



# OSHA REGIONAL NOTICE

U.S. DEPARTMENT OF LABOR

Occupational Safety and Health Administration

<b>DIRECTIVE NUMBER:</b> 13-30 (CPL 04)	<b>EFFECTIVE DATE:</b> November 26, 2013
<b>SUBJECT:</b> Local Emphasis Program: Native Health Care Facilities	
<b>REGIONAL IDENTIFIER:</b> Region 10	

## ABSTRACT

<b>Purpose:</b>	This Notice transmits the policies and procedures to be followed when conducting programmed and unprogrammed safety or health inspections at Native Health Care Facilities in Alaska.
<b>Scope:</b>	This Notice applies in Alaska to inspections by federal OSHA at Native Health Care Facilities.
<b>References:</b>	<p>OSHA Instruction CPL 02-00-025, <i>Scheduling System for Programmed Inspections</i>, January 4, 1995.</p> <p>OSHA Instruction CPL 04-00-001, <i>Procedures for Approval of Local Emphasis Programs</i>, November 10, 1999</p> <p>OSHA Instruction CPL 02-00-150, <i>Field Operations Manual (FOM)</i>, April 22, 2011.</p>
<b>Cancellations:</b>	Seattle Regional Notice 13-10 (CPL 04), February 20, 2013.
<b>Expiration Date:</b>	This Notice will expire December 31, 2014, but may be renewed.
<b>State Plan Impact:</b>	None.
<b>Significant Changes:</b>	
<b>Action Offices:</b>	Anchorage Area Office and the Office of Federal and State Operations.

**Originating Office:** Office of Federal and State Operations

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Assistant Regional Administrator  
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By and Under the Authority of:

David L. Mahlum  
Acting Regional Administrator

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## EXECUTIVE SUMMARY

Previously, Native Health Care Facilities were under the jurisdictional authority of the State of Alaska Department of Labor and Workforce Development, Alaska Occupational Safety and Health (AKOSH). In September 2000, AKOSH representatives were denied entry to conduct a complaint inspection at the Kakanak Hospital, operated by the Bristol Bay Area Health Group, located in Dillingham, Alaska. The Alaska Attorney General determined that since the hospital is owned by the federal government and operated under contract with the Indian Health Service, AKOSH would not have jurisdictional authority to pursue compulsory process. The state later determined that there were similar hospitals owned by the federal government over which AKOSH does not have enforcement authority. The Commissioner of Labor for the state of Alaska submitted a letter to federal OSHA relinquishing jurisdiction over health care facilities that were federally owned and contractor operated.

According to the Bureau of Labor Statistics (BLS), in 2011 hospitals (NAICS 6221) reported a national Total Incident Case Rate (TICR) of 6.8 injuries per 100,000 employees and a Days Away Restricted and Transfer Rate (DART) of 2.7. The average TICR for all private industry as a whole in 2011 was 3.5 and the DART was 1.8. In 2011, the state of Alaska reported a TICR for hospitals of 7.4 and a DART of 2.5. In 2011, 67 cases of tuberculosis (TB) were reported to the Alaska Tuberculosis Program for an incidence of 9.3 cases per 100,000 population. This was an 18% increase in the number of cases and a 21% increase in the incidence of tuberculosis when compared to 2010. The United States tuberculosis incidence was 3.4 cases per 100,000 in 2011, a 6.4% decline from 2010 (Figure 1).

In 2010, there were 40,030 occupational musculoskeletal disorder (MSD) cases in private industry where the source of injury or illness was a health care patient or resident of a health care facility. This accounted for 14 percent of the 284,340 total cases of MSDs that resulted in a least one lost day from work in 2010. Almost all (97 percent) of the cases involving patient handling occurred within the health care and social assistance industry, composing 58 percent of the 67,700 total MSD cases in that industry. For MSD cases involving patient handling, almost all (99 percent) were the result of overexertion. Sprain, strain, or tear was the type of injury incurred in 83 percent of the MSD cases involving patient handling. Nursing aides, orderlies and attendants incurred occupational injuries or illnesses in 49 percent of the MSD cases involving health care patients. Registered nurses accounted for 17 percent and home health aides for another 6 percent. Other occupations with MSD cases involving health care patients included licensed practical and licensed vocational nurses; emergency medical technicians and paramedics; personal and home care aides; health care support workers; radiologic technologists and technicians; and medical and health services managers.

These alarming statistics, coupled with higher than average LWDI rates, provide justification for conducting comprehensive safety and industrial hygiene inspections under this LEP.

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- II. Scope.** This Notice applies in Alaska to inspections by federal OSHA at Native Health Care Facilities.
- III. Action Offices.** This Notice applies in Alaska to inspections by federal OSHA at Native Health Care Facilities.
- IV. State Plan Impact.** None.
- V. Cancellation.** Seattle Regional Notice 13-10 (CPL 04), February 20, 2013.
- VI. References.**
- A. OSHA Field Instruction CPL 02-00-025, Scheduling System for Programmed Inspections, January 4, 1995.
  - B. OSHA Instruction CPL 04-00-001, Procedures for Approval of Local Emphasis Programs, November 10, 1999.
  - C. OSHA Instruction CPL 02-00-150, Field Operations Manual (FOM), April 22, 2011.

**VII. Responsibilities.** The Anchorage Area Director shall use this Notice for scheduling both safety and health inspections in native health care facilities (SICs/NAICs 8011/621111 and 8062/622110).

**VIII. Actions Required.** These procedures will be followed when targeting inspections under this program.

- A. The Area Director shall establish and maintain a master list (Appendix A) of all native health care facilities under OSHA's jurisdiction. The list will be updated as needed, when new information is received about federally-owned facilities.
- B. During the annual planning process, the Area Director shall determine the number of native health care facilities inspections to be conducted during the fiscal year.
- C. The inspection cycle shall include all sites on the master list. Random numbers will be used to determine the order of inspections for a cycle; however, sites may also be inspected in any order which makes effective use of available resources. A new inspection cycle shall not begin until all sites have been inspected under the previous cycle.
- D. The Anchorage Area Office will develop an outreach program that supports the purpose of this LEP, with an emphasis on prevention of ergonomic-related injuries. The outreach program will consist of letters to target employers, informing them of the LEP and providing information to help them establish effective programs to prevent ergonomic injuries. The area office will also make compliance assistance materials available to all interested employers, professional associations and local unions.
- E. All safety and health inspections conducted under this program shall be comprehensive, wall-to-wall inspections of the work site. No records-only reviews will be conducted. Inspections will focus on the types of hazards considered common in hospitals and other health care settings, such as slips, trips and falls, bloodborne pathogens, tuberculosis, and ergonomics
- F. With regard to ergonomics, all inspections will include an ergonomic program evaluation component. At a minimum, the CSHO shall calculate the incidence and severity rates for ergonomic injuries (see instructions in Appendix B) for the most recent three years, and evaluate the employer's program, if any, to address ergonomic hazards.

Depending on whether rates are rising or falling, and the extent of the employer's program, the CSHO shall decide whether to continue the ergonomic portion of the inspection. Guidance on making such decisions will be provided by the Regional Ergonomic Coordinator in the Office of Technical Support, Seattle.

If the ergonomic portion of an inspection continues, guidance and coordination will remain with the Regional Ergonomic Coordinator, and a determination will be made regarding further actions, i.e., hazard alert letters or citations.

G. Special Instructions.

1. Inspection Record Coding: Inspections conducted under this program, both programmed and unprogrammed, shall be coded on the inspection record, with the LEP designation "AKNHC." Also, enter "ERGOINIT1" if ergonomic working conditions are evaluated during the inspection.
2. Evaluation Procedures: This LEP will be evaluated in accordance with the guidelines in Appendix A of CPL 04-00-001, Procedures for Approval of Local Emphasis Programs and Experimental Programs.

The Area Director will be asked to provide input concerning special problems that may have surfaced during the year; recommendations to improve the LEP; and recommendations to renew or not renew the LEP.

The Office of Federal and State Operations (FSO) shall review the input and prepare an evaluation to be submitted to the Regional Administrator for review by November 15 of each year. On the approval of the Regional Administrator, the evaluation report will be submitted to the Directorate of Enforcement Programs no later than November 30.

**APPENDIX A**

**LISTING OF HEALTH CARE FACILITIES  
FEDERAL OSHA ENFORCEMENT & AKOSH CONSULTATION JURISDICTION**

<b>Tribe</b>	<b>Name of Facility</b>	<b>Owner</b>	<b>Type Provider</b>	<b>Mailing Address</b>	<b>City</b>	<b>Zip</b>
AK Native Tribal Health Consortium	Alaska Native Medical Center	IHS	Hospital	4315 Diplomacy Dr.	Anchorage	99508
Aleutian/Pribilof Island Association	St. Paul Health Center	HIS	Mid-level		St. Paul	99680
Arctic Slope Native Association	Samuel Simmons Memorial Hospital	HIS	Hospital	P.O. Box 29	Barrow	99723
Bristol Bay Area Health Corp	Kanakanak Hospital	HIS	Hospital	P.O. Box 130	Dillingham	99576
Metlakatla Indian Community	Annette Island Service Unit	Tribe	MD/Dentist HC	P.O. Box 8	Metlakatla	99926
SE Alaska Regional Health Consortium	SEARHC Mt. Edgecume Hospital	IHS	Hospital	222 Tongass Dr.	Sitka	99835
Yukon Kuskokwim Health Corp.	Yukon Kuskokwim Delta Regional Hosp.	IHS	Hospital	P.O. Box 528	Bethel	99559

## APPENDIX B

### CALCULATING INCIDENT AND SEVERITY RATES FOR ERGONOMIC INJURIES

Evaluate OSHA log data for the last three years to determine whether employees are experiencing injuries and illnesses related to work-related ergonomic stressors.

For purposes of these calculations, include recorded cases meeting the current BLS definition of musculoskeletal disorders unless another, narrower definition is more appropriate given the circumstances. The BLS definition includes injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs, except when they are caused by slips, trips, falls, motor vehicle accidents, or similar accidents.

When evaluating OSHA log data:

- a. Use a highlighter to mark all suspected ergonomic cases. Exclude these which are obvious accidents such as slips, falls, struck by, etc.
- b. Request supplemental reports for all highlighted cases.
- c. Remove all non-ergonomic cases.
- d. Examine the remaining reports to determine if the listed is the result of exposure to work-related risk factors.
  - Are there medical or workers' compensation records that support work relatedness?
  - Where are these kept?
  - Were there cases which required surgery or long term disability to perform usual work duties?

Calculate the Lost Workday Injury and Illness Incidence (LWDII/DART) rates for various departments, to identify those areas which are of the highest priority. This data may later be used to establish the causal relationship between the task and the injury/illness. The difference in rates between jobs links injuries/illnesses with the task performed, and minimizes the influence of non-work factors.

The LWDII/DART rate is:

$$\frac{(\# \text{ of cases with lost workdays or restricted work in the past 12 months}) \times 200,000}{\# \text{ of hours worked in the past 12 months}}$$

Since many employers do not have good numbers for the hours worked, a simplified formula may also be used:

$$\frac{(\# \text{ of cases with lost workdays or restricted work in the past 12 months}) \times 200,000}{(\# \text{ of employees}) \times 2000}$$

Calculate the severity rate for the case used in the LWDII/DART rate to determine effectiveness of the company's efforts to address exposures, if any, and to prioritize areas for in-depth analysis. The severity rate uses the number of days away from work or restricted workdays due to injury or illness as a surrogate for the seriousness of the disorder.

The severity rate is:

$$\frac{(\text{total \# lost or restricted work days in the past 12 months}) \times 200,000}{\text{\# work hours during the past 12 months}}$$

NOTE: The magnitude of the severity rate can be influenced by medical treatment practices, the health benefits available to employees, and the opportunity for transfer to jobs that are less stressful. The severity rate can also be skewed by unusually long illnesses suffered by a few employees. The 2001 recordkeeping rule uses a different method of calculating lost work time than was used earlier. Comparisons of data from the two systems should be adjusted accordingly.