

Connecting the Dots:

Breaking Down the Silos Between
Industrial Hygiene, Safety, and
Environmental Programs

Today's Featured Speaker



Abby HOLOVACH

Owner & Principal Consultant



- › 10+ years across environmental compliance, hazardous materials management, and full EHS program development
- › Former TCEQ Environmental Investigator, EHS & Waste Director, Environmental Manager, and Environmental Program Manager
- › Deep experience spanning spill response operations, regulatory compliance, and military base environmental programs
- › Founder of DFW Environmental Pros and ASSP Region III Regional Vice President
- › Holds MS, CHMM, CSP, REM, and CIT credentials

What We'll Cover Today

Four shifts that turn separate programs into one system.

01 Why silos form, and what they cost

How IH, safety, and environmental grew up separate, and the price a plant pays when hazard information stops at the department line.
(The business case, not just the compliance case)

02 Where the real overlaps hide

A single chemical can sit inside four programs at once. We trace one and see who owns each piece.

03 What integration looks like

Shared visibility, a common language, clear ownership, and one record that outlives any single employee.
(Changing how information flows)

04 How to start on Monday

A practical 30, 60, 90 day path you can begin without new headcount or new software.
(Small, standing, repeatable)

Poll Question:

Do you suspect different teams have identified the same workplace hazard but that hazard was not shared?

The Same Problem

The “siloed” EHS organization is a structural problem

A Common Scenario:

Welding fumes logged as an IH finding, poor respirator use flagged in a safety audit, ventilation deficiency sent to maintenance.

Same root cause, three separate buckets

EHS Program Design Flaw

Each team did their job, but no one connected the dots

The Same Problem, A Different Day

One task. Four programs. Nobody comparing notes.

Another Common Scenario:

A parts washer runs a chlorinated degreaser. IH samples the breathing zone. Safety writes up missing gloves. Maintenance orders a new filter. Environmental books the spent solvent as hazardous waste.

One solvent. Four separate tickets.

The Hidden Thread

Change the solvent and every one of those findings changes with it. No one owns that connection.

Warning Signs You Are Siloed

1

Findings live in four places

Your IH samples, safety observations, environmental records, and work orders sit in four separate systems, and no one can pull them into a single view.

2

The same finding keeps returning

A deficiency you closed last year is back in this year's audit, because the fix treated the symptom one program saw, not the source another understood.

3

Changes surprise people

A raw material or process changed, and IH, safety, or environmental found out weeks later, by accident, instead of being told up front.

4

Corrective actions age

You have open action items more than a year old, sitting in the gap between two departments because ownership was never clear.

Why Silos Form & Stick

Silos Form:

Programs are built around regulatory frameworks, not risk profiles. IH, safety, and environmental each optimize for their own standards

Separate reporting chains, separate software, separate audits

Tribal knowledge fills the gaps between disciplines until someone leaves

Hazard information gets logged, but not shared, analyzed, or acted on across functions

Silos Stick:

Everyone is busy... Cross-functional review simply isn't built into anyone's workload

No shared system means no shared picture of facility risk

Compliance gets met, so leadership assumes the program is working

Incidents are investigated within a single discipline, so the cross-functional pattern never surfaces

Why the Silos Exist in the First Place

The disciplines did not drift apart. They were built apart.

Different Laws

IH answers to OSHA. Safety to recordkeeping and the general duty clause. Environmental to EPA under RCRA, air rules, and EPCRA.

Three agencies.
Three vocabularies.

Different Auditors

An OSHA inspector, a state environmental investigator, and an internal safety auditor rarely share a room.

Each visit reinforces a lane.

Different Systems

Exposure data, incident logs, waste and air records, and work orders each live in their own tool.

Systems that never compare notes.

What Gets Missed When Programs Don't Talk

The risk isn't just the hazard itself. It's the delay between identifying it and acting on it.

Corrective Actions Stall

When ownership isn't clear across functions, action items sit unresolved.

Each team assumes another is handling it.

Patterns Don't Surface

Five separate incidents get logged in five separate systems.

No one sees the trend until something serious happens.

Findings Repeat

The fix addressed one symptom, not the source.

The same issue comes back in the next audit cycle.

What Silos Actually Cost

The expense is not the hazard. It is everything that happens while no one acts.

Repeat Findings

The same deficiency returns audit after audit because the fix treated a symptom in one program, not the source in another.

You pay for every repeat finding twice.

Slow Corrective Actions

When an action sits between departments, the clock keeps running. Regulators and insurers both notice how long a hazard stayed open.

Time open is the liability.

Lost Knowledge

When the person who understood the connection leaves, the connection leaves too. The next team starts from scratch.

Turnover resets the program.

A Silo Failure, Start to Finish

One change. Three months. A finding no one saw coming.

The Change

Purchasing swaps a cleaning solvent for a cheaper equivalent. The SDS changes. Operations is happy. The change is never announced beyond the plant floor.

One quiet substitution.

The Gap

No one revisits the waste code, the air inventory, or the exposure profile. Each program keeps running on old assumptions about the old product.

Nobody owned the connection.

The Finding

An inspector pulls a manifest and the waste no longer matches the code on file. A one-line purchase decision is now a documented violation.

The gap became the finding.

One Hazard, Four Programs

Follow a single drum of solvent through the building.

01 The IH View

Is the vapor above the permissible exposure limit? What does the breathing-zone sample say, and does it drive respirator choice?
(Exposure and controls)

02 The Safety View

It is flammable. That means storage limits, ignition control, hot-work permits, and the right extinguisher within reach.

03 The Environmental View

The vapor may be a reportable air emission. The spent solvent is likely a listed hazardous waste with manifest and storage rules.
(Air, waste, reporting)

04 The Shipping and SDS View

Moving the waste triggers DOT hazmat classification and labeling. And one SDS revision can quietly change all three views above.
(One update moves everything)

It Is Never Just One Program

The solvent was an example. The pattern is everywhere.

Welding Fume

IH watches manganese and hexavalent chromium. Safety manages hot work and fire. Environmental sees an air emission from the fume and waste from the dust.

One arc, three programs.

Combustible Dust

Safety sees an explosion hazard and housekeeping. IH sees an inhalation exposure. Environmental sees a particulate emission. Maintenance owns the dust collector.

Four owners, one pile of dust.

Lithium Batteries

A lithium battery is a fire risk to safety, a universal or hazardous waste to environmental, and a DOT hazmat the moment it ships off site.

Same item, three rulebooks.

Where the Handoffs Break

The gaps between programs are exactly where hazards hide.

The Silent Gaps:

A process change swaps a raw material, but the waste determination is never revisited. IH data shows a new exposure, but PPE selection never updates. A near miss is logged, but the release it hints at is never flagged.

No one is negligent. The path just does not exist.

The Fix Is a Trigger

One change should reach every program it touches, all at once.

One Change: Who Needs to Know?

A simple management-of-change trigger closes most silo gaps.

01 Hazard Communication

A new SDS means updated labels, container marking, and a quick refresh of employee HazCom training for the new product.
(Labels, SDS, training)

02 Exposure and PPE

A new chemical can change the breathing-zone exposure, which can change respirator and glove selection. Re-sampling may be needed to confirm.

03 Waste Determination

A new product can change the waste code, the generator status, and the accumulation and manifest rules that apply to the spent material.
(Code, status, manifest)

04 Air, Reporting, and Shipping

The change can affect air emissions, EPCRA Tier II and TRI thresholds, and the DOT shipping description when the waste leaves the site.
(Air, EPCRA, DOT)

What an Integrated Approach Looks Like

It's all about changing how information flows.

01 Shared visibility

IH sampling, safety observations, environmental findings, and maintenance work orders feeding a common picture of facility risk.
(NOT four separate queues)

02 Cross-functional hazard review

Not just at incident response. Build in a routine cadence where disciplines look at findings together, not in sequence.

03 Clear corrective action ownership

Actions are assigned and tracked regardless of which discipline flagged the issue.
(No more assumptions on who will manage it)

04 Digitized processes

A shared digital record doesn't depend on who's in the room. Findings, actions, and outcomes are visible across the organization.
(They stay even when people leave)

Where Is Your Program Today?

1

Level 1: Siloed

Each program runs on its own. Findings live in separate systems. Cross-program issues surface only during an audit or after an incident.

2

Level 2: Coordinated

Programs still run separately, but they meet and share findings on a set schedule. Overlaps get caught in conversation, not by accident.

3

Level 3: Integrated

Findings share one record and a common hazard language. A change in one program triggers a check in the others by design, not by memory.

4

Level 4: Predictive

With connected data, patterns surface early. The program acts on a trend before it becomes an incident, and audits become a routine export.

Speaking the Same Language

Same Hazard, Different Words:

IH calls it an overexposure. Safety calls it a PPE violation. Environmental calls it a fugitive emission. Maintenance calls it a leaky valve.

Each label is accurate. None of them match.

When findings cannot be compared, the shared pattern stays invisible.

You cannot trend what you cannot line up.

A Common Spine:

You do not need identical classifications. You need compatible ones.

Agree on one shared list of hazard categories that every program maps into.

Tag findings by location and by source material, not only by discipline.

Now a valve, an exposure, and an emission can be seen as one problem.

The One Record That Remembers

1

Capture once, use everywhere

A finding entered a single time should be visible to every program that cares about it, instead of being retyped into four systems.

2

Connect the finding to the thing

Link every record to a location, an asset, and a material. That is what lets a valve, an exposure, and a waste stream line up as one issue.

3

Make ownership unavoidable

Every action gets a name and a due date the moment it is created, whichever program raised it. Open items stay visible to everyone.

4

Keep the history

When people leave, the record stays. New staff inherit what the program already learned instead of relearning it the hard way.

Who Owns a Shared Hazard?

Shared does not mean unowned. Name the roles up front.

01 One Accountable Owner

Every cross-program hazard gets a single named owner who is accountable for closure, even when several programs contribute to the fix.
(One name, not a committee)

02 Contributing Programs

IH, safety, environmental, and maintenance each supply their piece: the exposure data, the controls, the waste and air view, the equipment fix.

03 A Connector Role

Someone routes each change to every program it touches. This can be a person or a step built into your work process, but it has to exist.
(The trigger has a keeper)

04 Leadership Visibility

Open cross-program actions roll up to one leader who can clear roadblocks between departments and keep an aging item from being ignored.
(Someone can unstick it)

Breaking Down Process Silos

1

Audit your current data

Where do IH, safety, environmental, and maintenance findings live right now? Can you see them together? If the answer is no, that's your starting point.

2

Trace one recurring hazard type

Pick something that shows up regularly. Follow it across disciplines. How is each team currently handling it? What's falling between the cracks?

3

Establish a shared language

Hazard classification does not need to be identical across functions. It needs to be compatible enough that findings can be compared.

4

Build a cross-functional review cadence

Even quarterly is a start. The goal is a standing moment where disciplines look at findings together, not just in response to incidents.

Getting Buy-In Without a Reorg

What You Will Hear:

We are already too busy to add another meeting.

We are compliant, so why change anything?

That is another department's problem, not mine.

We tried software before and nothing improved.

What You Can Say:

This replaces rework, it does not add to it. Start with one traced hazard, not the whole system.

Compliant today is not the same as ready for the next change or the next inspection.

The gap between departments is exactly where the finding lands, so everyone owns it.

We fix the workflow first. A tool only helps once the language and ownership are set.

How Integration Efforts Go Wrong

Most failures are not technical. They come down to scope, sequence, and ownership.

Boiling the Ocean

Trying to merge every program at once stalls under its own weight. Teams burn out before the first win lands.

Start with one hazard,
not the whole system.

Tool Before Process

Buying software before agreeing on a shared language just digitizes the silos. The gaps move online but do not close.

Fix the workflow, then automate.

No Clear Owner

If cross-functional review belongs to everyone, it belongs to no one. Without a named owner and a set time, it quietly dies.

Give the cadence a host.

What Good Actually Looks Like

BEFORE

- ✗ IH, safety, and environmental findings live in separate systems
- ✗ Corrective actions fall through the gaps between departments
- ✗ The same hazard gets flagged repeatedly without resolution
- ✗ Institutional knowledge walks out the door with every personnel change
- ✗ Auditors find repeated findings



AFTER

- ✓ Hazard data flows across disciplines, not just up reporting chains
- ✓ Corrective actions are owned, tracked, and visible regardless of source
- ✓ Patterns surface early, before they become incidents
- ✓ Digitized records preserve what the program knows (not just what one person knows)
- ✓ You stay audit ready year-round

How You Know It Is Working

Pick a few simple measures and watch them move.

Speed to Close

Track how long corrective actions stay open, especially cross-program ones. Integration should shrink the time between finding a hazard and acting on it.

Time open should fall.

Repeat Rate

Count how often the same finding returns audit after audit. When the source is fixed instead of the symptom, repeats drop and stay down.

Repeats should drop.

Cross-Coverage

Track the share of findings tagged by location and material, and how many changes were routed to every affected program.

Coverage should climb.

Where to Start on Monday

1

Days 1 to 30: Map it

List where IH, safety, environmental, and maintenance findings live today. Pick one recurring hazard and trace it across every program that touches it.

2

Days 30 to 60: Connect it

Agree on a short shared list of hazard categories. Tag findings by location and material so records from different programs can finally be compared.

3

Days 60 to 90: Review it

Hold your first cross-functional review. Put the traced hazard on the table and give every open action a single named owner and a due date.

4

Day 90 and on: Keep it

Make the review a standing date, not an event. Capture findings in one shared record so the program keeps what it learns.

If You Remember One Thing:

A hazard found in one program is only as useful as the moment it reaches the others. Close the gap between finding and acting, and the silos start to fall on their own.

Connecting the Dots:

Breaking Down the Silos Between Industrial Hygiene, Safety, and Environmental Programs



Abby Holovach

Owner & Principal Consultant



vibeenvironmental.com

abby.holovach@vibeenvironmental.com

Questions?

Thank you.

Take these with you:

- › Map where your IH, safety, environmental, and maintenance findings currently live.
- › Pick one recurring hazard and trace how each discipline is currently handling it to find out what's falling between the cracks.
- › Build a regular cross-functional review where IH, safety, and environmental teams look at findings together, not just in response to an incident.
- › Assign corrective actions with a clear owner regardless of which team flagged the issue, so nothing sits unresolved in the space between departments.
- › When your people leave, your system should remember.

Next steps:



Power-Up Your Processes:

Incident Investigation Process Guide

fldata.com/guides/incident-investigation-process

