“Management works in the system; leadership works on the system.”
—Stephen R. Covey

By Karen O’Hara

Todd Baker distills his approach to clinic management down to a few critical, inter-related concepts: philosophy, entrepreneurship, economies of scale and communication.

Mr. Baker, executive director of ambulatory care services at Proctor Hospital, Peoria, Ill., is a proponent of the mixed-use model. He believes occupational medicine complements immediate personal care, and vice versa.

Under his direction, Proctor First Care operates a network of five geographically dispersed clinics offering primary, urgent and episodic care and occupational medicine services on a walk-in basis and by appointment. (Episodic care is defined as care provided when a patient’s own doctor is not available or when a patient does not have a primary provider.)

While the patient mix varies by location, about 8 percent of Proctor First Care’s business is true urgent care and 30 percent is occupational medicine. The remainder is primary or episodic care, Mr. Baker said during a presentation at RYAN Associates’ recent seminar on Integrating Urgent Care and Occupational Health Services.

“I submit to you that blending urgent care and occupational medicine is a philosophy that requires a certain type of leadership,” Mr. Baker told the assembly of occupational health professionals at the seminar.

The following is a “Baker’s dozen” of recommendations for the successful operation of a blended clinic network:

**Challenge 1: Competing Agendas**

In any community health system, it is not unusual to find an urgent care manager with one agenda reporting to a hospital executive, an occupational health program director with another agenda reporting to the same or a different executive, and clinics that “go into the never-never land where doctor’s offices owned by hospitals seem to go all the time,” Mr. Baker said. In such cases, multiple entities vie for resources within the same organization, potentially creating an “us-against-us” scenario.

**Baker’s Solution:** “Top management should make one person responsible for all those businesses. When that is the case, all of a sudden the politics start to crumble and we can get to economies of scale.”

**Challenge 2: Provider Coverage**

Physicians working in emergency departments often have sporadic, unpredictable
Industry Leaders Share Views on State of Occupational Medicine, Workplace Safety

T. Warner Hudson III, M.D.

T. Warner Hudson III, M.D., was installed as the American College of Occupational and Environmental Medicine’s (ACOEM) president for 2011-2012 during the college’s 96th annual membership meeting in Washington, DC.

In his acceptance remarks, *Heading in the Right Direction: An ACOEM Travel Guide*, Dr. Hudson compared his recent trip to Antarctica with the journey of occupational and environmental medicine (OEM). Dr. Hudson explored the diversity of the specialty in terms of practice settings, expertise and delivery (i.e., as public health officers, experts in emergency preparedness, MROs). Dr. Hudson also noted that despite this diversity, OEM physicians are united in their roles as primary, secondary and tertiary clinical preventionists as well as population preventionists.

Occupational physicians are now more than ever front-line clinicians who care for the health of millions of employees, their dependents and retirees, he said.

He also noted that ACOEM and OEM face numerous challenges including:

- the need for training and funding;
- meeting market demands and providing the educational resources to fill jobs with physicians qualified in OEM;
- continuing to develop the best evidence-based practices and health outcomes in ways that change practitioner behavior;
- addressing the unpredictability and “re-jiggering” of health care reform by focusing on underlying causes;
- becoming even more involved in the public policy arena;
- continuing to help build a model that pays for prevention and good health outcomes in addition to illness care;
- building stronger partnerships with federal government health and safety agencies;
- working together in the most coordinated and effective ways possible over the next five to 10 years to reinvent OEM physicians as population health leaders and preventionists;
- remembering that what OEM physicians do is for those who work, and to further help to make work something which fosters health, safety and the environment.

Dr. Hudson is medical director of the Occupational Health Facility at the University of California Los Angeles. He is on the medical staff at Ronald Reagan Medical Center and is responsible for occupational health for UCLA Campus and Health System employees at the Westwood and Santa Monica campuses.

Other officers installed for one-year are President-elect, Karl Auerbach, M.D., and Vice President Ronald R. Loeppke, M.D.. Members installed as directors for three-year terms (2011-2014) are Drs. Alan Engelberg, Dean Gean, Amanda Trimpey and Mark Taylor, who fulfills a new position of Young Physician Director.

NIOSH and the Occupational Safety and Health Administration (OSHA) observed their 40th anniversaries on April 28. The following is excerpted from a longer message. Refer to www.cdc.gov/niosh/enews/enews8n12.html

**The Second 40 Years:**
From the Desk of John Howard, M.D., Director, National Institute of Occupational Safety and Health

“After 40 years, one can take the measure of an organization with some degree of confidence in assessing how well it has carried out its assigned and ongoing mission: Has it been sufficiently flexible to meet inevitable social, economic and technological changes? Has it provided the benefits to society that it was intended to provide? Is it well-positioned to meet ongoing changes that the next 10, 20, or 40 years will bring?

“We at NIOSH are proud of our record, which spans many dramatic changes in the nature of work in the

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Aegis Gets New President

Pearson Talbert has been appointed president of Aegis Health Group, Nashville, Tenn., a member of the NAOHP Vendor Program, Chairman of the Board Roland Wussow announced. Mr. Talbert was serving as Aegis’ chief development officer. He replaces Henry Ross, who stepped down to pursue other interests. Mr. Ross will remain on the company’s board of directors.

Aegis is a leading provider of revenue growth strategies for hospitals. “Aegis is uniquely positioned to help hospitals of all sizes, regardless of affiliation, attract profitable market share and build physician loyalty,” Mr. Talbert said. “I look forward to continuing the legacy of leadership Aegis has forged in helping hospitals build revenue growth and market share.”

Mobile Application Introduced

Healthagen®, developer of a leading mobile consumer healthcare application iTriage®, announced a partnership with Practice Velocity®, a member of the NAOHP Vendor Program. Practice Velocity specializes in medical software solutions for the urgent care industry. The partnership will enable iTriage users to make appointments and pre-register for urgent care visits through Practice Velocity’s ZipPass® function. Integrating this feature into the iTriage application allows patients to register and “get in line” for an urgent care visit using their mobile device, company officials said.

“Physician appointment setting and pre-registration are emerging trends in the health care industry. iTriage is leading this trend by empowering the patient with convenient access through mobile devices,” said David Stern, M.D., CEO of Practice Velocity. “Since iTriage has both the largest international database of health care providers and smart phone users finding health care through mobile technology, patients will be able to easily and instantly book urgent care appointments.”

Doug Benner, M.D., Honored

Longtime NAOHP member Douglas A. Benner, M.D., received the American College of Occupational and Environmental Medicine’s most prestigious honor – the William S. Knudsen Award – at the college’s recent annual meeting.

The award, established in 1938 by Mr. Knudsen, who was then president of General Motors, recognizes an individual who has made an outstanding contribution to the field of occupational and environmental medicine.

Dr. Benner was recognized for exemplary efforts as a member on various ACOEM committees and for his leadership in the Western Occupational Environmental Medicine Association (WOEMA). He is known for his expertise on such diverse topics as utilization review, medical provider networks, and the permanent disability rating schedule, and for his vast knowledge of OEM.

“As Coordinator of Occupational Health at Kaiser Permanente Regional Occupational Health in Oakland, California, Dr. Benner has given freely of his time and expertise to the state of California’s efforts on workers’ compensation reform,” ACOEM President Natalie Hartenbaum, M.D., said in presenting the award.
schedules. When they transition to urgent care settings (as is often the case), they may bring along the expectation of working without a stable schedule, not realizing the customer values a greater degree of provider consistency.

**Baker’s Solution:** “Create a fixed schedule for providers. It’s a matter of not putting the physicians into a blender, pouring them out into the ice cube tray and whoever lands in the tray works the shift that day. Instead, Dr. X knows what days of the week he or she will be working in the clinic.

“We are talking about the same docs, in the same box, in the same day, all working a full shift. We have very few one-day-a-week docs in those boxes.”

**Challenge 3: Managing the Mix**

In a busy blended clinic, providers must learn how to adjust to the variety of patients who walk in the door on any given day. “That is going to be hard for your physicians,” Mr. Baker said. “They are not necessarily going to be able to shift hats on the fly, because your sales and marketing team will be doing such a great job filling up the waiting room.”

In addition, a treating clinician may wonder: What exactly is the difference between treating a woman who sprained her ankle while mowing her lawn and treating the same woman who sprained her ankle while pushing a cart at work? Regardless of the source of the injury, the patient is always the customer, but as occupational health professionals are well aware, there are numerous additional clients when managing a workers’ compensation case.

**Baker’s Solution:** “Allow your physicians to focus on the patient and

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**13 Trends Driving Changes in Practice Settings**

The following are 13 trends in occupational health and urgent care cited by Roy Gerber, senior principal, RYAN Associates, at a recent conference on *Profiting from Product Line Diversity: Integrating Urgent Care and Occupational Health Services:*

**Occupational Health Trends**

1. Continuing movement toward urgent care or mixed models driven by such factors as:
   - The changing nature of jobs, e.g., more temporary and part-time worker without benefits
   - Economic conditions
   - Declining work-related injury and illness rates
   - Research that shows chronic disease and obesity is responsible for 75 percent of health care cost increases
   - Growing awareness of links between health risk assessment and targeted interventions
2. Product line expansion to incorporate a comprehensive slate of wellness offerings.
3. Product line expansion toward the expansion of onsite service capabilities.
5. Sharing of health data:
   - Incentives under the HITECH Act are accelerating the adoption of electronic health record systems, even by those who do not qualify for incentives
   - Tech savvy patients are demanding electronic access to their data
6. Renewed emphasis on sales and marketing as a result of competition and other factors including:
   - Improved understanding of employer relationships and downstream referral benefits
   - Quality and performance expectations being set by for-profit organizations and franchises
   - Availability of training, coaching and mentoring for sales professionals
   - 7. Provision of episodic care for client company employees and family members is convenient, reduces group health expenditures and provides economies of scale.

**Urgent Care Trends**

1. Continued robust growth in the urgent care clinic market driven by such factors as:
   - nation’s primary care physician shortage
   - health care reform
   - emergency department costs
   - a shift to high-deductible plans
2. Expansion into occupational health/workers’ compensation to produce incremental revenue, be more competitive, and improve clinic value and community perceptions.
3. Chain drug stores/retail-based clinics. For example, CVS Caremark has about 550 Minute Clinics in 55 markets and plans to have 1,060 clinics in 100 markets within five years.
4. Incorporating specialty care to take advantage of available space and improve access for patients requiring referrals
5. Potential role as a key access points in Accountable Care Organizations and the potential for contracts with hospitals that do not have an urgent care division.
6. Using technology to attract and serve patients, e.g., telemedicine, smart phone applications, online registration and test results.
Challenge 4: Centralization

Human resource managers and other employer representatives frequently say they prefer a “one-stop shop.” With five clinics, they may be confused about which site to contact.

**Baker’s Solution:** “You need a couple of key people who are the primary contacts for occupational medicine. We have a service line director for occupational medicine and centralized staff dedicated to managing all employer relationships, so the employer doesn’t have to figure out which clinic to call. They serve as our liaison with companies, and they can offer employers a customized package of services in response to their specific circumstances. To appear seamless and reduce the number of follow-up calls that we need to make, we give the customer one number to call.”

Challenge 5: Establishing Relationships

While employers appreciate a centralized point of contact, they also want an established relationship with clinic staff.

“We have five clinics, we have observed that employers will evolve toward one clinic and use it all the time,” Mr. Baker said. “We go out and talk about extended hours, 24/7 service for drug screening, picking the location nearest you, etc., and we will still have a business on the north side of town that uses a clinic 15 minutes away instead of the one that is a three-minute drive. Why? Because they like it and the relationship they have established there.”

**Baker’s Solution:** “We don’t care which clinic they use, as long as they are using one of ours. Established clinic relationships give our dedicated occupational health staff more time for marketing and sales. So, you could say we have five independent clinics with a program in each clinic, supported by a central office, run by an individual and some support staff. That is great, because we can meet our customers’ expectations by getting people in and out right now.

Challenge 6: Being Responsive

In a mixed-use clinic, front office staff often complain about being too busy to respond in a timely fashion to occupational medicine patients and employers’ questions or concerns, while providers typically are with patients and not immediately available. The challenge is how to make both the patient and client company feel special at the time of treatment.

**Baker’s Solution:** “First, I always challenge the statement: ‘I am too busy,’ but I understand where that comes from. In our clinics, every receptionist has access to employer profiles that include all the information we need to convey back to the employer. When an occupational health patient comes in, they pull up the profile and it follows that patient all the way through the process. We have one receptionist per provider on the phone, entering charges, creating bills and collecting information. They are not just processing patients. It is an important position. You need exceptional staff in each clinic to figure that out.”

Challenge 7: Improving Profitability

Mr. Baker said he generally finds that professionals who are accustomed to running occupational health programs as a business entity tend to be more entrepreneurial in nature than personnel who transition into clinic management from other hospital departments.

“When you work in a hospital you deal with politics all day long just trying to figure out which way is up,” he said. “They move slowly in hospitals, and they are used to doing things a certain way. You have to be entrepreneurial to put this together. If you don’t have that spirit, you are going to struggle, because you are doing something different from the norm.”

When a health system operates urgent care and occupational health clinics as distinct facilities, it becomes harder to sustain profitability, especially in rural to mid-sized markets with a finite number of prospective clients. Many hospital-based occupational health programs also are encumbered by overhead. The result is an occupational health program that has to repeatedly justify its contribution to the health system to get the support and resources it needs to be successful.

**Baker’s Solution:** “Combine services. If you have a building with exam rooms and dedicated staff, there is no reason not to cross-train the staff to handle both urgent care and occupational health. Again, there has to be a leader to act as the driving force. Years ago, we added occupational medicine to increase volumes and produce additional revenue.”

Two other suggestions:

1. “When a non-client company recommends our clinic to an injured worker, our sales representative follows up with that company to upsell our services.”

2. Base physician compensation partly on production: “I say, doctor, here is where the money is. During the times when you are not seeing four or five patients an hour, I can give you an hour to perform work-related physical exams…it pays, it is gravy.”

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Challenge 8: Documentation & Billing

Group health documentation and billing differs from employer-paid and workers’ compensation documentation and billing.

Baker’s Solution: “We push the information out electronically. In essence the patient is the payer for urgent care. The occupational medicine patient is not the payer, so we have separate financial classes set up in our system: employer-paid/billed and workers’ compensation billing to the employer or carrier. Same staff, same window. It’s a training and implementation issue. We are introducing an electronic medical record system this summer that will allow us to use templates.”

Challenge 9: Wait Times

Patient and employer surveys suggest an expectation of no more than 15 minutes wait time and a total time of 45 minutes in the clinic for a routine visit. What if you know the clinic will be busy with walk-in patients at 8 a.m. and a client company wants an 8 a.m. appointment? What do you do when your clinic gets overrun with patients? How do you handle urgent care patients who complain when an injured worker appears to be given priority?

Baker’s Solution: “If the company wants an 8 a.m. appointment, give it to them, because that is good money. If your clinic gets overrun, communicate with the patients who are waiting. During flu season, ramp up providers; bring in a retired physician. We ‘park’ anyone who needs an X-ray in a treatment room (they are not going to be out of there in an hour anyway) and then process the other patients who are waiting.

“Some physicians prefer a ‘first-in, first-out’ system. That doesn’t work in a blended clinic. Sometimes a staff person has to help the doctor understand the flow: ‘This one is going to be here a bit longer, this is a school physical, this is a sore throat, and queue things up in the right way. We have to remember we are pushing our doctors and they have to change hats. We match every physician with a nurse, because it helps keep the flow going. Hospital executives want to know why we need a nurse for every doctor. I tell them it is because otherwise the doctors would end up performing nursing duties for which we cannot bill. You have got to make that point.”

Also pay attention to site-specific utilization and staff accordingly.

Challenge 10: Physician Expertise

Board certified occupational medicine physicians are difficult to find and there is a risk of under-utilizing their expertise in a mixed-use setting.

Baker’s Solution: “We have one board certified occupational medicine physician who works at a single location. The rest of our physicians are family practitioners.”

This was not the original model: “Early on we made a huge mistake: we thought we needed a centralized occupational medicine clinic that would serve as the hub and the urgent care clinics would be the spokes. It turned out the doctors on the spokes thought, ‘Why would I send my revenue to occupational medicine when I get paid to see that patient? What does this person know that I don’t know?’ We ended up dissolving the spoke-and-hub concept. Now the other physicians use our occupational medicine physician as a resource and we market his credentials.”

Challenge 11: Competitive Threats

Many blended clinic operators find themselves competing with a new crop of start-up operations and/or retail-based walk-in clinics. Some are getting into the quick-clinic business themselves in order to remain competitive, which presents its own set of challenges. “You can’t swing a dead cat without hitting a new urgent care center, but when there is that kind of growth, there is going to be shakeout,” Mr. Baker predicted.

Baker’s Solution: “I respect the ‘Minute Clinics.’ I am even a little afraid of them, although in our town Walgreens has downsized their clinics and released a number of nurse practitioners. I don’t know if you can sit in Walgreens sick while everybody else is buying newspaper and gum. We had a plan to operate our own cash-only, quick clinic, but we put it on the shelf because we didn’t want to confuse our brand. I am glad we did that now.”

Regarding the WalMart model in which a local provider organization enters into a contract to operate an in-store clinic, Mr. Baker’s says: “For those who are operating a clinic in the WalMart in your area, good for you. I thought their expectations were oppressive, so we backed away and the goliath hospital in our community is now in there.”

Challenge 12: Adapting to Trends

Occupational health professionals who are experienced with integrated delivery models are trying to determine where they fit within an Accountable Care Organization or medical home model in their organization.

Baker’s Solution: “I see urgent care as the front door to the ACO. Our operation is positioned that way and that is the direction we are going. I have no idea how it is all going to turn out, but I don’t want to be behind the curve.”
Observations from Pure-Play Proponents

Robert L. Broghammer, M.D., M.B.A., M.P.H., of Allen Occupational Health in Waterloo, Iowa and Jeffrey A. Westpheling, M.D., M.P.H., of St. Luke’s Work Well Clinic, Cedar Rapids, Iowa, are among those who do not favor the mixed-used model, as outlined in the following letters to Ryan Associates/NAOHP:

**From Dr. Broghammer:**

“It was with some dismay that I saw the announcement of the Ryan Associates’ seminar regarding mixing occupational medicine with urgent care. I realize this is a ‘trend’ currently, especially with Concentra, but I must vehemently disagree that the two are complementary let alone easily integrated.

“While it is true that much of what we do has an ‘urgent’ basis (i.e., lacerations, traumas, chemical exposures, etc.), occupational medicine is a distinct and separate discipline with its own Accreditation Council for Graduate Medical Education-approved post-graduate medical training programs and separate board certification process. As you know, occupational medicine training focuses on toxicology, epidemiology, statistical analysis, orthopedics, surveillance screening, impairment and disability, wellness and a host of other specific areas dedicated to the care of workers and their companies.

“Urgent care is nothing more than a descriptor for a clinic that will see you ASAP for a perceived medical problem. There is no specific knowledge base, even rudimentary, for urgent care providers who may provide services for injured workers covered by the workers’ compensation system or for the myriad of other occupational-specific issues that need to be addressed and taken care of.

“Urgent care providers may have extremely diverse backgrounds and there is no formal standardization of training to practice in an urgent care setting – one simply needs a license and a pulse. Family practitioners, internists, pediatricians, physician assistants, nurse practitioners, general surgeons and obstetricians are just a few of the disciplines that I know of personally that have/do practice in urgent care settings.

“Likewise, occupational medicine providers, such as myself, have very little or no training in the variety of medical problems that may present to an urgent care center which have no relationship to work. Imagine an infant presenting with a fever versus a normally healthy worker. The differential diagnosis for the two is vastly different. For instance, the worker may have metal fume fever but it is highly unlikely the infant does.

“No, the integration of the two separate and distinct services will only serve to confuse the clients and dilute the value of providing specific occupational medicine services. The trend is nothing more than attempting to squeeze a couple extra bucks out of clinics by shortsighted administrators.

“Not one of my colleagues who I trained with and who are board certified in occupational and environmental medicine would consider working in such a clinic long-term.”

**From Dr. Westpheling:**

“I completely agree with the above statements and would add the following comments:

“An advantage of a stand-alone occupational medicine clinic is avoiding the patient wait times typically associated with urgent care centers and emergency departments. Companies and their employees look to have issues addressed in a timely and efficient manner to reduce time away from work.

“I have always emphasized that urgent care centers are meant to see minor emergencies/urgencies as a backup to primary care providers and overcrowded emergency rooms. They are not intended, nor should they be, to provide long-term follow-up or primary care. When this occurs, the worker ends up seeing multiple providers over several visits resulting in poor continuity of care.

“The mixing of patient types also raises several concerns including well or injured workers sitting in waiting rooms with coughing/sneezing sick patients and continually having to shift thought processes from work injury to personal care.”

**Responding to the Market**

Ryan Associates and the NAOHP recognize the merits of all points of view on the shifting paradigm for the delivery of personal and work-related care. To a considerable extent, economic circumstances and health care reforms are driving employer and employee interest in a population health management approach, whatever form that may take at the clinical delivery level.

Providing occupational and episodic care in a customer-centric environment (and as an alternative to the emergency department) is one way to reduce costs and provide the total health focus customers seek. Whether a physician trained in occupational medicine works in a mixed-used setting or a dedicated practice, he or she provides a high level of assessment, treatment and care management expertise.

**Blended Clinic Models on Conference Agenda**

Ryan Associates 25th Annual National Conference, Oct. 17-19 in Atlanta, will feature a half-day course on Urgent Care and Occupational Medicine Services: Perfecting the Balancing Act. The course is designed for those already operating blended clinics and programs considering the integration of urgent care and occupational medicine services in response to market and economic demands. To learn more, visit www.naohp.com.
The following is excerpted from a panel discussion held during RYAN Associates’ recent seminar on Profiting from Product Line Diversity: Integrating Urgent Care and Occupational Health Services. The panelists are:

Frank Thomas, M.D., Center Medical Director, Concentra, Murfreesboro, TN
Robert Cranfield, M.D., President, Tennessee Urgent Care Association, Madison, TN
Tawnya Brock, Director, Occupational Health, Jellico Community Hospital, Williamsburg, KY

Q. What is your background and the nature of your organization’s mixed-use clinic model?

Dr. Thomas: I started out in academic medicine with training in internal medicine and a sub-specialty in infectious diseases. I taught for about a dozen years, wound up in private practice for awhile and then started doing urgent care/occupational medicine with OH+R in the Nashville area (OH+R was acquired by Concentra Health Services in 2005). I like the mix. The addition of urgent care is a relatively new development for Concentra, and in some ways we are still learning how to do it. I believe the blended model is here to stay, because a lot of your occupational medicine patients will need personal medical services at some time. If you can provide those services, they can simply go from one set of paperwork to another set of paperwork.

Dr. Cranfield: I decided to try urgent care starting in 1985 after serving as a flight surgeon in the Air Force. I have always worked with the blended model and never known another way for it to be. About 70 percent of our practice is urgent care and 30 percent is occupational medicine. It’s a hybrid system. We do have an onsite presence, and I encourage other providers to look into that. It has been a long road and I have seen a lot of changes in the field. Urgent care started out as a substitute for the emergency department. It has gone through a transition and has become its own “specialty.”

Ms. Brock: Our hospital-affiliated program has been providing occupational medicine since 1994 on the Tennessee/Kentucky line, balancing different state regulations and laws. It is a rural area without a lot of industry, so we have had to add some service lines (to keep it viable). In 1998 we started phasing in a rehab component (PT/OT/speech therapy) and have done well with that. We moved the occupational medicine practice to the hospital diagnostic center in 2005. In January 2010 we moved into a new building offering urgent and episodic care and follow-up, occupational medicine, rehab, a full lab and a diagnostic center with CT scanning capabilities. Next month we are adding primary care.

“The paperwork for workers’ compensation is very different, but a patient is still a patient.”

Q. What can we do to manage lack of occupational medicine provider experience in the urgent care realm?

Dr. Cranfield: Again, start with the little things. You don’t necessarily want to say, “I have got my doc who has been practicing occupational medicine for 30 years and now I am suddenly going to open the doors to people with a fever of 102 and lower abdominal pain.” Set parameters for the types of patients you are comfortable seeing in the clinic. Then, as a provider learns more, you can expand from there. About 75 percent of what we see in urgent care is upper respiratory infections, runny noses, coughs, earaches, sore throats. Those are pretty easy to manage; most of them get better whether you do anything or not. You may want to limit yourself to that – like what the Minute Clinics do – before you start expanding.

Dr. Thomas: I agree – you can set going to be easiest to add the injury care component first, because you already do that for your urgent care patients. Drug screening is another service you probably have to be able to offer. That requires additional expertise other than just collecting urine for a urinalysis. There is a lot to it.

Dr. Thomas: Occupational medicine is not as simple as folks would like to make it out to be. Get a feel for the companies around you and what their needs are. You may want to start with the small to mid-sized companies first, then develop your services so you could go into a larger company later. Get your processes down. The paperwork for workers’ compensation is different, but a patient is still a patient. That is how I look at it. We are trying to satisfy their need and return them to a sense of well-being. More specifically, you may also want to incorporate some Department of Transportation (DOT) medical exams in your practice. The rules are important. It would be useful for your provider to attend a DOT medical examiner’s course.

Ms. Brock: If you start with injury treatment that automatically will grow into drug screening and/or physicals.

Q. Our urgent care clinic is preparing to phase in occupational medicine services. What do you recommend we offer and build on?

Dr. Cranfield: If you are providing urgent care services and trying to incorporate occupational medicine, it is
parameters. A lot of doctors aren’t comfortable dealing with children. You can cut it off at a certain age and stick with it. As you know, the number of trained occupational medicine physicians in this country is dropping. They are not as readily as available as they used to be. So, you are going to have to depend on physicians with family, emergency or internal medicine training. It is not that difficult a transition, but I think it is more difficult for the occ med physician to see urgent care than the opposite.

**Q: How do you recommend handling different levels of comfort with different patient populations among practitioners in a blended practice?**

**Dr. Cranfield:** As long as it is not something that has to be handled acutely, if you have two providers with different comfort levels and they don’t work at the same time, you can have cross-referrals – tell the patient to come in when this doctor is here. In any case, we have established a standard: When we hire a doctor they go through a credentialing process in which they have to agree to demonstrate a certain level of proficiency before we will hire them. Our preference is that our clinicians have a certain comfort level from the start.

**Ms. Brock:** When we started our occupational medicine program, we did not have access to an occ med physician. We contracted with a board certified occupational medicine physician to educate our medical director and affiliated family practice and emergency physicians. Later, it was relatively easy for us to transition into urgent care because we were staffed by family practice and emergency physicians.

**Q: How can we best satisfy the expectations of multiple constituencies?**

**Dr. Cranfield:** You have to realize that when you are dealing with an injured employee you don’t just have the employee as a client, you also have the employer as a client, and the employer has needs that may make you think about that patient in a little bit different way.

**Ms. Brock:** There are a lot of regulations, guidelines and national standards out there. Do your homework and make sure you are meeting that standard of care and offering the correct quality to the employer and the patient.

**Dr. Thomas:** There are more layers of people involved in occupational medicine than there are in urgent care. Not only do you have the injured person, you have to deal with the employer, adjusters, nurse case managers…you have to make an effort to satisfy all of them at some level, even though the treatment may be no different from what you would provide to any other patient.

“Set parameters for the types of patients you are comfortable seeing in the clinic.”

**Q: Using DOT physicals as an example, how would you handle an examinee with high blood pressure or diabetes? Would you refer him or her to a primary care physician for follow-up? What if the examinee does not have his or her own doctor?**

**Dr. Thomas:** You can handle that a couple of ways: I usually try to get them set up with a primary care physician. If they want to see me they have to come to me as an urgent care patient; I can’t mix the two entities. If a driver’s blood pressure is not too bad, you can give him up to 90 days to get himself together before coming back for a re-check. He is likely to be motivated; if he is not driving he is not making any money.

**Dr. Cranfield:** For those people who come in with uncontrolled diabetes or high blood pressure, regardless of whether you are going to start treatment today or send them to a primary care physician, the fact is they are not going to get a full DOT card at that time. They may fail completely to get their card initially. As a practical matter, we don’t send them out to sign them back in again. If we take the examinee as a patient rather than just a DOT physical, he or she has to be logged in differently. I have my staff get the information we need and try to make it as seamless as possible.

**Ms. Brock:** If they have a primary care physician, we get on the phone and try to get them in to see their own doctor as quickly as possible. If they do not, our provider will see the employee and start whatever process they need. We provide follow-up visits, so they would come back for monitoring until they got to the point where they could qualify.

**Q: Some employers in our market are asking for primary care services for their workforce. What is the difference between primary care and urgent care?**

**Dr. Cranfield:** With urgent care you have episodic care and with primary care you are also going to be getting into managing the people with diabetes and high blood pressure and heart disease and making sure they are maintained on their medicine, getting their annual checkup, annual blood tests and that type of thing. There are some urgent care centers that do that. Our model is not to do chronic care; we send those patients to the family doctors. We have enough people who want to see us for their acute care needs that we don’t have to do that. There are a lot of physicians who bill themselves as urgent care providers when their goal is to open a practice, get patients to come in without appointments until they build up their practice and then switch over to family care.

**Dr. Thomas:** If you get patients who like the provider (in a blended clinic), they will try their best to attach themselves to that provider and will come back no matter what you do. You can get them set up with an internist or a family practitioner, but they just keep coming back. What I have done is tell them, “We do not do primary care management. I am happy to serve you when you come in, but I am telling you up front I am not your primary care physician and I do not see myself that way.”

**Dr. Cranfield:** There are certain people who use you routinely and consider you as their primary care physician, even though you are really are not. We may give those people a 30-day supply of medication to give them enough time to get them back to their primary care doctor or to find someone to help manage their chronic condition.

**Dr. Thomas:** The first time they can’t get an appointment with their PC they will be back.

**Q: Do you recommend having the capability to offer in-office medication dispensing?**

**Ms. Brock:** We had to deal with that issue in our rural area when we extended our hours to 10 p.m. All of the pharmacies within a 40-mile radius of our clinics close at 6, or even as early as 4 or 5 p.m. So, we dispense some spe-
Study Shows an Employer Can Influence Family Well-Being

In a 12-week program at IBM, 11,631 employees completed a voluntary, web-based program and earned a $150 rebate. Participants chose family goals from a list of options such as limiting fast food to once a week, walking children to school at least once a week, limiting video games to 30 minutes a day or involving children in meal preparation once a week.

Results:
• Family physical activity increased 17.1 percent;
• Eating healthy dinners five nights a week increased by 11.8 percent;
• Limiting screen time to a maximum of one hour/day increased by 8.3 percent.

Study authors suggest the results show that employers can improve short-term behaviors in children and parents in physical activity, meal planning and screen time.

Reference: An Observational Study of an Employer Intervention for Children’s Healthy Weight Behaviors; Pediatrics, November 2010.

By Karen O’Hara

In a symbolic move, the National Institute of Occupational Safety and Health (NIOSH) plans to change the name of its WorkLife division to Total Worker Health to better reflect the unit’s objectives, reports L. Casey Chosewood, M.D., WorkLife senior medical officer.

WorkLife/Total Worker Health seeks to eliminate artificial divides between “at work” and “non-work” by examining the intricate web of work and home life, public and personal protection, and overall health and well-being. For example, as workplace conditions affect employee health and well-being at home and in the community, activities and conditions outside of working hours can substantially determine health, productivity and responses to exposures during work, NIOSH researchers say.

The concept of Total Worker Health is strategically aligned with the Accountable Care Organization (ACO) and medical home delivery models promoted in the Patient Protection and Affordable Care Act. (An ACO is a collection of local providers held accountable for the cost and quality of care delivered to a particular population. See related article on page 12.)

While some say Total Worker Health threatens to dilute NIOSH’s fundamental purpose “to understand and decrease the risk of injury and illness in the workplace,” Dr. Chosewood said the federal agency’s primary worker protection mission remains unchanged. However, he said NIOSH recognizes the need to create new avenues to better understand and manage other factors affecting worker performance, such as stress, poor diet, limited exercise, smoking, medication and/or alcohol use, and a plethora of other physical, social, cultural and economic conditions.

“Worker protection has to be at the core of any program,” Dr. Chosewood said during a presentation at the recent annual American College of Occupational and Environmental Medicine (ACOEM) conference in Washington, D.C. “The first dollar needs to be spent on decreasing hazards the worker will encounter at work. After you have done that, then it is appropriate to invest in health promotion activities that will produce the end benefit of making the population as a whole healthier and safer.”

Speaking directly to occupational medicine physicians, Dr. Chosewood said: “We think there are missed opportunities in the clinic setting. There is a need for comprehensive health screenings for work-related and non-work-related risks. There also is growing interest in combining occupational health with a workplace-based primary care home model.

“You need to do all that you can to increase the percentage of preventive services that are part of the overall delivery model and encourage full integration in clinics, including the incorporation of behavioral health and traditional safety activities. We hope you will come along with us on our journey toward Total Worker Health.”
Best Practices

On a parallel track, Pamela Hymel, M.D., chief medical officer, Walt Disney Parks and Resorts and ACEOM past president, told physicians the college’s Workplace Health Protection and Promotion Committee is developing a response to the NIOSH total health program that will highlight best practices in the integration of protection and health promotion.

“We have found that workers with adverse health conditions such as obesity, hearing loss, poor eyesight and fatigue are more likely to sustain work-related injuries,” she said. At the same time, “there is often an abyss between safety and wellness. It will be important for ACEOM members to begin to build those linkages. At Disney, I have a meeting set up with our vice president of safety to begin conversing on this very issue.”

Dr. Hymel said occupational medicine practitioners can add value to the conversation by:

• reaching out to segments of the population, such as non-insured employees, who may not have easy access to information;
• designing targeted programs for at-risk groups in the workplace; and
• working within organizational hierarchies to introduce procedures, practices and norms.

Dr. Hymel said the ACEOM committee is studying public policy options that support integrated health protection and promotion efforts and incentives. It also is interested in synergies among ACEOM and government and private sector employers, opportunities for strategic alignment with emerging health care delivery models and evidence-based medicine, and NIOSH’s WorkLife Center of Excellence program.

In a related action, Dr. Hymel said ACEOM plans to waive the subscription fee for its health and productivity management (HPM) toolkit for college members to encourage greater utilization in the coming months. The toolkit features a collection of educational materials and is intended for use by professionals involved in the implementation of HPM programs. To learn more about the toolkit, visit http://hpm.acoem.org/index.html.

U.S. since the year of Super Bowl V, Apollo 14, and the founding of NASDAQ, NIOSH worked closely with its diverse partners in the start-up years of the early 1970s to address the priority safety and health needs of an economy driven at that time by manufacturing. Through the decade of the 1970s, NIOSH’s research helped to reduce hazardous exposures to asbestos, lead, benzene, vinyl chloride, and other substances produced or used every day in factories, plants, and steel mills…

“…For all of our progress, many of the traditional hazards of the 20th century workplace still persist. Research remains vital for eliminating coal workers’ pneumoconiosis, silicosis, work-related hearing loss, motor vehicle fatalities on the job, lead poisoning, and other legacy problems. At the same time, new concerns demand our attention so that the mistakes that occurred too often in the last century are not repeated, such as the rush to use new technologies, materials, and practices without first understanding their implications for worker safety and health. Nanotechnology, work organization, and safe green jobs are examples of those areas where NIOSH has established strategic research programs.

“We also face the challenge and opportunity of helping to shape a new business paradigm for the 21st Century. In this model, the prevention of work-related injuries and illnesses is correctly counted as an asset to business rather than a cost. We are working closely with partners to develop this business case for safety and health, predicated on the fact that safe, healthy, and secure workplaces are efficient workplaces and integral to profitability and economic growth. Having an able and motivated workforce is critical to success in today’s environment, as the economy recovers, as high-quality jobs are created, as the public and private sectors develop strategies for containing healthcare costs, as the baby boomer generation begins to retire, as small businesses are nurtured, and as the workforce becomes more diverse.

“Predictions are difficult, but I am confident that the investments we make now will pay great dividends for society over the coming years and decades and that the next 40 years will be as challenging and gratifying for NIOSH as the last 40 years were.”

Related Resources


3. NIOSH WorkLife Centers for Excellence that conduct multi-disciplinary research, training and education:

   • University of Iowa Healthier Workforce Center for Excellence: www.public-health.uiowa.edu/hwce

   • Center for the Promotion of Health in the New England Workplace at the University of Massachusetts: www.uml.edu/centers/cph-new and the University of Connecticut: www.oehc.uchc.edu/healthywork/index.asp

   • Harvard School of Public Health Center for Work, Health and Wellbeing http://centerforworkhealth.sph.harvard.edu

4. Guide to Community Preventive Services, systematic reviews on programs and policies designed to improve health and prevent disease: www.thecommunityguide.org
The following is excerpted from Accountable Care Organizations: Distinguishing Rhetoric from Reality, a report prepared earlier this year for the California Association of Health plans by Phil Polakoff, M.D., and Peter Boland, Ph.D., of Polakoff/Boland, who specialize in translating complex health care reform provisions into practical implementation strategies. Refer to www.polakoffboland.com/ACO White Paper.pdf.

In their paper, they define an ACO as a local health care organization with a related set of providers such as primary care physicians, specialists and hospitals that are accountable for the cost and quality of care delivered to a particular population. They say that the purpose of an ACO is to deliver more efficient and coordinated care that is rewarded with a financial bonus for achieving performance benchmarks established by the Centers for Medicare and Medicaid Services (CMS).

Ten Selected Observations
1. Provider-sponsored ACOs will initially focus on Medicare beneficiaries through demonstration pilots but are expected to compete for commercial lives through Health Insurance Exchanges offered by states in 2014.
2. ACOs will have a cascading effect on the market. Medicare pilots based on shared risk (2012) will lead to other financial risk models such as bundled service and episodes of payment (2013).
3. It makes strategic and business sense for health plans and providers to collaborate on how to take substantial costs out of the delivery system. Health plans and providers should commit to reasonable clinical and cost goals, and share resources to minimize expense and financial risk. The alternative of provider organizations going it alone will not necessarily lead to lower costs.
4. ACOs represent an opportunity to “cross the chasm” from fee-for-service to bundled payment.
5. As payer reimbursement incorporates global payment and different forms of capitation, most provider organizations will need additional capital, information systems and clinical decision support from insurers. Health plans understand this reality; relatively few providers do.
6. Both payers and providers need ACOs to succeed in order to stave off ongoing pressure for a government-run health care system.
7. If providers are left with the primary responsibility to “police” themselves without the threat of serious financial penalties agreed to in advance with payers, then efforts to align the incentives of physicians and hospitals will not be more successful than previous efforts by Physician-Hospital Organizations (PHOs) to reduce costs.
8. It is in the interest of provider-led ACOs to partner with payers in early stages to jointly develop risk-reward strategies that are reasonable and that replace point-counterpoint negotiation over rates.
9. Conversely, it is in the interest of health plans to partner with ACOs early because they need time to develop and refine the necessary enrollment and risk analytics to be effective partners.
10. There is a significant delivery gap that requires every stakeholder to become engaged so they are 100 percent committed to each other’s success.

Accountable Care Cost-Control Methods
Primary Care Physicians (may be applicable to primary occupational medicine):
- Health promotion
- Early diagnosis
- Unnecessary testing
- Unnecessary referral
- Preventable ER visits
- Preventable admissions
- Preventable readmissions
- Care coordination
- Medical home-care management
- Chronic care management
- Complimentary medicine treatment
- Group visits
- E-visits
- Telemedicine visits
- After-hours and weekend clinics
- Staffing urgent care as an alternative to ERs
- Proctoring “minute clinics”
- Specialist selection (most efficient)
- Practice efficiency
- Group practice design
Understanding the Impact of Workforce Presenteeism

Presenteeism is a concept many in the field of occupational health consider to be significant but difficult to quantify—somewhat akin to catching lightning in a bottle.

It means being present but not fully productive at work, primarily because of intervening physical and/or mental health conditions.

While there are a number of approaches being used to measure the impact of presenteeism in the U.S. workplace, findings remain inconclusive. In response, the American College of Occupational and Environmental Medicine (ACOEM) and the Integrated Benefits Institute (IBI), an organization that works with employers to demonstrate the business value of health, are preparing to test the reliability of survey instruments used by supervisors and employees to rate productivity.

The ACOEM-IBI study is a byproduct of an investigative process launched in November 2008 when more than 40 leaders from public and private sector organizations convened in Santa Ana Pueblo, NM, for a national summit on health and productivity management (HPM). Summit participants issued 10 consensus statements and a series of recommendations in 2009, including a call to examine presenteeism as a tangible factor affecting the bottom line.

Kenneth Pelletier, M.D., Ph.D., of the University of California, San Francisco School of Medicine and the University of Arizona School of Medicine, reported at the recent annual American Occupational Health Conference sponsored by ACOEM that study objectives include:

- estimating the cost of absenteeism and presenteeism beyond wage replacement;
- calibrating measurement ranges/scales used in self-report instruments; and
- converting performance measures to ratios such as days lost to dollars lost.

“We have found that some self-report tools work better than others at detecting degrees of presenteeism,” depending on their purpose or application, Dr. Pelletier said. “We need to develop methodologies to determine relationships between scores generated by self-assessed health-related work performance surveys to supervisor evaluations and employee work performance.”

**Productivity Measurement Tools**

Companies need new and better tools for measuring employee productivity to “highlight important productivity measurement issues for consideration in an overall business strategy,” according to an article by Steve Schwartz, Ph.D., of Health Media, Inc., and John Reidel, M.P.H., M.B.A., of Reidel and Associates.

They outline key issues in the design and use of productivity measurement tools with real-world applications in an article published in the Journal of Occupational and Environmental Medicine. (Refer to Productivity and Health: Best Practices for Better Measures of Productivity, S Schwartz, J Riedel, JOEM, 52(9):865-871, September 2010.)

The ability to identify the “best” tool for measuring productivity depends on both how and why the information will be used. “Descriptive measurement” looks at the effects of health on worker performance, while “comparative measurement” examines the impact of various health risks and conditions. A third category, “evaluative measurement,” focuses on changes in productivity over time—a critical consideration in judging the benefits of employee health programs.

Companies need norms or benchmarking data to evaluate health and productivity improvements that can be realistically achieved. In addition, some way of monetizing the productivity impact of health conditions, and the potential for improvement, is necessary to assess the effect on the bottom line, the authors said.

Worker health and productivity data also must be formatted in a way that makes it usable by decision makers. Dashboard formats are considered a particularly promising approach because they present data in a concise manner.

The authors said they hope their article will help prompt the maturation of high-utility instruments for measuring worker productivity, and for using the information to improve worker health and the financial outlook for employers.
Hospital-Physician Management Agreements

More hospital administrations are entering into co-management agreements that pay physicians to run a specific department to improve its performance, according to Report on Medicare Compliance. Under such arrangements, physicians and the hospital establish and jointly own a limited liability company, which the hospital may contract with to manage a specific service line. The hospital pays the LLC a management fee, which is split between the parties. The physicians in the co-management arrangement typically receive pay for general compensation and performance incentives.

Paycheck Fairness

The Paycheck Fairness Act re-introduced in Congress calls for increased employer liability for compensation decisions and heightened government involvement in remedying pay inequality. The latest bill, which is identical to a previous proposal, was introduced in the U.S. Senate (S797) and the U.S. House of Representatives (HR1519) on April 12, “Equal Pay Day, 2011.” If enacted, the legislation would alter key provisions of the Equal Pay Act of 1963, which amended the Fair Labor Standards Act to prohibit employers from paying women less than men for performing the same or “substantially equal” work in the same establishment. Gender-based wage discrimination remains a problem and a percentage of the wage discrepancy cannot be explained by non-discriminatory factors, government and private experts said during a public forum held recently at the U.S. Equal Employment Opportunity Commission office in Washington, D.C.

Scientific Response to Emergencies

A federal advisory board has approved recommendations related to the scientific responses to major public health events such as the 2009 H1N1 pandemic and the Deepwater Horizon oil spill. The draft recommendations developed by a work group of the National Biodefense Science Board will be forwarded to Health and Human Services Secretary Kathleen Sebelius and Nicole Lurie, M.D., assistant secretary for preparedness and response. The group said scientific investigations should be fully integrated with disaster planning and response to ensure that critical knowledge gaps are addressed in a timely manner. Refer to www.phe.gov/preparedness.

Illinois Comp Law Repeal Proposed

House Bill 1032, introduced by state Rep. John Bradley, would repeal the Workers’ Compensation Act and put workers’ compensation cases into Circuit Courts in Illinois, LRP Publications reports. While the proposal has support from a legislative panel, several groups are opposing it, including the state Chamber of Commerce. A Republican legislator called the idea a “nuclear bomb.” Meanwhile, federal prosecutors are investigating reports that hundreds of employees at an Illinois prison received awards, as did some arbitrators who decided workers’ compensation disputes.

OSHA Actions

Fall Protection

The U.S. Court of Appeals for the Seventh Circuit rejected a challenge by the National Roofing Contractors Association to an Occupational Safety and Health Administration (OSHA) directive on the use of fall protection in

party administrators. The SMART Act (HR1063) pending in the House could have a significant impact on this issue, industry observers said. The SMART Act would create a pathway for the Centers for Medicare and Medicaid Services to calculate and provide to settling parties the MSP repayment amount before settlement so parties are aware of and can promptly pay their obligation.

Translators Needed

Health care providers are advised to prepare now for an increasing demand for the translation of information to languages other than English under a July 1 health care reform law deadline. Meanwhile, in Guiron v. Santa Fe Extruders (Cal. W.C.A.B. 2011), the California Workers’ Compensation Appeals Board held that the employer was required to pay for interpreter services provided during medical treatment appointments.
residential construction. The directive withdrew an earlier one that allowed certain residential construction employers to bypass some fall protection requirements. A compliance directive requiring contractors performing residential construction to comply with the residential fall protection standard was scheduled to take effect June 16. The standard generally requires that guardrails, safety nets or personal fall arrest systems be used on residential job sites that are more than six feet off the ground.

**Hair Product Alert**

The agency issued a hazard alert to hair salon owners and workers about potential formaldehyde exposure from working with some hair smoothing and straightening products. Visit www.osha.gov/SLTC.

**Outreach Program**

OSHA has revised its voluntary Outreach Training Program requirements to improve the quality of courses and ensure the integrity of authorized trainers. The voluntary program, part of OSHA’s Directorate of Training and Education, involves a national network of more than 17,000 independent trainers who teach workers and employers about agency regulations, workers’ rights and how to identify, avoid and prevent workplace hazards. Trainers are now required to verify that the training they conduct is in accordance with approved procedures. Other program enhancements involve limiting classroom size to a maximum of 40 students, limiting the use of translators to those with safety and health experience, and limiting the use of video presentations during training.

**Prevention Efforts**

As residents recovered from damage caused by storms throughout the South, OSHA urged employers, workers and the public engaged in cleanup activities to protect themselves against a variety of hazards. The agency also announced a national outreach initiative to educate workers and their employers about the hazards of working outdoors in the heat and steps to prevent heat-related illnesses.

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**California Workers’ Compensation Institute Reports on Opioid Prescription Patterns**

The top 10 percent of doctors who prescribe extremely potent, highly addictive Schedule II opioids for injured workers in California account for nearly 80 percent of all workers’ compensation prescriptions for these narcotic drugs, according to a study published by the California Workers’ Compensation Institute (CWCI). The study also found nearly half of the prescriptions were for minor back injury claims.

In a follow up to that study, CWCI followed prescribing patterns for fentanyl, the most potent of the Schedule II opioids. Using the claim sample from the earlier study, the follow-up report analyzes prescription data from 16,890 California work injury claims in which Schedule II drugs were prescribed, as well as 5,253 non-surgical medical back claims from the sample, to measure the extent to which fentanyl is being used in California workers’ compensation. Among the key findings:

- More than one out of five injured workers who received Schedule II opioids were prescribed fentanyl. Among those with non-surgical medical back problems (strains and sprains) who received Schedule II opioids, more than one out of four were given fentanyl.
- Fentanyl accounted for 20.3 percent of all Schedule II opioid prescriptions given to injured workers and 21.8 percent of the Schedule II prescriptions dispensed to non-surgical medical back claimants.
- More than a quarter of the doctors who wrote Schedule II opioid prescriptions for injured workers prescribed fentanyl, while 3 out of 10 doctors who wrote Schedule II prescriptions for non-surgical medical back patients prescribed fentanyl.

As in the earlier analysis, the new study found that most of the fentanyl prescriptions for injured workers were written by a small percentage of the Schedule II opioid prescribers, with the top 10 percent accounting for 84 percent of the prescriptions. Use of fentanyl to treat non-surgical medical back problems was more widespread, however, as the top 10 percent of Schedule II prescribers accounted for 72 percent of the fentanyl prescriptions written for these claimants.

Most of the fentanyl prescriptions were transdermal patches, which have limited FDA-approved uses and have been the subject of multiple FDA warnings. California workers’ compensation pain management guidelines also say the patches should only be used for chronic pain patients requiring round-the-clock therapy, who have developed a tolerance for other opioids, and whose pain cannot be managed by other therapy.

Furthermore, there was no evidence of cancer-related illness or injury among any of the injured workers in the study sample, indicating that off-label use of fentanyl lozenges or tablets, which are only FDA approved for breakthrough, chronic cancer pain, has become an issue in the California system.

The study found that off-label use of fentanyl was concentrated in the 10 percent of claims (1,690 cases) with the highest volume of Schedule II opioid prescriptions, where nearly 12 percent (199 cases) had prescriptions for lozenges or tablets. A closer look showed the rate of off-label use was even higher for the top 10 percent of non-surgical medical back cases with the most Schedule II opioid prescriptions, where 77 of the 525 patients, or nearly 15 percent, were prescribed fentanyl lozenges or tablets.

Class Action Suit Alleges Restrictions on Medical Care

In a class action suit approved by a federal judge in Colorado, retail giant Wal-Mart Stores, Inc., is accused of conspiring with Concentra Health Services, Inc., Claims Management Inc. (CMI), American Home Assurance Co. (AHA) to lower its costs by controlling the nature and timing of workers’ compensation medical treatment received by its employees.

The suit alleges violations of the federal Racketeer Influenced and Corrupt Organizations Act (RICO) and Colorado laws prohibiting employers from dictating medical care for injured workers. As many as 6,900 current and former Wal-Mart employees in Colorado may be affected. Attorneys said Wal-Mart also could face similar class action lawsuits in states with similar laws if the plaintiffs prevail.

The defendants deny the allegations.

The suit alleges that Wal-Mart gave authorized treating physicians (ATPs) at Concentra “protocol notes” that stated certain treatments were not covered and directed them to call Wal-Mart’s claims subsidiary before referring patients to other physicians or prescribing more than five physical therapy sessions.

According to court documents, Wal-Mart argued that a class action was not justified because some employees had “obtained treatment, suffered no denial or delay in treatment, and suffered no harm caused by the allegedly unlawful policies.” Wal-Mart also argued that the policies challenged by the plaintiffs were modified, effective January 2008, and that the plaintiffs’ claims “are not relevant to the defendants after the policies were modified.”

Among possible ramifications in the case (Josephine Gianzero, et al. v. Wal-Mart Stores Inc., No. 09-656, D. Colo.) is a legal determination regarding the point at which employer involvement in medical care delivery jeopardizes provider independence, said Bill Newkirk, M.D., medical director for PureSafety, who spoke about the case at a recent RYAN Associates’ seminar. “You need to know your state laws,” he said.

More About the Case

Ms. Gianzero, a Sam’s Club employee in Colorado, suffered multiple injuries in a fall at work on Nov. 26, 2005. She was treated at a Concentra Medical Clinic and later developed lingering wrist and thumb pain. A suit subsequently was filed March 24, 2009 in the U.S. District Court for Colorado on behalf of Ms. Gianzero and also Jennifer Jensen, another Wal-Mart employee injured in a separate job-related incident.

Under the Colorado Workers’ Compensation Act, workers who are injured on the job are entitled to receive medical treatment for their injuries “without interference or dictation” by their employer or the employer’s insurance carrier. In citing examples of the “unlawful dictation of medical care,” the suit alleges:

- Wal-Mart, CMI and/or AHA as part of a pattern and practice, unlawfully and improperly dictate(s) and/or interfere(s) with type and duration of medical treatment received by injured Wal-Mart workers.
- CMI, AHA and Concentra, as part of a pattern and practice, aided and abetted Wal-Mart in implementing policies, practices and procedures designed to unlawfully and improperly dictate, withhold, delay, deny and/or interfere with the medical treatment of injured Wal-Mart employees.
- Concentra assisted with the development of and/or agreed to follow Wal-Mart, AHA and/or CMI’s imposition of unlawful and improper restrictions on the treatment of injured Wal-Mart workers.

According to court documents, Concentra allegedly required ATPs to adhere to treatment restrictions and/or requirements in the course of treating and/or making referrals for the treatment of injured Wal-Mart employees. For example, protocol notes required the ATP to obtain pre-authorization from CMI for referrals to other treatment providers (e.g., specialists), delaying patient treatment and the receipt of benefits in violation of state law. “Flowsheats” and protocol notes also allegedly prohibited the ATP from prescribing any chiropractic treatment and limited work schedules.

In addition, CMI is accused of routinely denying authorization for treatment referrals by challenging medical necessity during the required pre-authorization process.

Attorneys for the plaintiffs said plaintiffs and class members “have suffered and will continue to suffer damages” in an amount to be determined at trial.


Family Leave Case

The Ninth Circuit Court of Appeals in San Francisco held that the employer, not the employee, has the burden of proving a legitimate reason for not reinstating an employee to a former position following an absence under the Family and Medical Leave Act (FMLA). An employer who denies reinstatement to an employee must be prepared to prove the employee had no such right, according to Jackson Lewis, a national employment law firm. Refer to Sanders v. City of Newport, No. 08-35996, 9th Cir. Mar. 17, 2011.
pecific medications. We are not keeping any kind of scheduled drugs, just a minimal amount of antibiotics to get them through a day or two. It is not a profit center; it is a value-added service.

Dr. Thomas: The reimbursement you would get from dispensing would be negligible. There is also the hassle factor.

Dr. Cranfield: We can still do it for occupational medicine patients, but it is not as easy on the urgent care side, primarily because most insurance plans include pharmacy. Unless you have a pharmacy with pharmacists on staff and have signed up with that insurance plan to dispense, you are not going to get a lot of that business. It used to be really big, but it has tapered off quite a bit.

Q: What have you found is the most effective way to market your centers?

Ms. Brock: One of the first things we learned when we added urgent care was there was a lot of confusion in the market as to what we had become: “Are you seeing primary care?” “Can I bring the kids over?” We thought we had marketed it very well. Our mistake was that it was not a clear, consistent message, and I don’t think we did enough marketing, either. We did a massive marketing campaign when we first opened. Then we just assumed that because we had been there for so long, everybody would know who we were originally. We found that was not so.

Dr. Cranfield: It seems as if it is still the roadside sign, word of mouth and the Yellow Pages, believe it or not, that bring people in. My office is located just south of Hendersonville, which is a rapidly expanding community. Five years ago, in order for people to get the things they needed, they had to come down to my part of the woods. When Herdersonville got its own (major chain stores), it kept people there up to a point. We ended up using a strategically placed, visually appealing billboard right at the cutoff point.

Another thing we have found to be successful are television ads. I am usually the one who speaks in them. You get groupies who say, “I saw you on TV!” even long after the ad stops running.

Dr. Thomas: Our surveys show a lot of the public doesn’t understand what urgent care means. If you tell them walk-in, that means one thing. Some of them think of urgent as more for emergencies. You have to realize that when you do your advertising and marketing, it is helpful to have your provider involved in the marketing, particularly in occupational medicine. Having the provider involved in what you are trying to do to promote your facility is important to your survival and success.

“We learned there was a lot of confusion in the marketplace as to what we had become.”

Q: When Concentra was marketing itself as a pure-play occupational medicine specialty practice and then converted to the blended model, how did you deal with the switch from a marketing perspective?

Dr. Thomas: The trick is for a company that has been a pure-play model with a directed focus to get the providers to switch directions. For me it was not a problem because I was used to seeing sick people — that was my background. For some physicians it is almost as if they have to go back to medical school, in their minds at least, to accept it.

Q: What is your best piece of advice for operators of mixed-use clinics or those who are considering introducing the blended model?

Dr. Cranfield: I didn’t start skiing until I was 34 years old. I started on the bunny slope and quickly moved up the mountain. Don’t be afraid to try something new. It is going to be hard when you first start, but once you learn how to do it, it will be an easy ski down the slope after that. You have to start on the baby slopes but don’t wait too long to get to the top of the mountain.

Ms. Brock: Either you control the day or the day controls you. Given the nature of the competition and what is happening to our profession, I would rather be on the forefront and controlling my own destiny than have someone do it for me, even if I am speeding down the ski slope. Move forward. Even if you fall on your face, you are still moving forward. Go with it.

Dr. Thomas: Try to know where you have been before you try to know where you are going. Have a feel for what has happened in the past in your area. Get a feel for the landscape. Pick a path, start on that path and stick with it. Don’t deviate too much from the original plan for your journey.

Recommended Resources

Asbestos Roadmap; provides a research framework to address scientific uncertainties for asbestos and other particles to allow NIOSH to update its recommended exposure limit (REL); http://www.cdc.gov/niosh/docs/2011-159.


Non-fatal Occupational Injuries and Illnesses Among Older Workers – United States, 2009; although older workers had similar or lower rates for all injuries and illnesses combined compared with younger workers, the length of absence from work increased steadily with age and was highest for older workers; Morbidity and Mortality Weekly Report 60(16); 503-508, April 29, 2011; http://cdc.gov/mmwr/preview/mmwrhtml/mm6016a3.htm.

Occupational Highway Transportation Deaths, United States, 2003-2008; report on prevention related to highway transportation crashes, the leading cause of fatal injuries in the United States for both workers and the general population; Morbidity and Mortality Weekly Report 60(16); 497-502, April 29, 2011; http://cdc.gov/mmwr/preview/mmwrhtml/mm6016a2.htm.
RYAN Associates’ National Conference Curriculum Focuses on Demonstrating Business, Clinical Value

October 17 Highlights

Keynote Address: The Evidence Is In: Occupational Health as the National Medical Delivery Model
Kathryn Mueller, M.D., M.P.H., Medical Director, Colorado Division of Workers’ Compensation and Professor, Department of Surgery and School of Public Health, University of Colorado

Concurrent Sessions-Morning and Afternoon
1. Program Diversification
   • Delivering Services Outside of the Clinic
   • Complementary Products and Services
   • Responding to the Increasing Demand for Prevention and Chronic Disease Management
2. Occupational Health Business Management:
   National Best Practices for Clinicians
   • This full-day program is designed for clinicians (and those who work closely with them) who wish to hone their business management skills.
3. Core Components for Profitable Occupational Health Program Operations
   • This three-day seminar-within-the-conference is a NEW and UPDATED version of RYAN Associates’ popular occupational health operations overview course.

General Session:
Expanding Your Organization’s Capabilities Through Vendor Alignment

Concurrent Sessions-Morning
1. Special Topics for Hospital-Affiliated Programs
2. Special Topics for Freestanding Clinics and Other Non-hospital Affiliated Programs

Concurrent Sessions-Afternoon
1. Update on the NAOHP Benchmarking Pilot Project.
2. Cultivating the Interface Between Clinical and Administrative Perspective
3. What Customers Tell Us: Lessons from 25 Years of Employer Market Research
4. Transitioning to a Medical Home/Accountable Care Organization (ACO) Model
5. Core Components for Profitable Occupational Health Program Operations, continues

Discussion Groups:
   Conference participants will be invited to complete a survey in advance to rank selected topics of interest/value to them. Multiple facilitated roundtable jam sessions will be based on the top-ranked topics.
2. Mentor-Protégé “Speed Dating”

October 19 Highlights

NAOHP Open Board Meeting:
Using the Association to Advance Your Objectives

General Session:
Insights from the Centers for Disease Control and Prevention (CDC)

Concurrent Sessions:
1. Urgent Care and Occupational Medicine Services: Perfecting the Balancing Act
2. Legal, Regulatory and Ethical Issues Facing Medical Providers and Employers
3. Core Components for Profitable Occupational Health Program Operations, concludes

Annual Software User Group Meetings and Updates:
Integritas, Inc. (Agility EHR and Stix)
Pure Safety (Occupational Health Manager and SYSTOC)
May 14-19

May 17-19

May 24-26

June 6-8
NIOSH-Approved Spirometry Course, followed by CAOHC-approved Hearing Conservation Course; sponsored by M.C. Townsend Associates, LLC; Pittsburgh, PA; www.mctownsend.com.

June 7-8

June 12-15
Safety 2011: ASSE PDC & Expo; sponsored by American Society of Safety Engineers; McCormick Place Convention Center, Chicago, IL; www.asse.org/education/pdc11.

June 20-23
Public Health Leadership: The Key to a Healthier Nation; sponsored by U.S. Public Health Service; New Orleans, LA.; www.phscoevents.org.

July 12-13

July 18-21
National Workers’ Compensation and Occupational Medicine Conference; sponsored by SEAK; Resort and Conference Center at Hyannis, Cape Cod, MA.; www.seak.com.

To list your event, email information to Karen O’Hara, VISIONS Editor: kohara@naohp.com
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Integritas, Inc.
Kansas City, MO
816-399-3951
Jewelsm1210@integritas.com

Dr. Steven Crawford
Corporate Medical Director
Meridian Occupational Health
West Long Branch, NJ
732-263-7950
scrawford@meridianhealth.com

Southeast – AL, FL, GA, MS, NC, SC, TN, VA
Leonard Bevill, CEO
Macon Occupational Medicine
Macon, GA
478-751-2925;
lbevill@maconocmedicine.org

Great Lakes - KY, MI, OH, WI
Karen Kosidowski-Bergen, R.N., Administrator
Encore Unlimited
Stevens Point, WI
715-966-5468;
kkosidowskibergen@encoreunlimited.com

Midwest - IL, IN
Tom Brink, President and CEO
Methodist Occupational Health Centers
Indianapolis, IN
317-216-2520; tbrink@clarian.org

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Mike Schmidt, Director of Operations
St. Luke’s Occupational Health Services
Sioux City, IA
712-279-3470; schmidtms@stlukes.org

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Dr. John Braddock,
CEO & Medical Director
Cascade Occupational Medicine
Lake Oswego, OR
503-635-1960;
braddockj@cascadeocmed.com

AT LARGE
Michelle McGuire, Application Specialist
PureSafey
Lawrence, KS
207-474-8432;
michelle.mcguire@puresafety.com

Troy Overholt, Director
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Cedar Rapids, IA
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