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Occupational Health Forecast: Be Prepared for Changing Patterns

By Karen O'Hara

The start of a new year is an auspicious time to chart a course for an innovative occupational health delivery model based on experience, reasonable forecasts and willingness to accept a certain degree of risk.

The following predictions from industry experts provide insights to help organizations adapt to the changing landscape in 2016 and beyond.

ACCOUNTABILITY

Dale Bugay, *Executive Director, Occupational Accountable Care LLC, a cooperative offering guidance to employers, providers and payers to improve health and productivity of employed populations, based in Columbus, Ohio*

Mr. Bugay has an extensive track record in occupational health and risk management services.

In his latest endeavor, "accountability" is his watchword.

He envisions the integration of risk management and occupational health solutions through the development of cooperative agreements among providers, employers and claims administrators. His primary objective is to "establish an accountable care relationship with employers and payers that documents quality improvement in the health and productivity of employed populations."

Optimally, he would like to see occupational health programs act as population health guardians and care coordinators. While he reports incremental progress, he believes a makeover is required.

The following summarizes some of the predictions Mr. Bugay made during a presentation at RYAN Associates' October 2015 national conference on *Providing Healthcare Services to Employers:*

1. Customer satisfaction ratings, rather than patient satisfaction scores, will be key drivers of performance incentives.
2. Participating employers will no longer have the option of holding out for full duty without job modifications. Safe return to work following an injury or illness, with or without accommodations, will be an essential component of accountable care programs.
3. Occupational health professionals will become much more engaged with employers' risk management and cost control programs. Consequently, leading providers will emerge in most markets, surpassing those who are perceived as "just another provider in the network."
4. Payers will start to recognize occupational health programs for providing quality, cost-effective injury management services. In many jurisdictions payers take

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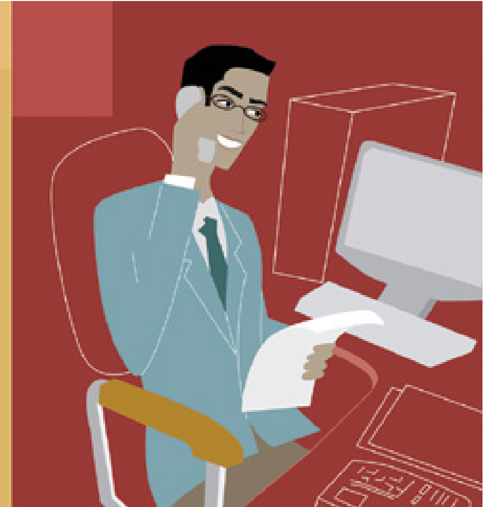
NAOHP Town Halls Address Critical Issues

Town Halls are complimentary 30-minute conference calls for NAOHP members. There is a new topic every week. The following represents participant questions and selected responses.

Week 40: August 24

DEVELOPING WIN-WIN RELATIONSHIPS WITH SENIOR MANAGEMENT



Q: How do we know what senior management really wants?

A: "We have found it goes beyond the operational to how our program benefits the [larger] system, such as referrals and physical therapy."

A: "You need to ask and much depends on exactly how you ask. Your questions [should be put] in context and always drill down to quantitative expectations."

A: "We document our outcomes and try to leave a clear paper trail defining expectations with copies sent to relevant parties."

A: "We ask them directly what type of reports will meet their needs."

Q: How can we reach the senior-senior management team?

A: "First ask yourself if you really need to reach out to this level. Many will simply defer judgment anyway."

A: "We appeal to their strategic orientation, i.e., why are we doing this in the first place? Later on, we can say that our program supports the mission of the parent organization."

Q: In what realistic ways can we involve senior management in our program?

A: "We often invite key employer contacts to come to our hospital to meet with senior management. It creates a connection."

A: "It depends on personalities. People are different: some are eager to become involved and do so productively, others are eager but their involvement may be counter-productive, and others are neither interested nor effective. Understand your players."

A: "We reach out and put things in context. For example, tell them, '*this is why we need your involvement.*' Play to their (senior management) egos by offering legitimate praise in a sincere and honest manner."

Q: How do we best articulate the value of our program to our health system?

A: "Ask management directly, 'How do you define value?'"

A: "Quantify, quantify, always quantify. Identify and gather relevant data; minimize empty phrases like value and enhanced visibility."

A: "I have learned to be wary of generating so many metrics that you can't see the forest through trees. Throw away things that may be interesting but clutter the landscape."

Q: What are the core reporting metrics for senior management?

A: "Volumes, revenue, productivity, referrals and patient satisfaction."

A: "The net bottom line trumps everything. Remember, your program is just a small piece of senior management's galaxy."

Q: How often should we provide reports to senior management?

A: "Keep it real and watch out for overkill."

A: "It depends where the senior administrator is in the hierarchy. We seldom send reports to upper management but report to the next level frequently."

Q: What is the best approach to tell senior management of our need for increased staff?

A: "We use productivity measures to provide evidence of our needs."

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A: "Don't forget that you are competing with other parts of your organization that are also looking for additional staff. Relative need is likely to be more important than absolute need."

A: "Quantitative measures alone are often not enough. Numbers need to be supported with anecdotal information from constituents. We do annual surveys that (among other things) ask employers to rate the adequacy of our clinic staffing."

Town Hall Schedule & Topics

January 11	Occupational health trends and strategic visions
January 18	Martin Luther King Jr. Observation no town hall
January 25	Integrating occupational health and employee health
February 1	Integrating wellness services
February 8	Occupational health sales marketing
February 22	Benchmarking and outcome development
February 15	Presidents Day observation, no town hall
February 29	Developing an on-site services program
March 7	White collar occupational health services
March 14	Operational efficiencies
March 21	Legal issues in occupational health
March 28	The employer and payer perspectives
April 4	New and cutting edge ideas
April 11	Integrating occupational health and urgent care services

Week 41: August 31

USING YOUR EMR FOR OUTCOME DATA

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

A: "We find great value in not having to pull out data as we need it and instead tracking data along the way"

A: "Identify the parameters you wish to look at from the beginning, outcomes that are important to you."

A: "If you don't know exactly what you are looking for, get help and ideas from your software vendor."

A: "Transition to a different mindset. How do we set priorities within the context of the realities of our time? Quality and cost are central to healthcare. We can use our EMR to enhance quality and affect costs at the program and end-user level."

Q: What types of outcome data are most important to gather and analyze?

A: "Look at treatment metrics per ACOEM guidelines and NAOHP service metrics such as time from admission to discharge."

A: "Look at things you have some control over. If you have no control, it is not a productive use of your time."

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

A: "Decide at the outset how you wish to share information and what you want the recipient of that information to do with it. "

A: "We have found great value in supporting our coding and making adjustments to payments. We also review and react to follow-up ratios, observing how they measure against historical ranges."

A: "Be careful not to share outcome data in a vacuum; try to ask other parties what action should be taken to bring outcomes from sub-optimal to optimal or, if measured as optimal, what the program can do to leverage this information."

Q: How do we get outcome data if we do not have occupational software?

A: "Manual systems are time-consuming and it is best not to go that route. If necessary, you can use Excel to look at coding mixes and physician evaluations, for example."

A: "One low-cost option in the absence of software is to survey your employer clients once a year and ask them to rate your program's ability to generate positive outcomes and then ask sub-questions. It gives you some numbers and a sense of performance."

Q: What EMR measures are best for benchmarking?

A: "Money per center, productivity per provider, visit-type data."

A: "Best practice ACOEM standards used in treatment, document and code appropriately, and provide feedback to client companies.

A: "We provide information directly through an employer portal. Allowing online access to information provides real-time employer access to information (drug test results, physical exams, injury management issues) and does not consume the clinic team's time."

A: "Focus on the three Cs that employers look for: communication, customization and costs."

Week 42: September 14

MANAGING A PROGRAM DIRECTOR'S MULTIPLE RESPONSIBILITIES

Q: I spend a great deal of time putting out fires. What can I do to free up some more time?

A: "Why are you putting out fires? A lot of fires are fires that have occurred before. That said, hire and train well so people are less likely to make errors. Problems are inevitable; the best thing to do is document what went wrong and prevent that fire from occurring again in the future."

A: "Understand your role, training, and responsibilities so you know how much time to allocate to putting out fires."

Q: I am a program director who also wears a sales and marketing hat. I can't seem to strike a balance between the two.

A: "Spend your sales and marketing time judiciously. You can probably

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Town Hall, continued from page 3

spend more time marketing than selling—reserve that for the primo clients. Put together a marketing plan and minimize direct sales time unless there is strong potential."

> "The best way for someone to grow in authoritative capacity is to not worry they are going to fail."

Q: How do I best diffuse authority among staff so I can have more time for myself?

A: "There are some people that simply don't have it in their DNA to be authoritative; they are more team players. Then there are people who take responsibility with a little too much enthusiasm. Instill authority in people, empower them and do not be overly concerned if a person falls short initially."

A: "When you empower someone, it's tempting to look over their shoulder. The best way for someone to grow in authoritative capacity is to not worry they are going to fail. Move forward."

A: "If the person who is the designated leader is going to enrich their employee with a leadership role, it is important for other staff to know that is the case. Otherwise, there may be a misunderstanding. Make someone a champion and let it be known to the whole organization."

Q: What resources can I use or create to become a more effective program director?

A: "In my experience, collaborative input will help you. It's too easy to put down rules and regulations and go with it, and harder to say, 'Once a week, let's take a look at different things we're dealing with. What do you think we need to do to get things done?' Emphasize that anything created is a team effort."

A: "As for existing resources, Frank Leone's sales and marketing book has very good instructions on how to initiate a value-added marketing program."

Q: Who should the program director report to and why?

A: "It would be nice for the program director to have a collaborative communication system with the program owners and the medical director."

Q: What is the best model for the program director/medical director?

A: "A lot of variables here, and it depends upon the specifics, i.e., the size of market, the organizational culture and the personas of the individuals involved. They should all be taken into consideration before you decide which is the best model. It is healthy to have a collaboration instead of a reporting structure, but that is not always the case. When we get by the 'it depends' variables, I like to see co-responsibilities managed among the two."

Week 43: October 19

CARE MAPPING

Q: What exactly is care mapping, and is it known by any other names?

A: "A care map is called a clinical flow process or a patient flow process. It can be used in benchmarking to look at performance flow processes. It's taking a component of what you're doing for a patient, outlining who is involved."

Q: When do we make a care map?

A: "The minute you decide you're going to have an occupational health program, start evaluating the services you're able to provide clients. Break down each of the services and identify who is involved in each process, how the patient is going to access the program, what forms will be used, who is responsible for filling them out and what testing will be involved."

A: "Look at the registration process, how the medical assistant is going to admit that patient – there may be special processes in place you have to be aware of."

A: "Care mapping is good for physical exams such as spirometry or physician examinations and substance abuse testing. It provides a great outline for what the clinic should expect and how to proceed with that."

Q: What do you realistically have to do to carve out the energy to care map? And what is the basic value statement for doing this?

A: "Bring your entire team into the development of a care map. Ask your registration staff what steps are taken to care for the patient from entrance until they are admitted. Ask the M.A. what their role is, then the physician, etc. Then define the role for follow-up visits, which leads to the billing person. This needs to be looked at as a team endeavor. Everyone should establish a care map for the key services you provide."

A: "Show that you are efficient in your operational processes; care mapping does that. It ensures that a patient is coming in and going out in a timely manner, ensuring that you won't have to go back and redo something you missed. There's role clarification, it looks at processing and helps avoid bottlenecks."

Q: What are the most important care mapping metrics?

A: "Standards of care within the clinic structure."

A: "Productivity. If we are providing excellent patient flow, this ensures there is no lag time so we can be sure each staff member is working at their optimal efficiency."

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credit for cost containment because they are handling the claims.

5. Occupational health providers will be expected to take more ownership across the care continuum. This will require improved tracking of related activities such as diagnostic testing, referrals to specialists and case management. "If occupational health providers' contributions to health systems as a whole are only assessed on the basis of direct revenue and patient volumes, that is primary care, not accountable care," Mr. Bugay said.
6. Advances in information technology will give providers access to medical and disability cost data to support comprehensive case management and reimbursement for care coordination. (For example, in Ohio, providers receive 115 percent of fee schedule to coordinate care. In Washington state, providers receive $42 per claim to manage care.)
7. Wellness and personal health services will be blended, not segregated, and occupational health will occupy a bigger slice of the total workforce health management pie.

TAKING IT TO THE WORKPLACE

Peter P. Greaney, M.D.*, President, CEO and Chief Medical Officer, WorkCare, Inc., a national company specializing in worker protection and workforce health management, based in Anaheim, Calif.*

Peter P. Greaney, M.D.

Dr. Greaney, an occupational medicine physician, uses this example to illustrate how prognosticating can be a tricky business: In an interview with *Inc.* magazine in the early '80s, he was asked about the future of workplace drug screening. At the time, he thought "drug screening will never fly." Today it is a commodity occupational health programs are obliged to offer client companies.

Sometimes there are unforeseen game changers, he noted. For example, in 1988, as part of the war on drugs, President Reagan signed an executive order that led to legislation requiring federal employees and some contractors to be tested for illicit substances. Private employers followed suit. Search-and-seizure protections also were relaxed during the Reagan administration.

The following are among the predictions Dr. Greaney made during a presentation at RYAN Associates' 2015 national conference in Chicago:

1. Keeping workers fit and productive is paramount to success. Therefore, it is reasonable to conclude that 24-hour telephonic triage, telehealth services using mobile devices, and on-site clinics with immediate care capabilities will continue to gain traction in the marketplace. Using Uber-like apps to redeploy medical providers and drones to deliver equipment where the need is greatest are also likely scenarios.
2. To help address the nation's shortage of occupational health nurses and physicians, employers will seek assistance from providers to find qualified on-site personnel such as paramedics and athletic trainers.
3. Reimbursement models will be changed to reward clinicians who effectively manage work-related injuries and return to work.
4. Regulated companies with significant exposure risk, multiple locations and aging workers will rely on occupational health professionals to establish exposure baselines upon hire, perform medical monitoring for the duration of employment and remain involved in surveillance post-employment.
5. Rising costs associated with mental health issues, coupled with ineffective employee assistance programs, will drive requests for a broader range of worksite-based psychosocial services. Providers will be expected to clearly demonstrate the value of an employer's investment in these types of services.
6. Similarly, opioid medication and medical marijuana use in the working population is problematic for employers. Occupational health providers will be expected to assess potential physical and mental impairment in connection with the use of medications and offer guidance on reasonable accommodations and interventions.
7. Paid family and medical leave will become the norm. This is already happening to some extent. President Obama supports paid leave for federal employees and contractors. Meanwhile, the proposed Family and Medical Insurance Leave Act (FAMILY Act) would entitle U.S. workers to paid leave – in essence expanding provisions of the Family and Medical Leave Act (FMLA) that allow workers to take up to 12 weeks of unpaid, job-protected leave.

However, Dr. Greaney said, there is a caveat: "Unless we have participation from the consumer, we won't see any dramatic changes in the healthcare landscape. They have to have skin in the game. Otherwise, they will continue to consume, consume, consume. We also need to get the message to kids before they develop (unhealthy) behaviors."

POPULATION HEALTH MANAGEMENT

Randy Van Straten*, Vice President, Bellin Health, a health system based in Green Bay, Wis.*

Randy Van Straten

Since 2000, Mr. Van Straten has focused on business development at Bellin Health through the provision of progressive population health management programs. At RYAN Associates' annual national conference, he explained why he believes occupational health providers must transition from purveyors of discrete service offerings to total health delivery models in the coming years.

Among his predictions:

1. Longer-term pay for performance or shared-savings guarantees will be applied to wellness programs and on-site clinics. For example, employers may be guaranteed

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measurable improvements in health risk assessment scores over a three-year period in exchange for the provider putting reimbursement for health coaching services at risk. Or, an employer may be eligible for compensation if an on-site clinic operated by a contractor does not reduce the company's insurance costs for a specified period of time; if savings are achieved, the contractor receives a percentage of the savings.

2. To be cost-effective, on-site clinic hours will need to be better aligned with workers' hours, for instance, split shifts, 24-hour operations and work in the field or remote locations. This will require programs to hire and strategically assign staff before a contract for on-site services is signed.
3. The ability to demonstrate a deep understanding of the population being served will help local providers compete with national and regional vendors. For example, Bellin helps employers analyze specific workforce health risks and develop plans to better manage costly co-morbid conditions among individual workers in the health system's service area.
4. The total health management model will succeed in organizations in which leaders establish a foundation for acceptance. Occupational health will be an integral part of the overall model when it is perceived as providing the right care, at the right time, at the right cost. Key components may include 24/7 nurse triage, scheduled appointments and managed referrals.
5. Occupational health providers cannot function as an island. Moving forward, they must partner with insurers, third-party administrators, brokers, claims adjusters, case managers and other stakeholders.

Noteworthy Trends Affecting Providers and Employers

AGING WORKFORCE:

Yes, we are *still* getting older. AON, a leading risk and human resource management consulting firm, follows the impacts of workforce aging on the U.S. healthcare system and the workers' compensation market. It refers to this trend as "Ageonomics." AON has published several white papers on the subject, including "Eight Strategies to Achieve Improved Claims Outcomes for Aging Workers."

Reference: www.aon.com/risk-services/ageonomics.jsp

INFORMATION TECHNOLOGY:

Over the next five years, experts say advances in information technology, analytics and big data will further refine healthcare delivery. For example, consumers can expect to be rewarded for using personalized technology to make informed choices. "To be competitive in this market, companies must be willing to provide better value, error-free healthcare, consumer rewards and a better patient experience," experts said during a 2016 Health Predictions webinar.

Reference: *Healthcare IT News,* Nov. 20, 2015: www.healthcareitnews.com/news/2016-health-technology-prediction-consumer-driven-healthcare

MEDICINE WORLDWIDE:

The *2015 Medical Trends Survey from Mercer Marsh Benefits* examines external trends that influence the competitiveness and sustainability of health programs provided to employees and their dependents around the world. Responses from 165 insurers in 48 countries suggest the cost of providing medical care to employees outpaces inflation in 29 major economies. Mercer's 2015 National Survey of Employer-Sponsored Health Plans will be released in spring 2016.

Reference: www.mercer.com/services/health/international-benefits/mercer-marsh-benefits-medical-trend-survey-2015.html

OCCUPATIONAL RESEARCH:

In 2016, the National Institute for Occupational Safety and Health (NIOSH) will be establishing research priorities for the next 10 years as it launches into the third decade of the National Occupational Research Agenda (NORA). Outcomes from the previous 20 years, resources and funding allocations are subject to scrutiny as part of this process. NORA is a partnership program designed to stimulate research and improve workplace safety in certain industry sectors.

Reference: www.cdc.gov/niosh/nora/decadereview.html

OPT OUTS:

Texas has allowed workers' compensation system opt outs for more than a century. Oklahoma passed opt-out legislation in 2013. Legislators in Tennessee and South Carolina introduced opt-out bills in 2015; Georgia may be the next to follow suit, according to industry observers. Opponents say opt outs provide insufficient benefits and are unconstitutional. Proponents say alternative programs foster better care and help expedite recovery.

Reference: www.workcompwire.com/2015/10/rims-exec-report-alternatives-to-traditional-workers-comp-systems/

REGULATORY CLIMATE:

In 2016, the Occupational Safety and Health Administration (OSHA) is expected to continue its drive to cite and publicize "bad actors" as part of its emphasis on enforcement. Civil penalties issued by OSHA will increase for the first time in 25 years under a provision in the Bipartisan Budget Act of 2015, signed Nov. 2 by President Obama. OSHA must first issue an interim final rule increasing its penalties to adjust for inflation between 1990 and 2015, which will raise proposed fines by about 80 percent. The one-time adjustment must occur before Aug. 1, 2016. OSHA can subsequently adjust penalty levels based on annual inflation. Meanwhile, the agency is seeking public comments as part of efforts to update its voluntary Safety and Health Program Management Guidelines, originally published in 1989. It also is requesting comments on a whistleblower guidance document.

Reference: www.OSHA.gov

WELLNESS:

Health promotion and wellness remain on the minds of employers and employees. The Healthcare Trends Institute says: "You can help employer groups decide if a wellness program is a good fit for them—financially and culturally—and what components (lifestyle or disease management) are likely to help them reach their goals."

Reference: Wellness Programs in 2015: Trends, Tactics and Insights www.evolution1.com/healthcare-trends-institute

"We need to offer employers more help with getting and keeping employees, fast-tracking their training and ensuring they are fit for their job. I see this as an issue we need to address as a nation," Mr. Van Straten said.

THE BIG PICTURE

***Arthur M. Southam**, M.D., M.B.A., M.P.H, Executive Vice President, Health Plan Operations, Kaiser Foundation Health Plan, Inc., and Kaiser Foundation Hospitals*

Arthur M. Southam, M.D.

Dr. Southam has national responsibility for Kaiser Health Plan marketing, sales, service and administrative activities. Kaiser Permanente is recognized as one of the nation's leading healthcare providers and not-for-profit health plans. It serves more than 10 million members and delivers approximately $50 billion a year in health services in eight states and the District of Columbia.

Dr. Southam brings a high-level view to discourse about the future of U.S. healthcare delivery. While it has been said before, he believes the message bears repeating: prevention is the key.

"We are a very medically oriented society," he said during his keynote speech at the November 2015 Workers' Compensation and Disability Conference & Expo. "Realizing that the current medical model won't work is one of the most important advances we need to make in terms of social and cultural awareness in America."

Studies show:

- Personal behavior drives the need for medical care 40 percent of the time.
- Genetics and family history dictate the need for care 30 percent of the time.
- Environmental and social factors such as income and level of education influence the need for medical care 20 percent of the time.

Realizing that the current medical model won't work is one of the most important advances we need to make in terms of social and cultural awareness in America."

"Why do we spend so much money on medical care and so much less on social services?" he asks. "We do the opposite of what many other countries do….some food for thought."

According to Dr. Southam, in the future:

1. Many healthcare encounters will be enhanced by telehealth functionality.
2. Employers will find ways to make it easier for employees to be active during the workday. "Improving the walk-ability of our workforce is one of the highest-yield things we can do," he said, noting that sedentary lifestyles contribute to costly, disabling conditions including depression, dementia, stroke, obesity and osteoporosis.

3. Worksite-based and freestanding occupational clinics will be part of the movement to ensure safe, timely, efficient, patient-centered care.
4. Mechanisms will be developed to connect people, departments and organizations that operate in silos. This will benefit all healthcare consumers.
5. Coding will be updated to reflect advances in population health management. However, there is a long way to go.
6. Extraordinary advances in healthcare technology and medicine justifiably capture attention because they save lives. The next generation of leaders will be challenged to redistribute resources with the following issues in mind:
   - Waste in systems and organizations
   - Disparities in care quality based on location, patient demographics, income, ethnicity and other factors
   - Preventable medical errors
   - Management of chronic conditions that are the leading causes of morbidity, mortality and work absence
   - Financial incentives that reward quality, care coordination and team-based care across functional disciplines
   - Incentives for patient engagement and behavior change
   - Information technology and knowledge management for good decision-making
   - Broader use of electronic medical records, interoperability and quality metrics
   - Performance transparency and patient privacy

"One of the most important recent advances in healthcare is the smart phone," Dr. Southam said. "Thousands of healthcare-related apps are already available. Further advances will take much of medical care out of the clinic or doctor's office and put it in your home, your workplace or your pocket."

Web-based applications and mobile devices that facilitate access to personal health information, medical records and individual providers allow for democratization in access. "It's quite transformational," he said.

Karen O'Hara is Director of Marketing and Communications, WorkCare, Inc. She is the former Editor-in-Chief of VISIONS and Senior Vice President of RYAN Associates.

On-site Clinics Impact Healthcare Costs, Recruitment and Retention

By Anthony Vecchione

The prevalence of health clinics operating in the workplace, known as on-site clinics, is soaring, and with good reason.

Under the Patient Protection and Affordable Care Act (PPACA), employer healthcare cost containment strategies have become more important than ever.

According to the results of a recent Wells Fargo Insurance white paper entitled "The role of employer-based on-site clinics: Total population management strategy," employers are searching for approaches to control spending, increase productivity and have a healthier and happier workforce. (For more information, go to https://wfis.wellsfargo.com/insights/white-papers/Documents/Employer-based-onsite-clinics.pdf)

According to Wells Fargo's data, employer-based on-site care has historically offered more traditional occupational services, such as emergency first aid, pre-employment physicals and workplace health and safety programs. The present-day on-site clinic concept is employee-centric and offers integrated, comprehensive services that go beyond the four walls of the traditional healthcare system and the limited occupational service model.

THE VALUE OF ON-SITE CLINICS

The Alliance, a Madison, WI- based not-for-profit, employer-owned healthcare cooperative, reports numerous benefits of an on-site clinic, including:

- Better management of chronic conditions
- Earlier treatment of illnesses or injuries
- Fewer emergency room visits
- Improved productivity due to a healthier workforce
- Reduced absenteeism
- Reinforcement of a "wellness culture"
- Improved retention of employees
- Improved ability to recruit new employees

ON-SITE CLINIC GROWTH IS EXPECTED TO CONTINUE

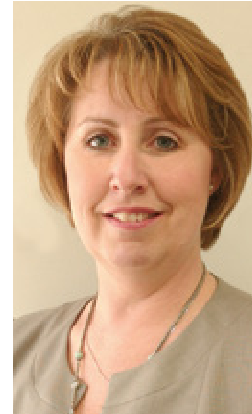
According to a 2014 report by Indiana University Health Business Solutions, the prevalence of on-site health clinics for employers with 5,000 or more employees increased from 32 percent to 37 percent between 2011 and 2014. Data from the report reveals another 15 percent of reporting companies were considering adding an on-site clinic in the next two years.

"While the penetration is not quite as high for companies with 500 to 4,999 employees, the trend is the same: 15 percent currently have workplace clinics and another 11percent plan to add them in the future. Increasingly, employers are coming together to participate in shared on-site programs. In these instances, two or more employers share an on-site or near-site clinic," the report states.

Industry insiders report that the growth of on-site health clinics is clear to everyone who is looking. Surveys show that many employers are increasingly accepting that the best way to manage healthcare costs and ensure the optimal health of their employees is to maintain a tight arrangement in their own facility with outside specialists.

Denise Dumont-Bernier, director of the Workplace Health occupational medicine department at Maine General Medical Center in Augusta, ME, said employers are looking for ways to reduce employees' time away from the job and improve access to health services at the workplace.

"Now employers are thinking more broadly and realizing that general healthcare concerns like chronic disease are all leading to increased costs and absence from work. Employers are broadening the scope of what they want to have on site," Ms. Dumont-Bernier said.



Denise Dumont-Bernier

"For us here in Maine, we have employers who are interested in employee wellness/well-being and we've put health coaches at the workplace to help with employee well-being for the past several years."

WHAT'S TYPICAL?

There's a saying among occupational health industry insiders: *If you've seen one on-site health center, you've seen one on-site health center.*

Many industry experts agree that clinic models vary and that they all offer nuances that are customized for a specific employer.

"In general, we offer the wide range of on-site healthcare services, and work with each client to customize the delivery of services," said Phoenix-based Cheryl Counts, associate vice president of Premise Health. Ms. Counts explains that some clients want it for employees and dependents, while others will open the health center to contracted workers, as well.

"There are also models where we have what we call coalition partners—it could be an on-site or near-site clinic that has two or more employers sharing the services," Ms. Counts said.

Dr. Ellen Davis, N.P., North East

Dr. Ellen Davis

Eastern Regional Clinical Advisor for Premise Health in Franklin, TN, said that often what clients think they need isn't really what they need, or vice versa. "We're able to customize each health center to the client's needs," Dr. Davis said. Premise's clients range from the transportation and energy sectors to manufacturing and financial.

INNOVATIONS AND VARIATIONS

Regarding the latest innovations and differences among on-site clinics, customization is a growing trend.

"Across the board the more our member organizations can refine what they are doing in any manner to suit the unique nuances of the individual company the better," said NAOHP Executive Director Frank Leone.

One company associated with Maine General's Occupational Medicine department has a call center of 30 employees housed in New York, while another company operates a small printing facility in Connecticut. Ms. Dumont-Bernier explains that they want to be able to offer the same wellness services to all employees wherever they are located.

"For two companies based in Maine we go to their out-of-state location on an annual or biannual basis to build a relationship, to see people in person and do biometric screenings, cholesterol and A1Cs," Ms. Dumont-Bernier said.

Making a face-to-face personal connection really helps people who want to make lifestyle and behavior changes.

"Our model for wellness is personal health coaching. We're looking at expanding telemedicine services, to be used in a health-coaching [capacity]," said Ms. Dumont-Bernier.

At Premise Health, Dr. Davis said one large client is planning a new health center focusing on lifestyle and holistic medicine.

She noted that because lifestyle medicine addresses the patient as a whole – it's necessary to be able to offer medical care as well as nutritional care and lifestyle education.

"If someone is making bad food choices and they are diabetic, not only do you educate them on how to make better choices, you help them learn how to modify their behavior," Dr. Davis said.

Premise is also mining EMR-data to help identify people at risk. "We are currently engaged with two delivery service providers in the state of Oregon," said Peter Vasquez, M.D., senior vice president of medical operations for Premise Health.

"We are using both direct secure messaging and the e-health exchange health information pathway. Our on-site health center is functioning as part of their closed-network of patient-centered medical homes." Dr. Vasquez said.

TYPICAL FEES

The majority of on-site clinics are a contracted service, not billed to insurance. There are several models.

According to Donna Lee Gardner, R.N., M.S., M.B.A., senior principal with RYAN Associates, the model that initially sold well to employers was a contracted service on a capitated basis, taking into consideration the cost of the NP/PA, administrative oversight, software, CMA and the specific reports required by the employer.

"They annualized those costs and established reimbursement on a quarterly basis. The benefit to employers is phenomenal," said Ms. Gardner.

She explained that employers' insurance premiums are predicated on frequency and severity of usage. For example, if you have an on-site clinic that's intervening and screening your employees and putting together wellness programs, employees are less likely to use urgent care centers and ERs and you are able to identify diseases early, before they require costly hospitalizations.

"I look at how many staff hours I am going to be providing to the company and I look at a cost-plus model. What are my staffing expenses, travel, any software we might be using and providing and management oversight?" said Ms. Dumont-Bernier.

"There are different pricing models. There is a fixed fee – where we are assuming a level of risk – the client is billed a fixed amount and we have to be careful in controlling expenses," said Ms. Counts.

In addition, Ms. Counts cited cost-plus or "the pass through of the direct costs for operating the health center." The plus is the management fee. The other pricing model is a risk-sharing model, where we bill the client a per-member, per-month fee."

SECRETS OF SUCCESS

What makes some on-site clinic programs thrive and others less successful?

Dr. Davis at Premise Health stressed the need to be flexible, meeting the client where they are and matching their needs to a clinic's offerings.

"I think that's a huge point for us. That is one of the reasons we are successful as a corporation. We really do meet the client where they are. We get RFPs from prospective clients and they're not sure what they want – it turns out that they just want a fitness center or a pharmacy – and we're able to do that for them. We ask them what they are trying to achieve."

PITFALLS AND CHALLENGES

At some point every on-site health center will face a bump in the road. What advice do the experts have when faced with difficulties?

One suggestion is to ensure there is alignment between the service that's being provided at the on-site center and the client's benefit plan design.

"They need to be sure they are incentivizing their employees to utilize the on-site health center versus going to a community provider and that the

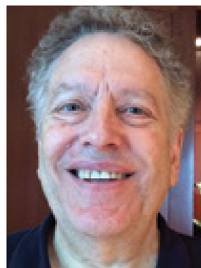
Continued on page 16

National Experts Reflect on Information Management Systems in Occupational Health

Twelve national experts on occupational health information systems weighed in as part of RYAN Associates' fall webinar series on the same topic. Excerpts from their comments follow. Audio recordings of the three-session series are available at http://naohp.com/forms/webinar/info-sys-webinar.html

FACULTY ROSTER

Dr. Steve Crawford
Medical Director, Meridian Health System

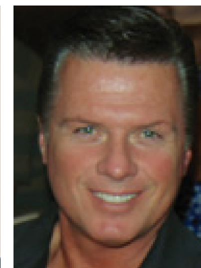


Dr. Joe Fanucchi
President and Medical Director, Meditrax

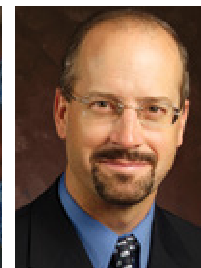
Ms. Donna Lee Gardner
Senior Principal, RYAN Associates

Mr. Tom Neville
Vice President, Health Care, UL Workplace Health & Safety

Dr. Kent Peterson
President, Occupational Health Strategies



Mr. Kelley Schudy
Senior Vice President of Sales, Net Health



Dr. David Stern
President, Practice Velocity

ADDITIONAL FACULTY (not pictured)

Ms. Connie Brandes
Director, Ambulatory Health, Franciscan St. Francis Health System

Dr. Scott Burger
C.M.O., C.O.O., Choice One Urgent Care

Ms. Lucy Carlson
Occupational Health Specialist, 3M Corporation

Mr. Tom Carson
Former President, Axiom Health Services

Ms. Tiffany Slocum
EMR Specialist, DocuTAP

Q: Getting occupational health-specific software to work in concert with larger institutional software such as Epic, Meditech or Cerner can be a daunting task for occupational health programs. What can program personnel do to facilitate a smooth integration?

Ms. Brandes: We are using our [program] as our platform and Epic as the repository. We upload into Epic rather than integrate Epic into our OM software.

Dr. Burger: We have interfaces and we have worked with vendors to create interfaces of data coming in and data going out.

We had a clearly defined project plan and even started using Six Sigma to get higher management support before we began the project, then looked into the capabilities of all the different systems.

Dr. Crawford: We required Citrix in order to be able to communicate, as well as Adobe. I found that both of them potentially slow things down in terms of data transmission.

Q: What has been the most significant challenge that you faced in doing this?

Ms. Brandes: It has taken a lot of discussion with IT because we thought we would use Epic and then download some of the information into our OM software; once we were hands on it was going to be a better fix if we use OM software and then upload into Epic.

Q: What have you learned that you can share with others who are just in the foothills of the process? What do they need to do?

Ms. Brandes: Gather as much data as you can from users of both your OM software and your system platform and find other institutions that have made similar interfaces work. Then be prepared to talk to your senior leadership with that information at hand.

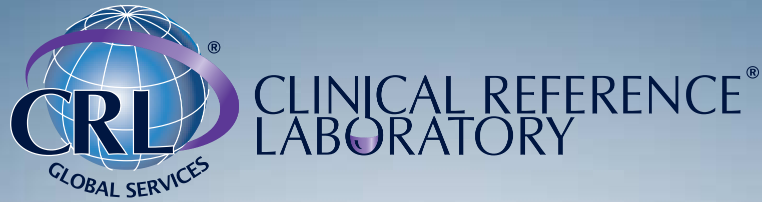
Ms. Gardner: The majority of time IT does not want you to compromise their system by having any kind of upload. They would be happy to download things. The majority of time you would register the patient in your mainframe and download that information into your OM software; that way you only register once.

Dr. Burger: Make sure you identify an EHR system that can work well in both worlds because there are different reporting criteria when you send information back to an employer or an insurance company. You need a system that redacts protected health information when you want to do occupational health in an urgent care environment.

Dr. Crawford: The biggest challenge is getting the other team, in our case Epic, to play nice with your software vendor and convincing them to embrace the process. We want to share information back with that person's provider in a meaningful way. We do not want to pull the information out.

Q: Information is essential but costs are a significant issue too. What can programs do to manage costs while ensuring timely access to crucial information?

Continued on page 13



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Ms. Brandes: The manual process, from report generation, to information gathering, is much more time consuming and costly than the automated process. Look at return on investment. How much time are you spending doing something now versus what you might be spending in the future?

Dr. Crawford: Are you charged an annual fee and is it based on the number of users? We try to minimize the number of users because that is where the costs start adding up. We end up sharing access.

Q: What advice do you have for managing an IT budget once they have their software in hand?

Ms. Gardner: Bells and whistles are wonderful but you want a core product. You do not want to spend money on things that aren't going to be used as part of product management. Interfaces are awesome and you need them for lab and radiology, but you may not need interfaces for every department in a hospital, so you want to be clear on what data needs to come in and what data needs to go out. You need to know how are you going to do your billing and who is going to monitor it because those interfaces cost money. Educate people in the clinic. How many sessions are you going to need, because those cost money as well.

Dr. Crawford: If users are not trained properly it means many of the benefits of the program are not being used. We have gone to a super user at each site—someone who knows the program extremely well. If someone gets stuck, that super user can be helpful.

Q: If you had to pick one thing from your experience, the one 500-pound gorilla in the room that is eating up costs unnecessarily, what would it be?

Dr. Burger: I like a system that is structured and regimented so it works the same way for everybody and doesn't have a lots of flexibility for people to customize things. My experience has been that we make mistakes when we do that.

If you find a system that is robust, meets your documentation needs and gives you the right E&M coding and procedure code, you can train people easily. It is important to not only train them but know what type of web-based training applications your partner uses. Our system has video-based training as well as hands on within the video so providers can actually practice and learn how to document a suture repair or a chest x-ray. That makes their process of integrating and starting to see patients easier.

Q: User training is critical. From either a user or vendor point of view, what constitutes outstanding user training?

Ms. Carlson: You have to have your own staff trainer as well as the vendor trainer working on the day-to-day interfaces. Working closely with the vendor is part of that.

They did not provide our clerical staff with the kind of in-depth training I wanted them to have. They got some basics and then they were on their own.

Ms. Carlson: For training to be worthwhile, you need to be able to measure it objectively. Ask yourself, is every employee that went through training competent? This is one area where I do not see a lot of testing on the company (vendor) side; making sure that users understand it totally.

Dr. Crawford: You need one person to be in touch with the folks at the system you are using so you have facilitated communications.

Q: It is inevitable that there will be turnover. What have you learned about the difference between initial training when you first get a certain kind of software and staff-turnover training? What has been your experience with new staff coming in one at a time?

Ms. Carlson: It costs money to have someone fly to California and train a new nurse who is going to turn over next year. So we spend phone time with people because it is not enough to simply have electronic training. We sit on the phone with them and share desktops so that we can see what they are doing and help them problem solve.

Q: What is your opinion on using Epic itself with modifications for occupational medicine versus specific OM software?

Ms. Gardner: Occupational medicine software was initially developed because [programs] could not find a vendor nationally that could meet the needs of an occupational health clinic. They provide a good mainframe, but they do not have an occupational medicine software product. It would be better use of time, energy and money to go with what is already proven, rather than develop something on your own or customize something that was never meant to be used in occupational medicine.

Q: What are the most onerous hidden costs associated with an operating information system?

Ms. Gardner: Have a clause in your contract that addresses ongoing monitoring and support above and beyond so that you have one person to call when you have a problem and they

Continued on page 14

are familiar with who you are, what you do, where you are, and what your needs might be.

Q: A common if not chronic concern of software users involves customer service. What are the earmarks of exemplary software support? Are there tipoffs to future lapses, poor service going in?

Mr. Schudy: Medical practices are looking for a culture and philosophy that a company has as it relates to customer service. Customer service starts on the front end when you start working with the sales [department]. Do they understand your pain points and business issues? Also, are software vendors offering ongoing educational webinars? What is the vendor's client retention rate?

Q: What is an example of over-the-top great software support and what is an example of support that has fallen short?

Dr. Crawford: Let me use the example of the ICD-10s, what an upheaval for a practice to have to change the way we code and bill things. A company that is able to implement and make the transition from an ICD-9 to an ICD-10 is a company that's making your life easier.

Dr. Fanucchi: It is not only the response time, it is the resolution time. Look past the cost of support. Is it going to cost you an hourly rate every time you want a minor modification to meet your work flow or implement a new form your state has demanded?

Q: What would you say is the biggest lesson you have learned?

Dr. Fanucchi: Connectivity. From the software provider's end—making sure we have enough staff to keep our phone line up 24/7.

Mr. Schudy: How well does a vendor respond in a crisis?

Q: From a clinical perspective how can occupational health software be used to enhance the practice of occupational medicine?

Dr. Stern: In workers' compensation it can be tremendously helpful to quickly see the entire history of what has gone on with the patient over the course of treatment.

In the past, when sorting through paper charts, it was difficult to see what was going on with the patient. There is tremendous benefit from being able to put notes in a system that potentially might not be seen, might not be part of the medical record but send a message to the next provider seeing the patient. If you are not following up with the patient the next provider can. You can get a message saying "consider MRI if not better next visit," which you might not want to put in the actual record. You have ready access to labs and you can quickly look and see if there are any MRIs or CT scans that have been done for the patient. It gives you the ability to see the whole picture of a workers' comp case clearly.

Mr. Neville: Documentation is key and it might only be in the first couple innings of a ball game in which we were able to use electronic medical records to enhance practice. When you get to the latter stages that is where the power and the opportunity is. If anybody has gone through the process of going from paper to electronic records you can see the difference. The number one thing from a clinical perspective is that electronic medical records provide as a tool to ensure that the data elements are much more controlled.

Dr. Peterson: Occupational health software is not going to be useful if it is simply a filing cabinet.

First would be automated data entry from peripheral devices like vision testing, audiometry or blood pressure. Second, flagging abnormal results and other clinical findings that need attention such as an abnormal liver function test or a positive stool for blood...like a red flag that makes sure that the data is acted on.

Ms. Slocum: The consistency of documentation from providers and ease of patient consistency from visit to visit is key in the electronic medical record world.

When a patient in the occupational medicine world comes in, they are not coming to see a regular urgent care provider, and when they are in and know that their records are there from their last visit it is easy for that provider to pull the second visit or the third visit. It is that ease from a provider or patient standpoint to not have to repeat themselves and have that documentation right there and be consistent each time.

Q: Integration of an occupational medicine EMR is quickly becoming the norm in occupational health software. What should users look for in this regard?

Dr. Fanucchi: Occupational medicine clinics that have parent organizations—hospitals for example—face the HIPAA issue and there are many parent organizations that want information stored on their data system as opposed to a confidential occupational medicine record that cannot be accessed by anyone without a HIPAA waiver. We have encountered a number of facilities that have difficulty implementing an EMR because their parent corporation wants all the information transferred over or some of it transferred over to their own in-house data base.

The fact that a parent corporation owns the occupational medicine clinic is not justification for violating HIPAA and those HIPAA compliance officers have been helpful to a number of facilities in saying administration and IT folks in the parent company may not use any of that occupational medicine information.

Mr. Schudy: It has to be easy because physicians are busy and they

> "Software has to be easy because physicians are busy and they want to make sure they can see as many patients as they need to see and not be tied down to keying in documents."

want to make sure they can see as many patients as they need to see and not be tied down to keying in documents.

Q: What are the must-have features that enhance the frontline user's experience, making their job faster, easier and more satisfying?

Dr. Fanucchi: The development of an ICD-10 module that allows permission in seven clicks to pull up the correct ICD-10 diagnosis and code is something that is going to help physicians and coders. As far as enhanced features, the ability to notify employees and supervisors of upcoming appointments and recall reminders so the clinic staff does not have to call everybody or email everybody individually to remind them of an appointment. The ability to attach scanned documents, electronic documents into a person's electronic record . . .

Mr. Schudy: Integration. Have all systems talking to each other so you are not manually keying information in from one system or doing things manually.

Dr. Crawford: I do not find the electronic medical record faster, but I do find it is useful in how you manipulate the data you do put in. Producing reports, being able to determine what this particular patient's respiratory, PFTs were last year and the two years prior.

Q: Are there systems that can incorporate all the must haves and all that you have mentioned? And can I find a system that will follow business work flow?

Dr. Crawford: You can but not without shopping. You figure out how their system works, how your system works and you need to have a bilateral discussion with them in terms of what you need and what they are capable of producing.

Mr. Schudy: Understand the business needs. Then you want the vendor to do a demonstration that shows how those needs would be handled in a solution that follows the work flow.

Dr. Fanucchi: Do your due diligence. It is easy to get on the phone or go on a webinar with several vendors and evaluate.

Q: Many long-time occupational health software users are dissatisfied with their product and would like to convert to another system, yet they are concerned about the time involved and associated complications and often remain mired in software purgatory. What should such users know about conversions and to what degree might their concern be justified?

Mr. Schudy: Find out how clean and relevant the data is. Whether it be scheduling data, patient data, clinical data, or billing data, if the data is clean and valid then I would convert that over. If the data has a lot of invalid information, you're going to have converted a lot of misinformation into a new system,

Dr. Fanucchi: The biggest issues are lead time, (are we going to be able to do this in a period of days so we don't shut down?), cost of conversion, cost of modifications, cost of training on the new software and of scrubbing data that is garbage that might be in a Legacy system.

Q: Many formerly pure-play occupational health centers are now offering urgent care services and vice versa. Accordingly, software that addresses both is becoming the norm. What factors need to be considered when selecting such software?

Dr. Fanucchi: The biggest issue is billing, because in occupational medicine you are billing either the employer, a drug testing company, or workers' comp. In non-occupational, you've got three or four different insurance carriers and billing can be a nightmare. When you implement a software program in a multispecialty clinic, you want to make sure you are going to be able to accomplish the varieties of billing.

Mr. Schudy: Is it meaningful-use certified? If you are getting into the urgent care space, you want to make sure your vendors are certified.

Dr. Crawford: You do have to have that meaningful use or you would not eventually be certified to do a lot of the CMS-type of work. There is a different set of rules that govern information exchange in occupational medicine versus [Medicare and private] health benefits. You have to pay attention to that consideration in the software program. Will it allow you to separate the two?

Q: What options might be available to the small practice that desires to go beyond the paper system but is short on funds?

Dr. Peterson: The modern option is SaaS or Software as a Service. Software as a Service means that the vendor simply needs to turn on your practice, they do not need to add a server or even a virtual server and they do not have to add in their server farm. They simply turn you on, give you a user name/password. Software as a Service can be cost effective because the pricing tends to be as you use it. If you only see ten patients a day, you only pay for ten patients or ten visits a day.

Q: Not being affiliated with a particular vendor, do you find that carve-out uses are reasonable and that somebody with short funds can still manage things by not trying to be all things to all people with their software?

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Dr. Peterson: Yes. Comprehensive integrated occupational health information systems are complicated, expensive and challenging to use. In the last few years we have had a number of simple, clinically oriented systems emerge and they are more user friendly.

Dr. Stern: Users have to understand the technologies that are available. If you do not have a large center and you are short on funds you want to go with an online service.

Q: What is the most significant stealth issue in judging the potential cost-effectiveness of multiple options that you might have in terms of software?

Ms. Slocum: Ease of usability for all your users and support for the service you are purchasing. It is going to take your users more time to learn a new software that is going to cause patient and staff dissatisfaction?

Dr. Stern: User friendliness is tops. User friendliness by Black Book Rankings ranks occupational medicine. You can see how users feel about a software product at http://www.blackbookrankings.com/

Dr. Peterson: I would use a real estate analogy. It is not the price of the house. It is the cost after the renovation and after the move.

Q: What will the next generation of software look like? Will it address other avenues of workplace health and safety and, if so, which? What user enhancements might be available?

Ms. Slocum: Allowing the patient to register for appointments from home and schedule that time slot in an occupational medicine world. If they need to have an employer register them and let the clinic know that they are already on their way so that they are seen as soon as they walk into that clinic, that is key.

Dr. Stern: How about loading all of your DOT results automatically once you finish the physical and go straight to the record? That is a hassle for a lot of folks right now and that is going to disappear next year for some systems.

The employer needs to see where everything is going. In a Jetson's type future we are going to be interoperable with client's H.R. systems; if there was a standard where we could interact with their HR and their safety systems, that would be a holy grail for the employers.

Q: What is the most important across-the-board advice that you can give on this matter?

Dr. Peterson: Do not listen to the sales people and look at what was being demonstrated, talk with customers, talk with users, visit them, see how they are using it and make sure that their use is going to meet your needs.

Ms. Slocum: Understand what your software is able to do for you and make sure it lines up with your goals.

Dr. Stern: Make sure your software actually has the specific design components for occupational medicine and make sure the functionality you need is there.

Mr. Neville: Expect to spend more money because of training and other considerations. You are going to keep learning as you go through the process, so a mentor would be essential.

Dr. Burger: When it comes to the electronic health record, make sure the system will work for all the service lines you are going to deliver.

Ms. Gardner: Do a grid analysis of each vendor and set by criteria.

Make sure you talk with your IS department initially before you decide on a specific software so they (IT) can be a partner in your decision.

Dr. Fanucchi: Do not be afraid to push your software vendor if you need enhancements or modifications.

Mr. Schudy: Go slow to go fast. Meaning, do your due diligence, understand what your needs are, then validate that against what the offering is and determine if you have a good partnership with the company.

On-site Clinics, continued from page 9

services being provided from the on-site health center are in alignment with the company's healthcare strategies and goals," said Ms. Counts.

There should be a balance between standard procedures, necessary for maintaining appropriate quality and delivery, and customization for the client, said Dr. Vasquez.

Navigating the different client benefit plans and community access realities in an effort to appropriately drive utilization of the health center is another key challenge.

"We need to market appropriately within the client culture. We need to work with the client to create appropriate incentives for utilization. And we need to work within the medical community so we are seen as collaborative and not as a business threat," Dr. Vasquez said.

BRIGHT FUTURE

The consensus in the occupational health community is that on-site medical clinics will continue to grow in popularity and remain a key strategic tool for healthcare delivery moving forward.

"I really do see a bump over the next few years as large employers start to realize the benefits of having an on-site clinic," said Dr. Davis, adding that the money saved in decreased time away from work is "huge."

"It's an opportunity to provide a distinctive brand of care," Dr. Vasquez said. "Our approach is helping people and medicine move from a transactional approach to healthcare to a relational approach by engaging people where they are not only geographically at the work place, but also where they are in their healthcare journey."

Marketer as a Community Builder, Do-Gooder and Resource

DAN DUNLOP EXPLAINS THE DAYS OF SIMPLE STORY TELLING ARE GONE FOR GOOD

Marketing expert Dan Dunlop is not a fan of his industry's conventional tools, i.e., the radio jingle, the television spot, the mail circular. In a general session address at RYAN Associates' 29th Annual Conference in October, Mr. Dunlop said most of the time in marketing we're just spewing crap. "It's narcissistic. It's all about us," he said. Worse yet, it doesn't work.

The marketplace has transformed, he said. Today's consumer is plugged into multiple devices and exercises enormous control over where and how they get information: podcast, streaming radio, blog, newspaper website, twitter feed, Facebook, Instagram. The options seem just about endless and attention is highly fragmented. To connect with consumers, marketers must reorient their strategies, smarten up to new behaviors or be left behind.

What does smartening up mean? According to Mr. Dunlop, it means seeing marketing as a community-building endeavor, finding ways to offer value to your target audience, listening to them as opposed to persuading them to hear your message.

"When you're marketing today, you want to provide value, you want to ask 'What problem am I solving for [my target audience]?' I know it's hard to step out of your day-to-day life and ask these kinds of questions, but it's really important," Mr. Dunlop said.

As a principle at Jennings (http://jenningshealthcaremarketing.com/), a healthcare marketing firm based in North Carolina, (with clients such as Signature Healthcare, Tufts Medical Center and WorldCare International) Mr. Dunlop has been on the frontline of marketing's new era for some time. He's watched closely as social media transformed the communication landscape, turning marketing's tried and true tools into ineffective relics.

Now, instead of delivering a message, dialogue and sharing are key. As marketers in a new era, ask yourself "how can I bring people together?" Mr. Dunlop suggested. Think about providing platforms on which your customers can interact and talk about their experiences with your program. When consumers read feedback from your customers on a social media site like Facebook or LinkedIn, they will be more likely to accept it as authentic.

As an example of providing value to clients, Mr. Dunlop told conference attendees about the blog he created for healthcare executives. Because staying on top of all the trade information is often too time consuming for busy healthcare executives, Mr. Dunlop's blog provides summaries of important healthcare articles—as a service. In the process, he's telling clients, "I know you're busy. Let me be a resource for you."

The marketer's role is evolving, to be sure. Today, half of your job should be focused on creating spaces for online interaction, facilitating conversation, responding to client and consumer comments. "You want to be generous, not selfish. Be gracious. Thank people for commenting." Some of the places where such communities can be built include Ning, Twitter, blogs on your own website and Facebook. Your website doesn't have to be just an online brochure, he said. It can be interactive. You can create a blog and post three times a week, including videos. You can provide ways for readers to comment and offer feedback.

"Think of yourself as a community builder," Mr. Dunlop said. "If you do, you're going to be successful."

RYAN Associates' 29th Annual National Conference

Speaker Dan Dunlop.

Sue Stock, last year's recipient of the NAOHP's Professional Achievement Award, announces the 2016 winner, Robert Carlson.

In the classroom at RYAN Associates' National Conference on Providing Healthcare Services to Employers.

Lunch is served at the venerable Drake Hotel in Chicago.

Chimes are used to ring in the next session.

RYAN President and CEO Frank Leone, who has attended all 29 conferences.

Keynote speaker Pete Knox, executive vice president, Bellin Health.

Kay Campbell, AAOHN executive director.

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UCAOA serves over 9,000 urgent care centers. We provide education and information in clinical care and practice management, and publish the Journal of Urgent Care Medicine. Our two national conferences draw hundreds of urgent care leaders together each year.

Joanne Ray
Phone: (331) 472-3747
jray@ucaoa.org
www.ucaoa.org

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Patty Williams
Phone: (855) 849-2023
pwilliams@pressganey.com
www.pressganey.com

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Marketing Coordinator
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rgerber@naohp.com
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Lauren McElroy
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Calendar

January

JANUARY 25-29, 2016
Leadership Strategies for Information Health Technology in Healthcare
T.H. Chan School of Public Health
https://ecpe.sph.harvard.edu/

February

FEB. 1-3, 2016
Work, Health and Wellbeing: Integrating Wellness and Occupational Health and Safety in the Workplace
T.H. Chan School of Public Health
Harvard University • Boston, MA
https://ecpe.sph.harvard.edu/

FEB. 15-17, 2016
Expanding the Value Proposition for Workforce Health: Connecting All the Pieces
Integrated Benefits Institute
Annual Forum
Westin St. Francis • San Francisco, CA
https://ibiweb.org/

April

APRIL 7-9, 2016
Safety in Action: World Class Safety & Expertise
Gaylord Opryland Resort & Convention Center
DEKRA Insight
Nashville, TN
www.safetyinaction.com

APRIL 10-13, 2016
American College of Occupational and Environmental Medicine (ACOEM)
American Occupational Health Conference
Sheraton Chicago Hotel and Towers • Chicago, IL
http://www.acoem.org/AOHC.aspx

APRIL 11-14, 2016
American Association of Occupational Health Nurses
Jacksonville Riverfront
Jacksonville, FL
http://www.aaohn.org/about-us.html

May

MAY 2–6, 2016
Leadership Strategies for Information Technology in Healthcare (Part 2)
T.H. Chan School of Public Health
Harvard University • Boston, MA
https://ecpe.sph.harvard.edu/

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

Board Roster

NAOHP REGIONAL BOARD REPRESENTATIVES AND TERRITORIES

PRESIDENT
Mike Schmidt 2015-2017
Director of Operations
St. Luke's Occupational Health Services
Sioux City, IA
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NORTHEAST – DE, MD, ME, NH, VT, MA, RI, CT, NJ, NY, PA, DC, WV
Dr. Stewart Levy 2016-2018
President, Health Promotion Solutions
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slevy@healthpromotionsolutions.com

SOUTHEAST – AL, FL, GA, MS, NC, SC, TN, VA
Brenda Jacobsen, MBA, CPA 2015-2017
Chief Executive Officer
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GREAT LAKES - KY, MI, OH, WI
Randy Van Straten 2016-2018
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MIDWEST - IL, IN
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HEARTLAND – AR, IA, KS, LA, MN, MO, MT, NE, ND, OK, SD, TX
Jackie Burt 2016-2017
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WEST – AK, AZ, CA, CO, HI, ID, NM, NV, OR, UT, WA, WY
Marilyn Trinkle 2014-2016
Director - Business Development /
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AT LARGE
Rick Schneider 2015-2016
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AT LARGE
Mary Alice Ehrlich 2016-2017
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