

Thursday September 26, 2013

**Karen Mulloy moderated a session on working with our Tribal partners.**

**Max Kiefer** talked about the activities of the Western States Office as part of the AI/AN Initiative including describing Action Plan, canvassing NIOSH, meeting with Tribal Representatives, collecting baseline data, performing research, and giving presentations. In the future, they plan to visit the Navajo Nation OSHA, present at North Dakota Environmental Justice Meeting, write publications, partnership with NCEH/ATSDR, attend meetings, and refine action plan. Their main pilot project is to see how the occupational health world can best interact with Navajo committees, especially with Navajo OSHA.

**Discussion:** How are you refining the action plan? Max gave more detail on the action plan, including that they hold periodic meetings to discuss progress and stay on track.

It seems like chronic disease and injury are problems in AI/AN communities, maybe this is similar to Total Worker Health (Total Worker Health) model, where occupational health is lower down in their priorities, but because the work place effects other chronic health problems there is interest. Recently was a diabetes prevention training for tribal members, to become lifestyle coaches, to get people together in groups, not just giving curriculum, but bring in culture into the classes, so can bring prevention in – then talk about Total Worker Health, is interesting opportunity. Chronic Disease group at Tribal Health has done Total Worker Health stuff too.

You are capturing injury data, but are you capturing disease data? Main focus in the mining industry – disease may be more important. Have no data on that, but agree that we would like to capture disease as well.

**Delight Satter** spoke about how we do not have enough people in official positions working on native public health (her office can't do it all!) We needed to build infrastructure, it was fragmented, and so we are building our infrastructure to make sure that tribe research is there and it is getting more integrated. We need every person in the room to ask for more native people in our conferences, as fellows, in graduate programs, studying public health. Recruit native people! She had done critical work of working to return specimens collected from AI/AN participants to the tribes.

**Discussion:** Occupational health makes an arbitrary distinction between occupational and environmental health, but in tribal health, are we merging? CDC has merged ATSDR and NCEH, rocky mountain spotted fever is an example where occupational and environmental health are integrated, no animal control in workplace, and so there is an environmental hazard. But what about NIEHS and NIOSH – oil and gas, occupational and environmental are addressed together – if we control worker exposure at the source, then there is an intuitive benefit to community, can we quantify it. Also, naturally occurring asbestos.

In addition, Health Resources and Services Administration (HRSA) funded a radiation screening program and many grantees are Native American, including communities in Flagstaff, Spokane, Navajo. This is an example of occupational safety and health, even if it isn't sorted that way at CDC and federal government.

We don't have data about improvements to occupational health in these communities, and only limited data in chronic disease data. Crossover between occupational health and chronic disease is all considered successes because it is capacity building. Even if there isn't an improvement in diabetes rate, capacity building is a success. We can't even measure diabetes rate reductions in native communities. We have had success in funded activities, but chronic disease has more data. Success is working with tribal council to get them to understand risks, it isn't necessarily a p-value.

In California you said there is a tribe being funded, but are tribes interested in occupational health? How would I know that? Could we have a webpage or topic page, or curriculum, so we could send it out and does it need to be tailored to each tribe? (Don't worry, Bob, it will be okay.) California has the hugest population of tribes, but 70% don't live on reservations, there are lots of urban tribes, and there are lots of partners. Contact Christina Perez and Herb Shultz, who have a huge urban Indian programs also Friendship house, American Indian Health Centers. Are there models of Occupational health? We work with Navajo because they have infrastructure – they have provided some support for the combination of tribes. USDA has a dedicated group.

“If you've seen one tribe, you've seen one.” The more you meet tribes the more you recognize the similarities and differences. Navajo is very unique because it is such a large land base. In California they are mainly from south of San Luis Obispo. In San Diego there are two cousin tribes who work together. And the tribe themselves can adapt the information, they want the science. No one on the Navajo reservation thinks you are Navajo, they want to know who you are, and they will do the cultural translation.

Also, another avenue is the Tribal Epidemiology Centers – housed and funded under Indian Health Services (IHS) are twelve 'area techs' who have relationships with tribes. Because of CDC and ATSDR relationships, there is now a connection there. I've come to a national meeting, where a lot of people say a lot of things about Navajo, but Navajo don't know that is what is being said about Navajo. We should be able to know what all the funding sources are, and how do we use that collaboratively. There are a lot of health disparities in the tribe, and we need to build that understanding up within our tribe. I agree, you meet one, you've met one. We are all different in government structure, and the best advice is to be respectful. It is a government to government relationship. Tip: for nubes for working with tribes, pretend in your mind you are going to another country. Are there forms I need to fill out, is there a different mindset of diplomacy. Native American Research Centers for Health (NARCH) is another group, there is a NARCH in S. California. There is an infrastructure to connect into, once you are ready. Also there is the California Health Interview Survey (CHIS), if you want to do data analysis, which over-sampled Native Americans in 2001 and 2010. It is the largest sample of native people– you could do some GIS linking, and some stuff with combining data sources.

## **Ken Scott moderated a session on pilot projects**

**Tracy Miller** spoke about the oil boom that has happened in the upper northwest region of North Dakota. The state and region are greatly changed by oil and gas, and public health and safety are affected but **none** of the money gained from taxing the new revenue goes to occupational health. There are more workers and more workers' compensation claims, but the rate has stayed the same. The highest rates are in the youngest age group in 2012. Most work place fatalities are caused by motor vehicles, which makes sense because oil and gas has brought lots of large vehicles and lots of drivers who do not have experience with driving in the inclement weather.

**Discussion:** Would have guess that the same thing applies in Texas, who also has an oil and gas boom, except that Texas doesn't have the same weather issues. There is funding being released for pilot projects from Eagle Ford. They are a hospital agency that spend two days in North Dakota looking at the impact on health care, and found that people are waiting for 3-6 months for immunizations. North Dakotans not in oil and gas are affected as well because there is such an opportunity to make a ton of money, many leave other jobs, and minimum wages at places like McDonalds and Wal Mart are continuously rising but cannot keep employees.

Are you engaged with industry? Do you look at exposures? We are just scratching the surface with trying to engage with commerce. OSHA and NIOSH need to get more data because it is hard to use workers' compensation data. We just got a school of public health in North Dakota, so are hoping to recruit MPH students to do a practicum at our department, and also do a Community Assessment for Public Health Emergency Response (CASPER)

In Wyoming, the governor did a press release about the high workplace fatality rate, which also was fueled by lots of transportation fatalities. You can possibly use the stop-work authority. In Wyoming, he reports CFOI data as a line list of fatalities, which shows a better picture of how the fatalities happened.

**Dave Bonauto** shared information about the Washington Department of Labor and Industries pilot project using workers' compensation data and claim rates to create incentives for primary prevention of occupational injury and illness, and shared some of the data pitfalls. Non-mechanized logging has a much higher claim rates than mechanized logging. In non-mechanized logging, the incidence is going up, as is the hospitalization rate. Lots of people in the industry use subcontractors and contractors to shift responsibility for workplace injury to lowest level employer. Pilot project is the logging safety initiative (LSI) accord. People in the logging industry will not hire non-LSI individuals, to make sure that people are reporting correctly and are trained. Used information from West Virginia Logging Safety Initiative, and also British Columbia as a guideline. Sent out premium auditors, and then had requirement of DOSH safety consultation, notify of work location within 48 hours, and documentation. If a company complies for 6 months, there is a 3<sup>rd</sup> party audit, and if pass they get a premium deduction.

**Discussion:** How big is the non-mechanized logging industry? Also, you talked about instituting a “safety culture” but used the word safety culture incorrectly, because enforcement is not part of “safety culture.” This is a unique industry, but is there really a movement to develop a culture, even if there is also enforcement. There are about 435 full-time equivalent (FTE) workers in non mechanized, more than 1000 in mechanized. Maybe I used “safety culture” wrong, but large landowners have different relationships than in other industries: they audit their contractors, look at PPE, go through the steps, and now they are interested in safety (they weren’t before) so yes, it is being “beat into them” but they are learning, and augmenting how the contractor is viewing safety. Before there was no accident investigation, now there are near-miss reports. Employees now know they need to demonstrate safe work practice. Deb Sahar would say “safety culture” it is the number of times the supervisor talks about safety – there doesn’t need to be an audit, they just need to talk about it.

Did you wear a green hat when you worked as a choker? You can easily pick out government employees working among loggers. Experience rating across industry, or do you go by individual employers? Using subcontractors, does that expose the high level company to tort vs. workers comp and make it more expensive? Prime contractor liability was a blanket approach, they were invited to come to a workshop – then sign up for “voluntary” audit. Instructed land owners that they couldn’t shield themselves from non-payment. Largest land owners subcontract out. Each one is an independent contractor, \$40K in insurance comp premiums, none of them are paying. We have the legal authority to collect from primary contractor, and this is a BIG stick. Experience modification is at the individual company level – if you are safer relative to your peers, you only pay a fraction of premium. It doesn’t work well in this industry because there are a lot of small employers, and so experience modification is very fragile. When you are in multiple different risk classifications, there are different accounts, and so experience modification can incentives safety.

Are companies also under reporting injuries? And tell us more about underreporting of hours. They don’t report small injuries (no MSD, no minor cuts). It is all half-your-leg-is-cut-off, and since these are hard injuries to ignore, they aren’t underreported. There is no such thing as an independent contractor in logging by federal law or Washington law (a guy with a giant saw being told to cut down a tree isn’t an independent contractor), so when people who said they were independent contractors get injured they then say, “Wait a sec... I am not an independent contractor.” They reevaluate the employee/employer relationship, and then they end up in numerator and are not in the denominator.

Free wheeling idea – ways of using pop culture, tweeting, texting, etc., and there is lots of stuff on TV, someone needs to be getting at photo novellas to get ideas about health and safety into these TV programs. We hate Axe-men. There was an interesting OSHA investigation, and someone on the show was supposed to be on long-term disability, and so they subpoenaed all the video tape, and now company isn’t in business anymore.

“In Anchorage we’ve stopped doing surveillance because we just turn on TV to see what is happening in fishing.” I have issues with Deadly Catch – fisherman don’t watch it, Pilots don’t watch it, loggers don’t watch it, I’ve thought about capitalizing on that but I don’t think workers in the industry actually watch those shows about dangerous jobs.

### **Kent Anger moderated a session on Total Worker Health**

**Brenda Schmitt**, founder and CEO of Viridian Health Management talked about how Viridian had a history in Total Worker Health before it was Total Worker Health. They worked in hard to reach industries with diverse populations. First client was Pilgrim’s Pride, who had Occupational clinic that mostly did amputations. They won a CDC healthy implementation program grant. We don’t call it wellness, because I take my dog to the vet and they say, ‘do you want to join a wellness program’ we call it worksite health. Comprehensive means you assess, plan, and then evaluate. Only 12% are actually doing comprehensive. We are trying to make it so that someone can go to the website and find all information they need.

Eric Dinenburg the Chief Medical Officer of Viridian discussed the occupational health perspective within Total Worker Health. Coaches are equipped with chronic stuff (tobacco, diabetes...) We could add health promotion to any occupational health programs.

**Discussion:** What about selection bias, 70% of employers chose to participate, are those the ones who will benefit. We think Total Worker Health is the way to go, and we have evidence based solutions. We have a benefit sheet showing benefits for employers and employees. Total Worker Health affiliates program, which plays by certain rules, and I think that will lead to standardization. What about bigger companies, can we have preferable status with vendors to add incentives to participate.

**Chi-Chia Chang** led us in the physical activity song “Bring Back my Bonnie.” She advocated taking an integrated approach, there is a lot of potential to work with health promotion. It is necessary to demonstrate leadership commitment, instill a “culture of health”, integrate systems, programs, and policies, and engage employees. Went over the Whole Worker Planning Worksheet. If we stood up each time Chia-Chia said “integrated” we would have had a better workout than the opening song.

**Discussion:** Integrating work safety and prevention, but our roots in epidemiology are in infectious disease. Are we missing opportunities if we don’t provide flu shots and TDap, and advocate hand washing and preventing norovirus.

We often find that an employer’s perspective and employee’s perspective are very different. So, we get funding to do immunizations and not suicide prevention. So how do you balance funding? Develop relationships, apply for funding for what they think are important.

Money talks. How we structure delivery of services when 90% of Occupational physicians are paid for by workers' compensation. Finally, uncoupling of insurance/health delivery and family health. Finally, money talks, is there money in doing this, or regulation or certification? A long term goal of our clinical centers of excellence, to certify people, and also from a corporate setting include worker safety and Total Worker Health in certification.

Bob says read June 2013 final regulations under ACA to understand incentives for participation in employer healthcare services. There are two programs. Those regulations don't say anything about work environment or worker health. Beginning in January, there will be lots of people promoting plans, and the extent to which they are supported by data, is questionable. We need to know where we can add data. But, it doesn't have anything to do with occupational health as we think of it.

**Lili Teney** spoke about new aspects to Total Worker Health including social media. She shared a video from Health Links Colorado. The take home message: it is simple. Collaborating with business, launched website. Trying to communicate three messages: get informed, get certified, get funded, get connected. We are becoming small business consultants, and want to identify some of the issues that business community talk about. Knocking on the door helps with employers in the small businesses to embrace message, and then we can send web resources.

**Discussion:** I get hopeful and excited for the health of the workforce, but worry that it is more focused on health promotion than health protection. Because people at risk are the ones that are harder to reach, and so how is this part of the conversations? Who are the employers you work with? Are there high-risk employers? We acknowledge this is an issue. We have had companies that have high-risk workers, and really have more of a focus on industrial controls. So we have been focusing on intervention. We found that companies w/ truckers were gaining 35-40 lbs in first year, and so added the health promotion.

Do you take other indicators than Body Mass Index (BMI), A1C, blood pressure, so people can see over time if their health indicators are increasing or decreasing? Are you using that data? Our focus is at employer level, so we aren't collecting biometric data. It is why we partner with the American Heart Association (AHA), because they will offer it. And that is offered sometimes, and at health fairs. Hopefully we will be able to look at that, but that is a huge thing.

The marketing is great. Website, video, love it. Like that it is non-threatening, however "put up a sign" might not be the best way to represent preventing workplace injuries. I have never had enough funding in any NIOSH grant on how to do the web development, but yours is great. Our start-up development went into that, and was supported because we have Lee, a business owner, and he acknowledged that a program like this needs a webpage. That was the focus of this project, and the funding came from outside, from a WC carrier. Business community wanted to do this, they funded it.

What about translation – how are you reaching underserved populations and those who don't speak English. That was one of our initial goals, how do we reach low income, Latino owned businesses? We are working with MiKasa and the Latino Chamber of Commerce. We are doing a survey. We will offer some stuff in Spanish, once we figure out what changes need to be made.

One size doesn't fit all for Total Worker Health, you need buy in, especially because the employer and employee perspectives are very different. How do we weigh employee and employer concerns? Very carefully. Case example: company was very enthusiastic about walking program, because they recognized large % of workforce was overweight. But they hadn't done a needs assessment. We provided evidence that before you do this, you should ask what employees think or need. Not sure how you would do that with drug abuse, but we suggest that the first important thing is getting buy-in from employees and management.

About websites – You have all driven us to the website. To each presenter, what does your website do? 1. Health Links: We have social media, which is where new information is. Also we have success stories. And then we have a research center with online resources. 2. Viridian: We manage the CDC website. Training we have, resources including workplace health resources, and then toolkits, and then each community has a community site.

### **Corey Butler moderated a session on Bureau of Labor Statistics Data**

**Jacqueline Midkiff** described what CFOI data can do including investigating: height of falls, fatalities by age, new contractor data, fatalities among AI/AN, nonfatal injuries in AN/AI, injury and illness rates by state (Montana is highest in West), differences between new and experienced workers. Also showed us how to use the profile system to get occupational injury and illness profiles.

**John Myers** is the chief of everything statistics and data. He explained that NIOSH Division of Statistical Research now has all the same CFOI data the BLS has, and so now states can contact him and his office to ask for special runs. This authority was granted in 2013. With hydrofluoric acid and methylene chloride, we couldn't report a lot of information because the numbers aren't big enough. But we had success in sharing the deaths in the construction industry in Louisiana.

**Discussion:** Could we post info that is sent to other states by request? Or make sure that requests are sent out on a list-serve? Probably. Also, tell David B about any hydrofluoric acid deaths. The CFOI request from NIOSH is useful because once you know that CFOI won't help you can look elsewhere for information.

We don't put confidence intervals on rates because CFOI is a census, but we do use confidence intervals when we do Poisson regression.

**Meredith Towle** discussed how the CFOI actually works. Data that we feed to BLS are query able at state level. You can site memorial websites, social media, notes from a phone conversation, or SSN death index to confirm a death. We own data as a state, but once it is entered into the BLS system it becomes BLS data, and we have to be very careful with how to share it. BLS is very picky and strict about “pre-release” and so you can’t actually provide your state back with information about current clusters or trends, even though we have up-to-date information (because BLS owns the data). Illness numbers are stripped from the final numbers those data have been collected but have been screened out. As of 2013 d/n need to collect information about illness deaths.

**Discussion:** Where does info come from? Death Certificates, OSHA, Vital Records, etc, When we receive information about a death we open a file and start looking for confirmation. We have leveraged the needs of the program along with information we have, so that we can collect more info.

What will with illnesses now that you aren’t reporting them? Probably won’t research. They are mostly heart attacks that happen while at work.

BLS is basically buying the info from the states, but if you keep your own reporting system, the numbers don’t jive, and there is no comparison. Many states, like those with FACE systems, have multiple systems. These are the criteria under which we work. Even though now I work very intimately with data, how do I work with the data, because I want to maintain the relationship with BLS, and BLS wants the data to be used.

**Bob Harrison:** There are TONS of palm trees – 100,000’s. In backyard of homeowner, there are palm trees. In California, a tree trimmer died, we put out a fatality report. If a palm tree trimmer clips one too many fronds, the whole ring collapses and the tree trimmer can soffocate. We will do another health alert and a digital story. 1,600 groundskeepers have died since 2003, and 647 were tree trimmers or pruners. It might be easier to look at IMIS data for this. Have to overcome the view that these deaths are freak accidents

**Discussion:** How do you get good distribution? Day labor sites. It matters even if there are only 4 cases.

In LA, you can’t remove white oak trees without certified review, maybe this is a model for palm trees.

Possible to collaborate with Better Business Bureau or Consumer reports.

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**Margaret Kitt** –talked about new things at NIOSH including the data and statistics gateway, current intelligence bulletin about nanotubes, and Emergency Responder Health Monitoring and Surveillance (ERHMS) that has been adopted by the national response team. There is a new Virtual Center for Workers’ Compensation Studies, and Total

Worker Health. Changes in the workplace and workforce make it harder to guarantee that workers voices are heard when we are dealing with an ununionized workforce. The workplace is changing in many ways including job insecurity, extended hours, contingent workers, aging workforce, less unionization.

**Discussion:** Will youth effort be an arm for workplace wellness? Now they are being rolled out as separate initiatives, but enough work to go around, will be interfaced eventually.

Talking Safety has been part of curriculum in Oregon schools. This meeting has been one of the successful meetings we've had across the institute for the last six years. It is definitely worth going.

You said you just spoke to steel workers. What are the steel workers interested in? What was your message to them? Steelworkers are a diverse group – include health care workers, law enforcement, beryllium workers, public sector workers, teachers, so we talked about health hazard evaluation program as a way they can get assistance, changing workplace/workforce, nurses and violence, multigenerational workers and categories – and they liked that a lot. Was told they weren't interested in the "safety culture" conversation, because they didn't want it to seem like workers were blamed for any injury and illness that happened.

**Jennifer Lincoln** told us that fisherman don't watch the deadliest catch! The highest industry fatality rates in Alaska are in commercial fishing, and water and aviation transportation. Alaska Aviation Safety Research Program – 1 in 8 people in Alaska have pilot certificate. Part of the problem was Controlled Flight into Terrain (CFIT) – in 2000 there was an effort to combat problem, we now see both fewer crashes and fewer CFIT crashes. Now working on fatigue prevention project. In fishing, There are more fatal falls overboard than vessel loses, but they don't make the news. Since 200, none of the workers who died by falling overboard have been wearing a personal flotation device. "Why doesn't someone buy a whole bunch of these and ask what we think of them?" New campaign with Angus – livetobesalty.org is an actor. Trying to create Dos Eques guy – but didn't want an obese fisherman, and we didn't want him smoking, we couldn't go against any public health message (excessive drinking, smoking, sex...)

**Discussion:** Are you addressing smoking cessation, drinking? No... We are mostly focused on preventing fatalities.

Great information about hypothermia – it takes 30 minutes, even in 34 degree water for hypothermia to set in. You don't get hypothermia immediately. With flotation, hypothermia is not going to kill people, there is time for the boat to turn around and be rescued.

Simulation – I was on the dock for 3-4 minutes before it was too cold to take it. Fish farming – aquaculture. In Alaska, there are oyster farms, in lower 48 there are places they are farming salmon and other species. We have only looked at wild caught fish, but we

are including aquaculture in goals in NORA sector council. Don't have plans to address in our group.

Most of what you are seeing is people overboard. Is it accidents or weather? Is there a point where you can't go out to sea because the weather is so bad? Operator chooses, but sometimes there is pressure to go out. About half of falls overboard are unwitnessed because they are on deck alone or on vessel alone. 30% are pulled overboard by gear. Sometimes people go overboard, get back on board, and then die. Sometimes they go overboard, and the crew gets back to them, and can't get them on board.

Did you ask about race/ethnicity in commercial fishing, English as first language, or multiple languages being spoken? 8 different languages spoken on vessel. All workers need to know where to muster, also general work practices and safety – making sure that people who speak different languages get information.

**Scott Laney** discussed the Spokane Mining Initiative. Focus is on metal and non-metal mines. Miner age is increasing, and the younger workforce is coming in untrained. Interested in MSDs and aging workforce, coordination with total worker health and miner safety.

**Discussion:** Metal or non metal mines – naturally occurring radioactive material is in certain places. We are taking the approach to deal with this who want to deal with us, convenience sample. We won't be able to take stratified sample in non-metal mines. Need more work to understand non-metal mine hazards.

Why not coal? We are good at coal – we have a mobile medical unit, we have a nationally recognized program, we have staff, we have outreach, we understand coal. But we don't know as much about non-metal metal mining – this is the first research to do this.

Shift work and drug problems among coal miners are related; workers have long shifts and so they needed to get sleep aids. Are you collecting info or have recommendations about how to deal with shift work and sleep problems? Data we have on that is that the mining workforce has declined and productivity has increased. One way to make sense of that is technology – need fewer people, other is man hours worked, It used to be with unionization you had 38-40 hour week, now people work 80 hour week and people are loaded with work and cannot clear their system. There is anecdotal stories about drug problems, but we don't research this. We are really interested in pneumococcal, and if we ask about drug analysis or urine we don't ask because then we don't get participation.

Exposures like particulate, noise, and sedentary lifestyle all contribute to cardiovascular disease, but that info isn't in workers' compensation, it is in health insurance data. How do you access that data? We are aware of that, and also how to do cardiovascular disease assessment in the field. We would like to do more analysis, but often physicians don't even know the occupation of people they see. We want to go to large community of miners. Electronic Health Records are one of the things that NIOSH is actively involved

in. We are hoping that I&O is in the basic health record. And once you have that, all of those problems will be easier to deal with.

### **Rebecca Jackson moderated a session on investigating occupational disease**

**Mike Van Dyke** discusses occupational exposures in marijuana grow houses, specifically to law enforcement responders and children living where marijuana is being grown.

**Derry Stover** reported on the results from an investigation into histoplasmosis among day camp counselors.

**Jason Wilken** shared information about three investigations of coccidioidomycosis in California, one among construction workers, one in a TV shooting, and one at a solar farm. He described the surveillance system that was developed to help identify and investigate outbreaks.

### **End of meeting comments:**

- Lesson about understanding the needs of workers and using expertise and knowledge to address needs so it ends up as a win-win situation.
- I wonder/suggest if next year is there a possibility that we could bring in someone from industry to come in. We are talking to the converted, it would be nice to here from the sinners. We talked to them, these are the benefits we saw, here is the effort and reward – so we could have perspective on how occupational health has improved their workplace.
- Networking is phenomenal – breakout workgroup sessions. We go home and urgent trumps important. Comments in previous years that by going to breakouts people missed out on discussions, and people want to give talks.
- We have gotten most of our ideas from you guys because we go through these and we don't start officially planning for a couple of months. So let us know! We want to make sure it is still a place people want to return.