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Special Report: Anthrax in America

Anthrax places focus on bioterrorism response, keeping employees safe

Occupational health professionals must address fears

They told us the mail had to go through in rain, snow, and sleet, but they never said nothing 'bout no anthrax!" These words, spoken by an unidentified postal worker to a CNN reporter, seemed to put it all in perspective: Workers all across America are not only shocked, but they're more than a little scared.

Editor's note:
As this issue of *Occupational Health Management* went to press, public health officials and management teams at government agencies had just recently begun their response to something many had feared but had hoped would never happen: The intentional spread of an infectious agent in America.

While much of the focus has been placed on Washington, DC, and especially on Congress and the U.S. Postal Service, employees at several media organizations have also been affected. Even the venerable U.S. Supreme Court was forced to close — for the first time in decades, and companies who regularly picked up bulk mail packages at specific post offices were also placed on alert.

With such a fast-breaking and fast-moving story, it is difficult even for daily publications to stay on top of changing developments. But we felt it was imperative to address this issue as soon as humanly possible and to explore, as a service to our readers, some of the implications this new reality holds for occupational health professionals.

Continued from cover page

COMING IN FUTURE ISSUES

- Addressing the underlying issues behind unscheduled absences
- The implications of consolidation in the occupational health clinic industry
- Taking care of the caregiver: Occ-med for nurses and physicians
- How can workers 'do less with more' but keep stress in check?
- Confidentiality: The impact of recent legislation on clinic practices

The facts of the anthrax attacks, as they currently stand, hardly qualify as an epidemic. A total of 32 workers have been exposed to anthrax; 13 have been infected, and, tragically, four have died.

But no one is sure when new exposures will stop springing up — whether other tainted envelopes are still out there — or how many employees are at risk. *That* is what's driving the fear, and sometimes resentment, among postal workers, and causing concern among workers across the country. That is why thousands of postal workers are now being tested and/or prophylactically treated, and why occupational health professionals across the country are having to address the mental health ramifications of the attack.

Learning as we go?

Unfortunately, whatever protocols had been in place prior to the event have proven less than adequate, and the responses have shifted as new information emerged. For instance, the Centers for Disease Control and Prevention (CDC) in Atlanta believed at first that sealed envelopes containing anthrax posed no threat to postal workers, but two deaths proved that belief tragically wrong. Initially, Bayer-AG's Cipro (ciprofloxacin) was designated the 'drug of choice,' leading to a mini-run on the drug in pharmacies, especially along the East Coast. Now, however, doxycyline is being recommended, because it is more readily tolerated. And it was most recently announced that workers on the front line, such as laboratory staff and perhaps postal workers, will now be given the anthrax vaccine.

As to this last action, it will take quite awhile to provide these workers with significant protection against anthrax; the administration of the vaccine involves a series of shots over a period of 18 months. "As with most series, you gain more antibody with each exposure," explains **Jan Schwarz-Miller**, MD, MPH, director of occupational medicine for Atlantic Health System in northern New Jersey. "It will probably not make a big dent in what's currently going on."

Public health officials admit as much. What they're seeking to do, they say, is provide protection for workers who may be under an ongoing threat from such attacks — a sobering fact that can't do much for their peace of mind.

Although standards and protocols may of necessity change from time to time to reflect new knowledge, this has not stopped leading agencies from issuing guidelines to help protect workers.

For example, the CDC issued a health advisory on Oct. 24 for protecting mail handlers from both cutaneous and inhalational anthrax.

The advisory addresses engineering controls, housekeeping controls, and protective equipment. The engineering controls include using vacuum cleaners with HEPA filters; HEPA-filtered exhaust hoods for mail-handling equipment; HEPA filters in HVAC (heating, ventilation, and air conditioning) systems; and installation of air curtains. The housekeeping controls include avoiding dry sweeping and dusting. The protective equipment section is most extensive, addressing the prevention of both inhalation anthrax (i.e., using NIOSH-approved respirators) and cutaneous anthrax (the type of protective gloves that should be used, the type of clothing recommended, and guidelines for washing and skin and eye care). (The complete CDC advisory may be found on the web: www.bt.cdc.gov/DocumentsApp/45.pdf.)

The United States Postal Service web site (www.usps.com) has a wealth of information on its web site, including a regularly updated fact sheet on infections and exposures, and a summary of its own new safety measures. In addition, it has posted a detailed advisory from the General Services Administration on how to respond to an anthrax threat in a mail center.

How we should respond

What does all this mean for occupational health professionals who are either directly or indirectly affected by recent events? "In terms of mail and packages, they need to follow the guidelines published by most departments of health, the CDC, and the post office," advises Schwarz-Miller. "I think at this point you certainly see specific areas of risk, such as government workers, the media, and postal workers, but we don't know if that's going to change. It would be wise to be cautious, but not fearful."

Speaking of fear, how can occupational health professionals calm the fears of employees? "At our site, I put together an e-mail with the director of public safety and security about how to handle packages," says Schwarz-Miller. "We've provided additional training — an inservice to educate employees so they know how anthrax is spread. We also created a bulletin for employees about anthrax, and we continue to work on ways to educate people."

She sees this type of employee education as a crucial role for occupation health professionals. "It can be very reassuring for people outside of the sectors we've seen affected to realize we're talking about a very limited group, yet at the same time giving them enough information to make them feel empowered," Schwarz-Miller asserts.

Her health system also created its own response protocol, which will hopefully not only add a layer of protection but help workers and staff feel more secure. "Being in New Jersey, it's not surprising that in our hospitals, people have come in with powders that concerned them. They're worried about letters or packages they received weeks ago," notes Schwarz-Miller. "We work very closely with our [emergency department (ED)], and we've put together a fairly structured protocol on what to say to people who find something that concerns them." This protocol, currently in draft form, is very similar to what the CDC has put up on its site, she says, but it is customized to the specific facility.

Of course, even a proactive approach such as this won't make every employee feel calm and secure. "We absolutely encourage employees who are having bad feelings to seek help," Schwarz-Miller notes. "And this can be from the World Trade Center attacks or the anthrax attacks. If I'm seeing an employee for another medical issue who has recently felt more depressed and out of control — and the anthrax situation certainly will increase those fears — I absolutely will refer them to our EAP [Employee Assistance Program]."

While there's a wealth of information available on how to protect employees from infection and how to treat them if they become infected, hospital-based occupational health professionals must also concern themselves with the health and safety of first responders and others who may come in contact with these patients.

What sort of precautions should be taken? "There are, of course, isolation standards, which we always use," says Schwarz-Miller. "Most of these were developed in response to HIV. The other concerns are respiratory and droplet and contact. Unless it's cutaneous, anthrax is not passed by any of those routes. There's a tiny, tiny, tiny risk, so we do use contact precautions. Thank goodness we do not need to worry about person to person spread."

What if we *were* faced with an outbreak of something more contagious? "That's a totally different story," Schwarz-Miller says. "Then, it depends on how it's transmitted. A worst-case scenario would be something like smallpox, simply because we

only have a certain number of negative pressure rooms. The number we have is more than adequate for what we consider to be a standard situation, but in an epidemic there would have to be huge cohorting [among providers]."

What's most important for the occupational medicine physician, she says, is to have a well-structured system in place to deal with any such emergency. "I believe our setup is ideal because we are divided into public safety and occupational safety departments," she says. "The public safety department deals more with emergency response, such as fires. Occupational health deals more with environmental issues and OSHA [Occupational Safety and Health Administration], and they report to me, as does infection control."

To successfully deal with a bioterrorism event, Schwarz-Miller says, a hospital needs an integrated working team. "The ED, the pharmacy, the lab, and infection controls must all be at the table," she asserts. "Everyone must be involved."

In short, she says, your role must go far beyond the standard definition of occupational health. "Your employees are people who are potentially at risk, yet most of us — including our nurses — have never seen a lot of these diseases. Therefore, you've got to get a very coordinated, cohesive group of experts and the people who will be on the front line brought to the table. Make sure everyone is comfortable with his or her role, has resources he or she needs, and feels reassured — and is ready," she concludes.

[For more information, contact:

*• **Jan Schwarz-Miller**, MD, MPH, director of occupational medicine, Atlantic Health System, Morristown Memorial Hospital, 100 Madison Ave., P.O. Box 94, Morristown, NJ 07962. Telephone: (973) 971-5440. Fax: (973) 290-7978. E-mail: jan.Schwarz-miller@ahsys.org.]* ■

Management needs open doors for occ-med nurses

Delivery, business emphasis take center stage

In the dynamically changing world of occupational health, new opportunities are opening up for the occupational nurses who are prepared to recognize and pursue them. While those who remain in more traditional roles face incredible job demands and potential burnout **(see related story on p. 137)**, professionals willing to "think outside the box" may find careers that prove much more rewarding — both emotionally and financially.

"Companies are taking a much closer look at the cost of doing business, and through the recent downsizing trend, they are seeing an erosion of the corporate knowledge base," notes **Deborah V. DiBenedetto**, MBA, RN, COHN-S, ABDA, president of the Atlanta-based American Association of Occupational Health Nurses (AAOHN). "To help fill that gap, some nurses have had to expand their role from a more traditional one into benefits, insurance, risk management, or case management. In today's business environment, working in teams is important. In many cases, nurses have become the gatekeeper on anything that impacts the return to work process."

The new paradigm, she asserts, is the delivery of services — providing services and information that will impact on the health, safety, and productivity of the work force.

"We've seen a broader focus on occupational and environmental health programs — disease management, the diversity of products and services that are required, case and care management, and roles have become more generalized with a business model approach, vs. a specialized role," adds **Ann R. Cox**, MN, RN, CAE, executive director of AAOHN.

What has caused the change?

Cox identifies several forces at work that have dramatically changed the environment in which AAOHN members now work:

• **A dynamic business environment:** Reorganization, downsizing and mergers have put demands on everyone to do more with less, and to deal with the impact of those changes on the worker population. Ironically, this could also be a threat to employment.

• **Technology:** It has dramatically changed the way we do business. The occupational health nurse must be able to use technology to become both more efficient and more effective, to track trends, and to use the Internet for health information. "They will also be required to give more information more quickly to employees," Cox adds.

• **The changing profile of the occupational and environmental health nursing population:** It is an aging population, notes Cox, but some people are selecting the profession as a second

career. This requires additional education in order to meet the expanded job requirements. "There are still the issues of pay inequities, high customer demand, and who will come in and fill these roles in the future," she notes.

What's out there?

So exactly what opportunities have been created by this 'new reality'? They're almost too numerous to count, say the experts.

"It has provided opportunities such as self-employment, consulting, and other horizons people have not even thought of — real cutting-edge work," says Cox.

"The traditional model is alive and well, but companies and nurses have to start thinking out of the box to provide value for employees," adds DiBenedetto. "Nurses can help manage wellness, unscheduled absences, compliance, manage [Family Medical Leave Act], [Americans with Disabilities Act], or manage both occupational and nonoccupational absences, and oversee integrated disability management. They may expand into work/life programs — anything from EAPs [employee assistance programs] to legal services, child care, and elder care."

Some may look forward to acquiring the title of productivity manager, or return-to-work coordinator, notes DiBenedetto. "A growing number are becoming consultants, hanging out their own shingle. Our consultants group is probably one of our largest growing specialty areas. I would think that includes about 10% of our members — including me."

"There are a lot of occupational health nurses doing consulting now, and that can range anywhere from Occupational Safety and Health Administration (OSHA) compliance to disability management and integrated disability management," adds **Merrie L. Healy**, RN, MPH, an implementation manager in Minneapolis for Sedgwick Managed Care, part of Sedgwick Claims Management Services (SCMS) Inc., based in Nashville, TN. SCMS is a third-party administrator for workers' comp and short- and long-term

Employment decisions affected by health, safety

According to a recent survey conducted by the Washington, DC-based American Nurses Association (ANA), health and safety concerns play a major role in America's registered nurses' decisions to remain in the profession.

In the survey, 88% of respondents said health and safety concerns influence their decisions to continue working in the field, as well as the kind of nursing work they choose to perform. The acute and chronic affects of stress and overwork were cited as one of the top three health and safety concerns by 70.5% of nurses responding to the survey.

"Nurses are continuously asked to do more with less," says ANA president **Mary Foley**, MS, RN. "Patients will not get the type of care they deserve when nurses are stressed, overworked and concerned for their own health and safety."

The other top health and safety concerns reported by respondents included a disabling back injury (60%) and contracting HIV or hepatitis from a needle stick injury (45%). Other responses that garnered double-digit percentages were: the possibilities of being infected with tuberculosis or another disease (37%), sustaining and on-the-job assault (25%), developing a latex allergy (21%), and having a fatigue-related car accident after a shift (18.8%).

A total of 4,826 nurses responded to the survey, with the highest percentage of respondents falling between the ages of 41 and 50, with more than 10 years of experience.

Survey responses also revealed that fewer than 20% of the nurses felt safe in their current work environment. A total of 17% reported they had been physically assaulted in the past year, and more than half (56.6%) were threatened or experienced verbal abuse. And, while the implementation of federal law to require the use of safer needle devices has made a significant impact, 20% of the nurse respondents said that their facilities still do not provide safe needle devices for injections. An even greater percentage (39%) confirmed that their facilities continue to use powdered latex gloves, a hazard known to cause severe allergic reactions in patients and workers with latex allergies.

[For more information, contact:

*• **Hope Hall**. Telephone: (202) 651-7027. Or visit the ANA web site: www.nursingworld.org.]* ■

disability and liability.

The current trend can often lead to responsibility for total absence management, Healy notes. "Employers realize it costs money not to have employees at work," she says. "They are starting to expand the same case management approach into the nonoccupational arena."

"There are also a lot of members who volunteer in other areas — a small population are becoming parish nurses," says DiBenedetto.

Positioning for change

Of course, most occupational health nurses were not trained for these new and changing roles. Quite often, a combination of more education and an attitude adjustment are required to be well positioned for the transformation.

"It would certainly require one to be knowledgeable about how businesses think and operate," says Cox. "If you don't have a particular area of expertise, ongoing education is also important. In other words, stay as competent as you can."

"You don't learn finance in nursing school — not even in your occupational health training," adds DiBenedetto. "It's important to know the financial impact of your services, and that is a big part of our mission now."

This is not as easy as it sounds, she admits. "A lot of times you don't have access to the numbers — such as unscheduled absences, the cost of health care, related benefits like work/life programs, or what the company's workers' comp costs are. Usually, they are managed by other stakeholders," says DiBenedetto. "You have to break through the silos, get everyone to the table and say, 'How can we act together to negate these problems?'"

Healy's path to her current position has been "a real progression," she observes. "Each job has led to a new learning experience, which in turn led to enhancing my skills and moving me to get a higher level of functioning. Each phase has been rewarding — a learning experience on which to build."

Healy came to her career relatively late in life. She got married first, and took 13 years to get her degrees. "I did surgical nursing, then went back to school to get my BSN, worked part time in home care and hospice work," she recalls. "I got my four-year degree and worked for a hospital in northern Minnesota that asked me to be coordinator of health management services. Half of that job involved coordinating health education programs for the community; the other half was employee health and safety, which included workers' comp."

Today Healy is responsible for implementing all of the managed care components of her company's services — utilization review, bill review, telephonic case management, field case management, the pharmacy program, and PPO networks. **(Are there any limits to the expanding role of the occupational health nurse? Read about the incredibly complex management position one occupational health nurse currently occupies and draw your own conclusions. See related story on p. 139.)**

Future filled with promise

Observers say the future holds more of the same for occupational health nurses, although recent events have added a new dimension — at least for the short term.

"After Sept. 11, it's a whole new ballgame," says DiBenedetto. "You have employees going on military leave, you've got to be dealing with the potential for violence and its psychological impact. People need to adjust and cope. Companies may have to cut off travel so the occupational health nurse can help all these people deal with those issues."

DiBenedetto foresees more reliance upon occupational health nurses in the future. "Companies recognize the value of their work force — especially after 9-11," she says. "Many nurses have responded by coordinating EAPs or briefing sessions, so their traditional role is being reinforced."

The typical role of the occupational health nurse in the future will be much more broadly focused, addressing environmental health issues, and families as well as individuals, says Cox. "You will need strong business skills, you will be programmatically oriented — a member of the team," she says. "Occupational health nurses will be leveraging their skills to be a business partner."

The challenge will always be the measurement of worth, contribution and value, she adds. "Nurses will have to demonstrate competencies and values," Cox asserts.

"There is another huge issue on the horizon, and employers are just beginning to realize it; it's the impact of the aging work force," notes Healy. "This will provide a new niche for occupational health nursing. Traditionally our role had been to take a look at occupational health and safety risks

of the employee population. Now, we will have to factor in an aging work force — and help keep them working, promoting their health and well-being, preventing absences. Employers need this population for productivity reasons."

Nevertheless, these new responsibilities will not be handed to anybody, warns DiBenedetto. "Occupational health nurses will have to sell [the concept] to their management," she says. "They must come forward and say, 'There are issues and opportunities that I can help you solve.' They'll have to work with human resources, risk management, operations, safety, legal — whatever it takes."

There will always be turf issues, she concedes, but people can come together and see the commonality, and "check their egos at the door." "We are very good at communication and collaboration, so we can put these skills to work," DiBenedetto offers.

Finally, she advises, "Position your practice for the 21st century. Look at where your company is, what its drivers are, what its business issues are, and see how you can be of service in terms of impacting the health, safety, and productivity of the employee population. What can *you* do that has positive effect and yields a positive return on investment?"

[For more information, contact:

- ***Deborah V. DiBenedetto**, MBA, RN, COHN-S, ABDA, and **Ann R. Cox**, MN, RN, CAE, American Association of Occupational Health Nurses, 2920 Brandywine Road, Suite 100, Atlanta, GA 30341. Telephone: (770) 455-7757. Fax: (770) 455-7271. Web: www.aaohn.org.*
- ***Merrie L. Healy**, RN, MPH, implementation manager, Sedgwick Managed Care, 7905 Golden Triangle Drive, Suite 150, Eden Prairie, MN 55344. Telephone: (952) 826-3844.]* ■

Position offers diversity, responsibility

Denise Z. Gillen, RN, BSN, COHN-S, CM, is hard-pressed to recite every single component of her job description; it's that big. As manager of medical case management and loss prevention services for HSC Risk Management Services, a TPA based in Albuquerque, NM, she is an example of the career possibilities that exist for occupational health nurses in today's business environment.

"HSC was originally established to specialize in helping hospitals with administrative issues and the challenges of doing more with less," she observes. "Now we service hospitals, manufacturing companies, hospitality organizations and construction companies." The company currently serves a total of over 2,000 employers, she adds.

On the medical case management side, Gillen oversees a team of nurses that provides occupational case management services to injured workers in New Mexico, Texas, Colorado, and Arizona. "We work with employers and employee groups in setting up occupational health programs, return to work programs, OSHA [Occupational Safety and Health Administration] compliance, and so forth," she says.

"On the workers' comp side, we also provide telephonic and field case management services. We have an integrated disability management program — workers' comp with short- and long-term disability; case management services for property, casualty and utilization review; and job analysis for small employers. Also, we do life care planning for catastrophic claims; hospital and construction are the highest risk claim areas."

And that's just *one* of her 'hats.' "My other hat is loss prevention," she says. This encompasses, among other services, annual safety audits for hospitals, a self-insured group of nursing homes, and self-insured hotels and motels. Her department also teaches life safety courses such as defensive driving, which is required for personnel of any health care provider who transport patients.

In addition, she provides training for handling bloodborne pathogens and hazardous materials, back care and proper lifting techniques, fire prevention, electrical safety, lockout/tagout, ergonomics and supervisory accident and incident investigation.

A logical progression

Gillen has been in her current position for two years, and says her career has been a logical progression. "Previous to this position I was working for another TPA as a consultant, doing more of the hands-on case management," she recalls. "Because of my occupational health nursing background, I was able to handle the type of claims that a traditional case manager might not have, such as chemical exposure or

occupation diseases," she notes.

She has also worked for a large national manufacturing company as part of its environmental health and safety team. "I worked with the ERT team and first responders," she says, adding that having been on both sides of the health care equation is an invaluable asset. "It's important to use occupational health nurses on the insurance side because we can bring that balance in," she observes. "We are able to say, 'I've worked on the employer side. I know what those needs are, and now that I'm on the TPA side, I can balance out the needs of the client and of the TPA.'"

Gillen notes that she needed more than a variety of jobs to prepare her for her current position; she has had to constantly expand her knowledge base. "I've had HazMat training, OSHA's 24-hour training course — a lot of courses in that particular area," she notes.

This did not happen by accident; Gillen had a plan in mind. "I really felt like case management was the future, and that the occupational health nursing profession was moving towards more of a business approach," she notes. "This was an intuition that has proved absolutely accurate over the last two years."

As part of the business team at HSC, Gillen works closely with the manager for workers' comp claims. "He manages the adjusters, so we are an integrated team," she explains. "Our model is an integrated disability/case management model where the adjuster and the nurse are put on the claim at the same time."

Gillen sees more positions like hers opening up in the future for occupational health nurses. "The role of the occupational health nurse is changing, especially with the advent of telehealth and telemedicine," she observes. "More and more they will be moving into business positions and managing large programs. It's an opportunity those of us who have an employer background plus experience on the insurance side to be able help mold a practice area for ourselves."

Does it represent an opportunity to increase income as well as job responsibility? "Absolutely," Gillen concludes.

[For more information, contact:

***Denise Z. Gillen**, RN, BSN, COHN-S, CM, manager, medical case management and loss prevention services, HSC Risk Management Services, P.O. Box 92200 Albuquerque, NM 87199-2200. E-mail: dgillen@nmhsc.com. Web: www.nmhsc.com.]* ■

Design, implementation keys to wellness success

Science-based programs, proper staff essential

Research shows that employee wellness programming can not only improve the health of the worker population, but it can also yield significant financial returns.

Of course, starting a fitness or lifestyle change program and calling it a "wellness initiative" does not in and of itself guarantee success in either area. It takes careful planning and implementation, says **Ron Z. Goetzel**, PhD, vice president of consulting and applied research in the Washington, DC, office of The MEDSTAT Group, based in Ann Arbor, MI.

"Globally speaking, wellness programs need to be science-based, well-designed and configured, and should use the best-known currently available research and science to support their foundation. That is often talked about but not so often done," says Goetzel. "People have tons of programs out there with very little evidence these things work. The extent to which documentation or theory foundation, or using objective methods, is employed for specific programming is one of the keys to success."

Proper implementation is also critical, he notes. "You can have great scientific underpinning, but the people [implementing the program] need to know what they're doing, and they need to have the proper tools to implement the program," he advises. A subset of this is management support, which is also a critical element needed to ensure success.

Finally, notes Goetzel, poor (or nonexistent) evaluation can doom any program to failure.

Establish your baseline

A solid wellness program will typically begin with some form of screening, says Goetzel. "This can be anything from a self-reported HRA (Health Risk Appraisal) to more rigorous biometrics and screening," he notes.

This baseline data will enable you to triage employees into different intervention programs that fit their needs. It will also help you evaluate how serious the health risk is in individual cases.

"Providing proper triage and customized intervention is very important," notes Goetzel. "That's

especially true for people at high risk, who require a lot of high-touch, one-to-one intervention — something more intensive than group learning."

Proactive outreach to your employee population will get more people involved, which will produce the best clinical outcomes and thus the best financial results, says Goetzel. "You need to get peoples' attention — get them to participate," he asserts. "Only then will they begin changing their attitudes, mindsets, and behaviors."

There are clearly certain types of programs that will more readily yield quick results and/or a higher return on investment (ROI). These include prenatal care, obesity and stress, to name a few.

However, Goetzel does not necessarily recommend such a "rifle" approach. "I advocate a program that targets multiple risk; I'm not a proponent of going out and changing one thing at a time," he says. "People walk into these programs with multiple risks — psychosocial, physical, and behavioral."

That doesn't mean, says Goetzel, that if you have a population with a high percentage of diabetes or back pain you shouldn't introduce programs that specifically target those conditions. What it *does* mean is that you try to address all the factors that contribute to the health risk of these individuals.

Research shows the savings can be significant. In a MEDSTAT study of programs serving many thousands of employees, it found the following:

- ROI estimates for health management programs in nine studies ranged from $1.40 to $4.90 in savings per dollar spent.
- ROI estimates for demand management programs (expanded use of self-care and giving beneficiaries greater control of health care usage) in six studies ranged from $2.20 to $13 in savings per dollar spent.
- ROI estimates for disease management programs in three studies ranged from $7.30 to $10.40 in benefits per dollar spent.
- ROI estimates for multiple component programs in three studies ranged from $5.50 to $6.50 in savings per dollar spent.

In one specific program at Citibank, MEDSTAT demonstrated savings of $8.9 million vs. administration expenditures of $1.9 million, for a net savings of $7 million.

Of course, not every employer is Citibank, and, notes Goetzel, smaller employers have a bigger challenge. "My advice is to partner up with a national organization with a proven track record," he says. "If you go with vendor 'A' and they can prove they've gotten a good ROI with larger populations, then you should be able to expect the same kind of program impact at your workplace if they administer it in approximately the same way they did for the bigger client."

In short, he says, these programs should be fairly standardized, so that you can expect the same design no matter where you see it – in much the same way that you see the same layout every time you step into a McDonald's store. "There's no need go around recreating things," he observes. "You should be able to assume you will have the same kind of results."

[For more information, contact:

• ***Ron Z. Goetzel**, PhD, vice president of consulting and applied research, The MEDSTAT Group, 4301 Connecticut Ave. NW Washington, DC 20008. Telephone: (202) 719-7850. E-mail: ron.goetzel@medstat.com.]* ■

New model helps slash WC expenses

Primary physicians paid more, but can't self-refer

Here's a new idea for lowering your workers' compensation costs: Pay your primary care physicians more money.

No, that's not a typographical error; it's the basis of a new model for treating injured workers that has three primary components:

1) Substantially increased reimbursement for the primary care physicians who treat the workers;

2) Automatic on-site consultation by musculoskeletal specialists at no extra cost to the primary care facility;

3) Inability of the primary care physicians to profit from self-referral for tests and treatment.

This "specialist-direct" system was tested for a period of two years, and compared with a more standard discounted-fee clinic. Patients self-selected the system they used, and the entire cost of the claim was assigned to either system of care.

Claim costs were 63% lower in the specialist-direct system, medical costs were 45% less, indemnity was 85% less, and claims were closed nearly six months faster in the specialist-direct system.[1]

The specialist-direct system was developed by

a group in Reno, NV, called Specialty Health, Inc. **Steven G. Atcheson**, MD, a rheumatologist, is president of the organization, which now has a statewide network.

"We started operations in 1995 based on a theory; we had some encouraging preliminary results and opened our first clinic in 1999," he recalls. "We called them 'Model Clinics.'"

The aforementioned study was arranged with two large hotel-casinos for the calendar years 1995-96, and covered all workers' compensation claims filed. The work force averaged 4,000; a single benefits administrator processed all the claims, all of which were closed and paid by January 1999.

"[Co-author] Dr. [E. James] Greenwald and I had worked for the person who administered all the claims for these two hotels for several years," Atcheson explains.

"We told her we thought that discounting doctors for workers' comp care is destructive. She already had a handpicked panel of physicians and clinics that had agreed to a discounted fee schedule. We said, 'If you don't quibble about the extra time we spend with patients, we'll come in and not charge you extra. Let's see if the docs make more when they're not hassled by managed care.'"

After a year, he says, the hotels saw the savings were substantial, so they continued testing the model for two more years. "We've been contracted ever since at a management fee," says Atcheson.

Since the casinos were self-insured, they were allowed under Nevada law to direct all injured employees to a specific panel of medical care providers. Employees were required to first report all work-related injuries to security personnel, who were prohibited from recommending one facility over another.

The employees had several options: three local hospital emergency departments; one general practice clinic; three chiropractors (for spine problems only), and three occupational medicine clinics.

Of the three occupational medicine clinics, one was staffed by primary care physicians who were assisted by two musculoskeletal specialists. Each specialist attended the clinic a half day each week and could see patients with musculoskeletal problems within three days of the first clinic visit.

The other occ-med clinics had to refer patients to an outside specialist. All referrals had to be made to a single panel of specialists.

All the primary care physicians in the discounted-fee clinics were paid a 15% - 20% discount from the prevailing fee schedule published by the Nevada Division of Insurance, as were all the other physicians on the panel. The primary care physicians in the specialist-direct clinic were paid on a fee-for-service basis at 100% of the same fee schedule. Since the consultants were not actually paid during the two-year test period, a fair-market value of $36,000 per year was assigned for calculation purposes.

Atcheson asserts the nearly 50% difference in medical costs resulted from a reduced volume of services provided. Previous studies, he notes, show that physical therapy is initiated far more often by physicians who profit from those services, and that MRI scans are more likely to be medically inappropriate when ordered by a doctor with financial ties to the imaging facility.

As for indemnity costs, wrote the authors, "The rapid access to musculoskeletal consultations enjoyed by the physicians in the specialist-direct clinic was a major contributor . . . patients were rarely taking off work, because the specialists strongly encouraged that patients remain at work with safe restrictions."

Atcheson concedes that not all occupational health clinics could participate in a model like his. "We never made a nickel until we lined up 12,000

people based on expectations of reimbursement," he notes. "Also, it's crucial to recognize the third leg of the triad is that we did not allow compensation for physical therapy, ordering tests, and so on, so there were no conflicts of interest. That's *crucial* — if you look at industrial medicine clinics where physicians are poorly paid, they are forced to own these other facilities. This will dissuade facilities at many industrial medicine clinics from following our model, because they take such deep discounts on medical care."

Nevertheless, he says, the concept is taking hold. "We just made an agreement with a group of hospitals, and we will be their workers' comp arm; they will use our network for their injured workers," he notes. "We can put our clinics next to any hospital ER and it will work just fine."

Of course, the attitude of hospital administration is a critical ingredient. "It depends on their foresight," Atcheson observes. "If they look just at volume and income, they might not be interested. If they look at a partnership, where ultimately all will benefit, that's fine."

The bottom line, he insists, is that doctors have to takeback control of basic patient decisions. "If you had a company that decided they would contract in such a way that the doctors at the head of the line were treated the best, then this model would work," he concludes.

[For more information, contact:
***Steven Atcheson**, MD,* 93 *Bell St., Reno, NV 89503. Telephone: (775)-329-6772.]*

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Long-term Zyban use curbs smoking relapse

An added bonus: much smaller weight gain seen

If you're running, or plan to run, a smoking cessation program, here's something you should know: Longer-term use of the drug bupropion (Zyban) will reduce the likelihood that your employees who stop smoking will resume the habit.

That's among the key findings of a study conducted at the Mayo Clinic in Rochester, MN.[1] The researchers found that smokers were less likely to relapse if they used the medication for one year.

The study involved not only the Mayo Clinic, but the Palo Alto Center for Pulmonary Disease Prevention, in Palo Alto, CA; Brown University, Providence, RI; Oregon Health Sciences University, Portland, OR; and Massachusetts General Hospital in Boston. This was reportedly the first long-term, multi-center study to evaluate the use of the antidepressant bupropion to prevent relapse.

In the study, 784 participants took the drug to help them stop smoking. After seven weeks of treatment, 461 participants had successfully

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Editor: **Steve Lewis.**
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5534, (coles.mckagen@ahcpub.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@ahcpub.com).
Production Editor: **Emily Palmer**.

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stopped. Half of that group continued with bupropion for a year, and the other half took a placebo. At the end of one year, 55% of the group continuing to take bupropion were abstinent, compared with 42% in the placebo group. "That's a significant and encouraging difference," says **J. Taylor Hays**, MD, associate medical director of the Mayo Clinic Nicotine Dependence Center and lead investigator in the study.

At the two-year follow-up, however, the abstinence rates were nearly the same for both groups, about 40%. This underscores the difficulty in helping employees quit smoking; research shows that 70% - 80% of smokers who stop, relapse within six to 12 months, according to the Mayo Clinic.

Nevertheless, **Sue Jackson**, vice president of the Farmington Hills, MI-based American Institute for Preventive Medicine, is encouraged by the findings.

"It makes perfect sense, and I'm glad to see this study come out," says Jackson, who coordinates a large number of smoking cessation programs. "Zyban is a really great product, but there are a lot of smokers who are hesitant to take it. Many times it gets portrayed to them as an antidepressant and they don't understand how an antidepressant can treat nicotine addiction." Jackson points out that the dosages are different when the drug is being used to combat nicotine addiction vs. when it is being used as an antidepressant.

She also cites another fear the general public tends to have about drugs. "People tend to be afraid of medications, and they think the less they take the better they are. This study contradicts that belief," she notes.

Jackson is quick to point out that no drug, in and of itself, will be an effective cure for nicotine addiction. "In our experience, we've seen that Zyban should be used in conjunction with behavioral programs like our 'Smokeless,' which really looks at smoking from many different directions. You must explore how to change daily routines to eliminate the triggers of smoking, what to eat and drink, how to handle stress, and so on," she explains. "But Zyban definitely enhances the program's effectiveness."

Jackson notes that generally at the end of a behavioral program, you will see between 20% and 50% abstinence after a period of one year. "With this study, you're looking at 55%, which is really wonderful," she enthuses.

"In our programs, not all the employees take some kind of medicine," she explains, noting that such a choice is always voluntary. "But Zyban is most appropriate for any smoker."

Jackson observes that the study also showed the participants who took the Zyban had a smaller weight gain. "That's also a really significant finding," she asserts. "People who quit smoking fear weight gain because nicotine helps burn calories. But the people on Zyban had weight gains that were an average of seven pounds less, which is very significant to people who want to quit."

[For more information, contact:

*• **The Mayo Clinic**, East 18B, Rochester, MN 55905.*

*• **Sue Jackson**, vice president, American Institute for Preventive Medicine, 30445 Northwestern Highway, Suite 350, Farmington Hills, MI 48334. Telephone: (248) 539-1800. Fax: (248) 539-1808. Web: www.healthylife.com.]*

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AMERICAN HEALTH CONSULTANTS®

2001 SALARY SURVEY RESULTS

Occupational Health Management™

A monthly advisory for occupational health programs

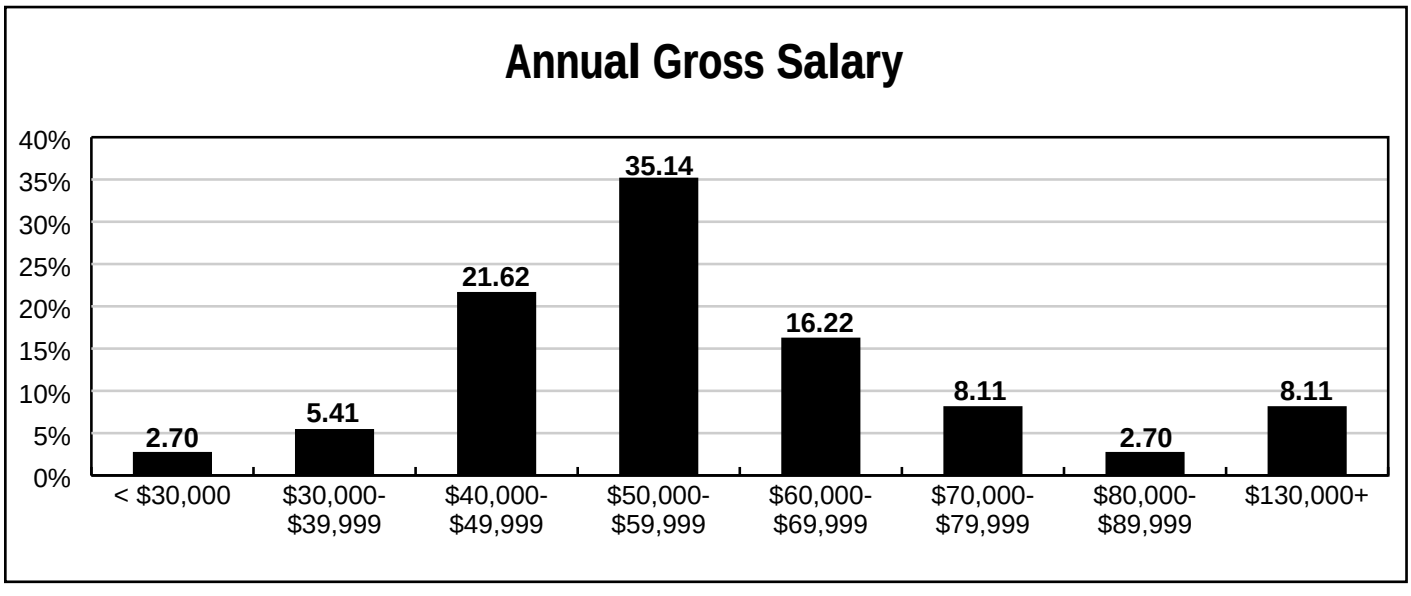
Salary gains modest, but growth opportunities remain

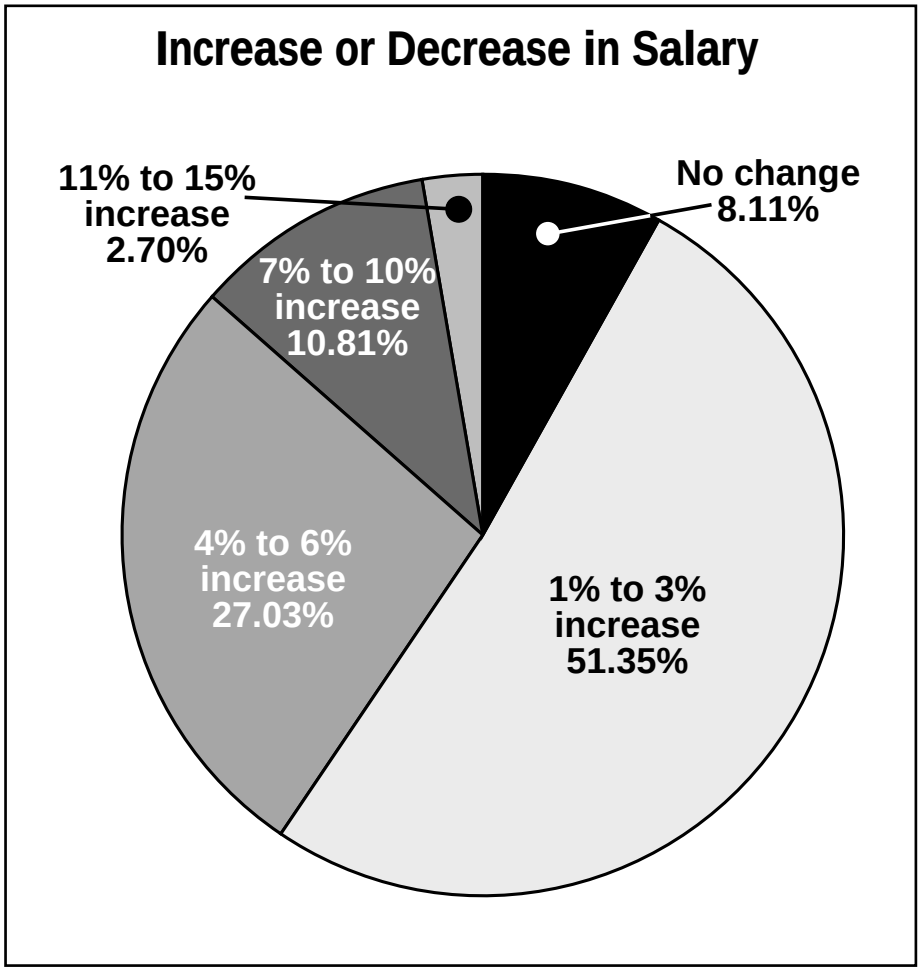
The past year saw only modest salary gains in the occupational health field, according to an exclusive 2001 Occupational Health Management salary survey. Experts in the field note, however, that this is not unusual for professionals in most fields of employment in the United States.

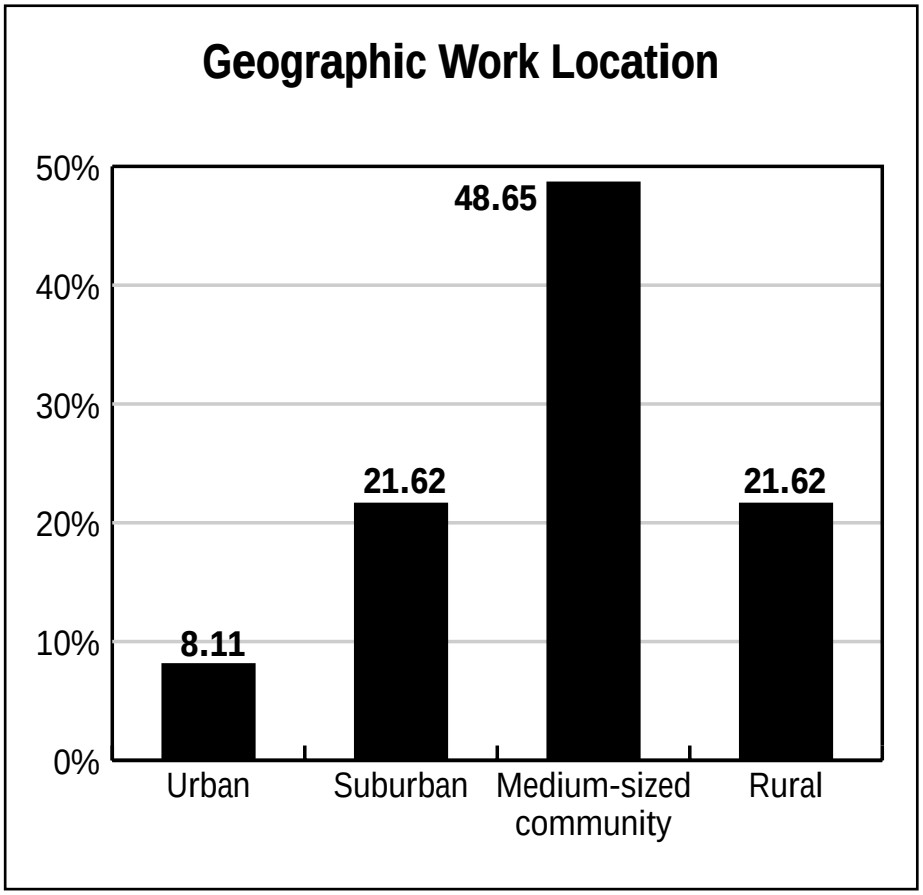
They add, however, that if you look beyond the numbers, the picture tends to brighten considerably. For example, employers, they say, may not be willing to spring for that big salary increase, but they *are* becoming more generous with fringe benefits such as pension and profit-sharing plans. Benefits such as these, they note, can translate into significant "value-added" dollars in terms of your actual compensation. And, they add, you can still find that quantum leap in income you're looking for if you're willing to think outside of the box and make some tradeoffs in terms of location.

OHM is pleased to provide readers with the results of this 2001 survey. Our exclusive report illustrates some of the key factors that may influence salaries and benefits among occupational health professionals, and allows the reader to "customize" the results in terms of location type, salary range, age, gender and other factors so that they become even more meaningful for the individual reviewing them.

The 2001 *OHM* salary survey was conducted in the summer. Survey responses were tallied, analyzed, and reported by American Health Consultants, publisher of *OHM*. We trust you will find the survey of value in







helping you gain insight into the leading salary and compensation trends in this dynamic industry.

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Most salaries rise 1%-3%

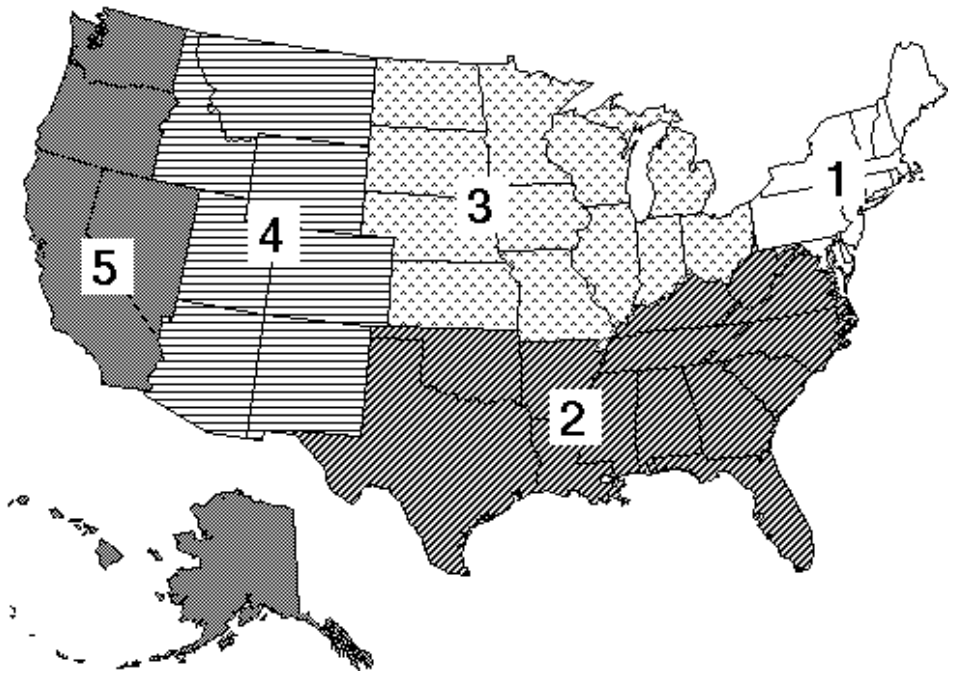
Responses from occupational health professionals indicate that by and large, only modest salary increases were forthcoming in 2001. A majority of the respondents, 51.35%, reported a salary increase of between 1% and 3%. Another 27.03% reported increases ranging between 4% and 6%. Only 13.5% of the respondents reported increases of 7% or greater.

These results came as no surprise to **Deborah DiBenedetto**, MBA, RN, COHN-S, ABDA, president of the Atlanta-based American Association of Occupational Health Nurses (AAOHN). "Most professional employees are seeing those smaller increases, unless they are technical workers," she notes.

But with a growing nursing shortage, doesn't employee supply / demand come into play? "A lot of the nursing shortage is not found on the occupational health side, but in acute care," she explains. "There are plenty of us to go around. With the new graduates, however, there are not enough to go to the bedside; we are training more specialists. So, who's to say what will happen in 10 years?"

To some degree, physicians can control what they earn, notes **William B. Patterson**, MD, FACOEM, MPH, president of Wilmington, MA-based Occupational Health & Rehabilitation (OH&R). "There's a tremendous amount of variability in salary based on the desirability of the location," he asserts. "People who are willing to go out into the less urban areas or medium-sized

Where Do You Work?



Region 1	27.03%
Region 2	21.62%
Region 3	40.54%
Region 4	5.41%
Region 5	5.41%

cities can often do a lot better in terms of salary, and they will have a lot lower cost of living as well."

Patterson notes that OH&R operates 46 offices in nine different states, which gives the company a very broad perspective on industry trends. "We talk with a lot people from different parts of the country," he observes. "It helps keep us informed about what's happened in a number of different markets."

Why would major cities, which tend to have higher costs of living, offer lower salaries than the suburban markets? And how can they get away with it? It's the old law of supply and demand, Patterson explains. "In locations in or near major metropolitan areas such as Boston, Minneapolis, or Chicago, there are usually more occupational health physicians," Patterson observes. "Therefore, you have a more competitive market and thus you get the lower salary. Whereas, if you go out to a smaller city, especially away from the coasts, you can do better. They *have* to pay higher salaries to get the kind people they want."

It's not all about salary

As the salary survey results make clear, occupational health professionals pay attention to a lot more than salary when evaluating a compensation package. When asked to rank medical coverage, a 401K or similar plan and pension plans as in terms of importance, in each case a total of 75.68% of all respondents rated them as "extremely important." Flexible work schedule (54.05%) and dental coverage (48.65%) also ranked high.

The good news is that employers are starting to listen to their employees. "Employers are looking at trying to enhance their benefits packages; they're encouraging 'matches' on 401K's, and adding profit-sharing plans," says DiBenedetto. "They're also giving employees a greater opportunity to manage their pension fund or profit sharing plans, allowing them more leeway in determining the investment vehicles in which their money will be invested."

In addition, she says, employers are seeking to enhance their work-life programs, based on what employees' needs are. "They are making sure that EAPs [Employee Assistance Programs] are available, especially for health care workers," she says. "And now, with the recent events in New York, Washington, DC, and Pennsylvania, many more employers will be looking at them." Employers are also investigating the possible expansion of legal services, eldercare, and childcare, she says.

"Still other employers are seeking to provide additional

benefits such as greater flexibility with paid time off arrangements," DiBenedetto adds. "They are moving towards a 'bank' of paid time off, so the employee can take off for a variety of reasons. The no. 1 reason for taking time off right now, for example, is personal issues."

Just because these benefits don't carry a dollar sign next to them, it would be wrong to assume they had no monetary value, DiBenedetto advises. "They *absolutely* have a dollar value," she asserts. "And the other side of the coin is that it doesn't add to the financial liability of the company. Every time you raise an employee's salary you have concommitant additional costs like FICA."

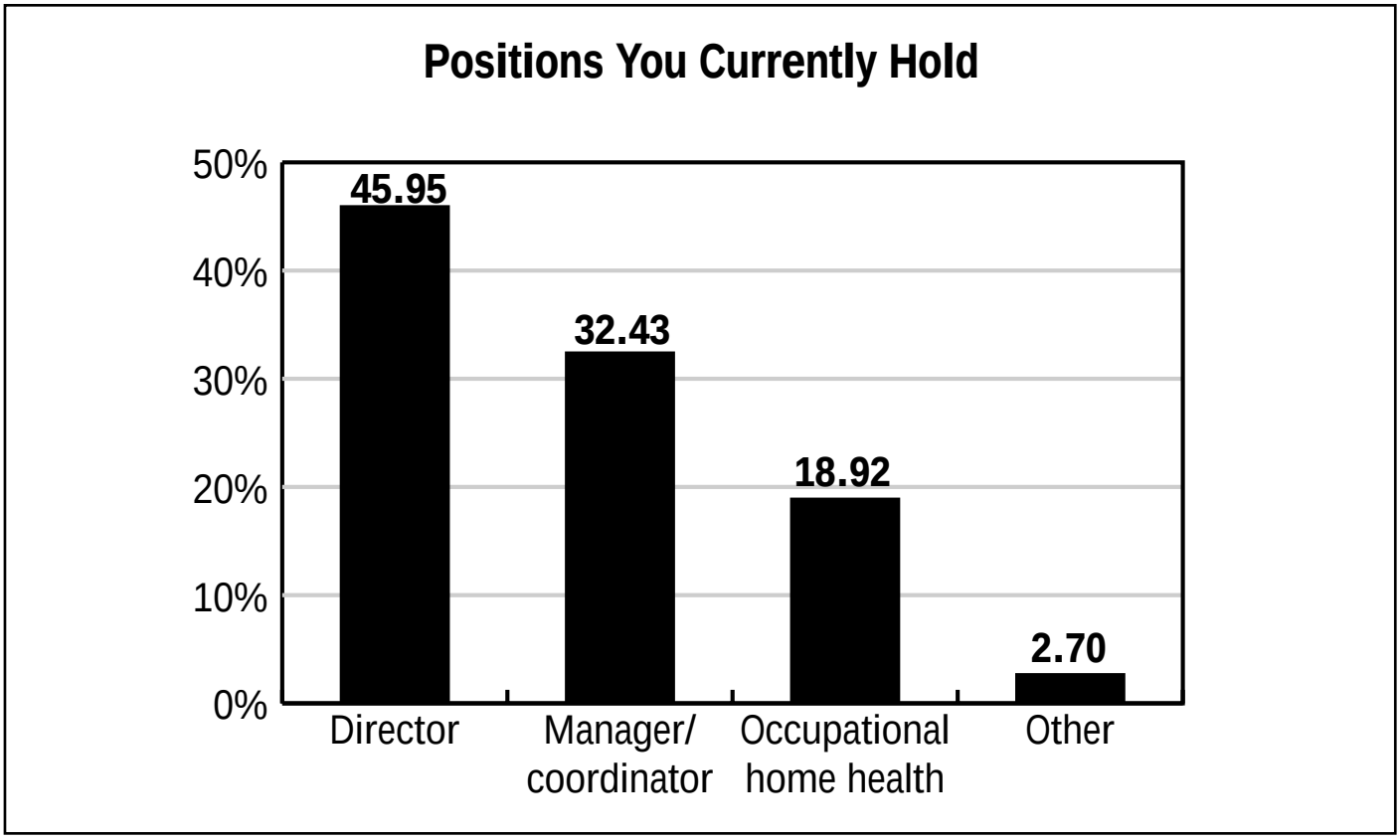
Corporate sector struggling

Looking to the overall job market, "the corporate sector is clearly struggling," says Patterson. "In a downturn in the economy, many corporate medical directors are laid off, and there is a lot more outsourcing of corporate medical services to various vendors of occupational medicine. For example, Lucent, Raytheon, and Kodak have substantially shrunk their corporate medical departments from last year."

Ironically, says Patterson, he has seen a number of hospital programs that have been paying their medical directors salary rates that are above the national average, "and typically those hospital programs are not well run from a business or financial point of view; they are not really tracking what appropriate doctors' salaries are," he notes. "They are overpaying by an amount ranging anywhere from 10% to 20%," Patterson continues. "Unfortunately, what is now happening is that when the hospital finally gets serious, the corporate medical directors may find themselves being asked to take a pay cut."

Meanwhile, Patterson notes, there continues to be steady consolidation among the leading occupational medicine vendors. "The top three are Concentra, USHealthWorks and us, in that order — and they clearly are all continuing to expand," he says. "As this trend continues, more and more of the providers will be working for large corporations. And in large corporations like ours every provider will be on some form of incentive-based compensation."

The actual formula used varies from company to company, he explains. "In some organizations, it is based on the productivity of the provider, while in ours, it is based on the profitability of the office as a whole," he says. "But there will continue to be a move toward compensation which is in part incentive-based." ■



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