Putting Occupational Health in the Context of Major Trends

“Occurrences in this domain are beyond the reach of exact prediction because of the variety of factors in operation, not because of any lack of order in nature.” —Albert Einstein, 1879-1955

Another New Year and many occupational health professionals find themselves reflecting on past experiences and applying them to opportunities and challenges that lie ahead.

When considering business development strategies, it is helpful to consider broad trends and specific forecasts for 2012 and beyond. Here is a selection:

Health Care in Motion
Health Care Employment Continues Growth Trend

The health care sector continued growing in November 2011, adding more than 17,000 jobs in the month, with the hospital industry accounting for nearly half of the new jobs, according to the U.S. Bureau of Labor Statistics. Health care is the second-fastest-growing sector of the U.S. economy and it has one of the highest injury incidence rates in comparison to other types of industries.

Healthcare Trends 2012, a Strategic Industry Forecast, Steve Valentine, president, The Camden Group

Mr. Valentine of the health care management and consulting group cited the following trends during a recent webinar:

• Accountable Care Organizations and “bundled payments” will have a major impact.
• Physicians will be “movers and shakers” in terms of changing the delivery system and containing costs, especially with regard to scaling down post-acute care.
• Leaders will need to identify health care needs in their geographical area, identify available resources, articulate goals, and structure their network of care around these elements.
• Utilization of embedded case managers and centralized case management teams will increase, with individual case managers in physician offices and hospitals working closely with physicians, including hospitalists, to effectively manage in-patient and outpatient care.
• Medical home models will continue to expand, with chronically ill patients being moved into “mini medical homes.”

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New Board Members

NAOHP President

Steven Crawford, M.D., served on the NAOHP Board representing the Northeast region from 2010-2011 and is now the President, serving until Dec. 31, 2013. Dr. Crawford is Corporate Medical Director of Meridian Occupational Health, New Jersey. He has been practicing occupational medicine for 20 years on the Jersey Shore and is also active in Sports Medicine, Addiction Medicine, and performs Independent Medical Exams. He is a member of ACOEM and the American College of Physicians.

Northeast Region

Patrick McIntyre has been elected to serve on the NAOHP Board representing the Northeast region, serving until Dec. 31, 2012. Mr. McIntyre is Occupational Healthcare Business Director at Reliant Medical Group, Worcester, Mass., where he oversees business growth and profitability of a multi-location occupational health department. Reliant Medical Group is a large medical specialty group with more than 250 doctors serving communities in central Massachusetts. Mr. McIntyre is a former vice president of local sales and a former director of operations-managed care for Concentra. He also is a former restaurant owner/operator.

Southeast Region

Trena Williams, RN, C.O.H.N., has been elected to serve on the NAOHP Board representing the Southeast region, serving until Dec. 31, 2014. Ms. Williams is Director of Clinical Services for the Corporate Health division at Spartanburg Regional Healthcare System, Greer, SC, which serves more than 600 client companies and encompasses two occupational health clinics, a mobile services division, two occupational health clinics on-site at client companies, and three episodic/wellness clinics on-site at client companies. She has been an occupational health nurse for 12 years and has experience working as a nurse in manufacturing facilities.

Heartland Region

Mike Schmidt has been re-elected to serve on the NAOHP Board for the Heartland region, serving until Dec. 31, 2014. Mr. Schmidt has served on the board representing the Heartland region for 16 years, and during his tenure has attended 16 consecutive RYAN Associates’ national conferences. Mr. Schmidt is Director of Operations, St. Luke’s Occupational Health, Sioux City, IA, where he was involved in the development of St. Luke’s new Center for Preventive Medicine. His experience includes a focus on sales, marketing and customer service, and oversight of a national drug-testing consortium.
Top Ten Healthcare Trends, Jack Uldrich, Futurist and Author

1. Genomics: The era of personalized medicine is finally upon us.
2. Robotics: Expect many more hospitals to have in-house virtual training simulators in order to teach, improve and hone surgeon skills in the use of robotics.
3. RFID: As Radio Frequency Identification (RFID) technology and sensors continue to improve expect hospitals to deploy the technology in new ways, including monitoring patient compliance with prescribed medications.
4. Smartphones: Low-cost applications will allow patients to remotely monitor themselves and send the information directly to their primary care physician. Coupled with continued advances in bandwidth capability and low-cost, high-resolution mobile web video the revolution in telemedicine is coming.
5. Artificial Intelligence: As more facilities get serious about electronic health care records and as ever-increasing amounts of genomic data are created, expect more hospitals to employ artificial intelligence to better manage this information.
7. Gaming: There is considerable potential for the development of gaming dynamics in the health care and insurance industries.
8. Business Analytics: One future possibility is that publicly available social network data can be data-mined by health insurers to offer discounted rates to individuals who travel in healthier social circles. (Privacy concerns and regulations may prevent such uses but, then again, maybe not.)
9. Mobile Web Video: The technology won’t eliminate hospital visits but it will gradually reduce the number. Expect a growing number of facilities to use the technology to monitor patients to lower re-admission rates and associated costs.
10. Heal Thyself: Healthcare professionals must become significantly more proficient at tapping into the most valuable resource at their disposal—the patient themselves. Patients, in turn, will continue to turn to their fellow patients for more healthcare-related information.

Top Ten Trends for Healthcare & Wellness in 2012, Bart Foster, founder and CEO, SoloHealth

SoloHealth is a health care technology and data analytics company that supplies kiosks and other products designed to help consumers take charge of their own health. According to Mr. Foster:

1. Technology will lead the way, providing a more efficient and effective experience among consumers, providers, insurers, and health and wellness businesses. Digital, social and mobile technologies will play a major role.
2. Awareness and prevention will have a renewed focus.
3. The “empowered consumer” will continue to rise along with the use of self-service technologies and channels.
4. Retail-based clinics and health care kiosks will connect with consumers to improve health care access, awareness and treatments.
5. Open access to health care data (while respecting privacy) will be more prevalent.
6. Lines between health care insurers and providers will continue to blur as mergers and partnerships cross traditional lines.
7. There will be increased government involvement and focus on health care as a major national issue
8. Health care costs will be more transparent.

Wall Street Journal - CEO Council edition

In this annual special edition, experts including members of the Wall Street Journal CEO Council address domestic and global challenges. Their top-two recommendations for improving the U.S. health care system are 1) prevention and awareness of chronic diseases and 2) the advancement and importance of healthcare technology.

Health Information Technology

Electronic Health Record Systems and Intent to Apply for Meaningful Use Incentives Among Office-Based Physician Practices, Centers for Disease Control and Prevention (CDC)

A newly released survey found 52 percent of office-based physicians in the U.S. intend to take advantage of incentive payments available for doctors and hospitals through the Medicare and Medicaid electronic health record (EHR) incentive programs. EHR incentive payments for eligible health care professionals can total as much as $44,000 under the Medicare EHR Incentive Program and $63,750 under the Medicaid EHR Incentive Program. The CDC data also show the percentage of physicians who have adopted basic electronic health records in their practice doubled from 17 percent in 2008 to 34 percent in 2011, with the percentage of primary care doctors using this technology nearly doubling from 20 to 39 percent. Refer to www.healthit.gov or www.cdc.gov/nchs.


In this commentary, Burrus Research, a consulting firm that monitors global advancements in technology-driven trends, focuses on three related trends, all relevant to occupational health operations:

1. Rapidly expanding power of “virtualized processing” on mobile devices via cloud-based technology, e.g., “Now your
handheld device is as powerful and advanced as your desktop.”

2. Creative applications, e.g., “give people the ability to do what they currently can’t do, but would want to do, if they only knew they could.” The key is to implement a communication vehicle that engages the different groups you serve.

3. Just-in-time training that will enable people to use their laptops, cell phones and tablet computers as a tool to receive training precisely when they need it.

Managing Paper Patient Records in a Clinical Practice, Nuance

This 2011 report by the speech software company discusses the use and implementation of electronic health records in ambulatory physician practices:

- Review of paper documents and integration into the EHR are major issues.
- No ideal solution is available whether through technology or process.
- Personnel-intensive workflows are common in handling paper, along with errors that result when humans are involved.
- A technology solution that helps automate handling of paper is needed.
- The ability to extract data from unstructured paper documents would be welcome.

We Can’t Wait: U.S. Department of Health and Human Services (HHS)

HHS announced plans to expedite the use of health IT in doctors’ offices and hospitals nationwide to improve health care and create jobs. While protecting confidential personal information, health IT can improve access to care, help coordinate treatments, measure outcomes and reduce costs, HHS Secretary Kathleen Sibelius said. The new administrative actions are supported by the HITECH Act.

To encourage faster adoption of electronic health records, the secretary announced that HHS intends to allow doctors and hospitals to adopt health IT applications this year without being required to comply with new implementation standards until 2014.

These policy changes are accompanied by greater outreach efforts that will provide more information to doctors and hospitals about best practices and to vendors whose products allow health care providers to meaningfully use EHRs. For example, in communities across the country HHS will target outreach, education and training to doctors who have registered for the EHR incentive program but have not yet met meaningful-use requirements, which are the foundation for impending payment changes involving patient-centered medical homes, accountable care organizations, bundled payments and value-based purchasing.

Cost Containment

Behind the Numbers: Medical Cost Trends for 2012, PwC Health Research Institute

The PriceWaterhouseCoopers Institute predicts medical costs will increase from 8 percent in 2011 to 8.5 percent in 2012. Reactions to the recession and slow recovery, health reform and other variables are factored into the equation, which takes into account trends contributing to rising costs (accelerators) and decreasing cost trends (deflators).

Noteworthy accelerators include:
- Continued provider consolidation
- Cost-shifting from Medicare and Medicaid
- Increasing burden of post-recession stress on the workforce

Deflators include:
- Blockbuster brand name drugs going off patent
- Out-of-network provider “tiering” (defined as the classification of health care providers or treatments into different groups based on objective or subjective criteria such as measures of cost, quality, safety or value)
- High-deductible health plans forcing cost-sharing

Refer to www.pwc.com/us/en/health-industries.

2011/2012 Staying@Work study, Towers Watson/National Business Group on Health

Findings from this study paint a complex picture: Although companies with highly effective health and productivity (H&P) programs have gained ground, advances are tempered by shortfalls in some key areas for all companies, including those with best practices. Challenges include the difficult economic environment, a growing epidemic of workplace stress claims and failed attempts to change unhealthy lifestyles. These issues have collective impact on direct medical costs as well as the hidden costs associated with absence, presenteeism and overtime.

As North American employers seek to control these rising costs, they are increasing their investment in the health and work effectiveness of their employees. What’s more, employers are finding this strengthened commitment — demonstrated by a philosophy and programs that make employees accountable for managing and improving their own health — can have positive effects on their organization and bottom line, according to the report.

Refer to www.towerswatson.com/united-states/research/6031

Amy Gallagher, vice president, Cornerstone Group, New England

Advising large companies on benefits, Ms. Gallagher predicts health care cost hikes of approximately 10 percent for employers in the coming year. She also cites the following as emerging trends likely to shape the future of health care in 2012 and beyond.

Benefits: New value-based benefit
plans that use incentives such as reduced co-pays and deductibles to encourage patients who are chronically ill to follow recommended treatment plans and change unhealthy behaviors.

HMOs: A resurgence of interest in Health Maintenance Organization (HMO)-style delivery models that focus on the primary care relationship to manage patient care.

Wellness: More employers are realizing that helping employees improve their health impacts the bottom line.

PEOs: Professional Employer Organizations allow companies to co-lease employees for purposes of benefits only, pooling risk with other small businesses for purchasing clout.

Fitness

According to more than 2,600 fitness professionals who completed an American College of Sports Medicine survey of the top fitness trends for 2012. The top ten fitness trends predicted for 2012 are:
1. Educated and experienced fitness professionals.
2. Strength training.
3. Fitness programs for older adults.
4. Exercise and weight loss.
5. Children and obesity.
6. Personal training.
7. Core training.
8. Group personal training.
10. Functional fitness, i.e., using strength training to improve balance and ease of daily living.

Performance Measurement
Comparative Effectiveness Research, Patient Centered Outcomes Research Institute

The institute recently announced it has received more than 850 applications for two-year comparative-effectiveness research grants. The organization will announce funding for 40 projects in March. Established under the Patient Protection and Affordable Care Act, the institute said it attracted a larger-than-expected number of applications from stakeholders, patients and patient advocates because of a “high level of interest and readiness to shift the research paradigm toward a patient-centered approach.”

Projects that receive funding will address methods for engaging patients in various aspects of research. The findings will be used to build a foundation for the institute’s activities moving forward. The Patient-Centered Outcomes Research Institute (www.PCORI.org) is an independent organization created to help people make informed health care decisions and improve health care delivery.

Defining and Paying for Value: Theory Becomes Reality, PwC Health Research Institute

Findings from a survey of 1,000 U.S. adults suggest health care organizations must demonstrate they are delivering better value; those that do not will be penalized. The survey findings reveal inconsistencies in attitudes toward health insurance offerings.

• 52 percent of respondents indicated they would be interested in a value-based insurance plan such as one in which treatments known to be effective would cost little but new treatments with unproven benefits would cost more.

• 65 percent of respondents believe health plans should offer a wide range of hospitals, doctors and treatment options from which to choose.

• However, 47 percent of respondents said they would rather have a health plan that costs less and offers fewer doctors and hospitals than a higher-cost plan with greater choice.

Refer to www.pwc.com/us/tophealthissues2012.

Physicians’ Viewpoint
Physician Perspectives About Health Care Reform and the Future of the Medical Profession, Deloitte

A Deloitte survey of randomly selected members of the American Medical Association indicates physicians are skeptical about core promises associated with the Patient Protection and Affordable Care Act. For example, only 27 percent of physicians surveyed believe the act is likely to reduce costs by increasing efficiency, and only 33 percent feel it is likely to decrease disparities. Moreover, half say access to health care will decrease because of hospital closures.

The report also shows that the majority of doctors (73 percent) are not excited about the future of medicine and 69 percent believe the “best and brightest” who might consider a career in medicine will think otherwise.

The negativity is driven in part by concern over the pressure family practitioners will face when millions of newly insured consumers seek care. Another stumbling block for physicians is the view that reform will mean a loss of autonomy and more costs and administrative burdens in adopting processes and technologies.

Additional key findings from the study include:

• Nearly 75 percent of respondents think emergency rooms could be swamped if primary care physician offices are overbooked.
A stewardship program that provides a structure for stakeholders to jointly apply an analytical approach to workers’ compensation claims management has been shown to reduce costs and improve outcomes.

Expert panelists at the recent Workers’ Compensation and Disability Conference sponsored by Risk & Insurance cited numerous benefits of a cross-disciplinary collaboration including:

• The ability to establish baselines for comparative analysis.
• An opportunity to focus on trends to illuminate strengths and areas in need of improvement.
• A structure for the development of an action plan that delineates organizational goals, metrics and deliverables.

Each participant has a specific role in the stewardship process, but there also must be open-mindedness, collective buy-in and purpose, the panelists said during a session on Improving Your Workers’ Compensation Program Through Stewardship Meetings.

**Getting Started**

From the employer’s perspective, one of the first steps is identifying measurable performance indicators and the sources from which data will be collected. A good place to start collecting data is with the company itself, its third party administrator (TPA) or workers’ compensation carrier, and an external risk management information system vendor.

“You have to share data to get results,” said Sharon Gardner, senior manager of risk management for Chick-fil-A, Inc. “If you don’t trust the carrier/TPA, then you should find another partner. Knowing what you are all trying to accomplish will drive the data request.”

In addition to employer and payer representatives, collaborative partners may include occupational health providers, data analysts, safety consultants, and insurance brokers and agents. Ms. Gardner also recommended building on the basics by reviewing available “canned” analytical reports, determining what needs to be customized and rating the relevancy of specific measurable factors.

How data are collected also affects the end result. For example, she said issues to consider include:

• **Current vs. point in time**
• **Transactional vs. loss date**
• **Policy year/calendar year**
• **Capped vs. uncapped**
• **Coding accuracy**

“We want to focus on the claims that cost the most and spend our time and resources where it makes the most sense,” Ms. Gardner said.

“The goal is to get the best possible care for the injured worker at the best rate.”

**Network Penetration**

Another way for stewardship partners to better manage the claims process is to analyze managed care network penetration to assess the degree to which price and utilization are under control, said Sheila Clark, vice president and area account executive with Sedgwick CMS, Atlanta. She recommends examining the life of a claim over a 90-day period.

“The goal is to get the best possible care for the injured worker at the best rate.”
rate,” she said.

In reviewing network penetration, it is particularly important to consider, not what has been done, but what may be missing by asking such questions as:

1. Was the “best” provider utilized or did the claimant simply go to the nearest discounted provider?
2. Where is out-of-network leakage occurring?
3. Where and how can treatment be channeled?
4. How do outcomes between in-network and out-of-network providers compare?
5. Which outside providers should be nominated for network inclusion?
6. Are up-to-date panel physicians posted at the worksite? (Panels are constantly changing).

In addition, the research is “only meaningful if you have something to benchmark against,” such as data among similar types of industries or in certain jurisdictions, Ms. Clark said. In a five-state study, for instance, Sedgwick found 60 percent of claims billing occurred in network in Texas, where the company’s benchmark is 67 percent, compared to 93 percent in-network billing in Virginia, where the benchmark is 91 percent.

In Texas, further investigation may reveal valid reasons for not achieving the benchmark. Perhaps care is being delivered in a remote location and the only provider accepting workers’ compensation cases sees no need to join a PPO network, “which isn’t necessarily a bad thing,” Ms. Clark explained.

Careful review of in-network and out-of-network use of ancillary services such as diagnostic testing and physical therapy also is an effective strategy, she added.

“Identify the low-hanging fruit and knock off the top three,” Ms. Clark advised employers in the audience. “Be realistic with your time line and carefully select the data you are going to dive into.”

Avoiding Common Pitfalls

Cindy Larsen, senior vice president and claims consultant with Marsh USA, offered the following time line to help workers’ compensation system stakeholders engaged in a stewardship program avoid common pitfalls such as “analysis paralysis” and lack of attention to detail:

**90 Days Prior to Due Date**
- Determine final report delivery date
- Review prior reports for baseline
- Formulate preliminary concept
- Confirm process and establish expectations

**60 Days Out**
- Engage resources
- Conduct preliminary data review
- Discuss initial observations
- Reach preliminary conclusions and identify additional data needs
- Pre-draft report

**50 Days Out**
- Peer-review report
- Make needed revisions

**30 Days Out**
- Forward draft report to all partners

**15 Days Out**
- Finalize report for delivery

“It’s important to have a data analyst available,” Ms. Larsen said. “An account representative may not remember everything that has happened with a claim.

“It boils down to the ability to become change agents,” she said. “You have to be prepared to challenge the status quo. Let the results resonate and guide your next steps. Look at it as continuous quality improvement on the part of your organization. Be a partner: Everybody has to work collaboratively to drive results.”

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**Table 1: Sample data buckets for claims analysis**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Severity</th>
<th>Ratio</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Volume</td>
<td>Average/Total Incurred</td>
<td>Closure</td>
<td>Case Management</td>
</tr>
<tr>
<td>Litigation</td>
<td>Average/Total Paid</td>
<td>Medical vs. Indemnity</td>
<td>PPO Penetration</td>
</tr>
<tr>
<td>Examiner Caseload</td>
<td>Loss Stratification</td>
<td>Payment Analysis</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Lag Time</td>
<td>Lag Analysis</td>
<td>Diagnostic Physical Therapy</td>
<td>Bill Review ODG Durable Medical</td>
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<td></td>
<td>Litigation</td>
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<td></td>
<td>Subrogation/Recovery</td>
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<td></td>
<td>Loss Development</td>
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<td></td>
<td>Lost Time Days</td>
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When an employee is injured on the job, their employer’s immediate reaction typically is to seek appropriate, prompt treatment and, whenever possible, rapid return to work.

A more measured response involves an investigation into the root cause of the injury. The goal is to identify corrective actions that can be taken to prevent a recurrence.

Elkay Manufacturing, Oak Brook, Ill., is an example of a company that takes a methodical approach to unraveling what can be a complex set of circumstances using an Ishikawa fishbone diagram to demonstrate cause and effect, said Julie Sfurm, corporate risk operations manager. She spoke on the model at the Workers’ Compensation and Disability conference held recently in Las Vegas by Risk & Insurance and its partners.

The company’s slogan is: “We are in business forever,” so it’s not surprising Elkay Manufacturing is determined to get to the bottom of things. With more than 3,800 employees in 15 locations in North America and select international markets, the company manufactures sinks, faucets, water coolers, fountains, kitchen cabinetry and water filtration products.

Whenever an incident occurs in any plant, a root cause analysis is performed. “The diagram forces us to evaluate our processes and increase efficiency,” Ms. Sfurm said. “Reducing incidents and improving processes leads to profitability.”

In one of its plants, which she referred to as a former “poster child for bad behavior,” an in-depth, six-month root cause analysis helped reduce lost-time claims from 56 to 24. Subsequent interventions resulted in a stretch of 358 days without a single reported work-related injury.

Root cause analysis is the opposite of a Bandaid approach. The basic principle is that corrective actions or solutions are most effective when they address fundamental causes rather than merely skim the surface. In addition, Ms. Sfurm said, the 80/20 rules applies: the majority of accidents and losses are associated with a relatively small number of causes.

An accident rarely, if ever, has only one root cause, and there are many more incidents that could have resulted in an injury than there are actual accidents, but the lessons are the same.

“It may sound simple,” she noted, “but how many times have you presumed an employee was doing what they were supposed to be doing, following standard procedure, and it turned out they were not?”

**Conducting the Analysis**

There are a number of factors to consider when investigating an accident or near-miss incident. The investigation should result in a detailed description of what occurred and identified exposure risks. By keeping data on each investigation, trends can be identified, and preventive strategies and controls developed.

The fishbone diagram developed by Dr. Kaoru Ishikawa in 1943 is used to identify potential factors causing an overall effect. Each cause or reason for the injury is a source of variation. Causes are usually grouped into major categories to identify sources of variation. The categories typically include:

- **People**: Anyone involved with the process.
- **Methods**: How the process is performed and the specific requirements for doing it, such as policies, procedures, rules, regulations and laws.
- **Machines**: Any equipment, computers, tools, etc. required to accomplish the job.
- **Materials**: Raw materials, parts, pens, paper, etc. used to produce the final product.
- **Measurements**: Data generated from the process that are used to evaluate its quality.

**Figure 1: Fishbone Diagram Example**

![Fishbone Diagram Example](image-url)
• Environment: The conditions, such as location, time, temperature, and culture in which the process operates.

As each aspect of the incident is examined from various perspectives, a brainstorming effect occurs. Similar to answering a child who is repeatedly asking why, brainstorming with a multi-disciplinary group helps investigators focus on possibilities and priorities, Ms. Sfurm said.

Take falling off a ladder, a common cause of injury, for instance.

Questions:
1. Why did the employee fall? One of the rungs broke.
2. Why did the rung break? Because it was too weak to support his weight.
3. Why was it too weak? It was designed to bear only up to 300 pounds.
4. Why was there more than a 300-pound load on the ladder? The combined weight of the employee and the shingles he was carrying exceeded 300 pounds.
5. Why was the employee carrying shingles up the ladder? The hoist truck was delivering shingles to another job site.

What is the root cause?
1. Not enough hoist trucks to service all job sites in a timely manner.
2. Carrying heavy supplies up a ladder.
3. Ignoring weight restrictions on the ladder.

“This approach gets everyone throughout our organization involved in the process, which is tied into other safety activities,” Ms. Sfurm said.

Root-Cause Analysis Tips:
Freeze the Facts

1. Get details of the accident: date, time, place, supervisor present or not, job, equipment involved, people involved, detailed description.
2. Time: Time and day, shift, time cards (make sure witnesses worked at the same time), check time cards, schedules and production sheets.
3. Investigate: Immediately check the accident scene. Check all details to confirm or rebut. Take photographs; initial and date them. Check equipment and use a standards-size object such as a ruler or pen to illustrate dimensions. Take photos and video footage of job duties.
4. Witnesses: Determine who could possibly be a witness. Verify whether they saw anything to prevent collusion. Ask open-ended questions to get a comprehensive description and complete signed witness statements.
5. Accident report: Immediately. What are the consequences for late reporting? Do it every time – prove a negative. Write it down and have the employee who is involved sign it.

• More than 80 percent believe it is likely that wait times for primary care appointments will increase.
• More than half indicate that other medical professionals (physician assistants, nurse practitioners) will deliver primary care both independently and as an adjunct to physician services.
• Surgical specialists (57 percent) are much more likely to support repeal of the health care reform act, compared to primary-care providers (38 percent) and non-surgical specialists (34 percent). They are also more likely to say the legislation is a step in the wrong direction and believe their net income will decrease as a result of reform.
• There is a disparity among generations: 59 percent of physicians 50 to 59 years old feel the Affordable Care Act is a step in the wrong direction while only 36 percent of those ages 25 to 39 share this sentiment. Younger physicians (ages 25 to 39) are also more likely than older doctors (ages 40 to 59) to think the transition to evidence-based medicine will improve care.

Refer to www.deloitte.com/us/physiciansurvey.

Workforce Management
Strategic Human Resources and Talent Management: Predictions for 2012 – Driving Organizational Performance Amidst an Imbalanced Global Workforce, Bersin & Associates

Predictions included in the human resources management firm’s 2012 report highlight radical changes in the economy and the workplace as they relate to social networking for talent acquisition, informal and on-demand learning, performance management, employee engagement, talent development and mobility, and career development. Additional changes highlighted in the report include new models and modalities for leadership development, changes in the talent management software market, and all things social – including recruiting, learning, rewards, performance management, and career management. Among the predictions:
• Talent acquisition goes social – forcing a reinvention of agencies and job boards.
• New models, diversity and “Girl Power” will drive leadership strategies. Research shows that companies with significant female board representation had a 26 percent greater return on capital invested.
• Performance management will continue to shift toward a “coaching and development” model.

Refer to www.bersin.com
More Patients Using Retail-Based Clinics

Use of retail medical clinics located in pharmacies and other retail settings increased 10-fold between 2007 and 2009, according to a new RAND Corporation study.

Researchers accessed a database of commercial insurance claims from a population of 13.3 million patients in 22 markets from 2007 to 2009. Among 3.8 million enrollees who made at least one retail clinic visit, the monthly utilization rate increased from 0.6 visits per 1,000 in January 2007 to 6.5 visits per 1,000 in December 2009.

Proximity was the strongest predictor of retail clinic selection: Patients living within one mile of a retail clinic were 7.5 percent more likely to use one than those living 10 to 20 miles away. Other key predictors of retail clinic use included:

- gender: females are more likely to visit retail clinics than males;
- age: retail clinic patients tended to be between the ages of 18 and 44 (patients over 65 were excluded from the study);
- higher income: patients from zip codes with median incomes of more than $59,000 were more likely to use retail clinics than lower income groups;
- health status: patients with a chronic health complaint were less likely to use a retail clinic than those in good health.

“We identified 11 simple acute conditions that can be easily managed at a retail clinic,” said J. Scott Ashwood, a senior programmer/analyst at RAND and the study’s lead author. “These conditions, which include upper respiratory infection, bronchitis, ear infection, flu and conjunctivitis, were the most common seen at retail clinics.”

The researchers did not find a correlation between retail clinic use and the number of primary care physicians in the community.

Care initiated at retail clinics is 30 to 40 percent less expensive than similar care provided at a physician’s office and 80 percent less expensive than similar care provided in a hospital emergency room. However, it is not clear how increasing use of retail clinics will affect health care costs.

“If the growth in retail clinic visits that we noted represents substitution for other sources of care, then the increase in retail clinic use could lead to lower costs,” Mr. Ashwood said. “However, if these visits represent new utilization or induced demand—in other words, patients are seeking care when they would have otherwise stayed home—then costs could increase. Answering these questions requires additional study.”

Source: RAND Health, a division of the RAND Corporation, www.rand.org/health

Urgent Care Clinic Growth

Urgent care clinics in the United States treat an estimated 3 million patients per week, according to the Urgent Care Association of America. To meet increased demand, the number of facilities has steadily increased from 8,000 in 2008 to more than 9,200, including about 600 centers opened in 2011, and continued growth is expected, Kaiser Health News reported.

Economy Affects Insurance Industry

The National Council on Compensation Insurance examines the current state of the economy and the implications for workers’ compensation insurers in its December 2011 Gauging the Economy newsletter.

Among the findings:

Medical Inflation:

According to Moody’s Analytics, general inflationary pressure is expected to
ease in 2012 but medical inflation is expected to remain strong and will negatively influence medical severity. Medical price inflation will continue to outpace general inflation in the economy in the foreseeable future.

**Employment Growth:**
Continued weakness in the economy is projected to produce slow growth in private sector employment. Slower job growth indicates that there will be limited pressure on claim frequency and exposure.

**Wage Growth:**
Changes in average weekly wages are a key factor in determining indemnity severity. The projected weakness in the labor market suggests that pressure on indemnity severity due to wage inflation should increase only slowly.

**Interest Rates:**
Downward pressure on investment income for the property/casualty industry will likely continue primarily due to actions by the Federal Reserve to keep interest rates very low for an extended period.

In another NCCI study, medical services were shown to comprise nearly 60 percent of workers’ compensation claim costs, up from about 40 percent in the early 1980s. The study examines variations associated with severity, service group and claim size. Among the findings:
- Office visits and emergency services dominate the service mix for smaller claims.
- Surgery and anesthesia represent a larger share of services for mid-range ($5,000 to $100,000) claims than for other claim sizes.
- Hospital services and prescription drugs comprise more than 40 percent of the cost of claims that are greater than $100,000.

To learn more, visit www.ncci.com.

**Flu Vaccine Recommended For all Health Care Workers**
The Centers for Disease Control and Prevention, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. health care workers get vaccinated annually against influenza. During the 2010-2011 flu season, coverage for influenza vaccination among all health care workers was estimated at 63.5 percent, compared to 98 percent among health care workers who had an employer requirement for vaccination. In the absence of requirements, increased vaccination coverage was associated with employers offering vaccination onsite, free of charge, for multiple days. During the 2009-2010 influenza season, an estimated 62 percent of health care workers received seasonal influenza vaccine.

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### Recommended Resources

**Clinical Recommendations**

Occupational and Environmental Health: Recognizing and Preventing Disease and Injury, 6th Edition; B Levy, D Wegman, S Baron, R Sokas, editors; Oxford University Press, 2011.

**Fatigue**

**Electronic Medical Records**
Why small medical practices lag in EMR adoption; physicians in those settings are interested in the technology, but many factors conspire to stop them from making a purchase; P Dolan, amednews, posted Nov. 7, 2011; www.ama-assn.org/amednews.

**Flu Shots**
Recommendations on Strategies to Achieve the Healthy People 2020 Annual Goal of 90% Influenza Vaccine Coverage for Health Care Personnel; NVAC Adult Immunization Working Group; www.hhs.gov/nvpo/nvac.

**Injury Prevention**

**Physical Therapy**
A comparison of health care use for physician-referred and self-referred episodes of outpatient physical therapy; study suggests “the role of the physician gatekeeper in regard to physical therapy may be unnecessary in many cases”; J Pendergast, et al.; Health Services Research, published ahead of print Sept. 23, 2011.


**Trauma**

**Workers’ Compensation**
Workers’ Compensation: The First 100 Years; D DeCarlo, R Thompson; published by AMCOMP, 2011.
**ADA Accommodations**

New Title III Americans with Disabilities Act (ADA) Standards for Accessible Design are influencing Title I reasonable accommodation obligations, according to Carolyn Gray, an attorney with Proskauer Rose in Washington, D.C., who is featured in an article published by the Society for Human Resource Managers. Title I of the ADA requires employers to provide reasonable accommodations for qualified individuals with disabilities. Title III requires places that are open to the public to be accessible to people with disabilities. Until now, Title I and Title III did not overlap. The Title III standards have placed new limits on what can be considered a service animal. For example, while seeing-eye dogs and retrieval dogs are covered, other animals, including dogs that are not trained to do specific tasks, are not covered under Title III. Meanwhile, a new provision requires accessible common use circulation paths in new or altered employee work areas unless they are exempt.

**Cell Phones in Motion**

The American Society of Safety Engineers and the National Safety Council announced their support of the National Transportation Safety Board’s call for a nationwide ban on driver use of cell phones and other personal electronic devices while operating a commercial motor vehicle. “Too often overlooked is the fact that the number-one cause of on-the-job deaths of U.S. workers are incidents on our roadways. If NTSB’s call for a ban can help achieve significant reductions in distracted driving... then more American workers will be able to return home safely to their families each day,” said ASSE President Terrie S. Norris.

**Diabetes Education**

John Buse, M.D., Ph.D., of the University of North Carolina at Chapel Hill School of Medicine, has been named chair of the National Diabetes Education Program, a joint program of the National Institutes of Health and the Centers for Disease Control and Prevention. The program facilitates the adoption of proven approaches to improve the health of people with diabetes and to prevent or delay the onset of type 2 diabetes.

**Economy Affects Work-Return Practices**

Factors Influencing Return to Work for Injured Workers: Lessons from Pennsylvania and Wisconsin, a new report from the Workers Compensation Research Institute (WCRI), Cambridge, Mass., indicates the tight economy has limited employers’ ability to offer temporary modified duty assignments to injured workers and provide permanent job accommodations for disabled employees. The analysis suggests states should include financial incentives in temporary disability benefit termination plans and promote early return to work.

**Health Information Exchange**

At the start of implementation of the Health Information Technology for Economic and Clinical Health (HITECH) Act, only a small minority of U.S. hospitals electronically exchanged clinical data with unaffiliated providers. Health information exchange is a key part of reforming the healthcare system, and factors related to competitiveness may be holding some providers back, according to a study published in the November 2011 edition of the American Journal of Managed Care (Am J Manag Care, 2011;17(11):e443-e448). In 2009, nearly 11 percent of hospitals engaged in health information exchange (HIE) with unaffiliated providers. In communities where exchanges occurred, for-profit hospitals and those with a small market share were far less likely to engage in HIE than non-profit hospitals.
or those with a larger market share. Hospitals in more concentrated markets were more likely to exchange and hospitals in markets with higher Medicare spending were less likely to exchange.

Insurance Market

Average renewal premiums in three of four lines of business tracked by the RIMS Benchmark Survey™ increased in the third quarter, strongly suggesting that an eight-year period of falling commercial insurance rates is at its end. The survey administered by Advisen Ltd. tracks changes in average program renewal premiums for director and officers liability (D&O), general liability, property and workers’ compensation, as reported by risk managers. Of the four lines, only D&O posted a decrease, falling 1.9 percent. The average renewal premium increased 1.2 percent in general liability, 1.6 percent in property and 2.1 percent in workers’ compensation.

“Indications have been strong over the past couple of quarters that the market was near bottom, so it’s not surprising to see premiums drifting upward a bit now,” said Dave Bradford, president of Advisen’s Research & Editorial Division. “Sharply higher rates like we saw in 2001 are nowhere in sight, though. The market is still quite competitive.”

NIOSH Centers Funded

Congress has approved fiscal appropriations for 2012 that continue funding for the Education and Research Centers (ERCs) Program within the National Institute for Occupational Safety and Health. ERCs will be funded at the same level as 2011 – including millions of dollars that will be used to help train specialists in occupational and environmental medicine.

Salary Levels May Influence Benefits

More employers are expected to take salary levels into consideration when evaluating the types of health care benefit plans and dependent coverage they will offer employees in order to avoid penalties and comply with provisions of the Patient Protection and Affordable Care Act by 2014. Only one in 10 employers with 500 or more employees currently use a salary-based premium model in which those who earn less pay less. However, more companies are beginning to move in that direction, according to the 2011 Mercer National Survey of Employer-Sponsored Health Plans. One of the downsides of the salary-based premium model is that it is even more complex to administer than popular plans with variable rates for singles, couples and families, Mercer reported.

Transparency in Health Care

The National Business Group on Health applauded a final rule issued by the Center for Medicare and Medicaid Services that gives individuals more information to help choose their physicians. The Business Group called the measure a giant step forward in efforts to make the cost and quality of health care more transparent and to promote competition. The rule gives qualified organizations, including employers and consumer groups, access to data that can help them identify high-quality health care providers or create online tools to help consumers make educated health care choices.

OSHA Actions

Emphasis on Nursing Homes

New data from the U.S. Bureau of Labor Statistics show the incidence rate for health care support workers increased 6 percent between 2009 and 2010, a rate nearly two and a half times greater than the rate in all other types of industries. The rate of musculoskeletal disorder cases with days away from work for nursing aides, orderlies and attendants increased 10 percent. In response, OSHA announced the launch of a National Emphasis Program on Nursing Home and Residential Care Facilities. The agency plans to increase the number of inspections it conducts in these settings, with a focus on back strains and sprains, bloodborne pathogen exposures, workplace assaults, and slips, trips and falls. Experts predict the program will have a ripple effect on other types of health care institutions.

Whistleblower Protection

An interim final rule on regulations governing whistleblower complaints filed under the Sarbanes-Oxley Act of 2002 was published in the Nov. 3 Federal Register. The act protects employees of publicly traded companies and their subsidiaries, and of certain other employers, from retaliation for reporting mail, wire fraud, bank or securities fraud, and other violations of Securities and Exchange Commission rules.

Winter Safety

OSHA has created a web page to help protect workers from hazards they may face during winter storm response and recovery operations. The page includes guidance for workers clearing heavy snow in front of workplaces and from rooftops, workers encountering downed power lines or traveling on icy roads, and utility workers restoring power after winter storms. Visit http://s.dol.gov/L1.
RYAN Associates held its first educational seminar in Anaheim, Calif., in December 1985 with about 20 occupational health industry pioneers in attendance. Since that notable start, RYAN Associates and the NAOHP have offered scores of seminars, 25 national conferences, more than 50 sales and marketing training programs, telephonic coaching and mentoring programs and annual webinar series. The beat goes on in 2012.

Coaching/Mentoring in Sales and Marketing
Ten week course begins Friday, February 17
This series of one-hour telephonic sessions will be taught by Frank Leone, President and CEO of RYAN Associates. The class is limited to 10 registrants. Participants submit a homework assignment on each week’s topic (e.g., “the Perfect Sales Call”), and each session features a faculty presentation, review of all homework assignments and open discussion. The course is designed for new or inexperienced occupational health sales/marketing professionals, more experienced occupational health sales professionals who want to brush up on their skills and others who wish to learn more about occupational health sales and marketing.

Coaching/Mentoring in Occupational Health Clinic Operations
Ten week course begins Tuesday, January 31
Analogous to the sales and marketing mentoring program, this series of one-hour telephonic sessions is taught by RYAN Associates’ Senior Principal Donna Lee Gardner. The class is also limited to 10 registrants. The course is intended for any occupational health clinic staff member who wishes to learn more about state-of-the-art clinic operations, clinic staffing, quality assurance and information management.

Annual Webinar Series
Begins Wednesday, March 15
The theme of this year’s five-session series is Customer Service and Patient Satisfaction. Topics will include developing a customer service plan; dealing with difficult issues and people; hiring, training and motivating personnel; and designing meaningful performance evaluation methods.

Summer Seminar Tour
Begins June 2012
In conjunction with the publication of Frank Leone’s book, Marketing Healthcare Services to Employers (Sea Hill Press, due May 2012), Mr. Leone will conduct a series of half-day seminars/book signing events in markets throughout the country. Subject matter will parallel topics in the book, which is intended for any service line (e.g., occupational health, urgent care, wellness, women’s health) that offers services to or through employers. Likely venues include Boston, New York, Philadelphia, Nashville, Cincinnati, Cleveland, Detroit, Chicago, Los Angeles and San Francisco.

26th Annual National Conference
October 8-10
The venerable Drake Hotel in Chicago is the venue for RYAN Associates’ 26th annual National Conference. One or more pre-conference courses will be offered during the weekend preceding the conference, which is also the weekend of the Chicago Marathon. Social events include a Sunday afternoon golf tournament, two receptions in stately ballrooms at the Drake and the Tuesday night reception at world famous Gibson’s.

Practical Training in Sales and Marketing
December 5-7
A RYAN Associates staple since 1988, occupational health sales and marketing training will again be offered at the Sutton Place Hotel in Chicago. The program includes more than 10 hours of lecture, workshops, team and personal exercises, mock presentations and critiques. This is must-take training for any occupational health sales professional.
Jan. 29 – Feb. 4
Seminarfest 2012; sponsored by American Society of Safety Engineers; Flamingo Hotel, Las Vegas, NV; http://www.asse.org/education/seminarfest12/

April 2-4

April 15-18

April 16-19
Urgent Care Association of America National Convention; Caesars Palace, Las Vegas, Nev.; www.ucaoa.org.

April 22-25
Business Dimensions of Occupational Nursing; annual meeting sponsored by the American Association of Occupational Health Nurses; Gaylord Opryland Resort; Nashville, Tenn.; www.aaohn.org.

April 29-May 2

March 15

To list your event, please send it to info@naohp.com.
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The ACOEM Utilization Management Knowledgebase (UMK) is a state-of-the-art solution providing practice guidelines information to those involved in patient care, utilization management and other facets of the workers’ compensation delivery system. The American College of Occupational and Environmental Medicine has selected Reed Group and The Medical Disability Advisor as its delivery organization for this easy-to-use resource. The UMK features treatment models based on clinical considerations and four levels of care. Other features include Clinical Vignette – a description of a typical treatment encounter, and Clinical Pathway – an abbreviated description of evaluation, management, diagnostic and treatment planning associated with a given case. The UMK is integrated with the MDA for a total return-to-work solution.
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Medical Director/ Staff Physicians
• Colorado (Staff Physician) - NEW POSITION
• California - San Joaquin Valley (Staff Physician) — NEW POSITION
• Las Vegas (Medical Director)

Non-Physician Openings
• Florida (Nurse Practitioner) — NEW POSITION
• New Mexico (Practice Administrator) — NEW POSITION
• Miami (Occupational Health Sales Representative)

For details, visit www.naohp.com/menu/pro-placement.