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STATEMENT OF EDITORIAL PURPOSE
The occupational health professional in healthcare is vital to ensuring the health, safety and well-being of both employees and patients. The focus of this Journal is to: provide current healthcare information pertinent to the hospital employee health professional; afford a means of networking and sharing for AOHP’s members; and improve the quality of hospital employee health services.

EDITORIAL GUIDELINES

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OSHA’s Severe Injury & Fatality Reporting Rule: Three Years and Still Questions!

By Stephen A. Burt, MFA, BS
Government Affairs Committee Chair

On New Year’s Day 2015, the Occupational Safety and Health Administration’s (OSHA) new severe injury and fatality reporting rule became effective, significantly revising the triggering events for reporting workplace accidents to OSHA under the agency’s Injury and Illness Recordkeeping regulations at §29 CFR 1904.

How the New Injury and Illness Reporting Rule Differs

The new regulation differs from the long-standing severe incident reporting rule in four ways:

1. It lowers the threshold for proactively reporting a catastrophic incident from the hospitalization of three or more employees to the hospitalization of a single employee. This is a significant change from the prior reporting rule, which required a report to OSHA only if three or more employees were hospitalized overnight. It was extraordinarily rare for a single workplace incident to result in the overnight hospitalization of three or more workers, and so the instances of reporting under that rule were infrequent. The new rule, however, requires a report to OSHA for the hospitalization of a single employee.

2. It adds amputations (including partial amputations with no resulting bone loss) and loss of an eye to the types of injuries that employers must proactively report to OSHA.

3. It introduces an internet portal for employers to submit reportable events.

4. It requires publication of the reporting events on OSHA’s public website.

Requirements of the New Reporting Rule

**Employee Hospitalization**

OSHA has changed the definition of “hospitalization.” First, as defined by the regulation, an inpatient hospitalization occurs only upon: “formal admission into the inpatient service of the hospital or clinic for care or treatment.” Under the new rule, whether the hospitalization is a reportable event is determined not by whether the employee stays overnight, but rather, whether the employee is formally admitted to the inpatient service of the hospital. The visit, however, must involve medical care after the inpatient admission. If an employee is held only for observation or diagnostic testing, even if it involves inpatient admission, it will not constitute a reportable event.

Based on the plain language of the regulation and guidance issued by OSHA about what it means, there are two limiting elements that must be present for a visit to the hospital to be an “inpatient hospitalization”: • Formal admission to the inpatient service of a medical facility; and • Delivery of medical care or treatment after formal admission.

Therefore, to meet the definition of an inpatient hospitalization, the employee must move beyond the emergency room and emergency status at the hospital to a formal admission to the inpatient service. On top of that, medical care or treatment must be provided after that formal admission to the inpatient service.

Importantly, in the context of evaluating an inpatient hospitalization, the language of the standard does not limit “care or treatment” to “medical treatment beyond first aid,” as it does for recording injuries on the OSHA 300 Log. OSHA has clarified that for the reporting requirements, an inpatient hospitalization “involving any treatment,” even if it’s just first aid, must be reported to OSHA.

While OSHA reportedly continues to work on a formal guidance document in this area, the concepts of “formal admission” and “inpatient service” seem to be causing significant confusion. The following examples may shed some light on the inpatient requirement:

1. An employee breaks a leg and goes to the hospital emergency room (not the inpatient service of the hospital), where his leg is set and he is given prescription drugs for pain administered before release—Not Reportable because the event was not an “inpatient” hospitalization. However, this injury is a recordable on the OSHA 300 Log because of the rigid cast and the prescription for pain meds.

2. An employee breaks a leg and goes to the hospital emergency room where his leg is about to be set, but he begins to bleed out, so the emergency room (ER) staff replenishes his blood before setting the leg. The employee is then admitted to a ward for monitoring/observation because of the blood loss—Not Reportable because medical care was provided in the ER prior to admission, and admission was for observation only. Once again, this injury is a recordable on the OSHA 300 Log.

**Amputations**

“Within 24 hours after … an employee’s amputation …, as a result of a work-related incident, you must report the … amputation … to OSHA…. For an … amputation …, you
must only report the event to OSHA if it occurs within 24 hours of the work-related incident.” The long and short of the new reporting requirement is that an amputation constitutes an automatic report to OSHA even if it does not result in a hospitalization or any days away from work, or even require medical treatment beyond first aid.

What constitutes an amputation? The rule defines “amputations” as:

“[T]he traumatic loss of a limb or other external body part. Amputations include a part, such as a limb or appendage, that has been severed, cut off, amputated (either completely or partially); fingertip amputations with or without bone loss; medical amputations resulting from irreparable damage; amputations of body parts that have since been reattached. Amputations do not include avulsions, enucleations, deglovings, scalpings, severed ears, or broken or chipped teeth.”

There seems to be ambiguity around the distinction between a “partial amputation” and an avulsion or laceration. Based on OSHA’s definition, the term “amputation” would require the complete severing of an appendage such that it is no longer attached to the body in any way. Under this definition, it seems that a partial amputation would involve only a portion of an appendage (e.g., half of a finger or toe), but that portion would have to be completely severed from the body (as opposed to an entire appendage being partially severed). OSHA has been very clear that loss of the tip of a finger is considered an amputation. The definition of amputation expressly includes the loss of the tip of a finger with or without bone. There is no qualification for what portion of a fingertip must be severed to trigger the reporting requirement (i.e., just a small part at the top requiring nothing more than a Band-Aid versus a larger portion that may require re-attachment). Thus, employers should report any incident that results in some part of the fingertip being entirely removed. OSHA has reported that approximately half of all fingertip amputations required 18 or more days away from work, and the agency believes that a fingertip amputation may very well be a near miss of a more significant amputation.

Addressing Multiple Bases for Injury Reporting: So what happens if the amputation also requires overnight formal admission to the hospital? OSHA has been clear that an employer must separately report the amputation, even if the same incident was already reported as an inpatient hospitalization. In other words, if an employer later learns that an amputation occurred within 24 hours of the work-related incident, and the employer had already reported the incident because the employee required an inpatient hospitalization, a second report must be made to OSHA of the amputation. Both the inpatient hospitalization and the amputation can be reported at the same time if both are known by the employer.

Enucleations Concerning the loss of sight, workplace injuries resulting in enucleation do not seem to be causing much confusion. OSHA indicates that the loss of an eye is the physical removal of the eye, including enucleation and evisceration. The loss of sight without the removal of the eye is not reportable under the requirements of section 1904.39. However, a case involving loss of sight that results in the formal inpatient hospitalization of the worker within 24 hours of the work-related incident is reportable.

TIMING OF REPORTING CRITERIA

The new rule requires employers to report a hospitalization, amputation, or loss-of-eye injury to OSHA within 24 hours of when any management representative of the employer learns of the reportable injury. Note, however, that the injury must be reported only if it occurs within 24 hours of the work-related incident. It is reportable to OSHA, an injured employee must move beyond the emergency service to a formal admission to the inpatient service, and then receive medical treatment while in the inpatient service, all within 24 hours of the incident.

Third, instances where medical treatment is deferred for a day or two after an incident (e.g., surgery delayed until swelling reduces) are not reportable if no other medical treatment was provided in the inpatient setting during the delay.

Electronic Reporting and Inadvertent Admissions: A final concern about the new rule is the introduction of a web portal by which employ-
ers can electronically report incidents, in addition to the historical telephone reporting options (i.e., calling OSHA’s 24-hour hotline [1-800-321-OSHA] or the nearest OSHA Area Office). Employers should be wary of using this web portal to report incidents because it requires a detailed written explanation of an incident that has just occurred a few hours earlier, and for which a thorough investigation could not yet have been completed. These preliminary descriptions will be memorialized as the employer’s statement of the event, and could later be used against it as an admission in an OSHA enforcement proceeding or a personal injury or wrongful death civil action. Indeed, anyone can access these written reports through a Freedom of Information Act (FOIA) request, including plaintiffs’ attorneys, union organizers, the media, competitors, etc. Accordingly, the old-fashioned telephone call should remain the preferred method of reporting.

WHAT HAPPENS AFTER YOU REPORT?

According to the “Revised Interim Enforcement Procedures for Reporting Requirements under 29 CFR 1904.39” issued by OSHA’s Directorate of Enforcement on May 4, 2016, OSHA will automatically conduct onsite inspections for all reported incidents that involve:

• A fatality.
• The hospitalization of two or more employees.
• Injuries to employees younger than 18.
• Incidents at a workplace with a “known history of injuries” (i.e., the same or similar events within the last year).
• Incidents at a workplace with a history of egregious, willful, failure to abate, or repeat citations.
• A hazard that is the subject of a local or national emphasis program.
• Any report from an SVEP (Severe Violator Enforcement Program) employer.
• An imminent danger.

OSHA may (but will not necessarily) inspect reported injuries that involve:

• Hazards that continue unabated.
• Amputation hazards.
• Serious hazards (i.e. explosive materials, combustible dust, falls, and heat).
• Temporary workers or other vulnerable populations.
• Health issues such as chemical exposures, heat stress, etc.
• A referral from another government agency (federal, state or local).
• A pending whistleblower complaint/inspec tion.

Rapid Response Investigation:

Rapid Response Investigation: For all other types of incidents, and for those for which OSHA exercises its discretion to not inspect, OSHA will utilize its new Rapid Response Investigation (RRI) protocol. Here’s how the new RRI procedure will work:

• When it first receives an accident report, OSHA will send the employer a new questionnaire. Among other things, the questionnaire will ask employers to determine the cause of the accident and state whether similar accidents have occurred before.
• OSHA plans to place each report into one of three categories to determine whether it warrants an onsite inspection or a new RRI. Under the RRI program, the employer will receive an RRI letter which asks the employer to conduct an accident investigation, document the findings and corrective actions, post a copy of this letter where employees can review it, and submit the findings and corrective actions to OSHA.

o Category 1: Includes fatalities, hospitalizations of two or more employees, repeat offenders, hazards covered by an emphasis program, imminent dangers, or injuries to minors. These will automatically trigger an onsite inspection.

o Category 2: Includes reports involving two or more of the following. These reports may trigger an onsite inspection at the discretion of the area director.
• Continued exposure to the hazard.
• Safety program failure such as lockout or tag out.
• Exposure to serious hazards such as falls.
• Temporary workers.
• Referral from another government agency.
• Employers with a prior inspection history.
• Employers with a pending whistleblower complaint.
• Employers in a cooperative program such as VPP.
• Health issues such as chemical exposure or heat stress.

o Category 3: Includes reports that do not meet the criteria for Category 2. These reports may trigger the RRI, which is much more involved than the traditional phone and fax inquiry that OSHA now uses. Under an RRI, OSHA will send a letter requesting that the employer conduct its own investigation of the incident and report its findings with supporting documentation. The letter provides a blank investigation report form for employers to use. Some of the questions on the form are worded in such a way that could potentially raise liability issues for employers. As such, employers are highly encouraged to provide relevant information in lieu of completing OSHA’s form.

Finally, the procedures also call for a new database designed to capture all of the information received from employers. OSHA has not said how this data will be used or whether it will be made available to the public.

Employers facing a reportable incident should keep these considerations in mind:

• Are you actually required to report the incident under the new rule?
• Once you’ve sent in a report, assume your facility will be subject to an onsite OSHA inspection.
• Take care when responding to OSHA’s requests for additional information. As with any audit or investigation, your responses can be used by OSHA (or others who might obtain OSHA’s information through the FOIA) to hold your facility liable or to expand OSHA’s investigation. In a fatality, catastrophic accident or other significant cases, get the advice of legal counsel before responding with anything more than what you are required by law to initially report.
• Although the initial report is required by law, OSHA's new procedures are only internal enforcement guidelines and are not legally binding on employers.

Determining whether an inpatient hospitalization should be reported to OSHA, and by when, is not always clear, and the consequences of getting it wrong, either way, are serious. When an employee experiences an injury or illness that results in a visit to the hospital, an employer must determine, through reasonable inquiry and investigation, whether:

• The employee was admitted to the inpatient service of the medical facility.
• The employee received medical treatment beyond observation and diagnosis at the medical facility.
• The medical treatment was provided after admission to the inpatient service.
• The admission to the inpatient service and subsequent medical treatment occurred within 24 hours of the incident that caused the injury.
• The injury was work-related.

Only if the answer to all of those questions is yes must OSHA be notified of the hospitalization, and that notification must be made within 24 hours of learning of the relevant information to draw that conclusion.

AOHP Insight!

AOHP Insight, offered exclusively to AOHP members, provides a wide range of occupational health tools and resources that can enhance every level of practice from beginner to advanced. From up-to-date professional information to legislative updates, AOHP Insight is committed to deliver the knowledge you need to the right place, at the right time.

For more information about the benefits of your AOHP membership, visit http://www.aohp.org/aohp/MEMBERSERVICES/MemberBenefits.aspx or email info@aohp.org.

2016 15th Edition Getting STARTED

There's still time to buy the latest version of AOHP's renowned Getting Started Manual

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If you purchased the 2014 edition of Getting Started after March 1, 2016, contact Headquarters at info@aohp.org to receive 40% off when you order the 2016 edition Getting Started Manual CD.
Editor's Column

By Kim Stanchfield, RN, COHN-S
Executive Journal Editor

Surviving Flu Vaccine Season

This was my 30th influenza vaccine season. That's a lot of shots, a lot of people, and in my case, a lot of grumbling. I admit it; I very much dislike flu vaccine season. I do not know what it is, but flu vaccine can bring out the worst in employee behavior. And one should not have to dread October and November - two of the most beautiful months of the year!

When I first started in occupational health (then known as employee health), I gave a few hundred flu shots in a year and thought I did a good job. Then the hospital grew in numbers, became part of a health system, and flu vaccine changed from free and encouraged to part of a Mandatory Protection Policy.

If all I did was sit and administer flu vaccine, I could easily survive "the season." But there are always phone calls, emails, and questions... oh, the questions!

I am an optimistic person, cheerful by nature and happy with life. I know that during this "least favorite" time, I will have an encounter that makes it all worthwhile. This year it came in the form of an email from an employee. I have copied the entire email below (omitting the name of the employee). I hope all of you receive a similar word of encouragement from a life you touch this flu vaccine season!!

From a grateful employee:

Hey Kim,

Just wanted to show my appreciation for your relentless dedication to giving out flu shots. I know this is part of your job, but it has to seem thankless and unappreciated at times. Just remember how many people you are helping in this process; not only the people escaping the flu but all the people they come into contact with. You are probably saving thousands upon thousands of flu start-ups.

Helping me...

The KIM Buster...
**Association Community Liaison Report**

**By MaryAnn Gruden, MSN, CRNP, NP-C, COHN-S/CM and Bobbi Jo Hurst, BSN, RN, MBA, COHN-S, SGE**

**Association Community Liaison**

**Community Liaison Transition**

As you may be aware, earlier in 2017 I officially retired from the corporate world of occupational health in healthcare. With that comes the need to transition to a new Community Liaison. As my last official column, the format will reflect this transition. I would like to share some parting thoughts with you, introduce AOHP’s new Community Liaison and share updates from OSHA, NIOSH and other AOHP partners.

**Looking back...**

It has been an honor and privilege to have been affiliated with AOHP since 1990, initially serving at the chapter level, and then being elected to the Executive Board in 1995. It was my own curiosity about possibly being on the association’s Executive Board that led me to ask if I could run for Regional Director that year — how bold was that? Little did I know what lay ahead, as I have had the opportunity to serve in a number of roles for the association including Region 4 Director, Executive Vice President, Executive President, and President Emeritus. Since 2004, I have served as the Community Liaison. The networking opportunities with CDC, NIOSH, OSHA, The Joint Commission and other organizations have been exceptional and will continue and expand under the leadership of the new Community Liaison.

In the end, it has been AOHP that has provided me the greatest support and helped keep me sane as an occupational health professional in healthcare, although some might dispute that! AOHP has afforded me more professional opportunities than I ever thought possible, including challenges. Opportunities and challenges are still present and will continue to be a part of what we do in our jobs and by being part of AOHP.

Thank you to everyone who has supported me and helped me over the years, from the chapter level, to the Board, and to our Executive Director, Annie. The camaraderie and friendships have been so special. AOHP will remain near and dear to my heart.

I cannot conclude my remarks without thanking the “man behind the woman”, my husband and best friend, Bob Trujillo. He has been my emotional support, as well as “tech support”, especially late in the evenings when I was working on AOHP business and encountering computer glitches. If I had not had his support, not only for the work I did with AOHP, but for the demanding role in my job, I could not have done either very well.

I was very humbled at the Annual Business Meeting to be bestowed the Honorary Member Award. Thank you to the Executive Board for this honor. I hope to continue to serve in a less visible capacity for AOHP as I transition into retirement and the possibility of doing some consulting.

**Transition and beyond...**

The Executive Board has appointed Bobbi Jo Hurst, BSN, RN, MBA, COHN-S, SGE (Special Government Employee) from the Pennsylvania Central Chapter and Lancaster General Health/ Penn Medicine as the next Community Liaison. I am excited that Bobbi Jo will be filling this role. She already has links with OSHA as an SGE, as she is a surveyor for OSHA’s Voluntary Protection Program (VPP) and has been involved in the Healthcare Worker TB Screening Work Group, a national work group evaluating the usefulness/efficacy of annual TB skin testing among healthcare workers. We are in a transition that should conclude by the end of 2017. I wish every success to her and continued support to AOHP as the association supports its members and creates safe and healthy working environments for our colleagues.

**Moving forward... with Community Liaison Bobbi Jo Hurst**

I want to thank the Board for allowing me the wonderful opportunity to serve as Community Liaison. I also want to thank MaryAnn for the exceptional work she has done, as well as for her continued support as I transition into this position. The Community Liaison allows AOHP to have input into areas that affect our everyday work in employee health. Through our involvement with government and other regulatory bodies, we are able to help develop the best practices of which we will be evaluated.

**OSHA Update**

**Final rule to update walking-working surfaces and fall protection standards**

The final rule went into effect in January 2017. It updates and revises the outdated general industry Walking-Working Surfaces and Personal Protective Equipment (Fall Protection Systems) standards on slip, trip, and fall hazards, which are a leading cause of workplace injuries. Because the final rule harmonizes general industry requirements with OSHA’s existing construction industry standard and many American National Standards Institute (ANSI) standards, the new rule will make compliance both easier and less costly. OSHA adopted the existing standards in 1971 and has not updated them since. The final rule also adds new requirements on personal fall protection systems (29 CFR part 1910, subpart l). Several provisions had phased-in implementation dates.
All industries, including healthcare, are affected by this revised standard. In healthcare we may automatically think of maintenance and construction workers being affected; however, this standard covers any walking-working hazards in the workplace. Facilities must conduct fall risk inspections to identify fall risks on any walking-working surfaces. For more information on the final standard, including the complete language of the standard, please go to https://www.osha.gov/walking-working-surfaces/index.html.

**Connecticut company to compensate employees fired after raising TB exposure concerns**

A Connecticut district court has ruled that Charter Oak Health Center in Hartford must repay the lost wages of three workers who were fired after they announced their concerns about potential tuberculosis exposure in their workplace. OSHA found that the workers lost their jobs after they tried to raise awareness among fellow employees, management and the public, and after cooperating with public and workplace health agencies that looked into the workers’ concerns. Under whistleblower provisions enforced by OSHA, employers are prohibited from retaliating against employees who raise concerns about workplace health and safety. For more information, read the news release at https://www.osha.gov/news/newsreleases/region1/06192017.

**OSHA updates guidelines for effective safety and health programs**

OSHA has recently updated the Guidelines for Safety and Health Programs it first released 30 years ago to reflect changes in the economy, workplaces, and evolving safety and health issues. The new Recommended Practices have been well received by numerous stakeholders and are designed to be used in a wide variety of small and medium-sized business settings. The Recommended Practices present a step-by-step approach to implementing a safety and health program, built around seven core elements that make up a successful program. For a copy of the revised guidelines, visit https://www.osha.gov/shp-guidelines/.

**OSHA investigation finds psychiatric hospital workers remain exposed to serious workplace hazards**

A Massachusetts behavioral health facility faces $207,690 in proposed penalties from OSHA for violations found while conducting a follow-up inspection. On June 29, 2017, OSHA issued UHS of Westwood Pembroke, Inc. – doing business as Lowell Treatment Center – a notification for failure to abate a violation involving workplace violence. This follows a serious violation related to the same hazards that federal safety and health inspectors found on May 19, 2015. As a result of the 2015 inspection, the employer and OSHA entered into a Formal Settlement Agreement on April 12, 2016, which outlined specific provisions of a workplace violence prevention program. OSHA opened a follow-up inspection on January 5, 2017, after Lowell Treatment Center failed to provide documentation to show that it had implemented a workplace violence program, and the agency’s Andover Area Office received a complaint alleging employees remained at risk. OSHA found the center had failed to comply with multiple terms of its agreement, and that – despite previous citations and worker injuries – the risks for workers to suffer fatal injury or serious harm still existed. OSHA also cited the company for one repeat violation and three other-than-serious violations related to recordkeeping.

UHS of Westwood Pembroke, Inc. is one of the nation’s largest healthcare management companies. Through its subsidiaries, UHS operates 350 behavioral health facilities, acute care hospitals, ambulatory centers, and freestanding emergency departments throughout the United States, the United Kingdom, Puerto Rico, and the U.S. Virgin Islands. With approximately 130 workers, the Lowell Treatment Center is a 41-bed satellite facility of Westwood Lodge. The center is a psychiatric hospital that offers inpatient hospitalization and partial hospitalization for adolescents and adults.

UHS of Westwood Pembroke has notified OSHA of its intent to contest the findings before the independent Occupational Safety and Health Review Commission.

**NIOSH Update Total Worker Health® resources**

As announced during the summer, AOHP became a NIOSH Total Worker Health® (TWH) Affiliate. To enable AOHP to fulfill the Memorandum of Agreement with NIOSH, the Executive Board decided to include the TWH initiative in the association’s new strategic plan. Initially AOHP wants to ensure that members are aware of the resources available on the TWH website. These resources should be shared at chapter meetings and with facility stakeholders who are striving to improve the health of their workforces.

A quarterly newsletter is dedicated to providing updated TWH information and highlighting affiliate successes. In addition, a “Let’s Get Started” section serves as a guide for practitioners to create or expand organizational cultures of safety, health, and well-being. Resources on this site will provide information on how to create policies, programs, and practices which protect and promote worker safety, health, and well-being from the organizational and environmental level. It also includes a Hierarchy of Controls for TWH. For more information, visit https://www.cdc.gov/NIOSH/twh/.

**Updated website for hazardous drug exposures in healthcare**

NIOSH recently updated the Hazardous Drugs and Antineoplastic Agents webpages to enhance user navigation experience. All information related to the hazardous drugs listing, including antineoplastic agents, can now be found at one location. Stay tuned to this website for future updates to the NIOSH Antineoplastic and Other Hazardous Drugs List. https://www.cdc.gov/niosh/topics/hazard/default.html

**New video series: improving EMS worker safety**
safety through ambulance design and testing
NIOSH partnered with the Department of Homeland Security’s Science and Technology Directorate, to develop a seven-part video series that covers new crash test methods. The series highlights changes impacting ambulance design, testing, and manufacture. These changes support efficient patient care and improve safety in the ambulance patient compartment for emergency medical services workers, first responders, and their patients. To view the video series, visit https://www.cdc.gov/niosh/topics/ems/videos.html?

CDC releases 2018 Yellow Book
CDC Health Information for International Travel (commonly called the Yellow Book) is now available. For the first time, the Yellow Book includes a section on work-related travel. This is an important document for healthcare providers who work at travel clinics where people may be getting vaccinations, as well as for occupational health doctors. To access the Yellow Book, go to https://www.cdc.gov/travel/page/yellowbook-home.

New Jersey adopts Hazardous Drug Safe Handling Act
On May 11, the New Jersey (NJ) Legislature adopted Bill No. 837, Hazardous Drug Safe Handling Act, which requires promulgation of standards and regulations concerning safe handling of hazardous drugs by certain healthcare personnel. The NJ Legislature determined that it is the public policy of the state to provide for the appropriate regulation of the handling of hazardous drugs consistent with the 2004 NIOSH alert, as well as any updates to the NIOSH list of hazardous drugs. New Jersey is the fourth state to pass similar legislation following Washington, California, and North Carolina. Several other states have proposed similar legislation. More information on preventing exposure to hazardous drugs is available at https://www.cdc.gov/niosh/docs/2004-165/.

NIOSH MSD Program updates key ergonomics guide
The NIOSH Musculoskeletal Disorders (MSD) Research Program recently updated the NIOSH document Elements of Ergonomics Programs – a step-by-step guide to create, implement, and maintain an ergonomics program. The guide provides basic information useful for employers, workers and others in designing an effective ergonomics program to prevent work-related musculoskeletal disorders. The updated information and document can be found at https://www.cdc.gov/niosh/topics/ergonomics/ergoprimer/default.html.

NIOSH science blogs relate to healthcare issues
Two current NIOSH science blogs relate to current hot topics in healthcare. The first is Understanding Respiratory Protection Options in Healthcare: The Overlooked Elastomer, which can be found at https://blogs.cdc.gov/niosh-science-blog/2017/07/06/elastomers/. The second is Fentanyl Exposure Risks for Law Enforcement and Emergency Response Workers and can be found at https://blogs.cdc.gov/niosh-science-blog/2017/06/22/fentanyl/.

Study examines safe administration of liquid antineoplastic drugs
A web-based survey conducted by NIOSH looked at how organizational factors and perceived safety climate might affect use of personal protective equipment and engineering controls, as well as the likelihood of spills, leaks, or skin contact, during administration of liquid antineoplastic drugs. Antineoplastic drugs, also known as chemotherapy, cytotoxic, and oncology drugs, are used to treat cancer, as well as arthritis, multiple sclerosis, and other non-cancer medical conditions. This study was published in the July issue of the Journal of Occupational and Environmental Hygiene, and the abstract is available at http://www.tandfonline.com/doi/full/10.1080/15459624.2017.1285496.

Research Rounds
Lifting equipment linked to fewer injuries among nursing home workers
Injuries among nursing home workers significantly decreased after the start of a safety program that included mechanical lifting equipment and training on how to use it. The program also provided the nursing homes with detailed procedures for using and maintaining the equipment.

Using workers’ compensation claims, the investigators compared injury rates from before a safety program began to after the program had been in place for six years. Started by a large healthcare corporation to reduce musculoskeletal injuries, the program included purchasing mechanical lifting equipment and training workers to use it. The program also provided the nursing homes with detailed procedures for using and maintaining the equipment.

For this eight-year study, investigators compared injury rates from before a safety program began to after the program had been in place for six years. Started by a large healthcare corporation to reduce musculoskeletal injuries, the program included purchasing mechanical lifting equipment and training workers to use it. The program also provided the nursing homes with detailed procedures for using and maintaining the equipment.

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Congratulations! You’ve been escalated into a hospital leadership position. You now have a great opportunity to lead your organization to providing the highest quality healthcare and be an employer of preference in your area. While many equate a new position like this to higher pay, increased authority and other benefits, it also means increased accountability to your patients and their families, your Board of Directors and, most definitely, your employees. Your employees will look to you to exemplify your team’s safety culture. In a few words or with a pivotal decision, you can earn your credibility and their trust, or you can destroy it. So, how do you get on the right track to developing a high-reliability safety culture in which ownership, empowerment, and engagement are felt by everyone? Below are a few key points.

Communication

1. Communication is the key for successful safety communication:
   - The C-Suite must have consistent communication on employee safety issues and status. *(What are the issues, how are we resolving them, and what do our leading and lagging indicators look like?)*
   - This can come from a team such as the Employee Safety Committee, often an extension of the Environment of Care (EOC) or campus Safety Committee.
   - The System-Wide Safety Committee has representation from the whole system. Initiatives and developments from this committee should be communicated from the campus representatives back to the campus Employee Safety Committee and up to the C-Suite.
   - Finally, information and initiatives developed at the committee level need to be communicated back to each unit. A mechanism such as Safety Coaches, SOS Champions, or another is needed to accomplish this. They can also return feedback and input to the Employee Safety Committee from the employees.

Success Mode

- Employee Safety issues are analyzed and solutions are developed at the Employee Safety Committee, including feedback and input from employees on the floor.
- All Employee Safety Committee information is communicated to the C-Suite, who can provide support and resolution, if needed.
- With information in hand from the Employee Safety Committee, Safety Coaches or another resource provide the rollout to each unit.
- ALL committee members and others involved must be actively engaged.

First Steps

1. If your team doesn’t have one, build an Employee Safety Committee.
2. Leaders, ensure communication with your Employee Safety Committee chairs and System-Wide Safety Committee Representatives (who might be the same person). Request recurring updates.
3. With information and initiatives ready to roll out, send content through the Safety Coaches (or another resource) so that every employee gets the information.

Why?

- Employee Safety requires a team of cross-functional committee members to analyze hazards, determine hazard controls/solutions and develop action plans for safety initiatives, and also provide points of contact for Employee Safety issues from employees.
- The campus System-Wide Safety Committee member brings back information from that committee to the campus.
2. Setting Expectations:

- All initiatives from the campus Employee Safety Committee (including system-wide initiatives brought to the committee) need to be communicated to the C-Suite. Without this communication, the C-Suite can’t support the initiatives.
- Finally, with the initiatives ready to roll out, the Safety Coaches (or another resource) will ensure the information gets to every employee.

With gaps in communication, Employee Safety simply can’t improve.

2. Setting Expectations:

- Now that an Employee Safety Committee is in place to determine what issues need to be resolved, the committee will be able to:
  - Serve as the campus/organization point of contact for Employee Safety concerns, recommendations, input, and feedback.
  - Analyze Employee Safety data to determine where improvement is needed.
  - Make recommendations as to what hazard controls are needed (process change? equipment? training? other?)
  - Provide recurring updates on Employee Safety progress (gaps, needs, metrics, and more).
  - Provide directions and information for Safety Coaches (or another resource) to communicate to each unit.
  - And more!
  - With the Employee Safety Committee set up to analyze hazards, risks, and hazard controls, we now need to take the message, information, and most importantly, expectations, to all employees.

Setting Expectations

- All leaders, from the top down, communicate the expectation that safe work practices are to be followed at all times without exception. If there’s a question as to what the safe work practice is for a task, employees should ask instead of proceeding unsafely.
- Safe work practices must be in place for all tasks. If we don’t know how to work safely, and we haven’t communicated it and trained employees to do it, how can we expect them to do it?
  - For each task, ensure all employees are trained on the safe work practice using the hazard control in place.
  - For each task, ensure the hazard controls are readily available, accessible, and convenient.
  - Regularly communicate the hazard and hazard control at each opportunity (safety huddles, Town Hall meetings, newsletters, and more).

Success Mode

- If we poll employees, all would be familiar with not only leadership’s expectation that they work safely, but all safe work practices in their areas.
- For every task in every job classification, a safe work practice exists for every hazard.
- Every hazard control is readily available, accessible, and convenient for use at all times.

- Employee Safety information (hazards, hazard controls, and reminders to work safely) is communicated at every opportunity. If we check newsletters, bulletin boards, safety huddles, and other forums, Employee Safety is covered every time. Information doesn’t need to be long or detailed, but a one-minute Safety Moment does wonders for hardwiring information.

First Steps

- All leaders - communicate the expectation of safe behavior and openly ask for suggestions, recommendations, and input on how to better Employee Safety, offering all employees a chance to give their opinion. Communicate Employee Safety points of contact for your campus.
- Employee Safety Committee - ensure that safe work practices using hazard controls exist for every task (gap analysis) and, if needed, make recommendations to executive leaders on gap-fills.
- All leaders - ensure all hazard controls are in place and convenient for employee use (eliminate reasons for not using them).
- Designate points of contact to provide Employee Safety information, which can be pulled from the Workplace Safety SharePoint, to local communications for additions to newsletters, agendas, huddles, and more each week/month.

Why?

- Setting safety expectations lets all employees know the value and importance of safety.
- Asking for employee feedback creates buy-in.
- Before anybody can be expected to work safely, safe work practices must be known and in place.
- If hazard controls aren’t available, accessible, and convenient, employees might not use them. We don’t want to leave any reasons to work unsafely. (Back to expectations; the expectation should be that all employees are expected to use hazard controls at all times, regardless of circumstances.)
- If Employee Safety information is communicated regularly, it not only hardwires it, but it reinforces the perception of value and importance in the organization.

Without expectations, Employee Safety simply can’t improve.

3. Recognize and Incentivize!

- Once all hazards have been identified and controls have been implemented, with comprehensive communication and expectations set, now is the time to reinforce the expected safe behaviors and conditions.
- It can be tricky incentivizing safety, and OSHA can penalize employers for doing so incorrectly. We don’t want to inadvertently promote employees not reporting incidents, and we don’t want unsafe behaviors to continue as long as nobody is injured.
- We do, however, want to incentivize proactive processes that lead to increased hazard identification, assessment, and
control, and to positively promote the safety culture.

**Success Mode**

- For each component of the safety program – hazard identification, hazard control, information program, leading indicators, lagging indicators, and accident prevention – incentives should be tied to processes that lead to safe behaviors and conditions.
- Employees can be incentivized and recognized for participating on the Safety Committee.
- For example, during the hazard identification and analysis phase, employees can be incentivized for identifying hazards to leaders or recommending a hazard control.
- In another example, during the program phase, employees can be incentivized for leading a safety talk or writing a newsletter article.
- The leading indicator phase is especially important. With observation, inspection, near-miss, and other indicator processes in place, employees can be incentivized for participating (performing observations and inspections and/or submitting near-miss reports) and for performing (being observed working safely or identifying and correcting an unsafe condition).
- Lagging indicators must be handled with care. If employees are only told that they will be incentivized for a reduction in injuries or recordables, this could lead to employees simply not reporting them or getting lucky by achieving reductions resulting from working unsafely, instead of applying actual safe behaviors and conditions.
- Although promulgated by injuries and exposures, investigations can become proactive. For example, departments can be incentivized for completing 100% of the investigations in their departments, for implementing preventive measures for each investigation, or other proactive processes.
- Recognition is the fun part! Employees "caught" doing good things and working safely should be recognized publicly. It's amazing how much goodwill and positivity can come from a leader such as the CEO publicly recognizing an employee for working safely or participating on the Safety Committee.
- If you’re incentivizing or just requesting information and recommendations from your team, make sure you either implement their feedback or at least respond to it. If employees don’t see or hear anything about their input, they’ll eventually quit bothering, especially if it’s optional.

**First Steps**

- Processes must be established for each component of the program. Without employee engagement in hazard analyses, controls, communication, leading indicators, and investigations, they won’t understand what’s being incentivized.
- Engage the Safety Committee in determining what will be incentivized and what the incentives will be.
- Check with your legal advisor to ensure everything is correct in terms of OSHA compliance, taxes and the like.
- Ensure everyone knows about the incentive program, and train them on how to participate.
- Keep it consistent. Once everyone sees it happening on a recurring basis, it can become part of the culture.
- For each part of the incentive program, employees can be recognized. This is very effective and can be done as often as you’d like for no cost (well, perhaps the cost of a certificate...)

**Why?**

- What gets rewarded gets done!
- If employees are incentivized for proactive and preventive processes, this motivates them and provides you, the leader, with fantastic feedback and data from the field.
- Observations, inspections, near-miss reporting, and other proactive processes become part of the recurring workflow within the team, helping to hardwire the safety culture.
- By using this information, you’ll be able to implement effective solutions to safety concerns, something that employees will respect you for. But, if you don’t, they’ll notice that, also. Follow-through is very important.

**Final Thoughts for the Time Being...**

Ultimately, you’ve been placed in a leadership position because you’ve proven your abilities both technically and as a leader. Leading safety will prove to be one of the most important initiatives you do as a leader and can provide the best opportunity possible to engage and connect with your teammates. However, if done incorrectly, it can damage your credibility. If proactivity is incentivized, this will lead to increased hazard identification, hazard control recommendations and feedback observations, inspections, near-miss reporting, investigations and, by default, safe behaviors and conditions. This is much more effective than simply incentivizing a reduction that may be achieved by luck or bullying. Also, it’s certainly worth noting that recognizing employees for safety can be one of the most rewarding and fun activities you do as a leader!
Message from the 2017 Conference Chair

In Grateful Appreciation

By Dana Jennings
2017 AOHP National Conference Chair

I want to thank everyone, including the 2017 National Conference Committee, for all your excellent work in preparing for and participating in this year’s conference! It was one of the best attended and most successful in many years. We were pleased to provide our attendees a variety of topics including information on how to work in Safer Workplace Environments, Retaining and Managing an Aging Workforce, and working with today’s youngest workers. We heard important updates from OSHA, NIOSH and EEOC that affect occupational health practice. Stephen Burt reviewed the ever-changing legislative and regulatory topics that directly impact our work. Getting Started gave our new members the foundation for success in their evolving practices.

Through Discover Your Inner Champion, keynote speaker Tricia Downing captivated the audience with her story of perseverance through tragedy and how she has dealt positively with challenges in her personal and professional life.

We also personally welcomed the organization’s newest members who joined us in Denver, and we hope to see you at many conferences to come.

It was my pleasure to serve as your conference chair.

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Keep Your Benefits
Renew Your Membership!

AOHP is your single best source for advanced practice information and support, and the only national professional organization with an exclusive focus on the needs and concerns of occupational health professionals in healthcare. Our association represents thousands of healthcare workers – including you. AOHP’s success is measured by the level of experience and dedication shown by our members.

The deadline to renew your membership for the coming year is February 28, 2018, but you can renew at any time online at https://www.aohp.org/aohp/MEMBERSERVICES/RenewMembership.aspx. Just log in with your user name, as showed on the renewal notice, and password.

Please budget accordingly for 2018 so you can retain all the benefits AOHP offers while continuing to be a part of this vibrant, thriving organization that is well known as an authority in occupational health in healthcare.
Healthy Plant-Based Diet

What Does it Really Mean?

By Kim Allan Williams, SR, MD, Hena Patel, MD
## Do You Know the Many Benefits AOHP Offers to Members? Let’s Name A Few!

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<th>Listserv</th>
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<td>AOHP E-Bytes provides a summary of current occupational health information. It is distributed electronically from Headquarters every month and provides updates on the latest educational, regulatory and association information to keep members informed about pertinent, current information related to your professional practice.</td>
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Mark Your Calendar! AOHP 2018 National Conference
September 5-8, 2018 • Glendale
Renaissance Glendale Hotel • 9495 W. Coyotes Blvd., Glendale, AZ 85305

It is never too early to start planning. Join us at the 2018 National Conference – Occupational Health A-Z. It will feature the most up-to-date information from A to Z and everything in between. A conference for both novice and experienced professionals in many occupational health practices areas.

Need help to get approval?
Go to our website http://www.aohp.org/aohp/EDUCATION/NationalConference.aspx to download the Articulating Attendance Value Guideline and use the template to help to justify your conference attendance with your supervisor.

Keep Your Benefits - Renew Your Membership!
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AOHP E-Bytes provides a summary of current occupational health information. It is distributed electronically from Headquarters every month and provides updates on the latest educational, regulatory and association information to keep members informed about pertinent, current information related to your professional practice.

AOHP Insight!
AOHP Insight, offered exclusively to AOHP members, provides a wide range of occupational health tools and resources that can enhance every level of practice from beginner to enhanced. From up-to-date professional information to legislative updates, AOHP Insight is committed to deliver the knowledge you need to the right place, at the right time.

For more information about the benefits of your AOHP membership, visit http://www.aohp.org/aohp/MEMBERSERVICES/MemberBenefits.aspx or email info@aohp.org.
The Urgency of Creating a Culture of Caring: Start with You!

By Kim Richards
CALL FOR SPEAKERS

AOHP 2018 National Conference, September 5-8, 2018
Renaissance Glendale Hotel & Spa, Glendale, AZ

Deadline to submit: January 31, 2018. Successful applicants will be notified by April 27, 2018.

AOHP Annual National Conference Suggested Topics:
• Competencies for occupational health professionals (OHPs)
• How OHPs can demonstrate value to management using metric tools
• Innovative ideas for organizing an Occupational Health Department
• Career advancement in OH; educating new healthcare workers about the OH specialty
• Mental health for the OHP; coping with/reducing workplace stressors
• Leadership skills development for OHP managers; benefits of certification
• Embracing new technologies in the workplace
• Business-oriented classes, organizational charts, program management
• Cost avoidance
• Case studies highlighting evidence-based best practices
• Advance practice topics: financing, staffing, program development
• Professional ethics/legal obligations/compliance issues in occupational health
• Case management of occupational health issues
• Managing/developing a successful wellness program: budget, job descriptions, making a case
• Health, well-being and wellness topics
• Emergency preparedness; Emergency Response Team; disaster evacuation and restoration
• Mass dispensing drills
• OSHA compliance and inspections
• OSHA standards pertinent to hospitals and/or other healthcare settings
• OSHA, NIOSH, CDC (updates, hot topics)
• FMLA and leave management; ADAAA; Pregnancy Discrimination Act; other legal issues
• Fitness for duty as relates to policy, interactive process with employee, appeals, legal issues
• Legislative updates
• Drug diversion in the workplace; interventions for impaired workers
• Drug testing; DOT drug screening; alcohol testing
• Best practices for post offer physicals; drug screenings
• Pre-placement exams; new hire/transfer physicals
• Immunization programs: influenza, shingles, pneumonia
• Impact of mandatory influenza vaccination: worker health, nosocomial influenza, absenteeism
• Immunization updates related to CDC requirements for healthcare professionals
• Blood and body fluid exposure management; post exposure prophylaxis
• Safe patient handling in varied settings: bariatric, acute care, long term care, outpatient sites
• Dealing with worker injuries/safe patient handling/slip, trip and fall prevention
• Hazards in healthcare
• Workplace safety strategies and behaviors; accident prevention; accident/illness investigations
• Workers’ compensation topics
• Components of effective return-to-work programs
• Workplace violence prevention programs
• TB/Hepatitis C updates
• Legionella outbreak investigations
• Respiratory protection programs; personal protective equipment/annual respirator fit testing
• Air quality investigations in the healthcare setting
• Laser safety
• Managing emerging infectious diseases with appropriate surveillance program
• Sharps injuries; EXPO-S.T.O.P. survey updates
• Ergonomics implementation
• Surveillance for employees administering chemotherapeutic agents
• Chronic disease management
• Grief in the workplace
• Mental health topics, including methods for identification and screening
• Interventions for employees in crisis
• Identifying and managing issues related to the aging workforce; population health
• “Future trends.” What’s coming, and what changes need to be made to prepare

For more information, please contact AOHP Headquarters at 800-362-4347 or e-mail info@aohp.org.

Understanding Trends in Pertussis Incidence: An Agent-Based Model Approach

By Erinn Sanstead, MPH, Cynthia Kenyon, MPH, Seth Rowley, MPH, Eva Enns, PhD, Claudia Miller, MS, Kristen Ehresmann, RN, MPH, and Shalini Kulasingam, PhD

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You Can Be a ROC Star!

AOHP Recruit Our Colleagues (ROC) –
A Better and Greater Campaign.

The Recruit Our Colleagues (ROC) campaign is back, and it’s bigger and better than ever! ROC is a great way for members to help AOHP grow while earning rewards that can be used toward education and membership. The new ROC campaign offers five levels of individual awards, as well as an award for the chapter recruiting the most new members.

AOHP members are the organization’s most valuable asset, and the best way to spread the word about the value and benefits of our organization. When looking for ways to recruit new members to AOHP, consider the following:

• Connect with colleagues in your own organization who are not AOHP members. AOHP is not just for nurses. Reach out to physicians and advanced practice professionals who are involved in your occupational health program.

• Connect with providers outside your organization who partner with you in your program.

• Reach out to colleagues from other facilities in your local area.

• Obtain a list of facilities in your chapter’s geographic area, and make “cold calls” to the occupational/employee health employees in those facilities. (Lists were recently provided to chapter presidents). Briefly introduce them to AOHP and refer them to the AOHP website, or offer to send them information. Be sure to let them know what you value about your membership in AOHP.

• Connect with occupational/employee health providers in non-hospital facilities such as clinics and post-acute care.

The new ROC campaign offers a grand prize that includes free registration to the next AOHP National Conference, three nights hotel, airfare reimbursement up to $250, round trip transportation from the airport to the conference hotel (up to $50), and a free AOHP membership for the following year. The total value of this prize is approximately $1,500. It would be so exciting to award this prize for the first time to one of our members at our conference in Glendale, Arizona in September 2018!

The current ROC campaign period runs from July 1, 2017 through June 30, 2018. There is still plenty of time to work toward a ROC reward, so get busy!

**LET’S ROC!** The following ROC awards are available:

- **The Whole Shebang** – one award to the member recruiting the most new members (must recruit at least 10 to qualify).
- **Kit and Caboodle** – awarded to members recruiting 10 or more new members, but not the winner of The Whole Shebang.
- **Half Kit and Caboodle** – awarded to members recruiting six to nine new members.
- **Caboodle** – awarded to members recruiting three to five new members.
- **Feather in My Cap** – awarded to members recruiting one to two new members.
- **Pie in the Sky Chapter Award** – awarded to the chapter recruiting the most new members.


Every new member strengthens our organization. Participate in our ROC Revival by sharing the benefits of AOHP membership with your colleagues, and earn rewards that will benefit your practice. For more information, visit www.aohp.org, call Headquarters at 800-362-4347, or email info@aohp.org.

***In order to count as your recruit, new members must list your name as their recruiter when completing their AOHP Membership Application!***

Let’s ROC someone’s world!!! Recruit Our Colleagues!
Reach out and share the benefits of AOHP membership with your area colleagues.
WHILE YOU LOOK AFTER OTHERS, WHO LOOKS AFTER YOU? We do.

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While you look after others, who looks after you? We do.

Mission
AOHP is dedicated to promoting the health, safety and well-being of workers in healthcare. This is accomplished through:
• Advocating for employee and safety.
• Occupational health education and networking opportunities.
• Health and safety advancement through best practice and research.
• Partnering with employers, regulatory agencies and related associations.

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