

VISIONS

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Converting Occupational Medicine Patients to Urgent Care Patients

By Alan A. Ayers, MBA, MAcc

Guest Contributor

Board of Directors, Urgent Care Association of America
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Regardless of whether a center's roots are in urgent care or occupational medicine, for mixed-model clinic operators, the opportunity lies in cross-selling or "converting" workers' compensation, physical and drug screen patients to urgent care patients.

THE OPPORTUNITY FOR PATIENT CONVERSION

Successful urgent care centers appeal directly to the general public through paid advertising, grassroots and Internet marketing that together build top-of-mind awareness. This awareness is the kind that brings your center to mind first when a prospective patient has an illness or injury. Once patients are comfortable with a facility and its providers, loyalty is likely to develop. And that leads to repeat visits and positive word of mouth.

By contrast, when a patient is sent by their employer to a medical facility for work-related purposes, they often presume (incorrectly) that the center provides only employer services. Many patients will never realize there is a doctor present who can address their personal healthcare needs. The purpose of "conversion" is to educate occupational medicine patients on all of the services offered in the facility. As a marketing tactic, conversion is likely to be more impactful than external advertising because it addresses an audience that has already found the center.



THE IMPORTANCE OF KNOWING YOUR CUSTOMER

The conversion process starts with understanding the demographics and consumer behavior of the occupational medicine patient. Workers' compensation claims occur less frequently in office-based professions than in fields like construction, warehousing and healthcare. In addition, public safety and transportation jobs—including aviation, rail and trucking – are all more likely than service industries to require physicals. As a result, occupational medicine patients tend to be blue-collar and skew male and middle income with fiscally and socially conservative values that emphasize family and homeownership.

In blue-collar households, it is often the wife and mother who makes healthcare decisions for the family. The typical blue-collar family has employer-paid health insurance and ages-in to Medicare; they have a relationship with a primary care physician but often take preventive over-the-counter medications at the first sign of symptoms. When an

continued on page 4

The NAOHP offers a weekly complimentary service to all NAOHP members: a telephonic "Town Hall" question-and-answer period every Monday from noon-12:30 Eastern time. To date the response has been exceptional with as many as 65 different programs participating in the Town Hall at a given time.

THE FOLLOWING QUESTIONS WERE POSED BY NAOHP MEMBERS AND ANSWERED BY OTHERS ON THE CALLS:



Week #19: CARE MAPPING

Q: What exactly is care mapping; it is known by other names?

"It can also be called work flows or algorithms. They help you identify problems that you may have in your clinic processes. They may help you identify any variations in practices. It's the journey into your clinic.

"So you would map out or just follow a patient and discover what happens and follow it [sic] all the way through. Observe and document what happens to see if there's more than one way to do something, and then work with your team to identify any issues and figure out what to do to improve it."

Q: When do we do care mapping?

"We do it on each process we have in the clinic. We conduct internal audits on a quarterly basis for our care mapping."

What initiates what you need to change a process?

"We wanted all of our clinics to operate on a standard basis. I think you can start care mapping on any process.

How do you bring your staff together to begin the process?

"We do clinic in-services where a team that specializes in a process goes from clinic to clinic and instructs them on something brand new. If we need to revise a process, we use online resources where staff members can log in and review new policies.

"A lot of programs do care mapping by product line, like pre-placement physicals, or firefighter physicals. You need to make sure there is a process in there that standardizes [the practice]."

Q: One of the realities is that people at many program levels feel overwhelmed. What advice do you have for programs?

"Engage your staff because a part of mapping out the process is identifying what duplicate processes must be deleted, where time is being wasted and how to save it. It may take some time to get it running but once you do, you actually end up saving an employee time in the long run."

"Some programs start where they have the most issues. The staff members are the best resource to find [that] out. Ask them 'where do we have a

process that has a long wait,' 'Where can we improve?' That's an ideal place to start."

Week #20: MEASURING AND ANALYZING OUTCOMES DATA

Q: We are very busy and have little time to gather and analyze outcome data. What should we do?

"We use a formal clinic audit tool ... compare compliance to standards."

"We think of outcome data as a strategy that is part of a larger whole.... what do we want to accomplish, what data do we need to gather to get there, and what is realistic."

"Understand the limits on what you can do. All sorts of data is interesting. Don't bite off too much – strike a compromise between what you would like to have and what you really need."

"We use NAOHP program standards.....treatment, clinical, product lines, quality assurance, financial."

Q: How do we use outcome data once we have it?

“We have found that our outcomes are a good marketing tool.”

“Outcome data justifies actions you might take.”

Q: How important are subjective assessments of outcome data? That is, can you ask an employer if they are satisfied with the care outcomes?

“First define what you are doing – quantify how satisfied the employer is, whether his or her feedback would be timely and if there is enough data in order to implement a return to work plan.”

“Be certain to include scaled responses, such as a one to five scale, rank order results, and then supplement with open ended questions.”

Q: Do most employers really care about outcome data?

“They do as they become better educated. They care about how we communicate treatment plans, how well we provide modified duty and tend to review costs per claim.”

“You’ll never know unless you ask. Markets vary. Expect variance within your market as far as expectations and needs...”

“We do group meetings with employers....we see it as an opportunity to help employers define their expectations for the future.”

Q: How do we get out outcome data if we don’t have occupational software?

“It is not always necessary. For example, you can measure patient time through most EMRs as they indicate when a patient arrives and leaves.”

Week #23: MANAGING PATIENT WAITING TIME

Q: Does creative scheduling tend to make a difference and if so what should we do?

“Extend your hours as appropriate.... try to comply with both individual and collective employer scheduling needs.”

“Measure how long it takes staff to perform certain procedures..... be creative in how you schedule your physicians and support staff.”

Q: When there appears to be a long wait, what should we tell a patient that has just arrived?

“Two pet peeves of employers are long wait times and lack of effective communication. Try to deal with both proactively but recognize you aren’t always going to be perfect.”

Q: What is the best way to assess if patients are satisfied with their waiting time?

“Ask them to rate their degree of satisfaction on a scale of one to five. This allows you to quantify satisfaction and measure progress or lack thereof over time.”

Q: What can we ask clinical staff to do to ease waiting times moving forward?

“At times I ask them to postpone or expedite lunch, and we cross train as many staff as possible.”

“Consider a care-mapping study. Ask clinical staff what processes can be improved to facilitate a better flow.”

Q: What is considered an acceptable waiting time?

“There is one set of wait times for injury care and another for screenings. Assume about ten minutes of wait time for a basic exam and no wait time for drug screens.”

“Wait time is in the eye of the beholder. Know your market.”

Q: How do we learn from a bad experience?

“Be careful not to trade one problem for another. You can’t blitz through patients to get back on schedule or else you have a double whammy – the patient is not happy they had to wait, and they’re not happy the provider rushed through the encounter when they were finally seen.”

To learn more about programs and services, visit www.naohp.com/menu/naohp/

Can you Help?

The cover story in the Summer 2015 issue of VISIONS will be on the effects of health care organizations’ mergers and acquisitions on occupational health programs. If your program and/or parent institution has recently undergone a merger or acquisition, VISIONS would love to speak with you. Contact iwalker@naohp.com.

The NAOHP’s spring webinar series will address “Innovative Applications of Social Media in Healthcare Marketing.” Please let us know if someone from your program/organization has a perspective on this topic and would like to participate as faculty in the webinar series. Contact mtan@naohp.com



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Select Medical Acquires Concentra

Select Medical Holdings and the private equity firm Welsh, Carson, Anderson and Stowe has acquired Concentra from Humana for more than \$1.05 billion in cash. The transaction is expected to close during the second quarter of 2015. Select Medical currently owns 113 long-term acute care hospitals, more than 1,000 outpatient rehab clinics and 16 outpatient rehab facilities. A detailed review and analysis of the transaction will be featured in the summer 2015 edition of Visions.



Alan A. Ayers

unexpected illness or injury strikes, they are likely to head to the emergency room.

Not all occupational medicine patients fit

this profile, but it is clear that occupational medicine demographics do not mirror the population at large. Rather, they reflect demographics of those in industries that incur workplace injuries or require compliance physicals. It is important to understand the demographics of occupational medicine patients in your center so you can take their perspective when developing your conversion messaging and tactics. Patient communication needs to be straight forward, in the correct language (i.e., English or Spanish) and delivered in a way that will make it home to the decision makers.

START WITH LITERATURE IN THE CENTER

Visit any sports arena that seats 20,000 people and odds are you will find advertising by the likes of Budweiser, Southwest Airlines, and Ford—all of them paying big money to reach a captive audience. Similarly, a clinic that averages 55 patients per day (i.e., 20,000 patients per year) should leverage the marketing space on its walls, starting with collateral like posters and brochures in exam rooms, waiting rooms and at registration and check-out counters.

A flyer with photos and clear descriptions of the services that “we also offer” can be used by staff members to personally introduce the center’s entire scope of services to each patient and invite them back for their non-work related healthcare needs. Because it usually takes four or five exposures for an advertising message to stick, the more often the patient sees and hears about your urgent care services, the

more likely it is for your center to gain top-of-mind awareness.

The design and messaging of in-center marketing collateral differs from the collateral used for selling to employers. To begin with, many patients don’t know what urgent care is. Some believe it refers to the speed of service or perhaps, since they came to a facility called urgent care for a physical or drug test, they assume it’s only for employers. Effective collateral will clearly define urgent care, outline the circumstances in which the patient would use it, and highlight the benefits over waiting for a doctor’s appointment or paying a high co-pay at the emergency room. Blue-collar patients tend to not be readers, so collateral should favor photographs and bullet points over large blocks of text.

ENGAGING PROVIDERS AND STAFF IN CONVERSION ACTIVITIES

When providers and staff verbally introduce patients to their center’s services, reinforcing the message with a flyer and branded novelties like candy, pens, or magnets, patients are far more likely to remember the message than if they just see a poster. Some centers go so far as recording on a patient chart how many times the message was communicated. But the best introduction is always personal...such as when a medical assistant, upon learning that a patient has a child who plays sports, says, “well you can always bring Lil’ Johnny here for his school physicals.”

One challenge in fostering conversion is distance. When an employee commutes 30 minutes or more to work, the odds are that their employer’s preferred occupational medicine facility is nowhere near their home. It’s also unlikely that a patient will drive past multiple competing urgent care centers to seek care in an industrial setting. Thus many occupational medicine centers are at a disadvantage due to the lack of residential density nearby. You can improve the effectiveness of your conversion efforts by flagging patients who reside in the zip codes closest to your center for special conversion emphasis. For occupational medicine

patients who live outside your center’s 3-5 mile catchment, you can provide a map showing all of your other locations. And for all patients, the message can be: “take advantage of our services on your way home from work.”

EXTENDING THE CONVERSION MESSAGE TO EMPLOYERS

Rising expenses in group health plans tends to be a major concern for corporate executives. To be effective in urgent care, you need to accept each employer’s health insurance. The salesperson most occupational medicine centers employ to manage employer accounts should be tasked with selling employers on the benefits of urgent care in preventing minor illnesses from evolving into something more serious (and more costly) and in reducing emergency room utilization for non-emergent conditions. The key to an employer realizing this value, however, is for this message to be communicated by them to their employees.

Ideas for supporting employers in their communication with employees include posters for locker and break rooms; literature in new employee orientation packets; health and wellness fairs, benefits fairs, educational programs and display tables on-site. In addition, information can be included in annual benefits enrollment packages, paycheck stuffers, the employee newsletter and/or on the employee Intranet.

One goal of employer engagement should be pre-registration of employees in your urgent care practice management system. This will streamline their future visits reduce the hassle of using your center versus your competitor’s, and speed patient flow in the center. The more “fun” you can make your engagement with your clients’ employees, the more likely you are to be invited to visit the work place to deliver your message and return again to reinforce it.

MEASURING EFFECTIVENESS OF CONVERSION ACTIVITIES

Understanding how well your conversion tactics are working requires

In drug testing, you can never
have too many choices

(unless they all come from different companies).



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Oral Fluid



Hair



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Research Request Focuses on Preventing Chronic Disability

By Karen O'Hara

The National Institute for Occupational Safety and Health (NIOSH) is being urged to place a higher priority on research to help prevent work-related injuries and illnesses from unnecessarily becoming chronic disabling conditions.

In a Feb. 9, 2015, letter addressed to NIOSH officials, Gary M. Franklin, M.D., M.P.H., medical director, Washington Department of Labor and Industries, and Kathryn Mueller, M.D., M.P.H., president, American College of Occupational and Environmental Medicine (ACOEM), write:

"We believe secondary prevention requires serious consideration for substantially increased research funding. Although preventing injuries is an essential activity of NIOSH, preventing worker disability should also hold a prominent position. With increasing pressure on Social Security Disability Insurance (SSDI), it is essential that U.S. worker productivity for those who have been injured on the job be maintained and disability prevented."

In this context, secondary prevention may be defined as early diagnosis and treatment of work-related injuries and illnesses to facilitate safe return to work, recovery and full function. Workplace wellness programs that encourage healthy behaviors such as regular exercise and not smoking are examples of primary prevention strategies designed to stop a disease or condition from occurring in the first place. Tertiary prevention deals with managing an existing disease or condition to reduce its impact, such as controlling diabetes or asthma.

Proponents cite a number of reasons for an increased commitment to secondary prevention research:

- The majority of workers who develop persistent low-back pain and other chronic conditions initially experience injuries that were not considered serious at the outset.



- Studies show factors other than the injury itself contribute to a scenario in which about 80 percent of related workers' compensation costs are attributed to only about five percent of injured employees in the U.S.
- Productivity loss is measured in years – not weeks or months – lived with disability. (<http://jama.jamanetwork.com/article.aspx?articleID=1710486>)
- The nation's Social Security system is sagging under the weight of disability related costs.

BURDENS ON SOCIETY

Morbidity and chronic disability account for nearly half of the health burden in the U.S. Related medical, legal and benefits costs, lost productivity and diminished quality of life are liabilities borne by all citizens.

Mental and behavioral disorders, musculoskeletal complaints, vision and hearing loss, anemias and neurological conditions all contribute to increases in chronic disability. Three of the top five conditions accounting for the most Years Lived with Disability (YLD) in the U.S. in 2010 were:

- back (3.18 million YLD)
- other musculoskeletal (2.6 million YLD)
- neck (2.13 YLD) conditions

Anxiety and depression accounted for the other two of the top five conditions.¹

The most consistently reported early predictors of persistent disability after onset of low-back pain are a high

degree of pain interference with ability to work, psychosocial variables such as high fear avoidance and catastrophizing, low expectations of return to work and employer factors including no offer of work accommodation [Turner et al., 2008; Chou and Shekelle, 2010]. Aging and increasing rates of obesity, hypertension and diabetes in the working population are also factors that contribute to longer recovery times and the potential for long-term disability.

Disability originating in federal and state workers' compensation systems often finds its way into the SSDI system. For example, nearly a third of all SSDI recipients have musculoskeletal disorders—many of them attributed to a work injury. In the Washington state workers' compensation system, more than nine percent of compensable claims initiated in 2007 now appear to be headed for a permanent disability designation, Drs. Franklin and Mueller report.

In their letter to NIOSH, they suggest that workers' compensation claims and related data be used to identify strategies that contribute to decreased disability for injured workers and help direct "meaningful interventions for increasing secondary prevention."

RESEARCH OBJECTIVES

At a meeting of workers' compensation and occupational health leaders in December 2014, Drs. Franklin and Mueller said a number of stakeholders suggested secondary prevention research should be in the hands of insurers and others who possess related data.

"The problem," they said, "is that neither the research nor capacity to use data in meaningful ways resides [with] most insurers. In addition, from many years of experience using Washington state workers' compensation data for secondary prevention research, we believe it will take substantial research



Gary M. Franklin

of Environmental and Occupational Health Sciences at the University of Washington, Seattle, and a board-certified neurologist. His research interests include the use of workers' compensation data to study musculoskeletal treatment outcomes, predictors of disability and the impact of care delivery systems on cost, outcome and satisfaction. Dr.



Kathryn Mueller

She is nationally recognized for her role in the development of evidence-based treatment guidelines and knowledge of disability assessment and impairment rating methodology. [See Evidence-Based Occupational Medicine on page 10.]

With sufficient funding, they suggest secondary prevention research could focus on three areas:

1. Summarizing scientific evidence that has already meaningfully contributed to secondary prevention in workers' compensation systems, including:
 - modifiable and other risk factors for disability
 - screening tools to identify workers at greatest risk of developing long-term disability within two-to-six weeks of first report of injury
 - best practices and health system changes that show promise in preventing disability
 - evaluating research on return to work after an occupational injury

incentives to do so."

Both physicians have considerable expertise in this area. Dr. Franklin is a research professor in the Department

Mueller is a professor in the Colorado School of Public Health and medical director of the Colorado Division of Workers' Compensation.

2. Identifying systems and changes in delivery models that have shown promise in secondary prevention of disability and analyzing contributors to disability including overuse of opioid prescription medications, potentially harmful procedures such as spinal fusion and thoracic outlet surgery and prolonged physical therapy.
3. Investigating methods to prevent the transition from acute and sub-acute (musculoskeletal) pain to chronic pain, recognizing that chronic pain is typically concurrent with the development of disability in workers' compensation cases.

"Following the identification of promising approaches to preventing disability, NIOSH, either alone or in collaboration with other institutes, could promote intervention trials to reduce disability in the workplace. These trials would engage NIOSH with employers, workers and workers' compensation insurers in a common mission," Drs. Franklin and Mueller say in their letter to NIOSH Director John Howard, M.D., and Dr. Steve Wurzelbacher, director of the Center for Workers' Compensation Studies.

"NIOSH has not yet worked up a formal response to the letter," Dr. Wurzelbacher reported in early March, partly because the agency is awaiting receipt of draft proceedings from the December meeting.

NIOSH does not have an estimate of funding allocated toward secondary-prevention research, "but can look at the system," he added. "It is a bit difficult because there are many related projects, such as ergonomics, that overlap to secondary/tertiary prevention but are not necessarily coded as such."

FUNDING CHALLENGES

The doctors' request comes at a time when overall funding for NIOSH is threatened. The Obama Administration has proposed eliminating funding for NIOSH's Education and Research Centers (ERCs) and its Agriculture, Forestry and Fishing (AFF) program from the FY 2016 budget it presented to Congress earlier this year. The proposal represents a 15 percent cut in NIOSH's budget, which would total

Work Disability Prevention Guideline Retains Its Relevance

Preventing Needless Work Disability by Helping People Stay Employed is a landmark document that the American College of Occupational and Environmental Medicine (ACOEM) issued as a guideline in 2006.

Jennifer Christian, M.D., an occupational medicine physician and president of Webility, a company dedicated to improving communication among medical professionals, employers and benefit administrators, led the group that developed the guideline to:

- clearly describe the stay-at-work/return-to-work process that determines whether and how people with medical conditions can minimize the life disruption caused by illness and injuries
- recommend ways to improve the process and provide a blueprint to:
- help working people cope best with the impact of medical conditions on their daily lives
- improve outcomes for any type of medically related employment situation, whether covered by disability benefits or workers' compensation programs

The following are four key recommendations contained in the guideline:

1. Adopt a disability prevention model, recognizing that most work-related disability is preventable and successful SAW/RTW requires collaboration among several parties.
2. Address behavioral and circumstantial realities that create and prolong work disability.
3. Acknowledge the powerful impact motivation has on outcomes and make changes that improve incentive alignment.
4. Invest in system and infrastructure improvements.

Note: The Work Disability Prevention Guideline is *not* incorporated in the ACOEM treatment guidelines adopted by the California workers' compensation system as the presumptively correct standard of care. To learn more, visit www.webility.md/acoem-guideline-info.htm.

\$283 million.

In another letter sent earlier this year to congressional leaders, Friends of NIOSH – a coalition of industry, labor, professional, educational and scientific organizations – urged Congress to maintain funding for ERCs and the AFF program, saying their elimination “would limit the ability of workers to avoid exposures that can result in injury or illnesses, push back improved working conditions and eliminate occupational safety and health educational services to over 10,000 U.S. businesses, and ultimately raise healthcare costs.”

Previous bids to eliminate ERC and AFF funding have also been met with protests from the occupational health and safety community.

By comparison, under the FY 2016 budget proposal, the Occupational Safety and Health Administration (OSHA), the government’s enforcement arm, would receive more than \$592 million – an increase of more than \$39.2 million compared to FY2015. Federal enforcement funding would be increased by \$17.6 million, for a total of \$225.6 million.

The American Industrial Hygiene Association’s Government Affairs



Aaron Trippler

Director Aaron Trippler reports that the largest increase would go to whistleblower programs, which would get an additional \$5.1 million (about a 30 percent increase). But

Mr. Trippler warned that it’s too soon to draw any conclusions: “We haven’t even had a real budget the last few years, simply an omnibus bill.”

PREVENTION ORIENTATION

Given that certification in occupational medicine is awarded to physicians by the American Board of Preventive Medicine, an orientation toward population-based health management is to be expected. While clinical care

usually addresses the needs of an individual, public health deals with groups of people, such as workers in a certain type of industry or location. Primary, secondary and tertiary prevention can all be delivered at the population level, according to the Centers for Disease Control and Prevention (CDC).

Many physicians who practice occupational medicine dedicate time to evaluating workplace hazards, analyzing population health trends and making recommendations on preventive health interventions. However, while some employers have embraced evidence that suggests preventive programs result in savings and improved quality of life, others remain unimpressed with return-on-investment scenarios and are reluctant to make significant investments in prevention efforts.

Meanwhile, workers continue to get hurt on the job while occupational health programs and clinics depend on revenue generated from injury and illness treatment and management activities. The reality is that prevention-minded doctors frequently find themselves engaged in secondary prevention—which in turn helps employers recognize that delayed recovery can be anticipated and disability prevented in the majority of workers’ compensation cases.

RECOMMENDATIONS

One of the positive outcomes of secondary prevention research would be

the validation of measures that address “medicalization;” i.e., the process in which non-medical, psychosocial issues become defined and treated as medical problems. While waiting for definitive findings from scientific research, employers and other stakeholders in the workers’ compensation system are advised to²:

- work with qualified occupational health professionals who are prepared to address disability warning signs such as depression, poor performance, frequent absences and inter-personal relationship or financial problems
- arrange for appropriate medical guidance to be provided as early as possible after an injury to educate employees about their condition, evaluate self-care measures and establish realistic expectations for recovery
- advocate for a collaborative, cross-disciplinary approach to help minimize the impact of injury, illness, impairment and aging on employees so they can be functional, productive and enjoy their lives
- develop comprehensive on-the-job recovery and transitional work programs that support return to work and early mobility
- tap into human resources expertise; studies show workplace issues such as poor job fit and not getting along with one’s supervisor contribute to a disability mindset
- encourage the use of behavioral health and employee assistance programs (EAPs)

In addition, experts say employers and others who recognize the power of

National Occupational Research Agenda Under Review

The National Institute for Occupational Safety and Health (NIOSH) is involved in a range of occupational safety and health activities including surveillance, research and technology transfer.

Its portfolio includes National Occupational Research Agenda (NORA) programs that represent 10 industrial sectors and 24 cross-sector programs organized around adverse health outcomes, statutes and global efforts. In evaluating NORA impacts (www.cdc.gov/niosh/nora/) and preparing for the agenda’s third decade beginning in 2016.

NIOSH extramural research and training programs include investigator-initiated research, mentored research, scientist career development awards, training programs and small business innovation research projects. (To learn more, go to www.cdc.gov/niosh/oep/default.html). The agency also supports multi-disciplinary education and research centers, state surveillance programs and global occupational health initiatives.

intersecting conditions and processes are more likely to experience corresponding declines in long-term disability claims. Influencing factors include an injured employee's apparent coping skills and resiliency and access to qualified medical professionals. Washington, a monopolistic workers' compensation state, is providing a model for other jurisdictions. It is attempting to improve access to quality care by establishing a statewide provider network, and it is the first state to authorize the removal of physicians who have caused harm to injured workers [Washington State Legislature, 2011].

"These steps demonstrate the type of commitment that may be needed to make meaningful improvement in the performance of workers' compensation programs," Dr. Franklin and his colleagues say in an article published in the American Journal of Industrial Medicine. (<http://onlinelibrary.wiley.com/doi/10.1002/ajim.22399/full>)³

Applicable regulations, medical insurance and social welfare benefits, and labor laws including protective provisions contained in the Family and Medical Leave Act and the Americans with Disabilities Act, also play an influential role in outcomes, occupational health professionals say.

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Word on the Street

"What is a significant problem you have encountered recently and how did you resolve it?"



MONIKA VALENTINE
Executive Director,
OccMed Colorado,
Thornton, CO

"We have recently encountered the legalization of Marijuana in Colorado.

Our initial reaction was to take two aspirin and call the doctor in the morning! But we re-evaluated the service line options to include HR consulting and other screening options. There is a solution to every problem."



JOE FANUCCHI, M.D.
President and
Medical Director,
MediTrax, Almo, CA

"Four years ago we were faced with a sudden demand for our product. And

we didn't have the staff to be able to respond to all of those requests. We were losing customers because we never got back to the inquiries. I ended up having to look for people who understood sales, who understood occupational health, who understood employee health, and I hired one hired from Belgium, one from Austin, Texas, a nurse in Texas, and a clerical support person from southern New Jersey. Fortunately, we were able to do most of our stuff online."



PATRICK MCINTYRE
Business Director,
Department of
Occupational
Medicine, Reliant
Medical Group,
Worcester, MA

"Access. Traditionally we have been an appointment-based clinic, and it became an impediment to growth. Working with some of our biggest customers, we have moved to a 'hybrid' model that supports walk-in patients for injury treatment, DOT and employment based exams."



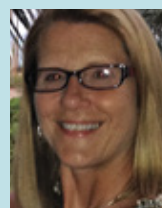
GEORGE PAPPAS, M.D.
President, Tyler
Medical Services,
Saint Charles, IL

"During the economic downturn, we were hit very hard. We looked at every process in our organization and paid very close attention to our overhead. We were able to maintain quality of care and (remain) viable until the economy rebounded."



CARLA HALL
Director of
Occupational Medicine,
WorkSmart, Tifton, GA

"Many larger companies don't want to spend the money for pre-employment physical exams because of employee turnover. We wanted to prove that these assessments can help a company's bottom line by providing an accurate screening tool for job function. We hired a PTA who will go on-site and provide job analysis and measurements and create a job evaluation tool for each position. We can then demonstrate the importance of hiring someone who can demonstrate ability to perform the essential job functions and how this also helps with modified duty, return to work exams and accommodations."



BECKY EDGE
Director of Occupational Health, Health-Link, Freemont, OH

"Many of our companies were having frustrations with injured workers being seen in the ER and then taken off work. After meeting with ED and company representatives, we have initiated a process where all work-related injuries are given a card that instructs them to follow up in our Occupational Clinic the next business day at 8:00 a.m. If the worker does not show up, we follow up with the individual and the company. This has been working very well for all parties."

Evidence-based Occupational Medicine: Integrating Research Evidence with Best Practices in Clinical Care

By Anthony Vecchione

Although formal assessment of medical interventions using controlled trials was established in the 1940s, it wasn't until the late 1970's early 1980's that evidence-based medicine (EBM) became part of the medical lexicon.

Today, applying the scientific method to clinical decision-making is a common practice in healthcare. David Sackett, M.D., the Canadian epidemiologist who helped pioneer evidence-based medicine, defines it as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient."

But what is the role of EBM in occupational medicine? And is it having an impact?

Swedish researcher Jos Verbeek, Ph.D., said that evidence-based medicine goes beyond the development of guidelines to urge practitioners to find the best evidence for any clinical problem. "Little is known about the clinical problems occupational physicians encounter in their daily practices, and the information needs raised by these problems, in contrast to the situation in general [medical] practice," said Dr. Verbeek.

Methods of evidence-based medicine, Dr. Verbeek surmised, could be difficult to apply in this field because occupational medicine differs from general clinical medicine.

Some experts, including Dr. Verbeek, argue that the application of EBM in occupational medicine is hindered because the field is more dependent than other specialties on government regulations. Other experts say EBM faces an uphill battle because there is a dearth of research evidence on occupational maladies.



Steven Crawford

Steven Crawford, M.D., corporate medical director at Meridian Occupational Health in West Long Branch, N.J., agrees that when it comes to

EBM and occupational health, there are other influences and factors at play. "If you hurt your back and you go to the doctor, there may be some secondary gain, but not necessarily monetary. In the workers' compensation world, there is potential monetary gain," Dr. Crawford said.

In his research, Dr. Verbeek and his colleagues attempted to determine if the methods used in evidence-based medicine could answer a few of occupational medicine's most puzzling and common quandaries. They concluded that EBM is a feasible and useful method for occupational medicine issues, but instruction and training will be needed for most occupational physicians to increase their searching and critical appraisal skills. More research will be needed to determine the information needs of these physicians, Dr. Verbeek said, and to develop tools that facilitate literature searches.

A 2009 study published online at *BMC Health Services Research* (www.biomedcentral.com) explored the knowledge infrastructures being used by occupational physicians (OPs) in different countries and how important they are for the successful practice of EBM. Study authors concluded that OPs use many knowledge infrastructure facilities and find them important for their EBM practice.

However, in the article entitled: "Do

knowledge infrastructure facilities support evidence-based practice in occupational health? An exploratory study across countries among occupational physicians enrolled on Evidence-Based Medicine courses," author Nathalie IR Hugenholtz and colleagues conclude that OPs are not used to using evidence-based sources and face barriers that are comparable to the barriers physicians face in primary care. (Read the article at www.biomedcentral.com/1472-6963/9/18.)

The study's authors found that to ensure high professional quality, EBM practice by OPs is essential and an exceptional grasp of the knowledge infrastructure can support this. However, they said that simply enabling (local) access to knowledge might not be sufficient to improve EBM practice.

Industry experts agree that interest in evidence-based occupational medicine is growing. A glance at the National Institutes of Health (NIH) website reveals an abundance of peer-reviewed articles on topics as diverse as:

- Evidence based guidelines for the prevention, identification and management of occupational asthma
- Occupational medicine practice guidelines for interventional pain management
- Evidence based practice-relevance to occupational health nurses

OCCUPATIONAL MEDICINE PRACTICE GUIDELINES GAIN A WIDER AUDIENCE

In October of 2013, the Reed Group, Ltd., acquired the American College of Occupational and Environmental Medicine's (ACOEM), Occupational Medicine Practice Guidelines.

While the Reed Group publishes and distributes ACOEM's Practice Guidelines, ACOEM continues to provide the research, content development and methodology for the guidelines.

Continued on page 12



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Industry insiders applauded the acquisition. Many said it would broaden the distribution base for the Practice Guidelines, increasing their availability to new audiences while at the same time providing access to valuable resources that would ultimately benefit users.

The integration of Reed Group's extensive return to work (RTW) and absence-management strategies and resources for employers with ACO-EM's guidelines was viewed as another benefit of the partnership.

The Practice Guidelines contain more than 2,500 evidence-based recommendations and 15,000 medical literature references and are considered by many to be the industry standard for effective treatment of occupational injuries and illnesses.



Joe Guerriero

"The acquisition has had a significant positive impact in that we have broadened our offering from RTW to the area of treatment and practice. The broadening of

our content has resulted in a broadening of our customer base," said Joe Guerriero, the Reed Group's senior vice president of Disability Guidelines.

"The ACOEM guidelines acquisition [have] allowed us to have deeper relationships with physicians and other allied clinicians as well as platform companies looking to provide a more informed point of care experience."

The Guidelines, Mr. Guerriero asserted, help employers by offering practical safe RTW content and data that provides actionable and measurable information for benchmarking performance.

SUCCESSFUL MODELS

Washington is a single-payer state for workers' compensation and as a result has better control over outcomes than other states. In fact, its Department

of Labor and Industry is designing new occupational health best practices that span the full period of an injured worker's recovery. Best practices currently used by the Centers of Occupational Health and Education (COHE) providers focus primarily on the first 12 weeks of treatment after an injury. The Centers of Occupational Health and Education is a Washington state agency that works with medical providers, employers and injured workers in a community-based program to improve injured worker outcomes and reduce disability by training providers and coordinating cases.

Also under development at Washington State's Department of Labor and Industry:

A Surgical Best Practices Pilot: A pilot program that will test a new set of best practices on surgical patients. A Surgical Health Services Coordinator will be located in the orthopedics clinic to assist 10 orthopedic and hand surgeons. In addition, a Surgical Health Services Coordinator will be located at the COHE in St. Luke's Rehabilitation Institute in Spokane.

Activity Coaching: A pilot program to help patients recover by increasing their activity. It includes a standardized intervention delivered by professional therapists trained by the Progressive Goal Attainment Program (PGAP™). Activity coaching can help patients by reducing psychosocial barriers to rehabilitation progress, promoting reintegration into life-role activities and facilitating return to work.

Functional Recovery Interventions: A pilot program to identify risk of disability and recommend interventions. It began in March 2013 and ended in February 2014. Its goals included testing interventions in cases where a patient was at high risk for disability. (Without interventions, nearly 40% of high-risk patients will still be off work one year after injury.)

Yet another example of Washington's Department of Labor and Industry making use of evidence-based decisions and guidelines is its Health Technology

Assessment program. This program is guiding a number of the state's agencies, ensuring treatments and services paid for with state dollars are safe and effective. It serves as a resource for any state agency purchasing healthcare.

The program commissions scientific reports on the safety and effectiveness of various medical devices, procedures and tests. An independent clinical committee of healthcare practitioners then uses the reports to determine if programs should pay for the service or device.

Participating state agencies include the Health Care Authority, the Department of Social and Health Services (Medicaid), Labor and Industries, Corrections and Veterans Affairs. State agencies using the same evidence-based reports make more informed and consistent coverage decisions.

In addition, this same department has developed The Medical Treatment Guidelines (also referred to as Medical Practice Guidelines or Review Criteria). These guidelines are used in the utilization review program, in claim management and for physician education. They reflect the best available scientific literature and outcome data for Washington's injured workers.

WORKING WITHIN THE SYSTEM

The Ohio Bureau of Workers' Compensation (www.bwc.ohio.gov) views EBM in occupational health as a boon, taking advantage of what research is available to discover what works and what doesn't.

"We have legal aspects to our system that allow the injured worker to get almost anything – so if there are limitations on what we can do, we try to promote the things we know have been successful in the past," said Stephen Woods, M.D., the Bureau's chief medical officer.

"We also recognize that there isn't a double-blinded randomized trial that covers every aspect of care, so we take the best evidence we have. We do this mostly through official disability guidelines [ODG]," Dr. Woods said.

According to its mission statement,

“Did we actually reduce that patients opioid consumption or did they simply move to another payer?”

ODG is designed for clinical practice as well as utilization review/management. Among the overall objectives of users of the treatment guidelines in ODG:

- To improve outcomes and patient satisfaction by focusing on restoration of functional capacity through prompt, responsible delivery of healthcare based on the best medical evidence.
- To reduce excessive utilization of medical services (and corresponding medical costs).
- To identify and target ineffective and harmful procedures.
- To reduce delayed recovery rates and indemnity costs with the concurrent management of treatment and time away from work.
- To improve clinical practice/utilization management by indexing procedures adjacent to a summary of their effectiveness based on supporting evidence, provided by way of link, in abstract form.

Dr. Woods asserted the ODG are relied upon for utilization review and they expect their providers to look at these as they develop their treatment plan. “It doesn’t mean that if there’s a special situation where a case may fall outside of ODG that the provider could not make an exception. That happens rather frequently.”

The Work Loss Data Institute (www.worklossdata.com) has determined that when it comes to implementing EBM at the state level using ODG, the decision to adopt guidelines is not as critical to success as which guidelines a state chooses to adopt. The institute has noted that ODG can improve medical and RTW outcomes as well as reduce costs and improve efficiencies.

One example of how EBM works in Ohio’s system, asserted Dr. Woods, is in the area of lumbar fusion. “We understand what ODG says about the standard of care for fusion. We understand what [the] North American Spine Society says. But we wanted to look at what happens when you apply those rules or guidelines to our system.”

Dr. Woods added that in the Ohio system they found that those who had fusion just didn’t do well. They used more medication (their pain scores were higher). In the first two years they may have done a little better, but after two years they went back to medication at higher doses with higher pain levels and nearly everyone ended up with psychiatric allowances in addition to their spine allowance.

“We shared that information with ODG and we’re looking at the necessity of potentially more (sic) strict guidelines. Not that we’re trying to limit care, but sometimes it just doesn’t make sense,” said Dr. Woods.

The Bureau is also addressing EBM in regard to drug utilization. Dr. Woods said it’s important to make sure workers are getting the medications they need and that those medications benefit their recovery and their return to work without causing side effects or other problems. (For example, if a worker is injured and requires an opioid, that they don’t end up with an addiction problem.)



John Hanna

John Hanna, pharmacy program director at The Ohio Bureau of Workers’ Compensation, said the pharmacy and therapeutics (P&T) committee is charged with

development and maintenance of their formulary. The formulary is managed according to the belief that if you have appropriate drug utilization you’re going to positively impact the worker’s recovery and his return to work with a reduced side effect profile and at a reduced cost. “But the cost follows everything else. And we’ve been able to

demonstrate that across the board . . . since the formulary went into effect in 2011,” said Mr. Hanna.

Mr. Hanna said the bureau has consistently added limitations to the original formulary and applied best practices.

“For instance, we don’t cover Soma [carisoprodol] or any other drug in that class because there are better and safer alternatives on the market,” said Mr. Hanna.

He added that they don’t cover any of the sustained release opioids like oxycodone, Exalgo (hydromorphone hydrochloride), until an injured worker has demonstrated that they cannot take basic morphine sulfate extended release.

“We have restrictions on the Benzodiazepines, on our maximum daily amount of Xanax (alprazolam)-type drugs. That was done by looking at the psychological literature that’s out there to [determine] what’s a reasonable dose,” said Hanna.

“We’ve seen a significant drop in our opioid utilization over the last four years,” he said.

The Bureau is in the process of reviewing the Ohio Pharmacy Board’s database. The Pharmacy Board has a prescription medication-reporting program and Mr. Hanna intends to look at patients who had a substantial change in their opioid utilization. “We are going to look at it [and ask] ‘did we actually reduce that patients opioid consumption or did they simply move to another payer?’ By mid-year we’re hoping to report that data.”

LESSONS LEARNED GOING FORWARD

Dr. Woods pointed out that the ability to review internal data is crucial to future decision-making. “We have a huge data warehouse and we can look at how people did based on what the guidelines were. If people aren’t doing as well as we expect, we may need to adjust the treatment protocols or guidelines,” said Dr. Woods. In addition to looking at spinal fusion, the bureau is currently looking at spinal

Continued on page 15



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cord stimulators and shoulder care.

In a 2006 article, “Evidence Based Occupational Health: From Theory To Practice,” published in *The Italian Medical Journal of Work and Ergonomics*, Giuliano Franco, M.D., tries to illustrate the opportunity EBM presents. Dr. Franco stated that in spite of some barriers, such as time constraints, the evidence-based decision-making process should be founded on evidence provided by major resources. “Acquiring the skill for information managing facilitates searching appropriate solutions to [the] problems usually met in professional practice and the adoption of behaviors which will improve the practice,” Dr. Franco said.

In the *BMC Health Services Research* article, the authors say that among the strategies important for the support of an EBM practice are: 1) support from colleagues and management to practice EBM and 2) the motivation of OPs to take responsibility for delivering the best possible occupational healthcare. They also say that new initiatives for providing cost-free access to medical and occupational literature databases and full-text articles would contribute to knowledge dissemination.

Occupational medicine experts contend that there is overwhelming evidence that scientifically based guidelines developed by occupational medicine physicians’ have had a major impact on addressing problems within workers’ compensation systems.

In an article published in a 2004 edition of *Health Psychology and Rehabilitation*, Kathryn Mueller, M.D., president of The American College of Occupational and Environmental Medicine (ACOEM), said that one of the key steps in the development of evidence-based practice guidelines is the creation of multidisciplinary teams.

“In an ideal world, you would look at all the pertinent literature and select the highest quality, evidence-based studies that address a given guideline. In reality, you often find that there are not any high-quality studies in the specific area you are reviewing.” Dr. Mueller, former medical director of the Colorado Division of Workers’ Compensation, added: “Given these limitations, you need the involvement of all of the relevant specialists for each guideline. They can bring a well-rounded perspective to the discussion of the available evidence in order to make an appropriate recommendation.”

Creating scientifically based guidelines, asserted Dr. Mueller, “performs a useful service for practitioners in this information age while at the same time provides the scientific foundation that individual practitioners can’t develop for themselves.”

Epidemiologist, Edward Whitney, M.D., said that among the many benefits of producing evidence-based guidelines is the issue of adherence. “Scientific support is one of the variables that gives guidelines credibility—making it more likely that practitioners will implement them.”

looking at a) the number and percentage of occupational medicine patients returning to your center for urgent care; and b) the number and percentage of your urgent care patients who were originally occupational medicine patients. Because many mixed-model centers utilize different practice management systems for occupational medicine and urgent care, this may entail “dumping” patient records into an external database and creating custom reports.

Patients who have top-of-mind awareness and fully intend to use a center for urgent care may not have an immediate medical need, so conversion is typically looked at in six, nine and 12-month intervals. A “forward” look matches occupational medicine patients during a certain month to urgent care records with the same identifier (i.e., social security number or home address) over each of the subsequent six to 12 months. Using this approach, conversion rates for a particular month will increase over time as more patients return to the center. This approach generally requires a full year to attain an accurate conversion figure. The alternative approach starts with urgent care records during a certain month and looks backwards to see if those patients had previously come in for occupational medicine. The advantage of the latter is a mature conversion figure at the outset.

A shortcoming is that both methods imply causation; the assumption being the patient came back for urgent care due to the conversion tactics as opposed to other reasons such as long-term loyalty. Conversion may be reported at the individual patient or household level (realizing the value of word-of-mouth in families and that a parent may return with a child) as well as for a single center or for all centers in a multi-site operation.

Additional metrics include questions on patient satisfaction surveys such as: “Are you aware this center offers urgent care services,” or, “At any time during your visit, did our provider or staff explain our urgent care services to you?” These types of questions not only force accountability on the center’s team but also reinforce the message as the patient completes the survey.

CONCLUSION

As we witness the convergence of occupational medicine, urgent care and clinic-based medical services, it should always be less expensive and easier to educate existing patients about additional services offered at your facility than to draw entirely new patients in from the street. Conversion tactics are somewhat simple to execute, starting with posters and flyers in your center and expanding to messages communicated by providers, staff and employer-clients. Success entails understanding the levers that drive your patients’ healthcare decision making, communicating your message in a way that sticks and establishing reporting processes that will help you gauge your performance.



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Embracing the Employer Perspective

Movie buffs surely recall the 2000 hit “What Women Want,” featuring Mel Gibson as an ad executive with the unique power to “hear” what women were thinking whenever one or more was in his presence.

Wouldn't it be nice if we too had the power to “hear” what our employer clients and prospective clients are thinking? While hardly Gibson-esque, RYAN Associates maintains a treasure trove of survey data from employers throughout the country that should provide programs with a sense of what is going on in the typical employer's mind vis-à-vis employee health.

Since it was founded in 1985, RYAN Associates has been conducting employer market research in hundreds of markets. Many questions in each survey are tailored for individual clients or have been asked in only a few surveys. However, many other questions have been asked in every employer survey and the cumulative data offer compelling insight into employer thinking and preferences.

Based on a statistically significant cohort of 2,096 employers who completed surveys recently in dozens of markets—a mix of urban, suburban and rural markets in every region of the country—the following data and their implications are worth considering.

QUESTION #1: Respondents were asked to rate the perceived value of various health services that might be offered to area employers on a scale of five to one. Below are numbers of respondents (given in percentages) who rated each service as “exceptionally valuable.”

State of the Art Rehabilitation Services	37%
Wellness Education	35%
Employee Assistance Program	30%
Women's Health Program	29%
Children's Health Program	27%
Family Health Program	26%
Addiction Medicine Program	24%
Work Site Safety Consultations	21%
Availability of a Fitness Center	20%
Sports Medicine Program	13%

DISCUSSION: The strong interest in rehab services suggests that employers generally recognize the value of “state of the art” rehab in managing the most chronic (and expensive) conditions of their employees. Many occupational health programs are either not adequately connected with their own organization's rehab services or fail to tout their rehab capabilities to clients and prospects.

Historically, wellness services are of keen interest to employers. The dilemma lies in translating this interest into sustainable programs that make a difference and pricing these services

appropriately. On the lower end of the list, a sports medicine program per se does not appear to be of interest to the respondents. Given the proliferation of fitness facility options in most communities today, the availability of a healthcare organization-affiliated fitness center may seem so yesterday in the minds of many employers.

QUESTION #2: Our employer participants were asked if their occupational health programs were extremely effective (5) or not at all effective (1) at communication in the following areas:

	Extremely Effective	Scaled score
Communication with Patients	21%	3.26
Communication with the Community	18%	3.32
Communication with Employers	15%	3.02
Communication Between Providers and Patients	13%	3.06
Communication Between Support Staff and Patients	12%	3.02
Communication Within their own Organization	8%	2.53

DISCUSSION: The “C” word—communication—is central to virtually any discussion of occupational health services. RYAN Associates' surveys explored six different types of occupational health program communication. It is notable that none of the six areas received a large vote of confidence in terms of mean score. Curiously, perceptions of how well healthcare organizations communicated within their own organization suggest widespread skepticism that things are going well behind the scenes.

QUESTION #3: Employer respondents were then asked to rate the perceived effectiveness of various marketing outreach methods on a scale of five to one (extremely effective to not at all effective):

An Open House at Program's Facility/Clinic	3.58
Receipt of Written Material via Mail	3.56
A Personal Tour of the Program Facility/Clinic	3.56
A Bi-weekly Educational tip via Email	3.42
A Free Educational Program at your Workplace	3.27
An Education Seminar at a Local Hotel	3.27
A Work Site Walkthrough by a Physician	3.12
A Phone call Introduction by a Physician	3.01
A Personal Visit by a Sales Representative	3.00
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An Educational Seminar via Audio/Web Hook-up	2.89

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DISCUSSION: How times have changed! High-touch/hands-on marketing is the new in and old fashioned face-to-face sales calls are the new out. At the heart of most programs' marketing should be a stream of open houses and tours of clinics by employer prospects. Surprisingly, that old staple—written materials sent through the mail—seems to be making a comeback as email and other technology driven marketing is starting to overwhelm. However, care must be taken to ensure that such distributions are accompanied by a personally signed letter and are considered an adjunct rather than a core outreach tactic.

QUESTION #4: Employer respondents were asked how satisfied they were with our client's occupational health program. The following table indicates the percentage of respondents who were "extremely satisfied" with each potential program attribute:

Location(s)	45%
Staff Professionalism and Courtesy	45%
Appointment Availability	38%
Written and Verbal Communication	38%
Overall Quality of Services	37%
Facilitating an Early Return to Work	31%
Diagnosis and Medical Treatment	31%
Billing Services	30%
Coordination of After-Hours Care	30%
Patient Waiting Time	25%
Quality of Emergency Department *	24%
Pricing	21%

*Asked of hospital-affiliated clients only

DISCUSSION: Notably, process-oriented variables such as accessibility (i.e., location), appointment availability and communication trump the core outcome variable: "facilitating an early return to work." It appears that many employers more easily grasp onto what they see before their eyes than something (i.e., outcomes) that is best measured over time.

Of the lower-rated variables, employer concerns with pricing, wait times and emergency department services are not surprising but do reinforce the need to proactively address these chronic problem areas.

Facilitating an early return to work is rated as the most important factor in selecting a provider (see question five below) yet less than a third of responding companies report that they are "extremely satisfied" with performance in this area. This suggests that if programs can document positive RTW outcomes to clients, they can gain an edge in the marketplace.

QUESTION #5: Employer respondents were asked to rate the importance of each of the following on a five to one scale with five being "extremely important" in selecting an external provider of occupational health services.

Employees' Return-to-Work (RTW) Performance	71%
Timely Patient Turnaround	70%
Proximity to Your Company	66%
A Physician Trained in Occupational Medicine	64%
Same Day Lab Test Results	58%
Provider Reputation	58%
Pricing	52%
Strong Rehabilitation Program	51%
Written Reports From the Clinic or Physician	51%
Streamlined Billing Services	51%
Availability of Walk-in Appointments	48%
Broad Range of Services	47%
Familiarity With Your Company	32%
Availability of Work Site Based Services	27%
24-Hour Service	24%
Employee Preference	24%

DISCUSSION: There is a large spread between the perceived importance of service attributes. Return to work performance leads the pack but is followed by a host of variables that reflect convenience and process: patient turnaround, location and same day lab test results all receive high ratings. Pricing is rated as important but is at a midpoint on this array.

That the "availability of work site based services" received only a 27 percent rating is misleading. Although fewer respondents were interested in this service, that 27 percent of employers think it is important suggests an excellent opportunity exists for pinpointing clients who are amenable to such high value relationships.

Key Take Away Points

1. Effectively integrate rehab services into your overall program.
2. Target intra-organization communication as an area for improvement.
3. Reconsider building that fitness center you had on your long-term to do list.
4. Make personal visits to your facilities a key marketing tactic.
5. Don't write off brochures just yet, but be sure a personal letter is included in the envelope.
6. Proactively plan strategies to minimize wait times, price fairly and (if appropriate) enhance your program's interface with your emergency department.
7. Use survey research to pinpoint opportunities for on-site services.
8. Work on return to work metrics and outcomes; it is your client's priority.

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WorkCompEDI, Inc.

WorkComp EDI is a leading supplier of workers' compensation EDI clearinghouse services, bringing together Payors, Providers, and Vendors to promote the open exchange of EDI for accelerating revenue cycles, lowering costs and increasing operational efficiencies.

Marc Menendez

Phone: (800)297-6906

Fax: (888) 454-2681

MMenendez@WorkCompEDI.com

www.workcompedi.com

Laboratories & Testing Facilities

Clinical Reference Laboratory

Clinical Reference Laboratory is a privately held reference laboratory with more than 20 years experience partnering with corporations in establishing employee substance abuse programs and wellness programs. In addition, CRL offers leading edge testing services in the areas of Insurance, Clinic Trials and Molecular Diagnostics. At CRL we consistently deliver rapid turnaround times while maintaining the quality our clients expect.

Dan Wittman

Phone: (800) 445-6917

Fax: (913) 492-0208

wittmand@crlcorp.com

www.crlcorp.com

eScreen, an Alere Company

eScreen is committed to delivering innovative products and services which automate the employee screening process. eScreen has deployed proprietary rapid testing technology in over 2,500 occupational health clinics nationwide. This technology creates the only paperless, web-based, nationwide network of collection sites for employers seeking faster drug test results.

Robert Thompson

Phone: (800) 881-0722

Fax: (913) 327-8606

marketing@escreen.com

www.escreen.com

MedDirect

MedDirect provides drug testing products for point-of-care testing, lab confirmation services and DOT turnkey programs.

Don Ewing

Phone: (479) 649-8614

Fax: (479) 648-3246

dewing@gomeddirect.com

www.gomeddirect.com

Oxford Immunotec

TB Screening Just Got Easier with Oxford Diagnostic Laboratories, a National TB Testing Service dedicated to the T-SPOT.TB test. The T-SPOT.TB test is an accurate and cost-effective solution compared to other methods of TB screening. Blood specimens are accepted Monday through Saturday and results are reported within 36-48 hours.

Noelle Snider

Phone: (508) 481-4648

Fax: (508) 481-4672

nsneider@oxfordimmunotec.com

www.tbtestingservices.com

Quest Diagnostics Inc.

Quest Diagnostics is the nation's leading provider of diagnostic testing, information and services. Our Employer Solutions Division provides a comprehensive assortment of programs and services to manage your pre-employment employee drug testing, background checks, health and wellness services and OSHA requirements.

Aaron Atkinson

Phone: (913) 577-1646

Fax: (913) 859-6949

aaron.j.atkinson@questdiagnostics.com

www.employersolutions.com

Medical Equipment, Pharmaceuticals, Supplies and Services

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Abaxis® provides the portable Piccolo Xpress™ Chemistry Analyzer. The analyzer provides on-the-spot multi chemistry panel results with comparable performance to larger systems in about 12 minutes using 100uL of whole blood, serum, or plasma. The Xpress features operator touch screens, onboard iQC, self calibration, data storage and LIS/EMR transfer capabilities.

Joanna Athwal

Phone: (510) 675-6619

Fax: (736) 262-6973

joannaathwal@abaxis.com

www.abaxis.com/index.asp

AlignMed

AlignMed introduces the functional and dynamic S3 Brace (Spine and Scapula Stabilizer). This rehabilitation tool improves shoulder and spine function by optimizing spinal and shoulder alignment, scapula stabilization and proprioceptive retraining. The S3 is perfect for pre- and post-operative rehabilitation and compliments physical therapy.

Paul Jackson

Phone: (800) 916-2544

Fax: (949) 251-5121

pjackson@alignmed.com

www.alignmed.com

A-S Medication Solutions LLC

ASM, official Allscripts partner, introduces PedigreeRx Easy Scripts (PRX), a web-based medication dispensing solution. Allowing physicians to electronically dispense medications at the point-of-care with unique ability to integrate with EHR or be used stand-alone. PRX will improve patient care, safety and convenience, while generating additional revenue streams for the practice.

Lauren McElroy

Phone: (888) 990-6510

info@a-smeds.com

www.a-smeds.com

Automated Health Care Solutions

AHCS is a physician-owned company that has a fully automated in-office rx-dispensing system for workers' compensation patients. This program is a value-added service for your workers' compensation patients. It helps increase patient compliance with medication use and creates an ancillary service for the practice.

Shaun Jacob, MBA

Phone: (312) 823-4080

Fax: (786) 594-4645

sjacob@ahcs.com

Keltman Pharmaceuticals, Inc.

Keltman is a medical practice service provider that focuses on bringing innovative practice solutions to enhance patient care, creating alternative revenue sources for physicians. Keltman's core service is a customizable point-of-care dispensing system. This program allows physicians to set up an in-office dispensing system based on a formulary of pre-packaged medications selected by the physician.

Wyatt Waltman

Phone: (601) 936-7533

Fax: (601) 936-7787

wwaltman@keltman.com

www.keltman.com

Lake Erie Medical & Surgical Supply, Inc./QCP

For 24 years Lake Erie Medical has served as a full-line medical supply, medication, orthopedic and equipment company. Representing more than 1,000 manufacturers, including General Motors, Ford and Daimler-Chrysler, our bio-medical inspection and repair department allows us to offer cradle-to-grave service for your medical equipment and instruments.

Michael Holmes

Phone: (734) 847-3847

Fax: (734) 847-7921

Mikeh@LakeErieMedical.com

www.LakeErieMedical.com

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CMAP Pro™ Version 2.0 provides physicians, patients, insurance companies, corporate self-insured, and other affiliates the ability to obtain objective, clinically-useful data on soft tissue injuries. CMAP Pro™ manages this through the deployment of a full suite of proprietary technologies.

David Schwedel

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dschwedel@med-tek.com

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PD-Rx

PD-Rx offers more than 8,000 prepackaged medications for your in-office dispensing needs. Our FREE, easy-to-use web-based dispensing software enhances the in-office dispensing experience, from managing your inventory and facilitating online ordering, to ensuring state regulatory compliance. PDRxNet software also provides the opportunity to ePrescribe directly from your Electronic Medical Record (EMR) to our web-based dispensing product. PD-Rx is fully pedigree compliant and is licensed in all 50 states.

Jack McCall & Bernie Talley

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Software Providers

Axion Health, Inc.

Axion Health provides employee health, occupational health, medical surveillance, and emergency preparedness software. Axion's ReadySet 4 is a 100% paperless mobile-friendly, Web-based solution that is easy to use, Internet-accessible, HIPAA and NIST-compliant. The solution also offers robust integrations with clinical, HR, and regulatory systems.

Scott Meier

Phone: 877-770-3073

smeier@axionhealth.com

www.axionhealth.com

DocuTAP

DocuTAP is a cloud-based, integrated EHR and PM software made specifically—and only—for urgent care. Meaningful use certified, DocuTAP has customizable provider templates to streamline patient workflow to down to the second, including occupational medicine and work comp. Save time with employer-specific protocols, fee schedules, and auto form population.

Dusty Schroeder

Phone: (877) 697-4696

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www.docutap.com

Net Health

Net Health is the leading provider of clinical solutions for outpatient specialty care. Our certified Electronic Health Record (EHR) is utilized by over 20,000 healthcare professionals in more than 1,100 healthcare facilities. Providers throughout the care continuum use Net Health's fully integrated platform to record clinical procedures and drive financial results while improving patient care and outcomes.

Renee Vandall

Phone: (412) 225-4987

rvandall@nhsinc.com

www.nhsinc.com

MediTrax

MediTrax provides affordable, user-friendly information management for occupational health. Optimize your efficiency with point-and-click scheduling, user-defined clinical protocols, automated surveillance tracking, integrated EMR, one-click billing and administrative reporting, and much more. With free on-site training, and no per-user fees or annual lease costs, it's the Gold Standard for affordability and ease of use!

Joe Fanucchi, MD

Phone: (925) 820-7758

Fax: (925) 820-7650

drjoe@meditrax.com

www.meditrax.com

Practice Velocity

With over 600 clinics using our software solutions, Practice Velocity offers the VelociDoc™—tablet PC EMR for urgent care and occupational medicine. Integrated practice management software automates the entire revenue cycle with corporate protocols, automated code entry, and automated corporate invoicing.

David Stern, MD

Phone: (815) 544-7480

Fax: (815) 544-7485

info@practicevelocity.com

www.practicevelocity.com

UL Workplace Health and Safety (formerly UL PureSafety)

Occupational Health Manager® (OHM)

is a results-driven software solution for occupational health and safety professionals. It has helped thousands of customers – from small onsite occupational health clinics, to employee health departments in hospitals and health systems, to Fortune 500 companies – increase efficiency and productivity, reduce workplace injuries and illnesses,

and improve health and safety awareness. Features include: medical surveillance, tracking and analysis, case and return-to-work management, immunization monitoring, and workforce safety and education modules.

SYSTOC® is a powerful information management software solution for hospital-affiliated occupational health programs, freestanding occupational health clinics, urgent care and mixed-use clinics. Our innovative tap2chart® technology generates transcription with a single click. Interfaces enable the exchange of information for drug and alcohol, lab and radiology diagnostic test results. Additional features include: support of electronic and/or paper-based recordkeeping and sophisticated insurance authorization and billing options.

Lauren Hoffman

Phone: (615) 567-0316

Fax: (615) 367-3887

lauren.hoffman@ul.com

www.ulworkplace.com

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Ms. Lisa Ward

Phone: (904) 296-1189

sales@xppte.com

www.xpresstechnologies.com



Calendar

April

APRIL 27-29

Beyond the Affordable Care Act:
The next frontiers for health
care reform

Harvard T.H. Chan School of
Public Health, Boston, MA

ecpe.sph.harvard.edu/programs.cfm?CSID=ACA0415&pg=cluster&CLID=1



To list your event, email Isabelle
Walker at iwalker@naohp.com

May

MAY 3-6

American Occupational
Health Conference
100th Annual Meeting of
the ACOEM

Hilton Baltimore, Baltimore, MD

www.acoem.org/

MAY 19-21

National Occupational Injury
Research Symposium (NOIRS) 2015
Camp Dawson Training Center
Kingwood, WV

NIOSH/American Society of Safety
Engineers/Liberty Mutual Research
Institute for Safety/National Safety
Council/Society for Advancement
of Violence and Injury Research
NOIRS@cdc.gov

June

JUNE 4-5

American Nurses Association
Ethics Symposium
The Sheraton Inner Harbor Hotel
Baltimore, MD

[www.nursingworld.org/
MainMenuCategories/Conference/
ANA-Ethics-Symposium](http://www.nursingworld.org/MainMenuCategories/Conference/ANA-Ethics-Symposium)

JUNE 7-10

American Society of
Safety Engineers
Safety, 2015
Kay Bailey Hutchinson Convention
Center, Dallas, TX
www.safety2015.org

JUNE 8-10, 2015

Customer-Driven Strategies for
Health Care Professionals
Harvard T.H. Chan School of Public
Health, Boston, MA
ecpe.sph.harvard.edu/programs.cfm?CSID=CDS0615&pg=cluster&CLID=1

Board Roster

NAOHP REGIONAL BOARD REPRESENTATIVES AND TERRITORIES

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Mike Schmidt 2015-2017

Director of Operations
St. Luke's Occupational Health Services
Sioux City, IA
schmidMS@stlukes.org

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NJ, NY, PA, DC, WV

Debbie Borisjuk, MBA, PT 2013-2015

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SOUTHEAST – AL, FL, GA, MS, NC, SC, TN, VA

Brenda Jacobsen, MBA, CPA 2015-2017

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MIDWEST - IL, IN

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MT, NE, ND, OK, SD, TX

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WEST – AK, AZ, CA, CO, HI, ID, NM, NV, OR,
UT, WA, WY

Marilyn Trinkle 2014-2016

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AT LARGE

Rick Schneider 2015-2016

Executive Director of Occupational
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AT LARGE

Randy Van Straten 2015

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