

NECOEM *Reporter*

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“Expanding Horizons- Local and Global”

December 1 and 2

**Renaissance Hotel, Bedford, MA
NECOEM/MaAOHN Annual Conference**

Dermatitis
Soft Tissue Injuries
Respiratory Infections
Health Care Workers ID Risks
(includes pandemic flu issues)
Work Hazards
Protect Patients: Role of Gov.
Scientific Integrity at Risk
Trade Union Contributions
Forensics and the FBI

OH Disaster Expert Network
Global Electronics Industry
(includes nanotechnology)
**Feature: Global Trends/
Standards, Joseph LaDou, MD**

Phthalates, male health
Lead and Ayurvedic Meds
Mental Stress
Knee Injury: PT Impact

New for Case Managers:
Absence Management
High Risk in Wk. Comp.
Failed Low Back Treatment

Register at
www.necoem.org
Chance to win

“Current Occ and Env Health”
autographed by author, Joseph
LaDou, MS, MD

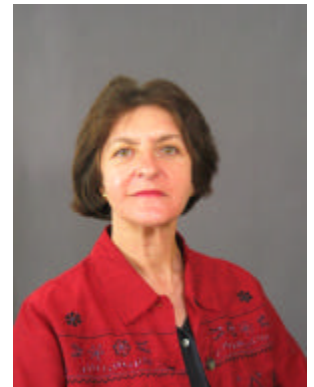
Safe Patient Handling: It Has All Been Said. Now, What Needs to Happen.

By Christine Pontus, MS, RN, COHN-S/CCM

Many nurses wonder what could be said about Back Injury Reduction Programs that has not been said already. We understand why many nurses think and feel this way, but nurses also recognize, it is not what we know or what has not been said, it is what needs to happen. It calls for a change in the way we think about nursing as well as the culture of

the organizations we work in before a paradigm shift can occur to make it happen.

Do you remember the term “Body Mechanics”? Body mechanics was part of the nurses’ training and education very early on in most nursing programs. In fact, it was one of the first behavioral objectives taught to nursing students to be evaluated on going into the



clinical setting. This approach ensured that the new acquired skill was

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OEMAC is Alive and Well in Connecticut

Peter E. Amato, MD, Medical Director, Saint Raphael's Occupational Health



As you know Connecticut is the only New England state that has its own ACOEM

component, the Occupational and Environmental Association of Connecticut or OEMAC. While only a fraction of the size of NECOEM, the organization is alive, well and participating in some exciting things.

We presently have approximately 91 dues paying members and as such have one representative

to ACOEM. The organization is fairly active and has a Board of Directors and Officers who meet regularly and have maintained an active CME meeting agenda for its members. We normally offer three or four CME dinners per year to the membership and to other appropriate professional groups from time to time.

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This year we have had presentations on disability evaluations by Dr. Dave Berube, a medical director at Liberty Mutual and a prior President of OEMAC. Some related research topics were presented by Dr. Glen Pransky Medical Director of Liberty Mutual's Research Center. More recently Dr. Marc Croteau, a UCONN faculty member, spoke on his research in disaster planning.

Obviously the topic of disaster planning and terrorism is still on everyone's minds and much is being done in this state. Dr. Connie Walker has been working for the past three years with the State of Connecticut Department of Public Health Emergency Preparedness as a representative of OEMAC. This active working group has members from a broad spectrum of state and local organizations including local emergency responders, state and public health departments, hospitals, human services groups, etc.

Connecticut was also the site of a TOPOff III exercise in the New London area. This disaster training exercise was sponsored by the Connecticut Department of Emergency Management and the Department of Homeland Security with participation by numerous state, local and private organizations. TOPPOFF III was a congressionally mandated exercise and involved two states, Connecticut and New Jersey, to test each state's ability to coordinate inter-agency preparedness and effectiveness in dealing with a large scale terrorist disaster. For those unaware of this process, a simulated large disaster is manufactured including disaster victims placed in difficult situations that require careful strategic extraction. There is much planning before the mock scenario is run and there are extensive lessons learned

through the analysis that follows. This mock disaster involved hundreds of people with the majority being the local emergency teams of firefighters, police, ambulance companies and hospitals. It has been reported that over 10,000 people were somehow involved in the planning, execution and analysis of the scenario. Connecticut was well represented by Dr. Jonathan Mittleman, a member of OEMAC's board and Dr. Victoria Cassano of the Hartford Medical Group.

As elsewhere in the country, we have seen vibrant Occ Med practices diminish in size and some close during the downturn in the economy over the past 3 or 4 years. At the same time the injury rates have decreased significantly. As in other industries the strong survive or at least those who adapt to the new financial challenges are still in business. The For Profit Occ Med centers have shown a period of consolidation as in other business sectors. Economies of scale, standardization and basic business practices such as billing and collection help larger entities in poorer as well as good times. Connecticut has seen its share of Occ Med Center closings and consolidations. Some hospital programs have been bought or become financial partners with a For-Profit rather than close. The Industrial Medical Centers of Connecticut were eventually obtained by Concentra who also has become affiliated with the OH + R centers under the Concentra name. They represent the largest group of clinics in our state. They certainly will give their local competition a run for their money.

Although Connecticut is a small state we have more than our share of insurers and managed care organizations. Managed care for Workers' Compensation is alive and well in this state. In the early 90s, the state legislature

passed regulations allowing managed care plans to be instituted. These changes were welcomed at that time by the business community in an effort to control run away worker's compensation costs. The Workers' Compensation Commission has since promulgated specifics on this subject. One can imagine that in the state that boasts of having Hartford as The Insurance City, managed care organizations (MCOs) would flourish. I am speaking here as both a medical provider of injury care and as a medical director of one of the larger MCOs in this state.

Lately we have seen a resurgence of managed care oversight as manifested by more and more utilization review questions about what most experts agree are the usual standard care. The hassle factor is once again rearing its ugly head. I have had to personally answer UR letters as to why I wrote a prescription for a patient for three Valium 5 mg tablets to help his anxiety before a closed MRI!

We have also seen the promulgation of third party companies whose only purpose is to provide discounts on medical services without any benefit to the medical system. More networks and PPOs with steeper discounts are appearing and of course being sold to other MCOs without the provider's knowledge. The silent PPOs have arrived in Workers' Compensation as they have in group health. They are alive and well to the disadvantage of the provider.

We have also seen companies develop that have obtained contracted discounts from MRI centers and have sold this concept to insurers and MCOs. Now as a department of a hospital, our clinicians must not only get permission for an appropriate MRI, or CT but this request is also forwarded to this third party entity who

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practiced throughout all the nursing/clinical rotations the nursing student would be exposed to. Body mechanics was one of the first concepts and actions a nursing student thought he or she was practicing to take better care of themselves as well as delivering patient care. Now the new found truth is that Body Mechanics does not work. What?? How can that be, is the general reaction most nurses have when getting the news. Well, it is simple. Injuries involving work-related musculoskeletal disorders show us that body mechanics do not work. It has become so evident that it has led some countries in Europe to restrict nurses, doctors and other emergency and medical personnel from manually lifting patients.

In late February 2005 Beth Pkinnick, chairperson of the Massachusetts Nurses Association (MNA) Safe Patient Handling Task Force and I attended a four day Safe Patient Handling Convention. Aside from the fact that we learned much and met many people, we also came back with very specific information to share with our Safe Patient Handling Task Force. The task force formed in 2004, is made up of MNA members who attend monthly meetings to discuss and develop legislation. Educational, training and nursing initiatives dealing with safe patient handling issues were also discussed. Another focus of our group was to get the word out about safe patient handling methods, ergonomics and lifting devices.

A specific point we were able to

clarify coming back from the conference was the fact that lift teams was not something we wanted to convey as an end all or panacea. In fact, we found the protocol and concept of the Back Injury Resource Nurse (BIRN) much more conducive to a long term effective approach. Beth and I came to this conclusion after attending both the conference and the Back Injury Resource Nurse Certification Program which followed the conference. We now better understand the value of a Safe Patient Handling & Movement Program that is planned out and well organized. This program works best in an integrated team approach when supported through out the organization from top administration. Members of the team are nursing staff (CCNA LPN, RN) Nursing Services-Safety Representatives, Peer Leaders (BIRN), Nursing Administrator, Risk Manager, Nurse Educator, Therapy staff (OT, PT, St) Purchasing, Engineering, Employee Health, Union, and others who are committed to creating a safe work environment.

A real benefit to attending the conference was that Beth and I actually met and spoke to certified BIRN nurses. These frontline staff nurses from James A. Haley Veterans' Hospital were trained and certified in this basic peer review education model. Their current practice with this model of instruction is a testimony to the success of the program when practiced in a supportive environment.

We also met other interested professionals from various backgrounds who are all contributing to what historically has been a nursing issue. Workers

have always experienced back injury in professions that require manual lifting. Clearly the challenge in the nursing profession has been that patients themselves do not come in one size or predictable loads. The requirements for safe patient handling are often more varied and unpredictable than many manufacturing facilities where the problem can often be engineered out in a more direct and planned approach. This reality puts the nurse and her profession at a disadvantage in that equipment, time, and nursing personnel are resources not readily available at most times while delivering patient care.

Therefore, unless there is a program in place in each facility to ensure compliance for the objectives of a safe patient handling program, equipment and personnel cannot be properly utilized. The Massachusetts Nurses Association believes this to be the foundation in a true prevention effort on behalf of nurses and all health care workers. In an attempt to ensure the practice of a proactive plan and approach for safe patient handling in the Commonwealth, the Massachusetts Nurses Association submitted a bill for consideration entitled, An Act Relating to Safe Patient Handling in Certain Health Care Facilities. This proposed legislation was filed on December 13, 2004, it was referred by the house to the Joint Committee on Public Health in April. The bill is sponsored by Jennifer Callahan and the bill number is HB 2662. If you

[Access color version of this newsletter online, www.necoem.org.](http://www.necoem.org)

MASSACHUSETTS NURSES ASSOCIATION

Position Statement On Safe Patient Handling

Statement of the Problem:

Nursing is the highest risk occupation in the United States with respect to lifting and handling-related injuries. It is the profession most associated with work-related musculoskeletal disorders and back injuries. Injury data show that nearly 12 out of 100 nurses in hospitals and 17.3 out of 100 nurses working in nursing homes report work-related musculoskeletal injuries, including back injuries, which is about double the rate for all other industries combined. According to a United States Bureau of Labor Statistics 2000 report, 6 of the top 10 professions at greatest risk for back injury are: registered nurses, nurses' aides, licensed practical nurses, radiology technicians and physical therapists. The rate of injury among workers in nursing care facilities is higher than in the trucking, logging or construction industries. The Veterans Health Administration (VHA) found that in 2000, nurses were injured six times more frequently than any other single occupational group; back injuries represented 19.1 percent of all injuries and another 25.5 percent, upper extremity injuries. Back injuries resulted in the most lost work-days.

Greater than one third of back injuries among nurses are attributed to the handling of patients and the frequency with which nurses are required to manually move patients. From a worldwide perspective, back injuries to nurses have point prevalence of approximately 17 percent, an annual prevalence of 40-50 percent and a lifetime prevalence of 35-80 percent.

Nurses lift, move, and turn patients who may easily weigh 250 pounds or

more on an hourly basis. Nurses would consider a 100-pound patient to be "light." However, many U.S. industries and the U.S. Postal Service follow lifting regulations to the letter by supplying lifting and handling equipment for any loads over 50 pounds or above shoulder height. The National Institute of Occupational Safety and Health (NIOSH) guideline for the maximum lifting load that anyone should routinely lift is 51 pounds. That 51-pound federal guideline applies to lifting of a stable object with handles. Moreover, nurses must frequently lift or move patients while also cautiously handling their patients' Intravenous (IV) or other tubing, casts, wound dressings, injured limbs, etc., which limits nurses' flexibility in their lifting movements and which places them at risk of harm. Patients don't come equipped with "handles." Patient lifting and handling is significantly more difficult and more demanding than is moving boxes around.

Some of the factors exacerbating the risk of work-related injuries for caregivers include those listed below. These factors are multiplicative: the more of these occurring at a given time, the greater the risk of injury.

- Heavy physical work
- Lifting and forceful movements
- Bending and twisting (awkward postures)
- Whole-body vibration
- Static work postures

Additional risk for nurses comes from the increasing levels of obesity among the general population; the

marketing by hospitals of weight loss treatments, resulting in previously unseen numbers of bariatric surgery patients who receive surgical treatment for morbid obesity. Other factors include gender, the aging nurse workforce, staffing shortages with fewer staff to share the lifting and turning of heavy patients, and cumulative trauma (both long term and short-term, related to nurses working long hours, overtime or on call hours). Stress due to organizational change (nurses working as temporary workers or "floating" to units where they may be exposed to unfamiliar or completely unrecognized manual handling risks), unfamiliar patients, unfamiliar lifting equipment, if even available are also important factors.

Finally, nursing education has historically emphasized patient safety but has been lacking in emphasis on self-protection. In contrast, the physical therapy discipline, underscores both self-protection and patient safety during all patient handling and movement tasks. The physical therapy culture also emphasizes promotion of the patient's functional status and independence, which can mean limits on use of handling aids. These professional cultural differences have led over the years to discrepancies in strategies and techniques for patient handling among nurses as well as between disciplines. It is time to promote an interdisciplinary approach to patient handling that will optimize caregiver and patient safety as well as patient rehabilitation.

A Plan of Action

The Massachusetts Nurses Association calls for an approach which would re-

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quire that all health care facilities in the state develop and implement a health care worker back injury prevention plan to protect nurses and other caregivers, as well as patients, from injury. The plan would mandate the following:

- **A systematic process in each facility for addressing ergonomics, recognizing occupational health and safety hazards and preventing injuries specific to each health care facility.**

Each facility will have a written organization-wide safe lifting and handling plan containing: policy and procedures describing safe patient handling and lifting, equipment type, (numbers and location): mechanism for addressing nurses' refusal to perform unsafe lifting and handling, and education and training programs conducted or utilized at their facility by qualified personnel.

Each facility will implement safe handling and lifting methods that are ap-

propriate for their patient populations, size and scheduling needs.

- **Needs assessment by facilities of patients' lift and transfer requirements and resulting handling, lift and equipment needs.**

Each facility will develop needs assessments appropriate to the lifting and handling requirements of their patients, with policy describing how the institution will manage the enforcement of policies and procedures.

- **Specialized training of health care workers and lift team members by qualified personnel, with demonstration of proficiency in handling techniques and use of handling equipment;**

Each facility will use qualified personnel, i.e. personnel with recognized certification such as Back Injury Resource Nurse (BIRN)

Trained Faculty, as resource nurses and educators in their patient lifting and handling education and training

programs.

- **Protection of workers against disciplinary action for refusal to lift or handle patients due to concerns about patient and worker safety.**

When there is insufficient or unsafe lifting or handling measures and/or equipment available and/or the lack of trained personnel, health care workers shall not be subject to disciplinary action by the hospital or any of its managers or employees. Each facility must have a policy and procedure in place describing a non-punitive process for resolution of such situations.

MNA has filed legislation for passage in the Commonwealth's 2005-2006 legislative session: HB 2662, "An Act Relating to Safe Patient Handling in Certain Health Facilities." This bill prescribes the measures required to produce safer working conditions for nurses and as a result, for patients as well.

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then makes an appointment for the test at our own hospital! The end result is delays in scheduling, occasional mistakes but most importantly big discounts on the price of the MRI. Of course not all these savings are passed on to the insurer or the company insured. Yet another business entity is taking a piece of these health care dollars away from the system.

Well, despite the above, Occupational Medicine is still alive and well

in Connecticut. We are blessed in this small state to have two Occupational Medicine Fellowship programs at Yale and at UCONN.

They seem to be flourishing. As for the rest of us in the field, we practice a little smarter and with more business acumen than ever before. Yes Occ Med and OEMAC is alive and well in Connecticut.

Respectively submitted by:

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The thoughts contained herein are solely the opinion of the writer and are not indorsed by the Hospital of Saint Raphael, Berkley Administrators of Connecticut or OEMAC.

NECOEM Dinner Meeting and Annual Conference PowerPoint presentations are always available online. Audio presentation of "Staying Out of Trouble—Risk Management in Occupational Health Practice" now available . See www.necoem.org for details.

Website Raffle to be drawn at the 2005 Annual Conference: an autographed copy of "Current Occupational and Environmental Medicine," 3rd ed.. Enter to win!win !.

FOR IMMEDIATE RELEASE

Occupational Health + Rehabilitation and Concentra to Merge

Hingham, MA, August 8, 2005-- Occupational Health + Rehabilitation Inc ("OH+R") (OTCBB: OHRI) today announced that it has executed a definitive merger agreement with Concentra Operating Corporation ("Concentra") pursuant to which OH+R will become a subsidiary of Concentra. When completed, the merger will extend the reach of Concentra's occupational health division to six new states and strengthen the presence of its existing network of health centers.

The terms of the transaction call for Concentra to acquire all of the outstanding common stock of OH+R through a merger and to assume its outstanding indebtedness. Stockholders of OH+R are expected to receive a cash payment of approximately \$10.00 per share.

OH+R expects to complete the merger later this year, subject to the approval of the merger by its stockholders at a specially called meeting and other customary conditions. Concentra currently intends to use its unrestricted cash balances to fund the transaction.

Commenting on the transaction, John C. Garbarino, President and Chief Executive Officer of OH+R, said, "We are very excited about the merger as it benefits all OH+R's stakeholders. Stockholders will receive a cash price which represents a significant premium over the recent, and in fact any historical, market price of our common stock. Joining the industry leader, an organization that clearly



understands that its people drive its success, provides OH+R staff with better opportunities for career advancement. This was an important consideration for OH+R's Board of Directors as they considered the merger. OH+R patients and clients should experience little change except for now having at their disposal the resources of the broadest and strongest occupational health provider in the country."

In 2004, OH+R reported approximately \$57 million in revenue and 508,000 patient visits. During the same period, Concentra's Health Services division reported \$577 million in revenues and more than 5.9 million patient visits. Concentra's Health Services division represented 52% of Concentra's total revenue during 2004. At June 30, 2005, Concentra had 268 centers operating in 34 states. After integrating OH+R's operations, Concentra will have approximately 295 centers that will be located in 40 states.

Daniel J. Thomas, Concentra's President and Chief Executive Officer, added, "OH+R's occupational healthcare centers will significantly enhance our national presence. In addition to providing centers that will be complementary to our existing operations in the states of Connecticut, Missouri, New Jersey, and Tennessee, OH+R provides us with the ability to expand into the states

of Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont. With this transaction, not only will we be able to offer existing customers of OH+R a continuation of the exceptional levels of service they have received, but we will also be in a position to offer Concentra's national and regional clients more locations where they can access our well-recognized workers' compensation and occupational healthcare services. The addition of OH+R will further enhance our stature as the largest provider in the country and will provide us with roughly a 10% share of the national workplace injury market."

OH+R is a leading occupational healthcare provider specializing in the prevention, treatment and management of work-related injuries and illnesses, as well as regulatory compliance services. The company operates 34 occupational health centers, and also delivers workplace health services at employer locations throughout the United States.

Statements contained in this release that are not based on historical information are forward looking statements subject to uncertainties and risks, including, but not limited to, economic conditions; pricing issues; the impact of competition; and other factors discussed in OH+R's filings with the Securities and Exchange Commission.

RI Committee on Occupational Safety & Health

Responding to Disasters

Having received inquiries regarding hazards and worker safety associated with cleanup and recovery efforts in the aftermath of the Gulf Coast storm we note some brief general guidance.

Only those properly trained, equipped should be deployed.

The variety of potential hazards are staggering: include electrocution from power lines and recovery equipment, dangers using heavy equipment and chainsaws, carbon monoxide poisoning from portable generators, an extraordinary range of biological hazards from animal vector to water pollution, and personal security as well. In addition the vaccine/ immune status of responders should be reviewed through interaction with CDC.

Other priorities for safety include insect controls, waste disposal,

bloodborne precautions and hygiene. All these issues should be reviewed prior to transit and reviewed once again on arrival at the disaster site. And they should be addressed in an agency's comprehensive safety plan. If an agency has no such plan then question their readiness for participating.

A key for any responder is to understand the local Incident Command System which is the common disaster management system that designates who does what, when and how. (A key component of the ICS is to address and assess responder safety. Responder safety improves when roles and responsibilities are clearly defined and understood.)

ICS is part of a matrix of management polices imbedded in the National Incident Management System (NIMS). NIMS is a core set of con-



The Industrial Canal levee and temporarily repaired breach, later breached again during Hurricane Rita. The severely affected lower Ninth Ward district of New Orleans is at the right. Note the huge barge that contributed to the levee destruction when it broke through the levee and ended up in the local neighborhood. Contamination and destruction of homes and businesses was extensive. Nothing was spared.

Tom Gassert MD, 9-18-05.

Photo by V. R. Dhara, MD

cepts, principles, terminology and organizational processes to ensure effective, efficient, and collaborative disaster management especially when there are

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Letter to the Editor:

October 11, 2005

Dear Editor,

Thank you for your invitation and encouragement to write my "letter to the editor."

Basically, I thought the context of the Summer 2005 edition of the "NECOEM REPORTER" was somewhat left of center with a definite anti-employer bias.

I appreciate your position, as editor, to publish articles which may generate discussion and interest among the readership. However, I would ask for more balance in your choice of articles and authors.

Thank you.

Herbert C. Hagele, Jr., M.D.
Lynnfield, MA

Ed. reply:

The "news" seems to be generated from the employee side. NECOEM welcomes contributions that highlight New England employers' activities that promote Occupational Health and Safety.

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NECOEM

NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the pre-eminent organization of occupational and environmental physicians and affiliates in the United States.

NECOEM has over 200 physician and affiliate members and is dedicated to preventing and treating occupational injuries and illnesses. NECOEM provides continuing medical education for its physician members and other clinicians in order to enhance the care that they provide to men and women in the workplace. NECOEM is an advocate for workplace safety, occupational health research, raising public awareness of occupational and environmental health issues, guiding public policy, and recognizing outstanding achievement by individuals in occupational and environmental health.

The editorial board welcomes letters to the editor. Write or email to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes.

multiple jurisdictions.

Resources

Fact sheets on issues and hazards relating to recovery and cleanup efforts following hurricanes are available on the OSHA's Natural Disaster Recovery page: www.osha.gov.

Specific Information on hazards and safely clean-up after a hurricane is available from several OSHA sources to help workers who are involved in recovery and restoration efforts. **Keeping Workers Safe During Clean Up and Recovery Operations Following Hurricanes**

Centers for Disease Control addresses the full range of health and safety issues: CDC.gov/disasters/hurricanes/recovery

Disaster Site Worker Training

The overall response and cleanup may go on for some time. As a result of problems associated with the cleanup to the WTC event in NYC federal OSHA has assisted in the development of a safety training course

for disaster site workers (e.g. utility, demolition, debris removal, or heavy equipment operation).

OSHA has proposed this Disaster Site Worker Course as part of the National Response Plan. Training deals with the safety and health hazards of chemical, biological, radiological, nuclear, and explosive agents that may be encountered at any disaster site. It highlights the importance of respiratory and other personal protective equipment and of proper decontamination procedures. It explains safety practices imbedded in the Incident Command System and alerts workers to traumatic incident stress that can result when working in disaster conditions.

Jim Celenza

RI Committee on Occupational Safety & Health

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