptive willful citations, because hazards associated with unprotected trench work are widely recognized.
- Give OSHA inspectors authority to “tag” a hazardous condition that poses an immediate danger of death or serious injury, which would require the employer to take immediate corrective action or shut down the operation. The Mine Safety and Health Administration (MSHA) already has this authority.
- Allow repeat citations for similar violations at workplaces in states with their own OSH enforcement agencies.
- Provide OSHA protections to public employees, unless the state where they work does.

- Give the agency greater latitude to protect contract workers by amending the OSH Act’s general duty clause.

Efforts are already under way to revise outdated regulations. In addition, OSHA scheduled a series of daylong meetings in June to collect public comments on proposed rules for Injury and Illness Prevention Programs, known as I2P2. As proposed, rather than wait for an inspection or a workplace incident to trigger correction, employers would be required to implement a plan to proactively identify and eliminate hazards.

Meanwhile, OSHA released 15 years of data on worker exposures to toxic chemicals. These data provide insights into the levels of toxic chemicals commonly found in workplaces, and how exposures to specific chemicals are distributed across industries, geographical areas and time.

“We believe this information, in the hands of informed, key stakeholders, will ultimately lead to a more robust and focused debate on what still needs to be done to protect workers in all sectors, especially in the chemical industry,” Dr. Michaels said.

Other Agencies on Board

Mining: Following the Big Branch mine disaster, the MSHA launched a coal mine inspection blitz in an effort to uncover workplace health and safety violations. At a May 20 hearing, Joe Main, MSHA director, told a U.S. Senate subcommittee the Justice



Department is conducting a “serious criminal investigation” into what led to the explosion at the mine. Mr. Main said MSHA is evaluating organizational changes to better cover the high concentration of coal mines in West Virginia.

Transportation: In the Department of Transportation, Secretary Ray LaHood formed a safety council to tackle critical issues facing the department’s 10 operating divisions, including the Federal Motor Carrier Safety Administration (FMCSA), which oversees the trucking industry.

“Now is the time to identify and address the top safety issues that cut across our agencies,” Mr. LaHood said. “The council will take our commitment to safety, which is our highest priority, to the next level.”

Minerals Management: Secretary of the Interior Ken Salazar has ordered a restructuring of the Minerals Management Service to ensure the independence of its inspection and enforcement duties. Mr. Salazar also sent a letter to Congressional leaders asking for their input on agency reforms.

“We have a responsibility to ensure that the operation and oversight of offshore operations are following the law, protecting the workers, and guarding against future incidents and spills,” he said in a letter to Congressional leaders. “The reforms will change the way the Department of the Interior does business in the offshore program to ensure that we fully attain these goals.”

Emergency Management: Federal Emergency Management Agency (FEMA) Administrator Craig Fugate announced the launch of a new mobile web site, m.fema.gov, to make it easy for disaster victims to access emergency preparedness and disaster assistance using a smartphone. A companion site, www.disasterassistance.gov/disasterinformation/deepwater.html – is designed to help Gulf residents and businesses affected by the oil spill file claims against BP.

Grassroots Interventions

While change at the federal level is percolating, there remains an ongoing need at the grassroots level to address risk factors that contribute to work-related injuries, illnesses and fatalities.

Risk factors to which employees are subject are numerous. Beside inherently dangerous conditions in some industries, they include stress, depression and fatigue. Studies show employees who feel unappreciated at work, have personal problems or are involved in conflicts with supervisors or co-workers are more likely to be inattentive or careless. Other risk factors include production quotas; inadequate training; ineffective use of personal protective equipment, lax rule enforcement; and failure to identify and eliminate hazardous conditions.

Some employees with chronic medical conditions have repeated absences. Others show up for work but are not fully productive because they are in pain, are taking medications that affect function or simply lack energy.

It is widely acknowledged that many of these factors can be addressed by occupational health and safety professionals with preventive solutions such as:

- onsite education and safety training;
- behavioral health evaluations and interventions, including medication, bio-feedback and/or counseling;
- ergonomic assessments and workstation/tool adjustments;
- medical surveillance;
- pre-placement and fitness-for-duty physical screening; and
- exercise, weight loss and smoking cessation programs.

In addition, occupational health professionals can help employers create a foundation for workplace safety year-round by emphasizing what may seem on the surface to be relatively benign risks, according to Job Genius, a publication of Express Services, Inc. Oklahoma City.⁽⁶⁾ For example:

Sleep: For every 90 minutes of sleep lost per night, daytime alertness is reduced by 32 percent, studies show. In a National Sleep Foundation survey, about one-third of respondents said lack of sleep affects their quality of life. Not getting enough sleep is associated with diabetes, heart disease, obesity and depression. The Centers for Disease Control and Prevention recommends adults get seven-to-nine hours of sleep a day.

Stress: Stress is linked to health issues such as high blood pressure,

headaches and stomach ailments, anxiety and depression, and it can lead to job dissatisfaction, poor performance, absenteeism and turnover. Employers and employees should be encouraged to focus on task management (priority-setting) and sustaining a healthy work-life balance.

Overexertion: Strains and sprains resulting from overexertion on the job can largely be avoided with ergonomic interventions, training on proper lifting and work posture, job rotation, frequently scheduled stretch breaks and other mechanisms.

Overtime: Employers and workers should be aware of the dangers of working harder, not smarter. Studies suggest that working excessive overtime affects one’s attitude as well as one’s cardiovascular fitness.

Finally, employers and employees are strongly encouraged to prohibit the use of cell phones and other electronic devices while driving. According to the National Safety Council, motor vehicle accidents are the leading cause of work-related fatalities, and it is estimated at least 25 percent of all crashes involve talking on a cell phone. Last year, more than 200 state bills were introduced to ban cell phone use while driving.

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Kids' Chance Awards Scholarships When Parents are Killed or Disabled

Children suffer both emotionally and economically when a parent dies or becomes severely disabled in a work-related accident. College plans, for example, often get shoved to the backburner.

But there is a way for families to overcome this harsh reality: Kids' Chance, a non-profit organization, offers educational opportunities and scholarships to children affected by workplace fatalities and catastrophic injuries.

Kids' Chance of America and its state chapters are supported by a coalition of groups within the workers' compensation system, including attorneys and the judiciary; insurers, medical providers, vocational rehabilitation specialists and employers. S. Woods Bennett, president of the Kids'



Chance of America Board of Directors, said the organization fills a niche not addressed in workers' compensation and benefits systems.

"Workers' compensation benefits only go so far," said Mr. Bennett, a Maryland workers' compensation defense attorney. "In most cases, state workers' compensation laws and national programs such as the Longshore and Harbor Workers' Compensation Act and the Black Lung Benefits Act do not provide benefits for children of injured workers to help them with their educational expenses.

"When there is a material impact on the income of the family, Kids' Chance steps in and provides scholarship assistance so children can pursue their educational goals."

Kids' Chance Outreach

Since the first Kids' Chance scholarship was awarded in Georgia in 1988, thousands of children have collectively received nearly \$5 million in educational assistance. However, there are many other youngsters who could



potentially benefit but never learn about the opportunity.

In addition to fund-raising, Kids' Chance – nationally and at the state level – faces the challenge of finding qualified applicants.

"NAOHP members and other occupational health and safety professionals can help us by identifying children who would benefit," Mr. Bennett said. "We are always looking for ways to increase our visibility."

In 2009, Kids' Chance of America served as an umbrella organization for 17 state chapters. An additional eight, state-specific scholarship organizations are listed on the Kids' Chance website (www.kidschance.org). The relatively new national organization is focused on fund-raising methodology and developing existing Kids' Chance organizations by ensuring they use best practices for non-profit organizations, Mr. Bennett explained.

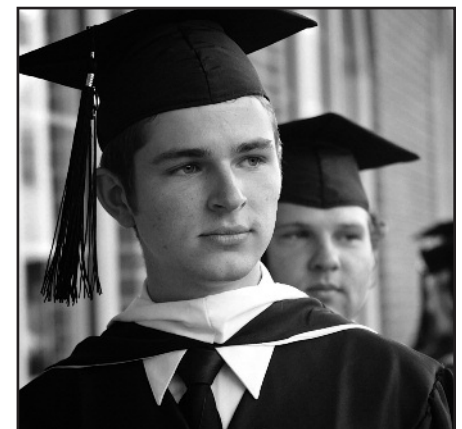
State chapters raise scholarship funds through grants and donations. Consequently, each chapter establishes its own qualification criteria. Some chapters exclusively provide scholarships in cases involving either a work-related fatality or permanent, total disability. Others also may award scholarships when a parental injury is deemed sufficiently serious to materially impact the family's source of income. State chapter rules related to the age of qualifying children also vary, although the majority of funds go to teen-agers after they graduate

from high school, Mr. Bennett said.

In letters and testimonials, scholarship recipients express their appreciation.

"Over the past four years, you have provided more than \$25,000 to help fund my education," writes a recent graduate. "You gave me the opportunity to learn and grow...in ways that will shape my life. You allowed me to enjoy a full college experience. On May 15, one day shy of the seventh anniversary of the death of my father, I graduated with a degree in computer science, and I have secured a position as a web developer.

"Without you, it would have been a much more arduous road. You went above and beyond to include me in Kids' Chance events, not just during my first year in college but every year. For this I will always be grateful."



OUTCOMES

Electronic Records Making Inroads in Occupational Medicine Practice

In preliminary findings, 67 percent of occupational physicians who responded to a national survey said they use electronic medical records (EMRs) in some form.

Members of the American College of Occupational and Environmental Medicine (ACOM) fielded the survey on the use of EMRs in occupational medical practice in the first quarter of this year. The early results are based on 605 responses to a web-based questionnaire. An additional 540 written responses are being tabulated. Kirk Harmon, M.D., an occupational physician affiliated with the Multicare Health System, Tacoma, Wash., presented the preliminary findings at ACOEM's 2010 American Occupational Health Conference in Orlando.

When asked about their professional status in occupational medicine, 27 percent of respondents identified themselves "group;" 21 percent "hospital;" 13 percent "solo;" 4 percent "academic;" 6 percent a "combination;" and 29 percent "other." Among responding physicians, 38 percent reported they see 51 to 100 patients a week and 36 percent see 21 to 50 patients a week. Of those using EMR systems, 46 percent said they primarily use them for "billing and clinical support;" 37 percent "mainly clinical;" and 17 percent "mainly billing."

In other findings:

- 22 percent of respondents who are not using an EMR system said there is an 80-100 percent likelihood of adoption within the next year, compared to 37 percent who cited a 0-19 percent likelihood.
- One third of respondents have used EMR software for two to five years; 25 percent five to 10 years; 25 percent less than two years; and 16 percent 10 or more years.
- Asked about their satisfaction with EMR, one-third said they are "very satisfied;" 26 percent are "slightly satisfied;" 12 percent are neutral; 15 percent are "slightly dissatisfied;" and 14 percent are "very dissatisfied."
- When asked about the most satisfactory aspects of their EMR software program, 54 percent cited documentation of medical records. Scheduling capabilities were considered the next-most-valuable feature by 33 percent of respondents. The least valuable feature was clinical protocols contained within the EMR system.
- Electronic documentation of medical records was considered the "most important" feature of EMR software by 83 percent of respondents. The next most important feature was handling of laboratory examinations and imaging modalities.
- Regarding quality, 66 percent of respondents felt EMRs improved quality either "considerably" or "somewhat;" 7 percent felt EMR use "worsens quality somewhat" and less than 2 percent felt it "worsens quality considerably." Open-ended comments related to quality included: "Improved legibility of medical care," "Neater medical record" and "Accessible." On the negative side: "...the quality of records is markedly declining due to increasingly widespread use of copy and paste functions..." and "I spend many hours a week reviewing other providers' medical records. Those with Dx templates are universally the worst records. That a global switch to EMR will improve quality and reduce cost is a myth."
- 64 percent felt EMRs improve safety "considerably" or "somewhat." About 30 percent were neutral.
- Respondents were asked about primary barriers to EMR use. Nearly one-quarter of respondents said

EMRs are "time consuming" and "not convenient." Other less significant barriers included cost, complexity and lack of familiarity. Comments included: "Clinical documentation is time-consuming." "I cannot use it and see patients at the same time." "Just about all the EMRs I've used are not well-suited for occupational health."

Other Insights on EMRs

Experts agree that both patients and providers stand to benefit from the convenience, portability, efficiency, improved accuracy and clinical decision support tools associated with EMRs. However, it is not yet certain how their use will affect patient safety and care quality.

For example, in a survey conducted recently by the Center for Studying Health System Change, clinicians said some features are "distracting" during patient visits and may compromise inter-personal communication with patients and other clinicians.

During a session on *Electronic Medical Records in Occupational Medicine Practice: A State-of-the-Art Review* at the ACOEM conference, Elpidoforos Soteriades, M.D., of Cyprus, a visiting scientist at the Harvard School of Public Health, said EMRs have inherent limitations relative to their effect on care quality.

"The IT industry is not yet standardized, and the technology is not well enough advanced to support improvements in safety and care quality," he said. "Research in this area is still in an embryonic stage, especially in the U.S.," which lags behind most other industrialized nations in EMR adoption.

Alluding to a *New England Journal of Medicine* article published in April 2009 by Harvard researchers on the status of



HITECH Act Impacts Medical Providers

When President Obama signed the American Recovery and Reinvestment Act of 2009, he also signed the Health Information Technology for Economic and Clinical Health (HITECH) Act, allocating nearly \$20 billion to spur the widespread adoption of electronic medical records (EMRs).

Under the act, hospitals and physicians must “meaningfully use” EMRs to qualify for Medicare and Medicaid incentive payments. Meaningful use is expected to include electronic prescribing; information exchange among systems; qualitative survey and reporting methods; and specific coding parameters.

However, “meaningful use” provisions have not yet been fully defined and may present some barriers to adoption, observers say. A work group of a national HIT Policy Committee reportedly was scheduled to release its recommendations on the definition of “meaningful use” June 16. If approved by the committee, the recommendations will be forwarded to the Office of the National Coordinator for Health Information Technology for consideration.

In another development, Health and Human Services (HHS) Secretary Kathleen Sebelius announced on June 3 the award of \$83.9 million in grants to help selected health care organizations adopt EMRs and other health information technology systems. The funds are part of \$2 billion allocated to HHS’ Health Resources and Services Administration (HRSA) to expand services to low-income and uninsured individuals through its health center program.

“These funds will help safety-net providers acquire state-of-the-art health information technology systems as they work to provide quality health care to millions of people in need,” said HRSA Administrator Mary Wakefield.

EMRs in hospitals, Dr. Soteriades said the hospitals most likely to have fully functional systems today are major urban teaching institutions, particularly those with dedicated coronary care units. He cited an average implementation cost of \$45-\$50,000 as a deterrent for smaller organizations.

Nevertheless, he encouraged ACOEM members to move forward with the transition from paper to digital records. He recommended the Health Resources and Services Administration (www.hrsa.gov), Department of Health and Human Services (www.hhs.gov/recovery/programs) and the Agency for Health Care Research and Quality (www.aHRQ.gov) as useful resources.

Steven Schumann, M.D., another speaker at the ACOEM conference, said electronic records represent an opportunity for occupational medicine physicians to enhance quality of care while protecting patient safety – with some caveats.

“EMRs should make care easier, better and safer, but the large variety of software applications, most of which do not communicate with each other, and other issues present barriers to adoption,” said Dr. Schumann, a practicing occupational medicine physician and former software developer and clinic owner. “For this to work, it has to be available where we see patients.”

Dr. Schumann cited the following as key features of an EMR:

- Patient demographics and insurance information;
- Medical notes, including vital signs, immunizations, past medical history and provider-generated content;
- Consultants’ reports;
- Lab, x-ray and imaging data;
- Accounts receivable and other financial information;
- Personal genomic information;
- Hospital and other specialty facility information; and
- Directives.

Going forward, Dr. Schumann said there are a number of potential barriers to implementation that will need to be addressed. These include the ability of providers to qualify for government incentives under “meaningful use” provisions that have not yet been fully defined.

“To qualify for federal incentives for EMR implementation, providers and system vendors will need to remain alert in order to comply with government requirements,” he said.

Other factors include patient privacy concerns, lack of physician input in EMR system selection processes at many institutions, and unease of providers and others using these systems. Another potential pitfall, he said, is a tendency to perceive the electronic medical record – rather than the care provided – as the work product.

TRENDSETTERS

Want to Improve Your Program? Ask MOM

By Karen O'Hara

Everyone would benefit if all employers and workers had a MOM who cares as much as this one.

Macon Occupational Medicine, fondly referred to as MOM, is the first program in Georgia to be awarded a three-year Quality Certification by the National Association of Occupational Health Professionals (NAOHP). The program was recognized for "Outstanding Achievement," with a score of 97.75 percent compliance to standard out of a possible 100 percent, following a May site visit.

The award acknowledges that MOM offers a high level of occupational and environmental medicine expertise to employers and employees in central Georgia. NAOHP Site Surveyor Donna Lee Gardner, a nurse and RYAN Associates consultant who was instrumental in developing the NAOHP's performance standards, said she is particularly impressed with MOM's emphasis on qualified staff, documentation and communication practices, and contributions to the community at large.

"I want to commend all of the Macon Occupational Medicine team members," Ms. Gardner said. "There are many aspects of the practice that truly set it apart, and they have been very generous about sharing their knowledge with others."

MOM has been serving Central Georgia employers and employees with a diverse array of services since 1990. The privately held company has operated from a freestanding clinic in downtown Macon since 2001. It also provides services at local worksites and offers 24-hour access to care via affiliations with local hospitals and urgent care clinics under detailed operational protocols.

"The NAOHP seal of approval says



Carrie Brown, C-M.T., checks a patient's blood pressure.

we provide excellent service," said Leonard Bevill, CEO. "We are pleased with our performance to date, and we will integrate lessons gleaned from the certification process into our continuous quality improvement activities.

"We have many companies that look to us to provide the best possible service. Now, as we reach out to new clients and payers, we can tell them we are the only certified program in Georgia."

While the NAOHP standards are extensive, Mr. Bevill found the certification process relatively seamless and easy to accomplish with information supplied in advance by the NAOHP and Ms. Gardner.

"My staff was able to put 95 percent of the material together in an organized manner prior to the site visit," he said. "Of course, like anything else of this nature, we were anxious to get the review underway."

For other programs considering a certification, he believes there is no time like the present.

"A major aspect of certification is that you can take advantage of the surveyor's expertise to enhance your overall operation and specific processes," Mr. Bevill explained. "For us, just the fine-tuning adjustments we made in documentation and coding as a result of Donna Lee's recommendations paid for the certification times two-or-three fold.

Meanwhile, he noted, "with health care changing dramatically as we speak, NAOHP certification means that your facility is doing what it needs to do to be in compliance with best practices and set itself apart."

Noteworthy Attributes

During her site visit, Ms. Gardner noted that MOM places a particular emphasis on staff training and certification in clinical areas.

“Certification is extremely important, especially in an occupational medicine environment. That is one of the ways we have been able to differentiate ourselves,” Mr. Bevill said. “We take pride in the fact that our staff has obtained training and certification in their areas of expertise.

“When you have the appropriate certifications and credentials, you can help your clients avoid potentially litigious situations. We don’t have on-the-job trainees or non-certified staff.”

Outcomes measurement is another area where MOM distinguishes itself, Ms. Gardner reported.

“We do a lot of outcome analysis and reporting for our clients, which has helped raise our program to the next level,” Mr. Bevill said. “Cindy Stephens, a licensed claims adjuster and case manager, keeps us in tune and ensures that patients don’t get lost in the system. That is how we adhere to guidelines and communicate effectively with all parties to avoid a spiral into lost time and disability. We strive to remain at the center of all of the touch points.”

MOM reports a national average of four physician visits for the treatment of an acute work-related injury and an average of six-to-eight rehabilitation visits. To adhere to these benchmarks, it has developed a protocol to manage cases more efficiently and effectively.

Under the protocol, if an injured employee exceeds the fourth physician visit or eighth rehabilitation visit, system software automatically flags the chart for a physician to conduct an in-depth case review. Information on the review is provided to the employer via a medical note and/or phone call. This may include referral for diagnostic testing, referral to an outside physician for evaluation, and/or future physician and rehabilitation visits.

Functioning as a case manager, Ms. Stephens verifies the medical rationale for physician recommendations and keeps the employer and insurer informed of patient status. In addition to her work as a case manager, Ms. Stephens functions in an educational capacity.

Cindy Nix, P.T., focuses on work injury rehabilitation.



Continued on page 14

MOM Points of Pride

Credentials and Certifications

- Professionals on the team include board-certified physicians/certified medical review officers; registered nurses; licensed practical nurses; and certified medical assistants. Other certified/licensed staff: industrial hygienists; safety professionals; ergonomic evaluators; radiological and medical technologists; physical therapists; exercise physiologists; impairment evaluation specialists; work capacity evaluators; hearing conservation specialists; breath-alcohol technicians; audiometric technicians; professional collectors and a professional collector trainer.
- Accredited by the Drug and Alcohol Testing Industry Association
- Certified Drug Free Workplace

Memberships

- American College of Occupational and Environmental Medicine
- American and Georgia Physical Therapy Associations
- American Association of Travel Medicine
- Better Business Bureau
- Council on Alcohol and Drug Abuse
- Greater Macon Chamber of Commerce
- National Association of Occupational Health Nurses
- National Association of Occupational Health Professionals
- National Hearing Conservation Association
- Society for Human Resource Management

Awards

- 2007 Partner in Economic Development, Macon Economic Development Commission
- 2005 Small Business of the Year, Greater Macon Chamber of Commerce
- 2004 Better Business Bureau Torch Award Winner for Marketplace Ethics

Community Partnerships

- Has contributed more than \$250,000 to local charities.
- Conducts free educational seminars for human resource and safety professionals.
- Promotes community involvement through affiliations with numerous local community-based and philanthropic organizations.



Sherri Austin, C-M.T. and Medical Director Lance Atkinson, M.D., view a foot X-ray.

“A lot of offices have nurses who do that – and that’s fine – but we provide that added piece by flagging cases. We know that by the fourth doctor’s visit the patient is not getting better in the timeframe we would typically expect,” Mr. Bevill said. “Many employers, especially at smaller companies, don’t understand the workers’ compensation rules in Georgia. Cindy educates companies on the basic concepts.”

This approach is consistent with MOM’s slogan: *The health of your business may depend on us.*”

Looking Ahead

MOM is focusing now on refining its wellness and health promotion offerings, with an eye toward developing a total health management delivery model. One step in that direction involves a new contract to manage employee disability for the city of Macon, which includes a wellness component. The contract supports a nurse with disability management experience. It also involves consolidation of services in a single location, saving the city more than \$100,000 a year.

Meanwhile, MOM continues to work with county government to develop an education and disease management program targeting high-risk conditions in response to established baseline biometrics.

In general, as national policies take shape in response to health care reform, Mr. Bevill says he will be watching closely to see how it plays out.

“With workers’ compensation being a state-sponsored system, who knows what will happen? But I believe wellness is what is really going to take off,” he predicted. “Prevention and disease management are major aspects of the reform act.”

To take advantage of the monumental shift from reactive medical care to proactive intervention, he advises occupational health providers to strive to clearly demonstrate return on investment and “value added” to clients and payers. Occupational health programs have an opportunity to take greater advantage of their ability to help companies save money on their insurance premiums, he said.

About NAOHP Certification

Occupational health programs and clinics undergoing NAOHP Quality Certification are evaluated in comparison to established national standards in six categories:

- Administration
- Operational Framework
- Staffing Processes
- Quality Assurance
- Product Line Development
- Sales and Marketing

“Outstanding Achievement” is 95-100 percent compliant with NAOHP standards, “Excellent Achievement” is 92-95 percent compliant and “Honorable Achievement” is 90-92 percent compliant; 70-89 percent compliance to standard results in a one-year provisional certification.

The NAOHP Site Certification Program was established in 2006 as part of ongoing efforts to recognize occupational health professionals for their contributions to the health and well being of the nation’s workforce. The NAOHP also awards a Certificate of Competency in Occupational Health Practice Management to individuals who pass a written examination. For information, visit www.naohp.com or send a request by email to info@naohp.com.

Three Key Certification Takeaways

- Fine-tuned documentation templates to facilitate cross-referencing by clinical staff and validate coding levels to maximize reimbursement but not over-charge.
- Modified coding and billing processes to obtain reimbursement for nurse case management interventions previously provided without charge.
- Launched statewide marketing campaign to promote Macon Occupational Medicine as the first program in Georgia to become NAOHP-certified and increase the association’s visibility with employers and payers.

IN THE NUMBERS

Hospitals Gaining Ground in Physician Recruitment

Hospital-owned practices were the most successful in attracting physicians in 2009. More than half (65 percent) of established physicians were placed in hospital-owned practices and 49 percent of physicians hired out of residency or fellowship were placed in hospital-owned practices, according to the Medical Group Management Association (MGMA) *Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data*.

“Physicians are moving to hospital-owned practices for a number of reasons,” said Brenda Lewis, president of B.E.L. & Associates, Inc., and MGMA survey advisory committee member. “There is uncertainty of reimbursement for the future. Physicians are looking to sustain income to pay office overhead and have a paycheck to take home, and those with large Medicare populations are more likely to want to move to hospital-employed positions.”

Higher starting compensation could be one of the drivers for this trend as primary care and specialty care physicians in hospital-owned practices were offered more in first-year guaranteed compensation than those in non-hospital practices. Historically, freestanding practices have offered higher first-year guaranteed compensation to specialty physicians. The gap between first-year guaranteed compensation offered for specialty care physicians had been shrinking since 2007. Primary care physicians reported median first-year guaranteed compensation of \$160,000 in 2009; specialists reported \$230,000 in the first year.

MGMA's data also show that:

- First-year guaranteed compensation has decreased 2 percent since 2006 for specialists in single-specialty practices while primary care first-year guaranteed compensation

increased 17 percent in the same timeframe.

- First-year guaranteed compensation for specialty care physicians in multi-specialty practices increased 3 percent since 2006. During this same period, first-year guaranteed compensation for primary care physicians in multi-specialty practices increased 14 percent.

About the Survey

The MGMA survey is produced in conjunction with the National Association of Physician Recruiters. It features data on more than 4,100 providers categorized by specialty and starting salary for more than 1,500 physicians directly out of residency. This year the report includes a new table that displays first-year guaranteed compensation by U.S. Department of Health & Human Services regions, new tables for loan forgiveness amounts and expanded key findings offering analysis on location of placement trends. Visit www.mgma.com.

Middle Class Uninsured Population Surges

Barely Hanging On: Middle-Class and Uninsured, a March 2010 report from the non-partisan Robert Wood Johnson Foundation, chronicles state-by-state health coverage trends.

Researchers at the State Health Access Data Assistance Center at the University of Minnesota averaged data from the U.S. Census Bureau from 1999/2000 and 2007/2008 and data from the U.S. Department of Health and Human Services. They found:

- More middle-class Americans are uninsured. Nationwide, the total number of uninsured, middle-class people increased by more than 2 million since 2000, to 12.9 million in 2008.

- The average employee's costs for health insurance rose, while income fell. Nationwide, the average cost an employee paid for a family insurance policy rose 81 percent from 2000 to 2008. During the same period, median household income fell 2.5 percent (adjusted for inflation).
- Fewer people were offered, eligible for, or accepted insurance coverage through their jobs.
- Nationwide, the percentage of people who worked for firms that did not offer insurance increased to 12 percent in 2008.
- The number of workers who were ineligible for employer-sponsored insurance—even though their employer offered it—was 22 percent in 2008, meaning more than one in five people who work in firms that offer health insurance weren't eligible for it.
- The percentage of employees nationwide who did not accept employer-sponsored insurance increased three percentage points since 2000; 21 percent of employees offered insurance in 2008 did not accept it.

“The facts show that everyone is suffering right now, regardless of income,” said Risa Lavizzo-Mourey, M.D., president and CEO of the Robert Wood Johnson Foundation. “For middle-class families, changes in the cost of insurance far outweigh changes in income. That means a bigger piece of the household budget must go to insurance, or families have to go without coverage, delay needed care and face bankruptcy if anyone in the family gets seriously ill. Business owners can't afford to shoulder more of the burden of health care costs. And states can't afford the influx of laid-off workers into public programs. It's a crisis in need of solutions.”

Reference:

www.rwjf.org/files/research/58034.pdf.

REGULATORY AGENDA

Carcinogens in Cigarettes

People who smoke certain U.S. cigarette brands are exposed to higher levels of cancer-causing nitrosamines in tobacco products than people who smoke some foreign cigarette brands, according to a new study. Researchers from the U.S. Centers for Disease Control and Prevention (CDC) compared mouth-level exposures and urine biomarkers among smokers from the United States, Canada, the United Kingdom and Australia. The results appear in the June 2010 issue of *Cancer Epidemiology Biomarkers and Prevention*.



Contractor Compliance

The Office of Federal Contract Compliance Programs reportedly is scrutinizing contractor compliance with affirmative action obligations related to covered veterans and individuals with disabilities. Federal contractors must employ, and advance in employment, covered veterans and individuals with disabilities pursuant to the Vietnam-Era Veterans Readjustment Assistance Act and Section 503 of the Rehabilitation Act.

Exposure Standard Lowered

The Environmental Protection Agency (EPA) lowered the one-hour health standard for sulfur dioxide expo-

sure to 75 ppb to protect against short-term exposures and revoked 24-hour and annual standards. The Clean Air Act requires the EPA to set national air quality standards for sulfur dioxide and five other pollutants considered harmful to public health and the environment. The EPA estimates health care savings associated with this rule are \$13 to \$33 billion a year, including preventing an estimated 2,300 to 5,900 deaths and 54,000 asthma attacks.

Meanwhile, the EPA is proposing to add 16 chemicals to the Toxics Release Inventory list of reportable chemicals, the first expansion of the program in more than a decade. Visit www.epa.gov.

Firefighter Study

The National Institute for Occupational Safety and Health (NIOSH) and the United States Fire Administration are examining the potential for increased risk of cancer among firefighters due to exposures from smoke, soot and other contaminants in the line of duty. The multi-year study will involve more than 18,000 current and retired career firefighters. The project will improve upon previously published firefighter studies by significantly increasing statistical reliability, officials said.



Mine Safety

Changes in simplified proceedings under the Federal Mine Safety and

Health Review Commission, the independent appellate court for enforcement actions, have been proposed to help the panel deal more expediently with a large backlog of cases.

Motor Carrier Background Screening Program

A new voluntary Federal Motor Carrier Safety Administration Pre-Employment Screening Program allows motor carriers to pay \$10 each for a driver history (up to five years of crash data and up to three years of inspection data) after they pay an annual subscription fee of \$100, or \$25 for carriers with less than 100 power units. A contractor, National Information Consortium Technologies, LLC, will provide the data to motor carriers with the operator applicant's written consent. The American Trucking Association reportedly has had the program on its safety agenda for the past eight years. Visit www.psp.fmcsa.dot.gov.

Ohio Changes Approach to Drug-free Workplace

The Ohio Bureau of Workers' Compensation will replace its Drug-Free Workplace Program with a Drug-Free Safety Program beginning July 1. The new program will be mandatory for companies that bid and work on state construction projects and voluntary for employers who wish to obtain a workers' compensation premium discount. The new program combines drug-free efforts with a comprehensive workplace safety program. It offers a 4 percent premium discount for a basic program and 7 percent for an advanced program.

Oil, Add Hurricane – Stir Vigorously

The National Oceanic and Atmospheric Administration (NOAA) has issued a series of oil spill response fact sheets including one detailing how hurricanes may impact, or be impacted, by the oil spill in the Gulf of Mexico. According to the document, if the oil

slick in the gulf remains small in comparison to a typical hurricane's general environment and size (200 to 300 miles), the oil is not expected to appreciably affect either the intensity or the track of a fully developed tropical storm or hurricane. The high winds of a hurricane would mix with the sea and weather the oil, which could help accelerate the biodegradation process, NOAA notes. The high winds also may distribute oil over a wide area, but the agency points out that it is difficult to model exactly where. Refer to www.noaa.gov/factsheets.



Patient Handling

Dr. James Collins, a senior scientist in the Division of Safety Research at NIOSH, testified as an expert witness before the Senate Subcommittee on Employment and Workplace Safety on the potential for injury when lifting patients and safe-lifting alternatives.

Pesticide Training Grant

The Office of Pesticide Programs is seeking applicants for a Pesticides and National Strategies for Health Care Providers Clinical Training Program. The program supports training for clinicians and other stakeholders in the agricultural and medical communities to recognize and manage pesticide-related health conditions. Visit <http://go.usa.gov/3Ud>.

Public Safety Legislation

The proposed Public Safety Employer-Employee Cooperation Act pending in Congress would usurp the authority of states to manage their own public safety employees, according to attorneys with Jackson Lewis, a national firm specializing in employment law. The act would

require states to recognize the right of law enforcement officers, firefighters and emergency medical services personnel to bargain collectively. As proposed, the Federal Labor Relations Authority would enforce the legislation. The most significant impact would be felt at the local level, where bargaining, potential interest arbitration and union representation have the potential to significantly increase the cost of providing public services, attorneys said.

Reform Law Analyzed

The recently enacted federal health care reform law provides insurance coverage to the largest possible number of Americans while keeping federal costs as low as reasonably possible, according to a new analysis from the RAND Corporation, a non-profit think tank. The RAND analysis estimates that 28 million Americans will be newly insured by 2016 under provisions of the Patient Protection and Affordable Care Act.

Researchers simulated more than 2,000 different policy scenarios using RAND Compare, a micro-simulation model. The only alternatives that would have covered more Americans at a lower cost to the federal government were all politically untenable, researchers said. The findings appear in the June edition of the journal *Health Affairs*.

Responder Settlement

A federal judge in Manhattan approved a plan to settle more than 10,000 health claims from police officers, firefighters and others who say they developed respiratory problems and cancers in the wake of Sept. 11. After the judge balked at a lower amount three months ago, New York City and its \$1 billion federally funded insurer, the World Trade Center Captive Insurance Co., agreed to add up to \$55 million to the settlement, bringing it to \$625 million to \$712.5 million, with most of the additional money going toward compensation for fatalities, serious injuries, certain cancers and severe respiratory injury, *Newsday* reported. In addition, lawyers for the victims agreed to reduce their compensation from 33 percent to 25 percent, leaving their clients with an additional \$50 million.

OSHA Actions

Infectious Disease Transmission

The agency published a request for data about infectious diseases being transmitted to patients and workers in health care settings, stating that some studies indicate voluntary infection control measures aren't consistently followed. "Another concern is the movement of health care delivery from the traditional hospital setting, with its greater infrastructure and resources to effectively implement infection control measures, into more diverse and smaller workplace settings with less infrastructure and fewer resources, but with an expanding worker population," the agency's request stated. Responses are due Aug. 4. Visit www.regulations.gov.

Safety Training

A new training component emphasizing workers' rights is required content in 10- and 30-hour Outreach Training Program classes. Topics include whistleblower rights and how to file a complaint. Visit www.osha.gov/dte/outreach/teachingaids.html.

Slips, Trips and Falls

The agency issued a notice of proposed changes to Walking-Working Surfaces and Personal Protective Equipment standards. The rule change would update fall protection standards in general industry and allow OSHA to fine employers who let workers climb certain ladders without fall protection. Most existing standards for walking-working surfaces are more than 30 years old and inconsistent with both national consensus standards and more recently promulgated OSHA standards addressing fall protection, officials said. To review the Notice of Proposed Rulemaking, visit <http://edocket.access.gpo.gov/2010/2010-10418.htm>.

Spill Response

The federal coordinator for the BP Deepwater Horizon response and OSHA signed a memorandum of understanding concerning the safety and health of clean-up crews. The memorandum clarifies joint efforts to monitor compliance with safety standards and to protect workers.

Recommended Resources

Best Practices in On-Site Wellness Series: Fingerstick or Venous Blood Draw for Health Screenings? Summit Health white paper discusses options; www.summithealth.com/whitepaper_blood_draw2.html.

Disability, Health and Leave Management Blog; sponsored by Jackson Lewis, a national firm specializing in employment law; www.disabilityleavelaw.com.

Effectiveness of exercise on work disability in patients with non-acute non-specific low back pain; exercise interventions are found to have a significant effect on work disability in patients with non-acute non-specific low back pain in the long term; P Oesch, et al.; *J Rehabil Med*, 42, March 2010; <http://jrm.medicaljournals.se>.

Grant Funding for Wellness and Health Promotion Programs; special report with examples of funding opportunities; Wellness Management Information Center; www.healthresourcesonline.com/health_grants.

Guide for Using Documents Related to Metalworking or Metal Removal Fluid Health and Safety, with a reference on Standard Practice for Prevention of Dermatitis in the Wet Metal Removal Fluid Environment; ASTM Management; www.astm.org/COMMIT.

Gulf Oil Spill Health Hazards; report describes the toxicity of chemicals in crude oil and dispersants being used in and along the Gulf of Mexico; Sciencecorps, Lexington, Mass., June 14, 2010; www.sciencecorps.org/crudeoilhazards.htm.

Nursing Handoffs: A Systematic Review of the Literature; minimal research has been done to identify best practices, despite well-known negative consequences of inadequate handoffs when shifts change; L Riesenber, et al.; *Am J Nursing*, Vol. 110, Issue 4, April 2010.

Physician Ownership of Ambulatory Surgery Centers Linked to Higher Volume of Surgeries; doctors invested in outpatient surgery centers in Florida performed an average of twice as many surgeries as doctors without a financial stake for five common outpatient procedures; J Hollingsworth, et al.; *Health Affairs*, Vol. 29, No. 4, April 2010.

Rapid and Simple Kinetics Screening Assay for Electrophilic Dermal Sensitizers Using Nitrobenzenethiol; researchers report on a simple, rapid, inexpensive test for chemicals that can cause allergic contact dermatitis; *Chem Res Toxicol*, 23 (5), April 19, 2010; <http://pubs.acs.org>.

State Indicator Report on Physical Activity 2010; Centers for Disease Control and Prevention reports many states do not have policy or environmental measures in place to help citizens meet recommended levels of physical activity; www.cdc.gov/physicalactivity/professionals/reports.

Workstyle in Office Workers: Ergonomic and Psychological Reactivity to Work; asymptomatic office workers with higher levels of self-reported adverse workstyle responded to a manipulation of work demands with greater psychological and biomechanical strain demands; C Harrington, M Feuerstein; *JOEM*, Vol. 52, Issue 4, April 2010.

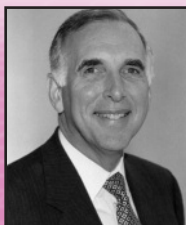


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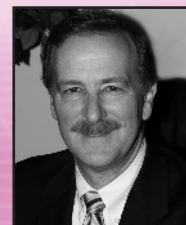
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JUL

July 17-22

35th Annual National Wellness Conference; sponsored by the National Wellness Institute; University of Wisconsin-Stevens Point; www.nationalwellness.org.

July 20-22

National Workers' Compensation and Occupational Medicine Conference; sponsored by SEAK, Inc.; Cape Cod, MA; www.seak.com.

July 29-30

Mobile Health (mHealth) Summit; sponsored by World Congress; The Lenox Hotel, Boston, Mass.; www.worldcongress.com/mHealth.

AUG

August 4-6

2010 Federal Occupational Health Conference; sponsored by Chesapeake Health Education Program, Inc.; Sacramento, Calif.; www.chepinc.org/conf.

August 15-18

65th Annual Workers' Compensation Educational Conference; sponsored by the Florida Workers' Compensation Institute; Orlando World Center Marriott; www.fwciweb.org.

SEP

September 26-29

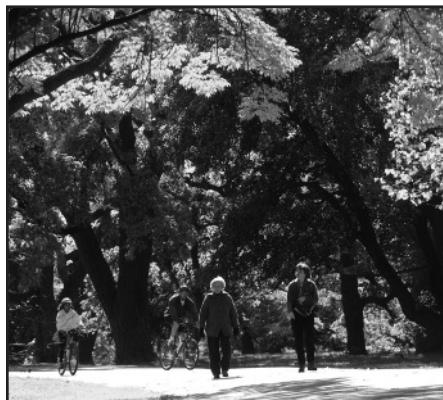
Changing Care, Changing Lives: Delivering on Quality for All Americans; Agency for Healthcare Research and Quality 2010 conference; Bethesda, Md.; <http://meetings.capconcorp.com/ahrq>.

September 30-October 2

Western Occupational Health Conference; sponsored by the Western Occupational and Environmental Medicine Association; Newport Beach Marriott Hotel & Spa; www.woema.org/WOHC.vp.html.

September 2010 to May 2011

International Program in Occupational Health Practice; enrollment deadline July 31; sponsored by University of Illinois at Chicago; online program offers three courses over a nine-month period; www.uic.edu/sph/glakes/ce/IntPrgOHP.html; email: syn@uic.edu or nlwagner@uic.edu.



OCT

October 3-8

National Safety Council Congress & Expo; San Diego Convention Center; www.congress.nsc.org/nsc2010.

October 11-13

Prospering in a Changing Occupational Health Environment, 24th annual national conference; sponsored by RYAN Associates; Hyatt Regency, Boston, Mass.; www.naohp.com; 800-666-7926.

NOV

November 6-10

APHA Annual Meeting and Exposition; sponsored by the American Public Health Association; Denver, Colo.; www.apha.org/meetings.

November 10-12

19th Annual Workers' Compensation and Disability Management Conference & Expo, sponsored by Risk & Insurance and LRP Publications; Las Vegas Convention Center; www.WCConference.com.

To list your event, email information to Karen O'Hara, VISIONS Editor: kohara@naohp.com



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