

DHR HEALTH & SAFETY NEWSLETTER

Spring 2018



The DHR Workers' Compensation Division is in the process of implementing many new regulatory changes, including the launch of our new Pharmacy Benefit Network to streamline and speed prescription drugs to work-injured employees. Changes include heightened oversight of opioid medications, so we are pleased to feature the following article by Douglas Benner, MD, Chief Medical Officer of EK Health.

Peggy Sugarman, DHR Workers' Compensation Director

STEMMING THE OPIOID CRISIS IN WORKERS' COMPENSATION



For years, physicians have been directed to provide pain relief to their patients despite the addictive nature of opiates. Slowly, the opioid crisis grew and is now a topic of conversation throughout the United States because of the risk of adverse events, including overdose and death. Accordingly, the State of California Division of Workers' Compensation has updated their guidance to treating physicians when it comes to treating pain.

The new regulations state: "Routine opioid use is strongly **not recommended** for treatment of non-severe acute pain (e.g., low back pain, sprains, or minor injury without signs of tissue damage.)" Opioids are only recommended for treatment of acute severe pain (e.g. crush injuries, large burns, severe fractures, injury with significant tissue damage) when not controlled by other agents such as Non-Steroidal Anti-Inflammatory Drugs (NSAIDs, such as Ibuprofen) and Acetaminophen.

The guidelines further state that the NSAIDs and Acetaminophen should nearly always be the primary treatment and should accompany any opioid prescription. When opioids are needed for acute severe pain, physicians are required to prescribe them at lowest possible dose and only for very short periods. These guidelines state that for most patients three days or less will often be sufficient and more than 7 days are rarely needed. The **maximum daily** oral dose recommended for patients in acute pain is 50 mg. More than that and the risks of overdose and death escalate. If doses exceed 50 mg. morphine equivalent doses and/or are taken for over 2-3 weeks, brief tapering of 3-7 days may be indicated.

The dangers of serious harm escalate when opiates are given for longer periods and at higher doses, and there is a lack of high quality support for their benefit in relieving chronic pain or improving function or quality of life. What is also unclear is why the United States consumes the largest amount of the world's production of prescription opiates.



A recent study published in March 2018 was from the Workers'

Compensation Insurance Rating Bureau titled: "Study of Chronic Opioid Use and Weaning in California Workers' Compensation" had some positive findings. Besides noting that after decades of growing use of opioids in workers compensation cases, since 2012 claims with opioid prescriptions have dropped. Most importantly the study found that about 47% of the injured workers who demonstrated chronic opioid usage weaned off of opioids completely within the 24-month study period. The injured workers who did not wean off completely over the study period still reduced opioid dosage by an average of 52%.

In summary, while opioids can be essential in the relief of pain in acute severe injuries, they may have been overused in less acute injuries. The evidence for the benefits of chronic use is weak but the risks of overdose and death are not. Patients using opiates chronically should and can be successfully weaned off them over time.

PREVENTING SUICIDE & SELF HARM

Discussing suicide is not easy. But among working age Americans it is consistently in the top 10 reasons for death and cannot be ignored if we are to honestly discuss health and safety. Talking about it does not make it more likely, instead it is the opposite.

In 2015, suicide was the second leading cause of death among persons aged 15-34 years, the fourth among person aged 35-44 years, the fifth among people 45-54, and the eighth among persons aged 55-64 years. 44,193 Americans were lost that year by their own hand.

Men are 3.53 times more likely to complete a suicide attempt but 3 times more attempts are made by women.¹ This disparity is due to the means usually used. Men are most likely to use more lethal means (firearms, hanging, and carbon monoxide) whereas most attempts from women use poisoning via overdose which takes a longer time and allows more opportunities for survival.

Let's discuss some of the long held myths. Perhaps the most dangerous is the trope that if someone *wants* to do it they are going to do it anyway. **Not true.** In a 1978 study, Dr. Richard Seiden identified 515 would-be Golden Gate Bridge jumpers who had been prevented from doing so or who survived the fall (1937-1971). He found that 94% were still alive or had passed from natural causes. Once people had faced death and had gotten through the acute crisis period (usually about 90 days), they wanted to live. Survivors of the bridge spoke to feelings of immediate remorse after they leapt.

"Instant regret, powerful, overwhelming. As I fell, all I wanted to do was reach back to the rail, but it was gone," said Kevin. "The thoughts in those 4 seconds, it was 'What have I just done? I don't want to die. God please save me.' Boom."

-Kevin Miles GG jumper/survivor

¹ Gender differentiation in methods of suicide attempts : <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3539603/> Konstantinos Tsirigotis,¹ Wojciech Gruszczynski,² and Marta Tsirigotis³

Research shows that suicide attempts are largely impulsive. Although some are carefully planned, interviews with near-lethal attempt survivors reveal that a quarter of them made the attempt less than five minutes after making the decision.



About half of those did so within 20 minutes, and three-quarters of suicide attempts occurred within an hour. In a separate study, survivors reported that many made their attempt within 24 hours of a crisis, particularly interpersonal crises and physical fights.²

Once the decision is made, the method chosen can quite literally be the difference between life and death. Living in a home that has a gun or having ready access to a gun increases the possibility of death by suicide **threefold**.³ Full Stop. That number is real. That makes sense when you remember the impulsivity and irrationality of a person in crisis. The lethality of gun suicide attempts is at 90%. Many of those who do survive are permanently disabled from the attempt. There is no opportunity to reconsider or halt once a trigger is pulled. That means that “guns are 45 times more fatal than attempts involving overdosing, around 30 times more fatal than those involving cutting or stabbing, and almost three times more fatal than suicide attempts by jumping.”⁴

This isn't only for those in obvious crisis. An estimated 9.3 million adults (3.9% of the adult U.S. population) reported having suicidal

NEWS! INTRODUCING ERGONOMICS & MOVEMENT

The Departments of Human Resources, Health Service Systems, & Public Health have teamed up to deliver a multipronged push to promote ergonomic education and encourage movement in the office. This includes a new campaign this year with promotional materials, prizes, guides, surveys, and a new electronic learning module.

The office ergonomics program will contain sections on proper seated and standing body positions, hand and arm positions, and tips for protecting eyesight with an emphasis on the importance of consistent movement during the day to keep employees comfortable and productive.

Planned to complement the city's current ergonomic programs, this new push will nest nicely with our current system of assessments, equipment, and educational materials/live classes. The program launch is expected by the new fiscal year.

If you have any concerns about your current workstation please discuss with your supervisor and safety officer or department personnel officer for guidance. You can also reference the [DPH](#) website for ergonomic information or contact me directly for other questions.

Carlos.Torrez@sfgov.org
DHR Safety Coordinator

² Simon, T. R., Swann, A. C., Powell, K. E., Potter, L. B., Kresnow, M., & O'Carroll, P. W. (2001). Characteristics of impulsive suicide attempts and attempters. *Suicide and Life-Threatening Behavior*, 32(1 Suppl), 49–59.

³ Anglemeyer, A., Horvath, T., & Rutherford, G. (2014). The accessibility of firearms and risk for suicide and homicide victimization among household members: A systematic review and meta-analysis. *Annals of Internal Medicine*, 160(2), 101–110

⁴ Miller, M., Azrael, D., & Hemenway, D. (2004). The epidemiology of case fatality rates for suicide in the Northeast. *Annals of Emergency Medicine*, 43(6), 723–730.

thoughts in the past year.⁵ These are our neighbors, friends, family members, and coworkers. Maybe it's you.

If you or someone you know is in crisis, please do not hesitate to take advantage of the multiple resources available.

- San Francisco Suicide Prevention (415) 781-0500
- US Suicide Hotline 1-800-784-2433
- NDMDA Depression Hotline – Support Group 800-826-3632
- Suicide Prevention Services Crisis Hotline 800-784-2433
- Suicide Prevention Services Depression Hotline 630-482-9696
- Child Abuse Hotline – Support & Information 800-792-5200
- Crisis Help Line – For Any Kind of Crisis 800-233-4357
- Domestic & Teen Dating Violence (English & Spanish) 800-992-2600
- Parental Stress Hotline – Help for Parents 800-632-8188
- Runaway Hotline (All Calls are Confidential) 800-231-6946
- Sexual Assault Hotline (24/7, English & Spanish) 800-223-5001
- Suicide & Depression Hotline – Covenant House 800-999-9999
- National Child Abuse Hotline 800-422-4453
- National Domestic Violence Hotline 800-799-SAFE
- National Domestic Violence Hotline (TDD) 800-787-3224
- National Youth Crisis Hotline 800-448-4663
- EAP (Employee Assistance Program) 415-554-0610

PROTECT YOUR HEARING!

Wow that's loud! Everyday Noise Exposure and Hearing Loss Prevention

We all have that friend – the one with the giant subwoofers in their car turned all the way up, rattling the windows of nearby buildings as they drive by. Or we have gone to a concert (maybe stood a little too close to the stage) with the music blaring so loud our ears were left ringing for hours afterward. These are the fairly obvious, and generally avoidable, overly loud situations we can escape easily when we choose. But what about the noise we may be exposed to on a regular basis in our daily lives? How do we know when the volume is too loud, and more importantly, what can we do about it?

Most of us are familiar with the risks of working in a loud environment. Occupational hearing loss, primarily caused by high noise exposure, is the most common U.S. work-related illness⁶. Approximately 22 million U.S. workers are exposed to hazardous occupational noise.⁷ However, the data shows that hearing loss is not reserved for just the workplace. According to the CDC (The Centers for Disease Control and Prevention),

⁵ Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services, 2014. Available at <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>.

⁶ Themann CL, Suter AH, Stephenson MR. National research agenda for the prevention of occupational hearing loss—part 1. *Semin Hear* 2013;34:145–207.

⁷ Tak S, Davis RR, Calvert GM. Exposure to hazardous workplace noise and use of hearing protection devices among US workers—NHANES, 1999–2004. *Am J Ind Med* 2009;52:358–71.

“Hearing loss is the third most common chronic physical condition in the United States, and is more prevalent than diabetes or cancer.”⁸

How do I know if the sound is too loud?

Sound is measured in decibels (dB), and the higher the number of decibels the louder the sound is. The generally accepted level and exposure time to limit potential damage to a person’s hearing is 85 decibels over an 8-hour time period. As the noise level increases, the amount of allowable exposure time goes down. OSHA mandates that for every 5 dB louder, the exposure time is cut in half. The DOE exchange rate stipulates to cut the exposure time in half for every 3 dB increase in volume. This means that with 100 dB noise level (which is the noise level inside a typical busy dance club), OSHA allows for one hour of exposure while the DOE allows for just 15 minutes.

The most accurate way to measure volume level is to use a noise dosimeter. These instruments are designed to measure the weighted noise level over a specific period of time. But who walks around with a dosimeter in their pocket?

OSHA documents refer to a “quick and dirty” method of making a rough estimate as to the loudness of the situation you are in: “A good rule of thumb to determine if a noise is too loud is the 3-foot rule. If you are standing 3 feet from someone and must shout to be heard, the noise level is probably over the OSHA action level and DOE exposure limit.” Here is my personal unwritten rule; if the noise is so loud that I involuntarily scrunch my face up like I just ate a lemon, it’s too loud! This amount of noise likely requires hearing protection.



Some of the things we use on a regular basis that may not seem too loud, such as earbuds from an MP3 player or smartphone, could be causing more damage than we think. A study conducted in 2010 showed the prevalence of hearing loss in participants aged 12 to 19 has increased significantly.⁹ The specific cause for this spike in hearing loss was not definitively determined, however the researchers postulate that listening to loud music with earbuds for extended periods of time could be the culprit.

How do I protect myself from loud noises I may experience in everyday life?

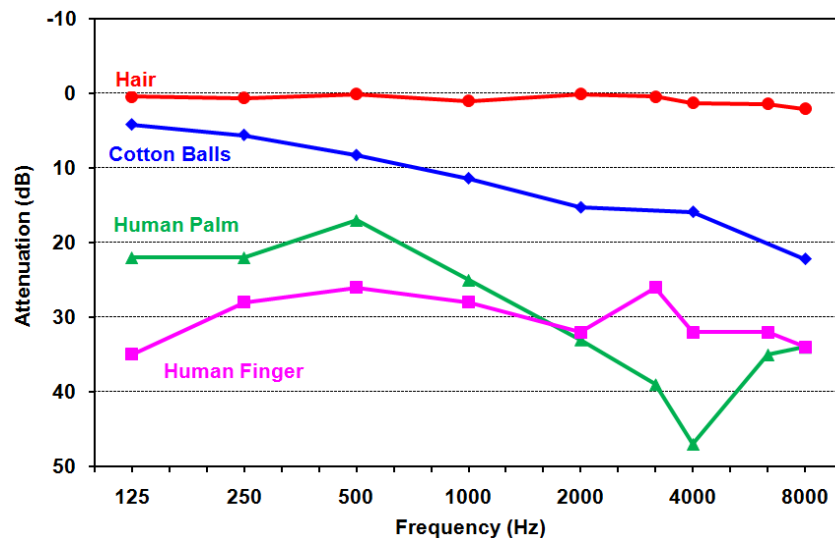
First of all, turn it down! Whether it is the television, your cell phone or a music system, think about the volume level and use the “bottom up” method; reduce the volume to a point that is just barely too soft, then increase it slightly. We often get carried away by the buttons on the remote or cell phone without realizing the levels are more than what we really need.

Another study was conducted to measure the effectiveness of non-standard hearing protection. They measured the effect of using cotton balls, your hand or finger, and even your hair to reduce the effect of noise on the ear. The researchers concluded that, *“As a short-term, immediately available option, using your hands is a reasonable choice for reducing offending sound levels when bona fide hearing protection is*

⁸ Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for US adults: National Health Interview Survey, 2012. Vital health statistics, series 10, no. 260. Atlanta, GA: National Center for Health Statistics, CDC; 2014. http://www.cdc.gov/nchs/data/series/sr_10/sr10_260.pdf

⁹ JAMA. 2010;304(7):772-778. doi:10.1001/jama.2010.1124

not available, whereas using cotton balls provides negligible protection and letting one's hair down provides none at all."¹⁰ The chart below gives a visual one how these four methods performed in reducing noise.



In a pinch, use your palm. When that loud siren goes by press your palms against the opening of your ear canals firmly, creating a tight seal. While not ideal, it may save some hearing over the long run.

It all adds up!

Our hearing is precious and should be conserved as much as possible. Be aware of the noise levels in your environment and

the steps you can take to preserve your hearing. The majority of noise-induced hearing loss is permanent, not repairable, and most importantly, preventable. Take action today to prevent potential noise damage to your hearing!

About the author: Josh Frantz, NBC-HIS/COHC is Certified by the National Board for Certification in Hearing Instrument Sciences, a Certified Occupation Hearing Conservationist and co-owner of Advanced Hearing Providers. Any questions can be directed to Josh at: jfrantz@yourhearingprovider.com

PROTECT YOURSELF FROM SEASONAL ALLERGIES

1 in 5 Americans suffer from seasonal allergies. For some, allergies are a mild inconvenience requiring perhaps a spare tissue or the occasional decongestant. For others it is the full suite of symptoms: Itchy watery eyes, runny nose, sneezing fits, and congestion. For these severe allergy sufferers, spring season can mean miserable commutes, missed days of work, lowered productivity, and a sense of lost time from antihistamine/decongestant drowsiness.



"Allergy symptoms are the No. 2 reason adults miss work," says James Sublett, MD, a board-certified asthma and allergy specialist in Louisville, Ky.¹¹ A standard allergy sufferer misses an average of one hour per week over the course of a year. However this time is usually concentrated in peak allergy season and can be up to 32 hours a week missed.¹² Another study showed that employees who suffered allergy symptoms but were

¹⁰ © 2013 Acoustical Society of America [DOI: 10.1121/1.4799992], Received 22 Jan 2013; published 2 Jun 2013

¹¹ <https://www.webmd.com/allergies/features/allergies-at-work#1> Accessed 3/28/2018

¹² <https://news.osu.edu/news/2007/04/25/sneeze/> Accessed last on 3/28/18

present at work showed a 10% decrease in productivity even though symptoms were managed with medication.¹³

The most common outdoor allergen --pollen -- is also the hardest to control. Curbing exposure to this allergen is best done by avoiding it. Pollen counts are at their highest in the morning to midday.¹⁴ Major allergy sufferers should take note each morning of the day's pollen count (this can be done by typing "pollen count" followed by the name of the city or section of the city you will be in, in to the standard Google search bar – give it a try!) Since staying indoors all day may not be an option, plan your trips accordingly. On high pollen count days, bringing lunch may be a better option than going outside during the lunch hour.

Of course allergens are not confined to the outdoors and even the best air filtration systems cannot keep all irritants and allergens outside. The most common indoor allergens are dust mites, animal dander, mold, and pollens carried inside on clothing. Dust mites feed exclusively on the dead skin cells every person sheds throughout the day. Therefore wherever we are you are likely to find dust mites. They live in the upholstered items in your home and office, in the stacks of papers on your desk, and the interior of your car. The droppings and exoskeletons of these tiny bugs cause allergic reactions when inhaled. Dust mites do not thrive in low humidity conditions so they are not likely to continue to colonize our office setting. However, they persist because we consistently bring new ones in with us every day. To minimize dust mites in your work area, you need to control the dust. Remove excess papers and books, clean your computer screen twice a week, use moist rags when dusting to collect and not just stir dust from flat surfaces.

If you have indoor pets at home, the dander will follow you even if invisible so consider turning outerwear inside out when you get to the office to limit adding allergens to the office.

Check with your health care provider to see about getting tested if you believe you may be suffering from allergies.

*You can cut all the flowers but you
cannot keep spring from coming.
-Pablo Neruda*

WORRIED ABOUT CAL/OSHA COMPLIANCE?

Be sure to check out our new DHR E-Library Compliance page on our website under the HR PROFESSIONALS tab.

Find useful info, links, and PDFs of compliance related materials, including required workplace postings, injury and illness tracking, and more.

Questions or suggestions for additions to our compliance page should be sent to DHR-eLibrary@sfgov.org

¹³ The impact of allergies and allergy treatment on worker productivity. J Occup Environ Med. 2001 Jan;43(1):64-71. Northwestern University Medical School, Bank One, Mail Code IL1-0006, 1 Bank One Plaza, Chicago, IL 60670-0006

¹⁴ <https://www.pollen.com/allergy/allergy-prevention> Accessed 3/28/18