

VITALITYATLAS

YOUR SOURCE FOR WORKING HEALTH SOLUTIONS

07 Study Examines Workers' Comp Benefits, Costs

09 Drug Testing Update

11 Metrics Needed to Validate Sustainability

12 Holiday Food Safety

COLD-WEATHER REMINDERS



1. Check the weather forecast and be prepared for changing conditions.
2. Take extra precautions if you are not used to exerting yourself at high elevations.
3. Wear cold-weather clothing in layers to retain body heat and repel water.
4. Use goggles or sunglasses to protect your eyes and sunscreen to prevent sunburn.
5. Drink plenty of water, eat nutritious foods and carry snacks to boost your energy.

Refer to WorkCare's Fact Sheet on [Cold-Related Injuries and Illnesses](#).

HOW IS THE U.S. FARING WITH OBESITY?

Not as Well as We Hoped

by Karen O'Hara

Obesity rates have doubled among U.S. adults and more than tripled for children since the 1980s.

With education and resources directed toward the nation's obesity epidemic, the alarmingly steep growth trajectory has leveled off in recent years. However, excessive body fat remains a persistent and costly public health problem.

Obesity is associated with serious health conditions including heart disease, hypertension, cancer and type 2 diabetes. (Refer to [Vitality Atlas](#) to learn about diabetes impacts in the workplace.) In turn, these conditions are related to high health care costs, long-term disability, income loss, poor quality of life and shorter life span.

Employees who are obese are also linked to higher than average injury incident rates and greater likelihood for work absence. For example:

- In a longitudinal study, overweight and obese employees were found to be 25 to 68 percent more likely to experience work-related injuries than normal-weight workers. ([Journal of Safety Research, Vol. 58, Sept. 2016](#))
- A 2011 study found that full-time employees who are overweight or obese, and have other chronic health conditions, miss an estimated 450 million additional days of work per year in comparison to their healthy peers. ([Gallup-Healthways Well-being Index survey of 109,875 employees](#))



The extent of benefits employers, employees and communities can gain from workplace interventions varies depending on management commitment, workforce demographics and local conditions. Consequently, a cross-disciplinary approach to obesity prevention and health management at the local level is recommended.

— Continued on Page 2

Obesity Causes

Obesity correlates with poor nutrition and lack of exercise, especially in certain parts of the country, according to newly released study findings. However, risk factors for obesity are complex. They include:

- Characteristics such as family history, age, gender and ethnicity
- Lifestyle behaviors such as nutrition, exercise, stress management and daily sleep duration
- Geographic location and living environment
- Educational level and socio-economic status
- Internal energy imbalance, certain medical conditions and medications

Energy balance is related to caloric intake: Fat cells store energy needed to regulate the body's temperature, respiratory system, digestion, physical movement and other functions.

The balance between calories stored and burned depends on an individual's genetic makeup, level of physical activity and energy expended while resting. People who consistently burn the calories they consume maintain their weight. People who consume more calories than they expend gain weight. Excess calories are stored in fat cells (adipose tissue), either by enlarging existing cells or creating more of them, according to a [Harvard Medical School publication](#).

Studies show a genetic predisposition to be overweight can range from 25 to 80 percent. Certain genes affect appetite, sense of fullness when eating, metabolism, food cravings, body-fat distribution and the tendency to use eating as a way to cope with stress. In addition, a high-calorie diet is believed to cause fat tissue to become inflamed and contribute to the development of type 2 diabetes in some people.



Prevalence

Body mass index (BMI) and waist circumference determine whether someone is overweight or obese. BMI is calculated as weight in kilograms divided by the square of the person's height in meters (weight/height²).

A high BMI is an indicator of potential health risk; it is not diagnostic of body fatness or the health of an individual, according to the Centers for Disease Control and Prevention (CDC). For adults, a BMI of 18.5 to 24.9 is considered normal weight, 25 to 29.9 is overweight and 30 or more is obese.

Obesity prevalence exceeds the nation's [Healthy People 2020](#) goals of 14.5 percent for youth and 30.5 percent for adults. According to the Kaiser Family Foundation, nearly 65 percent of U.S. adults are either overweight or obese (based on 2013-16 CDC [Behavioral Risk Factor Surveillance System](#) survey data).

Body Weight Linked to Cancer and Other Medical Conditions

Overweight and obesity are associated with increased risk of 13 types of cancer that account for about 40 percent of all cancers diagnosed in the U.S., the Centers for Disease Control and Prevention (CDC) reports. Overall, the rate of new cancer cases has decreased since the 1990s, but increases in overweight- and obesity-related cancers are likely slowing this progress, public health officials said.

"When people ask me if there's a cure for cancer, I say, 'Yes, good health is the best prescription for preventing chronic diseases, including cancer,'" said Lisa C. Richardson, M.D., M.P.H., director of the CDC's Division of Cancer Prevention and Control. "What that means to health care providers like me is helping people to have the information they need to make healthy choices where they live, work, learn and play."

Other obesity-related medical conditions include:

Type 2 diabetes: People who are obese have an increased risk of becoming resistant to insulin, which regulates blood sugar levels.

High blood pressure/heart disease: Excess weight makes the heart and cardiovascular system work harder.

Osteoarthritis: Weight placed on the joints escalates wear and tear. It also increases the likelihood of inflammation and back pain.

Sleep apnea/respiratory problems: Fat deposits in the tongue and neck can block air passages.

Gastroesophageal reflux disease (hiatal hernia & heartburn): Excess weight weakens and overloads the valve at the top of the stomach, allowing stomach acid to escape into the esophagus.

Infertility: Obesity disrupts hormonal cycles and function and can make it difficult to conceive.

Urinary stress incontinence: A large, heavy abdomen relaxes pelvic muscles and weakens the valve on the urinary bladder, causing leakage when coughing, sneezing or laughing.

Data from the [National Health and Nutrition Examination Survey](#) released October 2017 by the CDC show the prevalence of obesity in 2015-2016 was:

- 39.8 percent in adults and 18.5 percent in youth
- Higher among middle-aged adults (42.8 percent) than among younger adults (35.7 percent)
- Higher among non-Hispanic black and Hispanic adults than among non-Hispanic white and Asian adults

Changes in prevalence between 2013-2014 and 2015-2016 were not statistically significant.

According to [The State of Obesity: Better Policies for a Healthier America](#), a collaborative project of the Trust for America's Health and the Robert Wood Johnson Foundation, more than one in three adults are obese:

- Adult obesity rates exceed 35 percent in five states, 30 percent in 25 states and 25 percent in 46 states.
- West Virginia has the highest adult obesity rate (37.7 percent).
- Between 2015 and 2016, the adult obesity rate decreased in Kansas, increased in Colorado, Minnesota, Washington and West Virginia, and remained stable in the rest of the country.
- Colorado has the lowest obesity rate (22.3 percent) and the lowest rate of physical inactivity (15.8 percent).
- Obesity rates are higher among women (40.4 percent) than men (35 percent); women are almost twice as likely to be extremely obese.

Click here to view an [interactive U.S. obesity map](#).

Globally, the U.S. has the highest rate of obesity compared to other countries, followed by Mexico, New Zealand and Hungary. Rates are lowest in Japan and Korea, according to [Obesity Update 2017](#), an Organization for Economic Cooperation and Development (OECD) report. In the last few years, some OECD member countries have responded by combining healthy lifestyle campaigns with fiscal policies designed to discourage access to unhealthy foods. In the U.S., strategies for preventing and addressing obesity include improving nutrition standards in schools and the Child and Adult Care Food Program, and identifying areas with food "insecurity."

Ripple Effects

The *State of Obesity* report cites a number of social issues associated with the U.S. obesity epidemic.

Costs

An estimated \$150 billion in health care costs and billions of dollars in productivity loss are attributed to obesity. Experts say investments in obesity prevention programs provide a significant return for communities, taxpayers and employers, who benefit from having a healthier workforce.

National Security

Obesity impacts military readiness and collectively costs branches of the service about \$1 billion a year. Nearly 25 percent of military service applicants are rejected for exceeding weight or body-fat standards. A healthier population would help improve enlistment rates for otherwise qualified personnel.

Community Safety

Millions of obese and overweight Americans are in public safety positions such as first responders, firefighters and police officers. Firefighters have increased risk for cardiovascular events; police officers have a shorter life expectancy compared with the general population.

Children's Health

Obesity is a child development and academic achievement issue. In addition to physical health impacts, childhood obesity is connected to poor educational performance and increased risk for victimization and depression. Programs that encourage exercise/active play and healthy eating habits have life-long benefits.



Equity

Obesity disproportionately affects low-income and rural communities, as well as certain racial and ethnic groups, including Blacks, Latinos and Native Americans. According to 2008-2010 data, about 33 percent of adults who did not graduate from high school and earned less than \$15,000 a year were obese. Safe outdoor spaces to be active, access to social support networks, education, and affordable, healthy food options are among ways conditions can be improved, experts say.

“The individual decisions people make about eating and activity are not made in a vacuum,” it says in the *State of Obesity* report. “Where families live, learn, work and play all have a major impact on the choices they are able to make. Healthy foods are often more expensive and less available in some neighborhoods, and finding safe, accessible places and having time to be active can be challenging for many.”

Fitness and Nutrition

In addition to helping with weight control, people who have good nutrition and are physically active tend to live longer and have lower risk for heart disease, stroke, diabetes, depression and some cancers. However, surveys of U.S. adults show:

- More than 80 percent do not eat enough vegetables
- More than 70 percent do not eat enough fruit
- Nearly half drink a sugar-sweetened beverage on any given day
- Most people exceed recommended levels of fats, added sugar and sodium

In addition, more than 80 percent of adults and adolescents do not get the recommended amount of physical activity – at least 150 minutes per week of moderate intensity aerobic activity, 75 minutes per week of vigorous activity or a combination of both.

When a 2014 analysis of health survey records showed that Americans were exercising less, a team of Stanford University School of Medicine researchers concluded that inactivity, rather than overeating, is a leading culprit in high obesity rates. Examining national health survey results from 1988 through 2010, they found significant increases in both obesity and inactivity, but not in the overall number of calories consumed.

“What struck us the most was just how dramatic the change in leisure-time physical activity was,” said Uri Ladabaum, M.D., associate professor of gastroenterology and lead author of the study. “Although we cannot draw conclusions about cause and effect from our study, our findings support the notion that exercise and physical activity are important determinants of the trends in obesity.”

The study was published in the [American Journal of Medicine](#) August 2014.

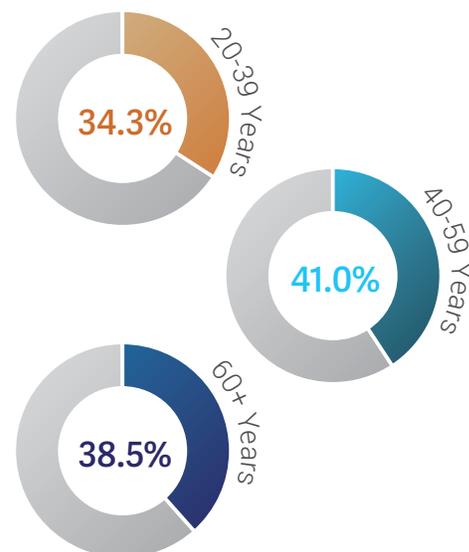
Study Examines Bariatric Surgery Outcomes

Bariatric surgery is recommended only for adults who are morbidly obese (body mass index ≥ 40) or who have severe, comorbid conditions and a BMI of at least 35 after conservative treatments fail. Bariatric surgery typically shortens the digestive tract, reduces stomach size and/or limits absorption of nutrients.

In a newly published study, researchers evaluated outcomes from 9,301 short-term disability cases with a primary diagnosis of morbid obesity. Subjects had one of four types of bariatric surgery: sleeve gastrectomy, adjustable gastric band (lap-band), Roux-en-Y gastric bypass or duodenal switch. The sleeve gastrectomy procedure was found to result in fewer complications, faster healing times and reduced medical costs.

Reference: [Research Brief: A Comparison of Functional Recovery Outcomes Among Bariatric Surgery Patients](#); M Pumilia, K Zaidel; ReedGroup MD Guidelines; ReedGroup Ltd., 2017.

Obesity Rates for Adults by Age



Source: [Centers for Disease Control and Prevention](#)

Solutions

Employers have the opportunity to be part of incremental change when they lead by example, discourage discrimination and avoid assigning blame, experts say. Many companies use health risk assessments to identify at-risk individuals and develop targeted assistance.

Promoting healthy food and beverage choices onsite, supporting disease management efforts, and encouraging employees to get regular exercise and adequate rest are among ways weight management and obesity prevention can become embedded in workplace culture.

An influential 2012 Institute of Medicine (IOM) report, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation*, proposes a strategy focused on making changes in certain environments: schools, physical activity venues, food and beverage establishments, health care institutions and workplaces.

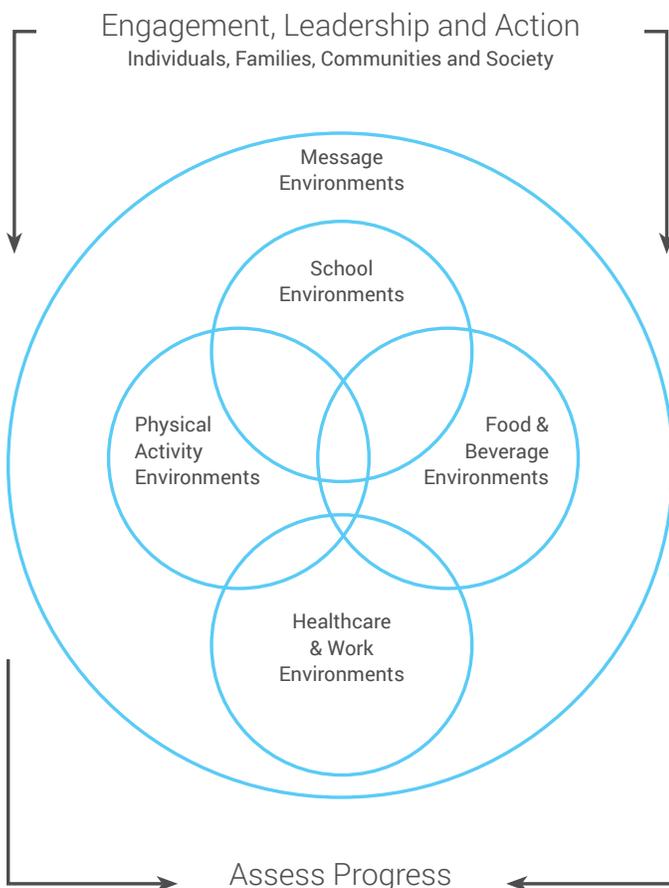


Figure 1: Comprehensive approach of the Committee on Accelerating Progress in Obesity Prevention, Institute of Medicine, 2012

The strategy is built around five basic goals with dozens of sub-categories:

1. Make schools a national focal point for prevention.
2. Make physical activity an integral part of life.
3. Ensure that healthy food and beverage options are the routine, easy choice.
4. Transform messages about the benefits of physical activity and good nutrition.
5. Expand the role of health care providers, insurers and employers in obesity prevention.

What Can Employers Do?

Workplaces of all sizes represent an important venue (Schulte et al., 2008) for reaching the majority of the adult population. Meanwhile, workplace wellness initiatives have been shown to benefit both employers and employees (CDC, 2011). Potential benefits include decreases in chronic disease costs, absenteeism rates and employee turnover, increases in workforce productivity, better morale and improved quality of life.

“In sum, employers, while bearing both the direct medical and indirect productivity costs of obesity, have an opportunity to help increase and promote physical activity, healthy eating, and overall well-being among a large proportion of the adult population,” it says in the IOM report.

The following is a compilation of suggestions for employers from a variety of sources:

1. Create educational opportunities for employees to learn about their risk factors and how to help their children maintain a healthy weight.
2. Ensure that employee and dependent health plans support obesity prevention, screening, diagnosis and care.
3. Consider policies and programs that help make healthy eating and physical activity part of employees’ daily routine.
4. Sponsor onsite BMI screening days and participate in community-wide health improvement events. Be part of the conversation at the local level, assess workforce health risks and leverage resources.
5. Make it fun: Reward employees who volunteer to participate in weight-loss or cooking contests. Create appealing stairways and outdoor paths. Allow employees to walk during meetings.

6. When focusing on nutrition, physical activity or both, use a combination of educational, behavioral health counseling and environmental change strategies.
7. Promote good sleep hygiene and stress management. There is a known correlation between weight gain and sleep loss. Lack of sleep may affect hormones that control hunger urges, while stress triggers the production of hormones that control energy balance and hunger urges.
8. Adopt policies that support healthy weight gain during pregnancy and create conditions suitable for breastfeeding mothers. Studies show that babies who are breastfed for more than three months are less likely to have obesity as adolescents compared with infants who are breastfed for less than three months.

In general, public health officials say wellness programs tend to be more successful when employers:

- Take an integrated approach to occupational health and safety
- Obtain support from senior executives, middle managers and frontline supervisors
- Tailor interventions and incentives to employees' expressed needs and preferences

Legal Considerations

Finally, employers are encouraged to give reasonable consideration to job accommodation requests while

monitoring legal developments with respect to obesity as a protected disability under the Americans with Disabilities Act (ADA) and its amendments.

Generally, non-morbid obesity is not considered a disability because it does not substantially limit an employee's major life activity. However, the Equal Employment Opportunity Commission, which enforces ADA discrimination provisions, views morbid obesity as a protected disability. (An individual is considered morbidly obese if he or she is 100 pounds over his/her ideal body weight, has a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions such as high blood pressure or diabetes.)

Meanwhile, some courts have held that morbid obesity in the absence of an underlying physiological condition is not protected. For example, in a 2016 ruling, the Eighth Circuit Court of Appeals found it is not a disability unless it is also a "physical impairment" and characterized as a "physiological disorder or condition . . . affecting one or more major body systems." (*Morriss v. BNSF Railway Co.*)

Companies must also consider individual state laws. Some states prohibit discrimination based on clinically diagnosed, actual or perceived obesity, or require employers to accommodate employees to enable them to perform the essential job functions. Employers also need to be mindful of protecting employees from harassment or exposure to hostile work environments.

For additional suggestions, refer to the CDC's [Workplace Health Promotions](#) website. ●



STUDY EXAMINES WORKERS' COMP BENEFITS, COSTS

*A newly released National Academy of Social Insurance report, **Workers' Compensation: Benefits, Coverage, and Costs**, suggests workplaces are getting safer. Meanwhile, medical benefits continue to comprise an increasing share of total workers' compensation benefits, rising from 29 percent in 1980 to more than 50 percent in 2015, the most recent year from which data are available.*



The annual report is used to inform policymaking and facilitate comparisons with other social insurance and employee benefit programs. In 2015, workers' compensation covered an estimated 135.6 million U.S. workers, an increase of 7.7 percent since 2011.

The academy reports \$61.9 billion in total benefits were paid in 2015, up 0.7 percent from 2011. Benefits declined 1.4 percent from 2013 to 2015. In addition, relative to workers' compensation:

- Total costs to employers increased sharply between 2011 and 2015, but costs as a percentage of covered wages only slightly increased
- Employer costs per \$100 of payroll were \$1.32 in 2015, the fourth lowest level since 1980
- Total benefits paid were 86 cents per \$100 of covered wages, a 15-cent decrease since 2011
- Medical and non-medical benefits were each 43 cents per \$100 in covered wages in 2015
- Workers' compensation benefits per \$100 of covered wages decreased in most states
- Employer costs per \$100 of covered wages decreased in 27 states and increased in 24 states

Christopher McLaren, senior researcher at the academy and lead author of the report, said changes in some state workers' compensation medical care delivery systems may influence results.

Workers' Compensation Basics

The National Academy of Social Insurance's 2017 report on workers' compensation benefits, coverage and costs includes a primer on the workers' compensation system.

Generally speaking, the academy explains, workers' compensation pays 100 percent of medical costs for injured workers and cash benefits for lost work time. Lost-time compensation may be subject to a waiting period (typically three to seven days) and may be waived retroactively if a case involves hospitalization or lengthy absence. Wage-replacement rates vary by state but are, on average, about two-thirds of a worker's pre-injury gross wage.

The three basic types of claims through which injured workers and medical providers may collect benefits are medical-only, temporary disability and permanent disability. The type of claim is determined by injury severity and whether a claim involves an injury-related work absence. Medical-only claims are the most common, while permanent disability claims are the most costly.

Over the last two decades, the ratio of benefits paid to employer costs has ranged from 0.63 (2006) to 0.82 (1999). In 2015, the benefit-to-cost ratio was 0.65. Between 2011 and 2015, the ratio declined 16.7 percent, the academy reports.

Estimates of workers' compensation benefits in the academy's report reflect amounts paid for work-related injuries and illnesses in a calendar year, the time period commonly used when reporting data on social insurance programs, private employee benefits and other income security programs. By comparison, accident year incurred losses (or incurred benefits) is the commonly used reporting measure for private workers' compensation insurers and some state funds.

Incurred benefits measure the total expected benefits associated with injuries that occur in a particular year, regardless of whether the benefits are paid in that year or future years. The two measures reveal important but different information, according to industry experts.

“Some of the changes involve, for example, implementing fee schedules that set maximum reimbursement rates for medical care or adopting treatment guidelines,” he said. “Many states have also enacted new disability rating procedures and compensability requirements that impact cash benefits paid. All of these factors influence the share of medical benefits, as well as total benefits and costs.”

“Part of the story behind the decline in benefits and costs as a share of payroll is that workplaces are getting safer,” said Marjorie Baldwin, a professor at Arizona State University and co-author of the report. “Both the incidence and severity of work-related injuries have declined steadily since 1990. In fact, according to the Department of Labor, the proportion of workers who experienced injuries that resulted in days away from work reached a 25-year low in 2015.”

Another factor that may affect workers’ compensation costs is that many employers are taking steps to intervene early and better manage injuries when they occur – before they become a claim, industry observers at WorkCare suggest. As an illustration, they cite WorkCare’s 24-hour Incident Intervention contact center staffed by occupational physicians and nurses who managed nearly 35,000 work-related injury cases in 2016. Among all cases, 76 percent resulted in self-care at the first-aid level and return to work, while just 2 percent involved medical treatment with lost work time. ●

MEDICAL COST TRENDS REFLECT STATE CHANGES

Several states have observed decreases in medical payments per workers’ compensation claim, according to [CompScope™ Medical Benchmarks, 18th Edition](#), a newly released collection of reports from the Workers’ Compensation Research Institute (WCRI).

For example, among 18 states, data for injuries occurring mainly in 2010 to 2015 showed medical payments per claim decreased 6 percent per year from 2013 through 2015 in North Carolina – more than in any of the other study states – largely reflecting the effects of fee schedule changes. Indiana experienced a 10 percent decrease following the adoption of a hospital fee schedule in 2014.

In California, claims with more than seven days of lost time decreased steadily after the enactment of reform legislation in 2013.

Comp Scope reports are used to:

- Help identify changes over time in the provision of workers’ compensation medical care
- Compare medical payments per claim, prices or utilization among states with similar claims
- Reveal areas where legislative changes or state systems may impact cost or service delivery

More on Cost Trends

Barry Lipton, practice leader and senior actuary at the National Council on Compensation Insurance, gave a presentation on [Medical Cost Trends Then and Now \(PDF\)](#) at the council’s Annual Issues Symposium (2017).

Lipton analyzes workers’ compensation costs in relation to factors such as the use of fee schedules, medical provider networks and Medicare set-asides; hospital expenditures; and drug/opioid prescription rates. Influential trends include:

- At least 44 states using physician fee schedules
- Increases in provider network penetration
- Rising hospital costs
- Declining opioid medication utilization rates
- Less time spent processing Medicare set-asides

Lipton reports: 1) The average medical cost per lost-time claim has gradually increased from about \$9,000 in 1995 to \$29,000 in 2016. 2) The gap between medical cost per lost-time claim and personal health care spending per capita has decreased over time.

Period	Workers’ Comp	Personal Care
1995–2002	9%	6%
2002–2009	6%	5%
2009–2015	1%	3%

Looking ahead, Lipton predicts medical treatment and practices will continue to evolve. He believes new and emerging medical treatments will increase costs in some cases, and in other cases cost-effectively result in safe return to work and full function. Consequently, he suggests the concept of permanent disability will require re-evaluation. ●

DRUG TESTING UPDATE

Federal Workplace, Commercial Driver Regulations Undergoing Changes

Revised Mandatory Guidelines that apply to federal workplace urine drug testing programs became effective Oct. 1, 2017.

The guidelines expand screening for illicit opioid use among federal employees in safety-sensitive positions. Officials say the revised guidelines and related educational efforts will improve workplace safety, especially in national security and public health and safety occupations.

In a related action, federal custody and control forms (CCFs) have been updated. Under the revised guidelines:

1. Federal executive branch agencies are now required to test for four additional Drug Enforcement Agency Schedule II substances (opioids): hydrocodone, hydromorphone, oxycodone and oxymorphone.
2. MDEA has been removed from the list of authorized drugs and added as an initial test analyze.
3. The pH cutoff level has been raised from three to four for identifying urine specimens as adulterated.
4. Medical Review Officer (MRO) re-qualification training and re-examination is required at least every five years after initial certification.
5. Collection of alternate specimen (e.g., oral fluid) is allowed with MRO authorization when a donor is unable to provide a sufficient amount of urine at the collection site.

The revised guidelines do not apply to specimens submitted for testing under U.S. Department of Transportation (DOT) Procedures for Transportation Workplace Drug and Alcohol Testing Programs (49 CFR, Part 40).

Custody and Control Form

The Office of Management and Budget (OMB) has approved use of a revised federal CCF, which essentially links testing changes with required testing specimen documentation. The new federal CCF may be used in a paper or electronic format, or a combination of both. For those using the paper version, industry experts recommend transitioning to the electronic format when adopting the new form.

The OMB will allow continued use of the 2014 federal CCF without the four additional Schedule II substances until June 30, 2018. As of July 1, 2018, the updated CCF must be used for federally regulated specimens; testing laboratories will be required to treat use of the 2014 version of the federal CCF as a correctable discrepancy.

DOT-regulated employers and their service agents (collectors, laboratories, MROs) are directed to continue using the “old” CCF until further notice because the agency has not yet enacted proposed drug testing rule changes to achieve parity with the revised guidelines.



To learn more, refer to WorkCare’s Fact Sheet: [Federal Drug-free Workplace Mandatory Testing Guidelines](#)

Tracking Commercial Drivers Who Violate Rules

The Federal Motor Carrier Safety Administration (FMCSA) has amended regulations to establish requirements for use of the Commercial Driver’s License Drug and Alcohol Clearinghouse, a national database that will operate under its jurisdiction. The rule took effect Jan. 4, 2017, with a compliance date of Jan. 6, 2020, to allow time for implementation.

The clearinghouse will be used to maintain records of federal drug and alcohol program violations in an accessible, centralized repository. Employers will be required to query the system to determine whether current and prospective employees have incurred a drug or alcohol violation that would prohibit them from performing safety-sensitive functions under FMCSA and DOT regulations.

Commercial drivers who violate drug and alcohol regulations are required to complete a return-to-duty process – including a professional evaluation and a recommended education or treatment program – before an employer may allow them to operate a truck, bus or other commercial motor vehicle on public roads. Records of violations will remain in the clearinghouse for five years, or until a driver has completed the return-to-duty process.



To learn more, refer to WorkCare’s Fact Sheet on [Tracking Commercial Drivers Who Violate Rules](#). ●

CLINICAL CONVERSATIONS

Sleep Apnea Risk High Among Drivers

An analysis of data from 16 studies suggests 41 percent of commercial drivers may have obstructive sleep apnea (OSA) – a rate nearly twice as high as it is for non-obese men in the general population. Further analysis of a select group of studies estimated a 35 percent rate of mild OSA in commercial drivers and a 12 percent rate of moderate to severe OSA.

Data from eight studies suggested a possible increase in OSA risk in occupations where workers are exposed to solvents, although this risk could not be statistically confirmed. A handful of other studies suggested possible increases in OSA among railroad employees, shift workers and World Trade Center disaster responders.

OSA is a common condition, but little is known about possible occupational factors associated with it. Researchers noted that commercial drivers may have elevated risk for OSA in relation to factors such as stress, obesity, hypertension and sleep disturbances.

“Pending more definitive data, clinicians should take into account occupational factors in considering sleep disorders and OSA, which carry significant associated costs from comorbidities and occupational disability,” researchers concluded.

Reference: Occupation and Obstructive Sleep Apnea: A Meta-Analysis; DA Schwartz, D Vinnikov, PD Blanc; [Journal of Occupational and Environmental Medicine](#), Vol. 59, No. 6, June 2017.

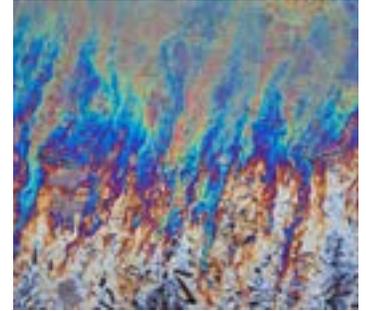
Proposed OSA Rule Withdrawn

An advance notice of proposed rulemaking on OSA was withdrawn by the Federal Motor Carrier Safety Administration (FMCSA) and the Federal Railroad Administration. The rule, Evaluation of Safety Sensitive Personnel for Moderate-to-Severe Obstructive Sleep Apnea, was proposed in response to OSA-related transportation incidents and crashes.

Under current regulations, OSA is defined as a “respiratory dysfunction.” When it is considered severe enough to be likely to interfere with safe operation, a qualified medical examiner may exercise his or her clinical judgment when deciding whether to issue a medical certificate to a driver, and for how long. Successfully treated drivers with OSA may regain their “medically-qualified-to-drive” status.

Oil Spill Dispersant Health Effects Studied

Workers who were likely exposed to dispersants while cleaning up the 2010 Deepwater Horizon oil spill experienced a range of health symptoms, according to scientists at the National Institutes of Health (NIH). A research team found that exposed workers were more likely to experience certain symptoms – cough, wheeze, tightness in the chest, and burning in the eyes, nose, throat or lungs – than those who were not exposed to dispersants.



One of the challenges the researchers faced was determining whether health effects were associated with the dispersants or petroleum products from the spill. Oil dispersants are a blend of chemical compounds used to break oil slicks into smaller drops of oil. Individuals who handled dispersants, worked near where dispersants were applied or had contact with dispersant equipment were included in the study.

Reference: Respiratory, dermal and eye irritation symptoms associated with Corexit EC9527A/EC9500A following the Deepwater Horizon oil spill: findings from the [GuLF STUDY](#); CJ McGowan CJ, et al.; *Environmental Health Perspect*; Sept. 15, 2017 (online).

Nurse Exposures: Safety Perceptions Matter

About 14 percent of nurses treating cancer patients reported experiencing an adverse event (spills/leak or skin contact with chemotherapy drugs) during the previous week in a survey conducted by the [National Institute for Occupational Safety and Health](#). Survey responses suggest that perceptions of workplace climate and management commitment to safety reduce exposures and contribute to more consistent use of engineering controls and personal protective equipment.

Survey responses also emphasized the value of training and implementing a comprehensive occupational health program that effectively communicates the importance of safe handling practices. Adverse events were associated with work environment (e.g., not-for-profit v. for-profit institutions) and job demands such as increased numbers of liquid antineoplastic drug treatments and administrations on more days of the week. ●

Reference: Effects of organizational safety practices and perceived safety climate on PPE usage, engineering controls and adverse events involving liquid antineoplastic drugs among nurses; [Journal of Occupational and Environmental Hygiene](#), Vol. 14, Issue 7, July 2017.

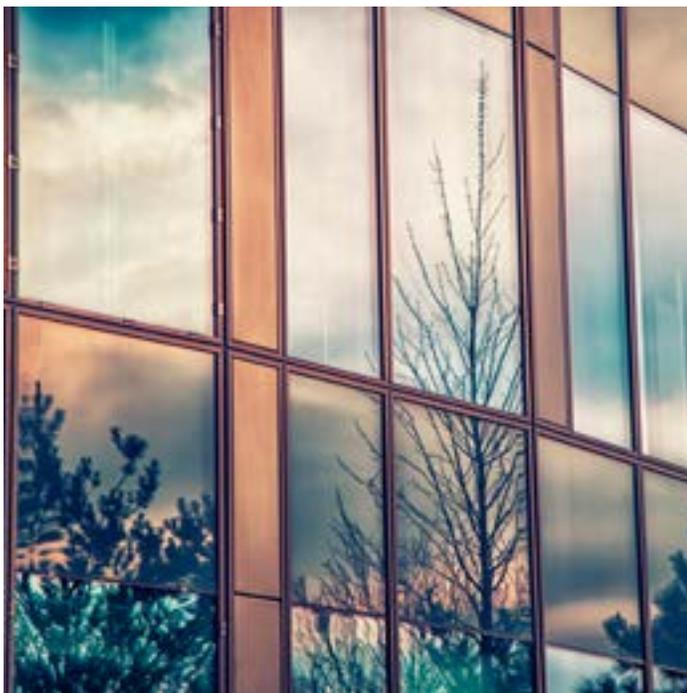
HEALTH, SAFETY METRICS LACKING IN SUSTAINABILITY

There is a need for more detailed and standardized reporting in relation to corporate sustainability practices and occupational health and safety (OH&S) performance, according to a new report from the Center for Safety & Health Sustainability (CSHS).

In its analysis, the center provides insight into how organizations identified by *Corporate Knights* as “Global 100 Most Sustainable Corporations in the World” publicly disclose information on OH&S-related performance indicators and how reported information:

- Helps provide an understanding of actual OH&S performance
- Lends itself to comparisons across organizations

In essence, the report suggests definitive standards are needed: “A compelling case can be made that voluntary ‘sustainability’ or ‘social responsibility’ corporate reporting schemes have failed to yield the kind of comprehensive and meaningful data needed by key stakeholders.”



Sources used for the study include the Global Reporting Initiative (GRI) sustainability reporting framework (version G4 Labor Aspects 5-8) and CSHS metrics. The findings will be combined with a 2013 study on sustainability reporting and used by international standards development organizations.

Recommendations contained in the report include:

1. Using two leading indicators to measure whether systems are in place to effectively manage employee health and safety – the percentage of owned or leased work locations that have:
 - Implemented an OH&S management system that meets recognized standards
 - Had their OH&S management systems audited by an independent third party
2. Identifying one or more indicators that measure OH&S performance in the supply chain.
3. Reporting the percentage of direct or first-tier suppliers' facilities in developing countries that were audited for compliance with health and safety standards. Suppliers in developing countries are especially vulnerable to OH&S risks.
4. Selecting specific formulas to be used in reporting data. It is sometimes a complex process, especially for stakeholders who are less familiar with the OH&S field.
5. Simplifying definitions. GRI uses nine terms to identify the parties relevant to injury and illness reporting. This adds an unnecessary level of complexity to the reporting process.
6. Directing organizations to use performance criteria that only award sustainability rankings to organizations that report on their work-related fatalities and show an improving trend.

CSHS was founded in 2011 to help shape global safety, health and sustainability policies. Its board is comprised of representatives from the American Society of Safety Engineers, American Industrial Hygiene Association, Canadian Society of Safety Engineers and Institute of Occupational Safety and Health (United Kingdom). Advisory council members include representatives from industry, government and technology. ●

Reference: *The Need for Standardized Sustainability Reporting Practices: Issues Relating to Corporate Disclosure of Information on Occupational Health & Safety Performance*; a report from the Center for Safety & Health Sustainability; August 2017.

HOLIDAY FOOD SAFETY

With the holidays approaching, it's time to send out reminders about food safety.



Potluck!

It's fun to try different types of food employees prepare at home, but precautions should be taken to decrease the risk of foodborne illness:

- Refrigerate perishable foods within two hours of purchasing or cooking.
- Wash your hands before preparing food. Don't cook for others if you or a family member are ill.
- Avoid handling foods with bare hands and do not taste with the same utensils you use to stir.
- For cold, mixed dishes allow ingredients to cool before mixing them together. Store mixed, cold salads at 40°F or lower. Keep hot foods at 140°F or above.
- When transporting prepared food, store cold dishes in an insulated cooler with ice or gel packs. For hot foods, use an insulated container such as a crock pot wrapped in paper bags. Wrap casserole dishes in aluminum foil.
- When serving, keep surfaces clean and provide plenty of long-handled utensils so people can avoid touching the food. Separate raw foods from cooked and ready-to-eat foods.
- After the party, discard any food that was left in the temperature "danger zone" (40°F-140°F) for more than two hours (more than one hour outdoors on a hot day). Immediately place leftovers in the refrigerator or freezer.

Talking Turkey

- Buy a fresh turkey one or two days before cooking it. If unthawing a frozen turkey, follow directions to unthaw it in the refrigerator, cold water or microwave oven. Don't leave it sitting out overnight.
- When handling raw poultry, wash hands, utensils, the sink and anything else that comes in contact with parts and juices with soap and hot water.
- Check the internal temperature while cooking. Place an oven-proof thermometer in the thickest part of the inner thigh. Before serving, check the wing and the thickest part of the breast to ensure the turkey has reached a safe minimum internal temperature of 165°F.
- Discard any turkey, stuffing and gravy left out at room temperature longer than two hours. Divide leftovers into small portions and refrigerate or freeze in covered, shallow containers. Use refrigerated turkey, stuffing and gravy within four days. If freezing leftovers, use them within six months. ●

Source: U.S. Department of Agriculture

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