Future of Occupational Health: Where Do We Go From Here?

In a half-day session at RYAN Associates’ 26th annual national conference, leaders in the field spoke about the future of occupational health as a business, a profession and a medical practice.

William Newkirk, M.D., medical director at UL PureSafety, former director of research at his Maine-based company Occupational Health Research, and the originator of SYSTOC software, created context by first reviewing the history of occupational health in the U.S. following passage of the Occupational Health and Safety Act.

Fast-forwarding to 2012 and beyond, in sum, he said the Patient Protection and Affordable Care Act will expand health insurance coverage to 32 million uninsured Americans, in turn increasing demand for medical care. In combination with the aging population, the looming physician shortage will worsen. The Association for American Medical Colleges reports that by 2020, the physician shortage will be more than 90,000, with approximately half in primary care, and by 2025 the country will be short 130,600 physicians.

In response, some occupational medicine providers – most notably the nation’s two leading occupational health clinic networks – have been acquired and are being repositioned to take on primary care.

His predictions for the future of occupational health are:

1. The Affordable Care Act will significantly exacerbate the primary care physician shortage, and this shortage will affect how occupational medicine programs are structured.

   “You will have insurance coverage, but you are not going to be able to find a doctor,” he said. “How are we seeing that play out in our field? We have had a revolution in the last 18 months” marked by the acquisition of Concentra by Humana, Inc., a leading provider of insurance products and preventive services, and of U.S. HealthWorks by Dignity Health, formerly Catholic Healthcare West, a major health system. The intent in both cases is to create local primary care access points.

   “Within the space of 18 months more than 500 clinics got bought out and converted to use for primary care,” changing the model of care for occupational medicine. Our field is changing dramatically,” Dr. Newkirk said.

2. Many employers will drop their employee health insurance. Instead, their employees will get their health insurance through exchanges, significantly raising the cost of the Affordable Care Act.

   continued on page 4
THE NAOHP BOARD HAS ADDED FOUR NEW MEMBERS

Deborah Borisjuk has been appointed to represent the Northeast region (New England, NY, NJ, PA, DE, MD, WV). Ms. Borisjuk is the Program Manager, Yale-New Haven Hospital Urgent Care and Worker Health Solutions. She joined the YNHH Ambulatory Services team in September 2010 to develop and operationalize the hospital’s first retail Occupational Medicine Program, Worker Health Solutions, a blended-model clinic. From 1996 to September 2010, she was the Administrative Director of Saint Raphael’s Occupational Health Plus, a three-site, occupational medicine model program, and its Outpatient Rehabilitation Program. Additionally, from 1988 to 1996, Ms. Borisjuk planned, developed and operated an Industrial Rehabilitation and Work Hardening Program at Temple Physical Therapy in New Haven, CT. Her term will expire Dec. 31, 2015.

Mary Alice Ehrlich has been appointed to represent the Great Lakes Region (MI, OH, WI, KY). Ms. Ehrlich is Executive Vice President, Med-1 Occupational Health System based in Grand Rapids, Mich. She has 12 years of experience in occupational health freestanding non-hospital based clinics. For 25 of her 30 years in the industry, she worked in hospital nursing and senior administration. In her current role, she established an annual educational symposium for employers in West Michigan and has hosted 11 symposia. In addition, she has instituted and continues to chair two regional client-based advisory boards. She is the 2010 recipient of the NAOHP’s Professional Achievement Award. Her term also will end Dec. 31, 2015.

Barbara Enochs, Director of Clinic Administration, Medical Specialties, Ozarks Medical Center, West Plains, Mo., will serve as an at-large member of the NAOHP Board. She has 20 years of experience in occupational health, and she has successfully started new occupational medicine programs in both industrial and health care settings. In her current role, she is responsible for directing operations of a hospital-based occupational medicine program and eight other medical specialty physician practices. Ms. Enochs is an RN and certified occupational nurse. She has a master’s degree in business administration with a health care emphasis. She will serve a two-year term.

Vickie Wipperman, M.D., has been appointed to represent the Midwest Region (IN and IL). For the past 12 years, Dr. Wipperman has been Medical Director of Wipperman Occupational Health in South Bend, Ind. She is board certified in occupational medicine and has been MRO certified since 2000. Dr. Wipperman was Gateway Medical Advisor for Liberty Mutual Insurance, and she is the former Medical Director of the Center for Business Health in South Bend. Dr. Wipperman’s term will expire at the end of 2013, completing the term of Tom Brink.

The NAOHP board is comprised of six regional representatives who serve for three years (two positions open up every year), two at-large members who are elected for two-year terms, and a President who is in office for three years. Incumbent regional board members are Trena Williams (Southeast region), Mike Schmidt (Heartland) and John Braddock, M.D. (West). Tim Ross is the incumbent at-large representative and Steve Crawford, M.D., will complete his final year as Board President in 2014.

Remembrance

It is with great sadness that we report that longtime NAOHP member and industry leader Hunter K. Giroux, 54, of Ellington, Conn., died suddenly in November. Mr. Giroux was CEO of Connecticut Occupational Health, LLC, and MedWorks, LLC, starting in 2000. He was also Administrative Director of Occupational/Employee Health for Saint Francis Hospital & Medical Center. He served on the Connecticut Workers’ Compensation Task Force and was a member of the Workers’ Compensation Alliance. “Hunter was just the nicest person, modest about his many accomplishment and very consistent. We have lost a special member of the NAOHP family,” said NAOHP Executive Director Frank Leone.
Timing It Right to Make a Lasting Contribution

Occupational health professionals have a significant opportunity to contribute to the nation’s health, says Emily Friedman, an independent health policy and ethics analyst. However, it will require perseverance.

Ms. Friedman cited a number of trends affecting the provision of health care services to employers during a keynote presentation on Changes, Chances and Challenges: Occupational Health’s Evolving Role in an Era of Health Reform at RYAN Associates’ 2012 national conference in Chicago.

As the country adjusts to life under the Affordable Care Act, she said occupational health interventions could produce remarkable results such as:

- A healthier workforce and general population
- Greater productivity and competitiveness
- Finally, true “compression of morbidity”
- Healthy aging as a reality
- Less discrimination against the chronically ill and disabled
- Concepts of “fault” and blaming the victim losing their punch
- Truly replicable models

To achieve these ambitious goals, occupational health professionals need to help employers respond with sensitivity to diversity, aging and disability in the workforce, and take advantage of advances in information technology and medicine.

“Good health, whenever possible, is a human right. It’s a privilege to work in such a way that you can help people achieve it,” said Ms. Friedman, a prolific writer, adjunct assistant professor at the Boston University School of Public Health and honorary life member of the American Hospital Association and the American Medical Association. “It’s not going to happen overnight, but it will happen.”

**EMPLOYERS FEEL EFFECTS**

The Affordable Care Act contains a number of provisions salient to employers, Ms. Friedman said. They include a tax credit for smaller companies, the availability by 2014 of state-run or federally operated health insurance exchanges and penalties starting at $2,000 per worker on employers with more than 50 employees who do not provide affordable insurance coverage.

“This is really going to be interesting: there is a guessing game as to whether large companies will opt to take the penalty,” Ms. Friedman said. “But as long as you configure your marketing in accordance with certain goals, you should be able to navigate these white waters.”

In the midst of this uncertainty, two things are certain: the U.S. population is aging and it is becoming more culturally diverse. In addition, the U.S. census found nearly 20 percent of the U.S. population has a disability; 21 percent of disabled adults age 21 to 65 are employed, and a subset of that group (28 percent) are severely disabled.

Better educated consumers are another factor influencing the delivery of occupational health services, she said. For example, both employers and patients are asking more questions about medications and treatment recommendations. “This is a long-term trend that can lead to a healthy partnership, and if not, could lead to all-out war,” Ms. Friedman predicted.

Advances in information technology and medicine also are rapidly changing the face of health care. “I am a real fan of IT,” Ms. Friedman said. She described e-prescribing as a “godsends,” particularly for homebound patients, and the advent of electronic medical records as a benefit for all health care consumers, especially in the event of an emergency. Advances in understanding of nano-technology, genetics, genomic medicine and customized drugs hold considerable promise, she added, although they are costly and require monitoring to prevent misuse.

“While it may not seem like it,” she said, wellness is another area that represents a chance for occupational health professionals to support employers, employees and the nation: “Whatever you can do to prevent chronic illness saves money for all of us. Boy do we need it…the cost curve just keeps climbing.”

Projections suggest the average health care cost per person is on track to become higher than the poverty level for a single individual. “If we do not get costs under control, we will price ourselves out of the market and no one will be able to afford anything,” she cautioned.

Unevenly distributed costs, with 50 percent of spending attributed to just 5 percent of the population, are added cause for concern.

**OTHER NOTEWORTHY TRENDS**

According to Ms. Friedman, other noteworthy emerging issues include:

**Accountable Care Organizations:**

“I am extremely cynical about ACOs…Having electronic medical records does not make you the Mayo Clinic. However, there are going to be a lot of ACOs coming out and hopefully they are going to be a fertile area for your efforts, because they are designed to provide a continuum of care for all levels of disease,” she told the audience of occupational health professionals.

**Recasting of primary care:** “The fact is we don’t have enough primary care physicians, so other types of practitioners are stepping in: nurses, physician assistants, nurse practitioners, pharmacists…”

**Expanded scope of service:** Occupational health providers can take advantage of their understanding of health needs in niche populations. For example, inmates in correctional institutions and Medicaid recipients represent under-served populations in need of intervention. There also are opportunities for triage to ensure true emergencies are treated as such and non-emergent cases also are treated appropriately from the start, she said.
In a May 2012 report, the Republican staff of the Ways and Means Committee published *Broken Promise: Why ObamaCare Will Force Americans To Lose the Health Care Coverage They Have and Like*. The staff analyzed 71 of the country’s largest companies and found that “these companies could collectively save $422.4 billion from 2014 through 2023 if they eliminated health insurance coverage for their U.S. employees and paid the employer mandate penalty.”

Philip Bredesen, former Democratic governor of Tennessee (2003-2011) and author of the book, *Fresh Medicine: How to fix reform and build a sustainable health care system*, analyzed health care costs of the Tennessee state government and concluded: “We can reduce our annual costs by over $146 million using the legislated mechanics of health reform to transfer them to the federal government.” Dr. Newkirk said Gov. Bredesen also has described a new ethos in which employer-sponsored health care insurance is seen as obsolete:

“For an entrepreneur wanting a lean, employee-oriented company, it’s a natural position to take: ‘We don’t provide company housing, we don’t provide company cars, we don’t provide company insurance. Our approach is to put your compensation in your paycheck and let you decide how to spend it.’”

“If Gov. Bredesen’s vision is correct, the entire fabric of employer-sponsored health insurance could unravel in response to the ACA’s financial incentives,” Dr. Newkirk said. “The question is, how many employers will drop insurance, 5 percent, half, all? Gov. Bredesen says new companies will never even think about it; instead they would pay the penalty. And if you are a small company, you are not subject to the penalty.”

Another question to consider: If reducing health care benefit costs is no longer a motivator for employers because they do not provide insurance coverage, what will happen to employer-sponsored wellness programs?

3. Occupational medicine will become increasingly global, standardized and integrated as large corporations try to control their costs and protect their brands.

“I have taught every other year for the last few decades at Harvard to doctors who have finished their master’s degree in public health and their residency in occupational medicine,” said Dr. Newkirk, a Harvard graduate. “When I started, the group was mostly male and English was their first language. My most recent class was mostly female and it had global representation.”

Whether jobs and products are in the U.S., China or other countries, companies recognize that their brand and image matters. “They want to be able to assure consumers that their workers are working at safe plants.” Looking ahead, “there will be a lot of opportunities in occupational medicine, but they will not be in the U.S.,” he said.

4. After a severe recession resulting in significant private sector job loss and a dramatic slow-down in construction, the economy is slowly improving and will continue to do so.

The changing nature of industry and the job market will have considerable ripple effects, Dr. Newkirk explained. “If you are a nurse in a hospital doing infection control, you will do pretty much the same thing as always. If you work in a freestanding occupational clinic, you have probably already added urgent care...What you see will depend on where you are.”

**PROSPECTS FOR NURSING**

Kay Campbell, EdD, RN-C, COHN-S, executive director of the American Association of Occupational Health Nurses (AAOHN), said she believes leadership training and education are the best ways to sustain the nursing profession and propel it forward.

As an educator, business consultant and expert on population health management, Dr. Campbell, has a unique perspective: “Occupational health nursing is alive and very well, so we are very excited about the future.”

Referring to an influential study, Dr. Campbell said the Robert Wood Johnson Foundation (RWJF) and the Institute of Medical (IOM) launched a two-year Initiative on the Future of Nursing in 2008 with the goal of producing an action-oriented blueprint to address the loss of older nurses to retirement and a shortage of schools and faculty to train new nurses. A committee produced *The Future of Nursing: Leading Change, Advancing Health in 2010*, and later worked with AARP on some pilots projects.

Among key observations and recommendations contained in the report:

1. Nurses should be allowed to practice to the full extent of their education and training in the state(s) in which they work. Statutes are needed to remove restrictions that create barriers to practice, Dr. Campbell said.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression. “Traditional task-oriented, segmented teaching approaches need to be broadened,” Dr. Campbell noted. “If you have been in nursing, you know it is disjointed. People get frustrated when they should be thinking about the skills sets they need to do their job, and more importantly, have passion around that job.”

3. There should be more residency training options for nurses to increase the percentage who attain a bachelor’s degree to 80 percent by 2020 and double the number who pursue doctorates. This would likely give nurses greater opportunities to fill perceived gaps in leadership roles in industry and healthcare settings, she said.

4. Nurses should be full partners with physicians and other health care professionals. “I am speaking here today as a result of collaboration,” Dr. Campbell said. “It’s the way of the future. We all must collaborate to learn and prosper.”

5. Effective workforce planning and policy-making require better data collection and information infrastructures: “This will allow patients, clients and employees to have better health care.”

The AAOHN offers a number of leadership, education and hands-on training opportunities to its members through its Academy and other sources. It also encourages members to be politically active, contribute to management teams, boards and community groups, and serve as professional mentors.

“We need to be full members of the health care team and the delivery system,” Dr. Campbell said. “We need to be seen as leaders. All nurses need additional information presented in new ways.”

EXPERTISE SHORTAGE

Dr. Campbell also cited a report which examined the status of occupational health and safety as a profession. The National Assessment of the Occupational Safety & Health Workforce was conducted in 2011 to help the National Institute for Occupational Safety and Health (NIOSH) determine how to best utilize training funds. Survey respondents included employers and OH&S training providers.

According to the findings, future national demand will significantly outstrip the number of OH&S professionals with the necessary training, education and experience to provide a broad range of OH&S-related services. At the time of the survey, there were about 48,000 OS&H professionals in the U.S. workforce, dispersed as follows:

- Safety professionals – 59 percent
- Industrial hygienists – 15 percent
- Occupational health nursing – 9 percent
- Occupational medicine – 3 percent

Employers are expected to hire more than 25,000 OS&H professionals within the next four years to fill an average of about 5,000 positions per year, 71 percent of them in safety.

“There are a lot of jobs out there, they just may not look like the jobs you are used to seeing,” Dr. Campbell said. “The same old leadership skills thing just keeps popping up. Employers who were surveyed said they need OH&S professionals who know how to think strategically and how to collaborate to make things work better.”

When asked about the role of occupational health nursing, employers said they depend on nurses for direction on wellness and health promotion. They also expressed a need for expertise in case management, transitional work programs, conducting health and safety assessments, analyzing workplace hazards and preventing workplace accidents. The survey results also indicated a need for additional training in leadership skills and knowledge of local, state and federal regulations and compliance issues, Dr. Campbell noted.

“For occupational health nurses, it’s all about communication and education…the ability to talk with workers, consult with senior management, engage with different cultures, teach, do technical writing, understand industry and how the jobs are done,” Dr. Campbell said.

On a global level, AAOHN is looking at ways to form alliances with nursing organizations in other countries. It also is collaborating with the World Health Organization on the potential development of the first international occupational health nursing center.

“The future is bright. We just need to make sure we have the skills that are needed for the next 20 or 30 years,” Dr. Campbell said.

HEALTH INFORMATION AT FOREFRONT

In the world of health information management, the future is now, said Mary Stroupe, president of Integritas, Inc., producers of Stix and Agility EHR software for use in occupational health programs, employee health departments and the rapidly expanding on-site and mixed-use clinic markets.

Speaking at RYAN Associates’ national conference, Ms. Stroupe covered a number of related issues: “All of the elements are inter-connected, but we can only talk about one at a time,” she explained.

The second phase of American Reinvestment and Recovery Act certification and health information exchange (HIE) implementation is approaching. The first phase, which is still underway, involves the establishment of electronic medical records (EMRs) by

continued on page 12
Hurricane Sandy threatened the lives and livelihoods of millions of residents in the New Jersey-New York-Connecticut corridor in October. Hospitals, clinics and providers of occupational health services were both victims of and responders to the crisis. With two main hospitals down in Manhattan and others in the region hobbled by overcrowding and compromised infrastructure, occupational health professionals and their colleagues rallied to help employers and their employees locate resources they needed to remain safe and on the job.

To learn more about preparedness and response in the wake of Sandy, VISIONS spoke with representatives from three leading health systems:

- **Lorraine Chambers Lewis**, assistant vice president, North Shore-LIJ Health System Employee Health Services, Long Island, NY. North Shore-LIJ operates 16 hospitals and related medical facilities in the New York metropolitan area. The corporate health team Ms. Chambers Lewis oversees is responsible for the health and safety of approximately 44,000 employees.

- **Christopher O’Connor**, executive vice president and COO, Yale New Haven Health System, CT, formerly an administrator at Ochsner Clinic, New Orleans, where he assisted with Hurricane Katrina response from an operational perspective. The system provides comprehensive healthcare services through Yale-New Haven, Bridgeport and Greenwich hospitals and the Northeast Medical Group delivery network. The system employs 11,000 people in New Haven and 18,000 in its medical delivery network.

- **Nancy Thorne**, manager, Meridian Occupational Health, northeastern New Jersey. The Meridian Health System operates six hospitals and related facilities on or near the Jersey Shore, including six occupational health delivery locations. It employs about 15,000 people.

**Q:** Your health systems are large and diverse. How did your system manage the overall emergency response and ensure patient safety given the complexity of the situation?

**Ms. Chambers Lewis:** We also have a command center structure. We have a designated location our senior leadership reports to for disaster planning. Computers are set up and key people have defined roles to address all facets of the emergency.

**Mr. O’Connor:** We have a Center for Emergency Preparedness and Disaster Response and an integrated emergency preparedness plan for the system. Three hospitals become the hub of our response. Because they are open 24/7, they are the first and major element for response in the community.

**Q:** How did you deal with the need to relocate patients?

**Ms. Chambers Lewis:** We have had to move patients from one location to another in the past. We had a similar experience with Hurricane Irene last year, so we had processes in place to quickly move patients out of harm’s way when necessary. We were well prepared from that standpoint.

**Mr. O’Connor:** This is one of those situations where size and scale enables a better response. We were fortunate in that we received patients, not moved them. We took in 40 hospice patients, and we were able to shelter both staff and patients during the storm.

**Q:** How did your occupational health program respond during and after the storm?
Mr. O’Connor: During the storm we focused on acute-care needs. The hospitals have connectivity and we are able to allocate resources where needed and appropriate. We were able to consolidate facilities within our system that were without power with those that did not lose power. For companies, we focused more on what would be needed after the storm passed. One of our clients, the local power company, was at the forefront of the response and also largely responsible for our own success. We worked with them to make sure they accessed services for their crews out in the street. Everyone approached this with a view of safety first.

Ms. Thorne: We were able to help ease overcrowding in the hospital emergency rooms by treating non-emergent patients in our offices, even though we don’t regularly do urgent care in our occupational health clinics. We also were able to help with communication early on because one of our sites is near the main hospital. From that location we were able to communicate with employers and provide resources if they needed us. We serve a number of utility companies and emergency responders. We wanted to make sure they knew that we were up and running and we could help meet their needs.

Ms. Chambers Lewis: We have a client where we operate an onsite employee health program, and they lost power for a number of days. We were closed there for a period of time but their workforce really needed help with medical care while they were at work. Even though the computers were not available yet, we were able to re-open the site using our back-up emergency paper health records. Once the power came back on, we just entered all of the information back into our electronic health record.

Q: Do you feel as if you had to step outside of your usual “comfort zone?”

Ms. Chambers Lewis: You have to be prepared to provide additional services that are not necessarily customary. Many of our offices were asked to provide minor acute care, which we don’t usually do. This was particularly helpful for employees that just need minor care for a cut, or a Tetanus shot. It was also helpful for employees to have somewhere to go for emergency medication refills. Many private physician offices were not open at the time. The convenience of having this service at work is also a plus. We also provided staff to support PAS (Personal Assistance Services) for people with disabilities, which is something we don’t typically do.

Q: It seems that one of the challenges in emergency situations is ensuring the safety of your own employees, who are well trained and motivated to help others, even under risky circumstances. How did you handle that?

Ms. Chambers Lewis: The magnitude of Sandy created some significant challenges with our workforce. Two (non-North Shore-LIJ) hospitals closed in Manhattan—NYU and Bellevue. This put a significant burden on our Manhattan location, Lenox Hill Hospital. The hospital had an extremely high census. We had to bring in extra resources to serve these patients. We had nurses from NYU coming into our hospital to work there. There was a screening process that we had to activate to satisfy regulatory issues.

Mr. O’Connor: We had an incredible response from each of our hospital staffs. We had more people than we probably needed. Those are all good things and the result of prior planning and exceptionally dedicated employees. It’s part of our responsibility as management to protect our employees. Our job is to make sure our staff members know there are limits on what they can and can’t do. They are our most valuable resource; we need them to go forward.

Q: In what ways did your employee health team have a significant, positive impact?

Ms. Chambers Lewis: From my perspective, our quick response and communication was the most important way in which we were able to support this health system. Our employees were calling and wanting to do something to help. People were still coming to work even though they didn’t have housing and other essentials. We put together an emergency employee resource center and webpage. We posted information “We had a similar experience with Hurricane Irene last year, so we had processes in place to quickly move patients out of harm’s way when necessary.”
on carpooling, medical resources, clinics, financial and housing assistance, paid time off and other services. By having those resources set up really quickly we could make sure our workforce was okay.

**Q**: Was that something you already had in place?

**Ms. Chambers Lewis**: We had the talent within our system to quickly pull it together. First, we were able to gather our web team and our communication specialist and activate a call center rather quickly. Those phone calls evolved into the identification of high-level needs: people needed housing, financial assistance, reassurance, to feel safe and healthy, and still be able to participate in the workforce as much as they could so they wouldn’t incur additional financial hardship.

**Ms. Thorne**: Similar to Nancy’s situation, we did not want to rely on computer resources during the storm, so we printed out the schedule for the next three days. Key EHS staff members took the list home, and they knew who to call in the event of an emergency situation. This ensured that appointments and services were managed, and that everyone knew what was going on. If you have that connection, it’s not a burden on just one person; it’s shared among your leadership team. Everybody knows who to call to rearrange their schedules and to make sure that you have internal contingency disaster planning.

**Q**: How well prepared do you think your organization was for the severe communication challenges you encountered?

**Ms. Thorne**: Because we had advance notice, we were able to print out paper patient schedules and patient contact information and take that home with us on Friday. Some of us were still able to use our phones; we were calling clients and patients from our homes. We also were able to redirect our staff to the hospitals and ERs that were getting busier and busier. We opened two of our office locations to help with emergency room overflows.

**Ms. Chambers Lewis**: It didn’t happen in our office, but I did hear there were some instances where refrigerators were not functioning and put medical supplies at risk. I would encourage all clinics to make sure all refrigerators that store vaccines have a generator backup. I also think we could do more to recognize subtle indications from employees who can benefit from a referral to our employee assistance program and counseling. Oftentimes we will be the only folks who see an employee vulnerable. We want our client companies to be aware that stress can have a significant negative impact on their workforce, so increasing awareness and making sure they know we are a resource for behavioral health services is something we want to focus more attention on.

**Mr. O’Connor**: Communications is always the hardest thing to maintain, particularly because much of the infrastructure comes under fire – you lose phone and Internet connectivity.

**Ms. Thorne**: Social media also played a role in our response. Any department that communicated any kind of messaging could send it to the IT folks. They would put it on our Facebook page, and we could direct our client companies to check there for information about service availability.

**Q**: If you had to go through this all again, what would you do differently next time?

**Ms. Chambers Lewis**: It didn’t happen in our office, but I did hear there were some instances where refrigerators were not functioning and put medical supplies at risk. I would encourage all clinics to make sure all refrigerators that store vaccines have a generator backup. I also think we could do more to recognize subtle indications from employees who can benefit from a referral to our employee assistance program and counseling. Oftentimes we will be the only folks who see an employee vulnerable. We want our client companies to be aware that stress can have a significant negative impact on their workforce, so increasing awareness and making sure they know we are a resource for behavioral health services is something we want to focus more attention on.

**Ms. Thorne**: We moved all of our vaccines to the hospital on Friday, so we were fairly prepared in that regard. In retrospect, we could have done more to help first responders, utility workers and clean-up crews be better prepared…their employers were scrambling to get their employees updated with their Hepatitis B, flu shots and Tdap. In the future that may be something we can help them with proactively.

**Q**: Did you apply lessons from your Katrina experience to preparations for Superstorm Sandy?

**Mr. O’Connor**: It actually goes back...
farther than that. I have been in hospital administration and operations for 20 years, starting out as an emergency room technician. I subsequently ran two different emergency departments. I experienced the 9/11 attacks (from a distance), preparations for Hurricane Ike and then went through Katrina in New Orleans. These types of events have helped prompt new and different ways of thinking about preparedness. It has become more of a focus for hospitals. For example, the Joint Commission now requires evacuation drills; that is what benefitted the folks at Bellevue in New York. Those types of drills were not required before Katrina in 2005.

Q: What additional advice do you have for occupational health professionals and healthcare administrators to help them be better prepared for a natural or man-made disaster?

Ms. Chambers Lewis: Make sure that employee health services or the occupational health program have their own disaster plan, including protecting medical records. Some of our offices were affected by floodwaters and we literally had to move paper charts to higher ground to make sure they were not damaged. Having an IT solution that is accessible and connected through all your locations helps to give you flexibility. It is great to have options regarding when and where you can restore normal services.

Ms. Thorne: Communication to both internal and external clients is the key. Especially now, our system is increasing utilization of social media. I think that’s important, because that’s where people working at our command center and our clients sent a lot of the messages—through Facebook. If we can’t physically call our clients on the phone, I want to know we have a place to direct them where they can get information.

Mr. O’Connor: The key is communication, including collaboration with state and local agencies, police, fire, ambulance, all of which are critically important. It’s much easier to establish rapport with these agencies when you are not in crisis mode. The more time you have to work together before an emergency situation arises, the better off you are. There is a tendency to underestimate the time it takes to develop an evacuation plan, a power-loss plan, all of the plans that are necessary to be sure you have a framework for a coordinated response. You are going to have to adapt during a crisis – that’s inevitable – and you will need fluidity in response. But at the end of the day you need a response plan that puts your staff and your organization at the forefront. If you do that well, you will be in a good position when the time comes.
In February 2009, St. Luke’s Hospital in Cedar Rapids, Iowa, was about to embark on a social media campaign. Laura Rainey, the hospital’s marketing communications director, was asking herself, “Does my target customer, my audience, really want to hear from us via social media?” She was particularly skeptical about the use of Twitter as an outreach mechanism.

“I thought, ‘Who’s really going to start a conversation when they are limited to only 140 characters?’” Ms. Rainey told occupational health professionals at RYAN Associates’ 26th annual national conference in October during a session on marketing in health care.

Ms. Rainey put her doubts aside and gradually introduced social media to the Cedar Rapids community. She soon saw positive results. For example, the hospital scored national media coverage when it used Twitter to showcase a new surgical protocol. Meanwhile, it has been able to consistently build and maintain impressive online traffic.

“I am committed to using social media as one of many tools in my marketing communications toolbox,” she said.

**WHY SOCIAL MEDIA?**

Business and marketing applications are a logical extension of social media for personal use. Millions of Americans are connected online and are accustomed to using social media to communicate with friends, family members, colleagues, and commercial enterprises.

The social media sites St. Luke’s uses most frequently are Facebook, YouTube, LinkedIn, and Twitter.

A good way to get started is by creating a Facebook fan page and posting links to photos and information about health events. Other easy-to-implement suggestions include Tweets about free events and classes and sharing links to health and safety news and regulatory agency sites.

From a marketing perspective, Ms. Rainey said it’s important to invite people to join a conversation, listen, learn, and share. It is *not* about direct sales or promotion of products and services. “You will lose people and your traffic will decline if you use social media to hawk your product,” she warned the audience of occupational health professionals.

To hone its social media strategy, St. Luke’s marketing communications team looked for health care-oriented sites they thought made effective use of social media. Cleveland Clinic and Henry Ford were among organizations on their list.

They also did research to determine why people visit St. Luke’s website and learned that the top four reasons are to:

- find a doctor
- check on appointment wait times
- employee recruitment
- customer loyalty
- community involvement
- invitations to seminars and classes
- forums for discussion by special interest
- convey benefits of preventive care, e.g., flu shots
- promote travel medicine, e.g., preparing for trips out of the country
- share tips for a healthier workplace, e.g., proper lifting
- highlight expertise and achievements of clinicians

**HITTING A HOME RUN: SURGERY ‘TWEET-CASTING’**

Soon after St. Luke’s Hospital in Cedar Rapids, Iowa, had introduced its social media strategy, the hospital started to use innovative new medical technology: robotic surgery.

Marketing Director Laura Rainey and her team decided to use a Tweet-cast to share the news. It arranged to Tweet a video of a hysterectomy while it was being performed via robotic surgery.

A team of two was assigned: one stationed in the operating room to shoot video and Tweet messages, the other immediately available to media representatives. Family members of the patient were onsite at St. Luke’s and others were following along on Twitter from other locations, including Florida.

Ms. Rainey was pleased with the local coverage, and “flabbergasted” when the Associated Press and 400 other media outlets picked up the story about how St. Luke’s Hospital in Cedar Rapids Tweet-casted a robotic surgery.

“Who knew? It was a major home run,” and it only took two people investing three hours of their time using social media, she said.
Converging forces are creating a surge in demand for occupational health services, says Linda MacCracken, vice president, Truven Health Analytics, who spoke on health care marketing tactics at RYAN Associates’ 26th annual conference in October.

Truven’s objective is to improve quality and lower the cost of health care through the better use of data and analytics.

In this climate of change, it is essential to be mindful of workforce demographics, employers’ concerns about rising health care costs and overall perceptions about what it means to have a culture of health, she said.

**MS. MACCRACKEN OFFERED THESE TIPS:**
1. Recognize urgency. What drives consumers’ decisions? What are their current and anticipated pain points?
2. Develop a range of engaging options and solutions to address customers’ problems. For example, help reduce costly emergency department visits by redirecting patients (as appropriate) to other care access points.
3. Build teams and partnerships. Strive to increase your understanding of various consumer and demographic groups to obtain their buy-in.
4. Identify personally relevant impacts for target generations, for example, disease-state marketing.
5. Demonstrate short-term wins such as downstream financial benefits and website visits and “click-throughs.”
6. Don’t let up. Establish “crawl-walk-run” solution stages for sales and marketing based on your available and anticipated resources.
7. Encourage culture change and a preventive mindset. Ask employers how committed they are to instilling a culture of health and what types of wellness incentives they believe would be most effective for their workforce. Work with clients to find ways to engage and reward employees for participating in health and wellness programs.
8. Help clients understand workforce diversity and generational differences.
9. Learn as much as you can about workforce similarities, differences and preferences. For example, how committed is the workforce to using social media (Facebook, LinkedIn, etc.) – extensively, moderately, hardly at all?
10. Interview clients and prospects about their health care costs, both workers’ compensation and personal health benefits. Share successes you have had driving down these costs for other employers.

**GENERATIONAL DIFFERENCES**
To help occupational health professionals effectively target customers, Ms. MacCracken provides useful sketches and characterizations of various demographic groups. Successful marketing strategies can be built around an understanding of each group’s tendencies and preferences (Table 1). She cautioned that it is important to recognize that diversity exists within each group, so while certain assumptions may be made, they may not be universally applicable to a given generation.

<table>
<thead>
<tr>
<th>DEMOGRAPHIC</th>
<th>% WORKING POPULATION</th>
<th>HEALTH EXPECTATIONS</th>
<th>CUSTOMER PREFERENCES AND VALUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Millennial: 1982-2001</td>
<td>14%</td>
<td>connect me</td>
<td>Communicate with their thumbs: prefer an electronic front door; immediate gratification: same-day appointments, drop in, strong internet-search focus; visits to ED, urgent care or outpatient clinics; uses alternative services; seeks location, short waits, free classes and enough time with clinician</td>
</tr>
<tr>
<td>Gen-Xers: 1961-1981</td>
<td>21%</td>
<td>educate me</td>
<td>Responsive to affinity groups; likes proven, innovative results; values reputation, experience, nationally recognized medical centers; may have primary care doctor; uses ED; manages care of their children</td>
</tr>
<tr>
<td>Baby boomers: 1943-1960</td>
<td>33%</td>
<td>engage me</td>
<td>Question authority; want to be sure they get the best; argue, shop based on price; manage health and advocate on behalf of aging parents and their children</td>
</tr>
<tr>
<td>Greatest/silent generation: up to 1943</td>
<td>14%</td>
<td>direct me</td>
<td>Direct mail, print ads, TV; top doctors and hospital ratings matter; they follow their doctor’s directions &amp; referrals; generally healthy/upper income patients use more tests and screenings and go to ER and clinics; face switching to another provider as doctors retire</td>
</tr>
</tbody>
</table>
independent providers, hospitals and health systems; phase two focuses on the ability to share data among providers and organizations.

“With the next wave of ARRA certifications for software in 2013, providers will need to demonstrate they can send and receive data through HIEs. It is already happening, and will become more and more ubiquitous,” Ms. Stroupe said. “Data structures and relationships are needed to properly secure and protect data.”

Key issues to consider in 2013 and beyond include:

**APPLICABILITY**

If you are exclusively offering occupational medicine services and don’t plan to exchange data, why should you care about these requirements? According to Ms. Stroupe:
- Patients will be asking for electronic copies of their work-related health records so they can aggregate them into their own personal health record.
- Employers will expect providers to satisfy their employees’ requests to exchange information with ambulatory electronic health records.
- When employers are paying the bills, they see advantages to using a system that helps avoid duplication of services and effort.
- Any certified record needs to produce data in a way that can be shared.

**MATCHING PATIENTS AND SERVICES**

Within any information system, a patient typically needs to be related to an employer, a payer, to family members and to a provider treatment site. It quickly becomes more complicated when a patient has multiple employers and/or insurers, or when multiple diagnostic and treatment sites are involved.

“When you overlay all of the services you are offering –wellness, urgent care, workers’ compensation – on top of that, you have to make sure the correct services are delivered to the right person. If you decide to expand your services, you need to make sure you have a database that can handle the expansion” and its relationships with other provider databases, such as lab or radiology, Ms. Stroupe said.

“If you are taking care of your own employees, the relationships become even more complex because you are acting as both the provider and the employer. For your own employees, there is quite a bit of sensitivity about not using their Social Security number as an identifier, but you will need it for workers’ compensation. You have to be able to identify patients in multiple ways.”

An information system also has to be able to verify a provider’s identity. Ms. Stroupe said providers should expect two-factor identification systems to be built into practice standards and become commonplace. Systems already in use typically involve a combination of a unique user code, “smart” card or bio-ID such as an iris scan or fingerprint.

**PRIVACY AND SECURITY**

Privacy means who can see and release information; security is how data is protected. Compliance with national privacy and security standards is recommended.

“The heart of the matter with regard to privacy and security is that employment-related information is an employment record, not a medical record,” she said. “You need to be able to distinguish between employment data and protected health information,” for example, clinical lab results versus a bill for services rendered. Health risk (wellness) data and urgent care treatment records are protected health information and subject to the Health Insurance Portability and Accountability Act.

Note: “A hospital EHR does not distinguish between employment-related and protected health information. From a data management standpoint, this is one of the biggest issues to come to grips with if you are expanding beyond employment-related services,” she said. “You also need a separate EHR for internal employee health information that does not belong in an ambulatory care electronic record.” However, some data, such as allergies and immunizations, should be shared in accordance with national standards.

**INTERFACES**

Hospital-affiliated clinics often are required to interface with hospital mainframe billing systems, adding another layer of complexity. One trend to watch in freestanding clinics is the use of registration kiosks or hand-held devices that allow patients to register and even pay by credit card. The patient-entered data automatically go into the clinic’s practice management or EHR system, significantly expediting workflow and other activities, such as medication dispensing.

**HEALTH INFORMATION EXCHANGE**

In terms of the future, Ms. Stroupe said, “what we are working toward as a country is analogous to the ATM (banking) network, enabling patients to access their health information from virtually anywhere.”

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Clear and direct communication with employees can help employers avoid litigation, according to Gregory Andrews, a veteran attorney with Jackson Lewis, a national firm specializing in employment law.

It may seem obvious, but many organizations do not heed this advice. Mr. Andrews offered valuable insights into employer-employee communication strategies at RYAN Associates’ 26th annual national conference on Providing Healthcare Services to Employers. Employers, particularly human resources and supervisory staff, should follow established communications strategies in order to avoid misunderstandings and conflicts with employees, he said.

Among his recommendations:

**BE MORE PROACTIVE**

Human resource professionals and frontline supervisors are responsible for initiating contact with employees when red flags such as frequent absences surface. Identifying potential problems early on can help reduce the likelihood of disagreements, confusion, hostility and litigation. Employers have an “affirmative duty” to act when employees need intervention to be able to safely perform their job, such as accommodations for a newly diagnosed disability or while recovering from an injury.

**PROTECT PRIVACY**

Employers should studiously protect their employees’ privacy to avoid claims under the Health Insurance Portability and Accountability Act (HIPAA) and the Americans with Disabilities Act (ADA). If an employee needs an accommodation because of an injury, illness or disability, the exact nature of the condition is protected personal information. The employer may only ask the medical provider basic questions such as: “Can the employee perform required tasks? If not, what accommodation is required? How long is the condition expected to last? What specific tasks is the employee capable of performing?”

**UNDERSTAND APPLICABLE LAWS**

The dynamic nature of occupational health- and safety-related statutes makes compliance challenging for employers who want to preserve the stability and productivity of their day-to-day operations while maintaining the dedication and morale of their employees, Mr. Andrews said. One example of this is the ADA Amendments Act of 2008, which heightened sensitivity to the nature of employer-employee communication and requires greater vigilance on the part of all stakeholders.

Federal statutes and state regulations impose specific burdens on employers and employees, sometimes with overlapping or even conflicting purposes, explains Mr. Andrews. For example:

**AMERICANS WITH DISABILITIES ACT:**
- **Goal:** access to jobs
- **Mechanism:** “reasonable accommodation” (http://www.ada.gov for definitions).
- **Communication strategy:** document the interactive process

**FAMILY AND MEDICAL LEAVE ACT:**
- **Goal:** job preservation
- **Mechanism:** leave of absence
- **Communication strategy:** document certification of health care provider

**STATE WORKERS’ COMPENSATION RULES:**
- **Goal:** compensate for loss of earnings and job preservation

**LITIGATION AVOIDANCE**

Mr. Andrews offered these five litigation-avoidance tips:

1. Communicate proactively with employees. For example, if an employee has frequent absences, inquire about what can be done to address the situation.
2. Do not ask questions about an employee’s specific medical condition or health status. Ask the employee to obtain documentation from his or her clinician that shows what tasks the employee is capable of doing.
3. Anticipate staffing situations that may require modifying the hours and/or tasks of an employee who has a chronic disability or episodic illness.
4. Ensure that human resources staff communicates with employees about repeated absences or an apparent inability to complete tasks they had performed in the past.
5. Keep abreast of legal and regulatory statutes, such as how to obtain documentation from a health care provider, employee rights to confidentiality under HIPAA, and protections afforded by the Genetic Information Non-Discrimination Act (GINA) and the ADA Amendments Act.

**OCCUPATIONAL SAFETY AND HEALTH ACT:**
- **Goal:** reduce risk of injury and illness in workplace
- **Mechanism:** communicate and reduce hazards
- **Communication strategy:** document training and hazard reduction
AAOHN COLLABORATION
RYAN Associates and the NAOHP will expand collaboration with the American Association of Occupational Health Nurses (AAOHN) in 2013 through a number of educational forums.

The AAOHN will sponsor a three-session webinar series on the role of nurses in occupational health sales and marketing beginning in January. Frank Leone, president and CEO of RYAN Associates and executive director of the NAOHP, will teach all three sessions, which will be held from noon to 1 p.m. Eastern time on the following dates:

JAN. 24: OCCUPATIONAL HEALTH MARKETING
JAN. 31: OCCUPATIONAL HEALTH SALES
FEB. 7: 40 ESSENTIAL SALES AND MARKETING TIPS

For information: www.aaohn.org/upcoming-webinars/

At the AAOHN’s annual national conference (April 14-17 at the Cosmopolitan Hotel in Las Vegas), Mr. Leone will teach a special half-day session on Marketing, Communication and the Occupational Health Nurse on April 14. The NAOHP also will be an exhibitor at the conference.

For information: www.aaohn.org/2012-national-conference/aaohn-2012-national-conference.html

COACHING AND MENTORING
Beginning March 15, RYAN Associates will sponsor “Coaching and Mentoring in Occupational Health Sales and Marketing,” a 10-week telephonic program capped at 10 registrants. The sessions will be held 10 consecutive Fridays from noon to 1 p.m. Eastern time.

URGENT CARE ASSOCIATION OF AMERICA
Donna Lee Gardner, a nurse and senior principal with RYAN Associates, will speak on an occupational health-related topic at the annual conference of the Urgent Care Association of America (UCOA) April 8-11 at the Dolphin Hotel in Orlando, Fla. The NAOHP will also participate as an exhibitor at the conference.

AMERICAN OCCUPATIONAL HEALTH CONFERENCE
RYAN Associates and the NAOHP will be represented at the American Occupational Health Conference (AOHC) sponsored by the American College of Occupational and Environmental Medicine (ACOEM) April 28-May 1 at the Rosen Shingle Creek Resort in Orlando. Mr. Leone is scheduled to lead a 90-minute session on “Communication and the Occupational Medicine Physician.” The NAOHP will also be an exhibitor. For information: www.acoem.org/aohc.aspx.

Nashville Venue for RYAN Associates’ 27th Annual National Conference
RYAN Associates will return to the Loews Vanderbilt Hotel in Nashville, aka Music City, USA, for its 27th Annual National Conference, Oct. 21-23, 2013. The conference will feature a baker’s dozen of educational tracks, a full slate of special weekend offerings and an array of top-notch social events. NAOHP members are being surveyed to solicit their input on conference topics. Faculty members will be recruited in early 2013. Full conference details will be available in the spring.
**Calendar**

**January**

**JAN. 24, 21 AND FEB. 7**
Three-part webinar series on Occupational Health Marketing, Occupational Health Sales and 40 Essential Sales and Marketing Tips for occupational health nurses; sponsored by AAOHN in conjunction with RYAN Associates; www.naohp.com

**February**

**FEB. 11-15**
NIOSH-approved Spirometry Refresher (Feb. 11), full course Feb. 13-15 taught by Dr. Mary Townsend; sponsored by M.C. Townsend and Associates in collaboration with Johns Hopkins; Feb. 12 respiratory fit testing workshop taught by Craig Colton, CIH; www.mctownsend.com

**FEB. 20-24**
Urgent Care Success Summit; Marriott City Center, Dallas, Texas; sponsored by Urgent Care Management Monthly; www.urgentcareconference.com

**April**

**APRIL 8-11**
Urgent Care Association of America annual conference; Dolphin Hotel, Orlando, Fla.; www.ucaoa.org

**APRIL 15-18**

**APRIL 28-MAY 1**
American Occupational Health Conference; American College of Occupational and Environmental Medicine annual conference; Rosen Shingle Creek Resort, Orlando, Fla. www.acoem.org/aohc

**May**

**MAY 18-23**
American Industrial Hygiene Association Annual Conference and Expo; Montreal, Canada; www.aihce2013.org

**June**

**JUNE 24-27**
Safety 2013; American Society of Safety Engineers Professional Development Conference and Exhibition; Las Vegas Convention Center, Las Vegas, Nev.; www.asse.org

**To list your event, email Stacey Hart at shart@naohp.com**
The following organizations and consultants participate in the vendor program of the NAOHP, including many who offer discounts to members. Please refer to the vendor program section of our website at: http://www.naohp.com/menu/naohp/vendor/ for more information.

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In other words, if five referrals result in five new memberships, the referring party will receive $500.

If you know of a vendor who would benefit from joining the NAOHP Vendor Program, please contact Stacey Hart at 800-666-7926 x12.
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Publications
Center for Drug Test Information
We are here to help you find the answers to your questions about alcohol and drug testing and the State Laws that apply. We provide specific state information and court cases you can use to protect your organization and save money by knowing your state’s incentives and workers’ compensation rules.
Keith Devine
Phone: (877) 423-8422
Fax: (415) 383-5031
info@centerfordrugtestinformation.com
www.centerfordrugtestinformation.com
Social Media Do’s and Don’ts

DO’S:
• Monitor conversations and respond quickly when appropriate.
• Facilitate use of mobile devices (e.g. smart phones, iPads).
• Establish a social media policy for responses to posts and for your employees.
• Keep your social media services active and current to encourage repeat visits.
• Make it easier for visitors to find your sites using key word search.
• Focus on consistent communication.
• Track a few useful data points such as visitors’ age ranges and the search engine they use.

DON’T’S:
• Avoid getting caught up in obsessive tracking of irrelevant data.
• Overly hawking or advertising your products and services puts your organization at risk of risk losing site traffic and earning “likes.”
• Never share personal health information in an online public forum.
• Once you start a social media service, don’t abandon it for days or weeks; keep it fresh.
**Board Roster**

**NAOHP REGIONAL BOARD REPRESENTATIVES AND TERRITORIES**

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**Job Bank**

The NAOHP/Ryan Associates Professional Placement Service is seeking qualified candidates for the following positions:

**MEDICAL DIRECTOR/ STAFF PHYSICIANS**
- Eastern Pennsylvania (Medical Director) — NEW OPENING
- Iowa (Medical Director) — NEW OPENING
- Western Pennsylvania (Medical Director)
- California - San Joaquin Valley (Staff Physician)

**NON-PHYSICIAN OPENINGS**
- New York (Nurse Clinical Program Manager) — NEW OPENING
- Southern California (Sales Rep)
- Florida (Nurse Practitioner)