New England College of Occupational and Environmental Medicine

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NECOEM *Reporter*

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NECOEM Announces a new venue for the 2009 Annual Conference

December 3 & 4, The Marriott Boston Newton

The Boston Newton Marriott at 2345 Comm. Ave in Newton is at the junction of Rts 95 and the MA Pike, guest room rates will be $105 and include high speed internet access, complementary parking and a beautiful venue overlooking the Charles River.

Save the Dates!

Solutions for the Future of OEM: A Value-Based Health Care Model

By Chunbai Zhang, MD

As the name implies, the field of Occupational and Environmental medicine (OEM) encompasses two entities: Occupational Medicine and Environmental Medicine. The former frequently demands knowledge for the delivery of health care at the work place; the latter provides scientific and medical evidence supporting the delivery. OEM has evolved a great deal since Alice Hamilton founded the field back in the 1920's. In the age of internet and nanotechnology, the two entities intertwine symbiotically. While most OEM professionals are familiar with the medical aspects of OEM, few have had exposure to the delivery side of the equation. Throughout my three-year internal medicine residency, and now in my OEM residency at Harvard, I have become increasingly aware of a void in my training on the *delivery* aspect of health care. This is a topic not typically taught at medical schools and residencies. Fortunately, I found a course

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The New ADA: Americans with Disabilities Amendments Act of 2008

By Tanya Robinson, SPHR, OEHN and Tom Winters, MD, FACOEM

Effective January 1, 2009, the new and updated Americans with Disabilities Amendment Act (ADAA) took effect. This legislation significantly broadens the federal definition of the "disabilities" that require accommodation under the Americans with Disabilities Act of 1990.

Americans with Disabilities Act of 1990

Title I of the Americans with Disabilities Act of 1990 prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training,

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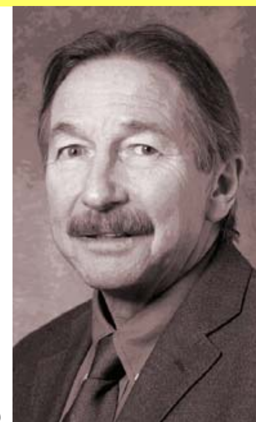

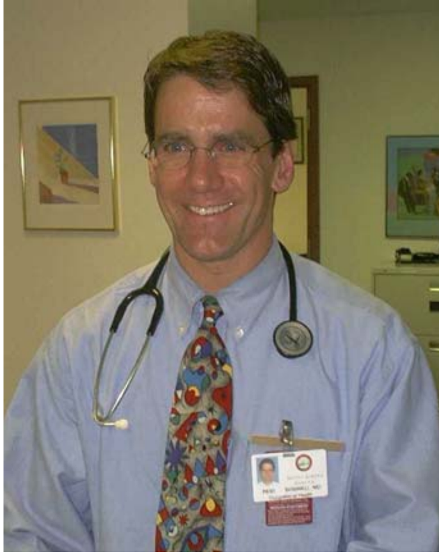

President's Column

It's an honor to be NECOEM's newest President, and I look forward to serving for the next couple of years. I would like to acknowledge Dr. Tom Gassert's superb leadership over the past 2 years and we wish him well.

NECOEM's annual conference was held at the Bedford Glen Hotel with the Massachusetts Association of Occupational Health Nurses on December 4th and 5th. Our attendance set a new record and by all accounts, it was an extremely successful event. Our thanks go to Dr. Scott Mirani for his efforts as program chair, and we are pleased that he has agreed to serve as chairman for the 2009 annual conference. There will be changes next year (for the good), including a new and larger venue to accommodate our growing audience.

The NECOEM Board continues to discuss the possibility of merging our component with the Occupational and Environmental Association of Connecticut (OEMAC). On our last teleconference with OEMAC officers, we discussed some of the details of how this would happen. Given the fact that NECOEM is officially a non-profit organization, we agreed that instead of creating a "new" component" (which would require us to go through the whole process of getting re-certified as a non-profit), most likely OEMAC would simply "join" NECOEM. However, discussions will be on-going and will depend to some extent on the feelings of OEMAC's general membership and their desire to remain independent.

On Tuesday, February 10th, the Massachusetts Division of Healthcare Finance and Policy held public hearings on proposed amendments to the Worker's Compensation Act which would increase reimbursement for primary evaluation and management of work related injuries and illnesses by 10-12%. Currently, Massachusetts has the lowest level of reimbursement for these services than any state in the country. Robert Neparstek, John Burress, Robert Swotinsky and I attended the hearings and gave oral testimony in favor of adopting the amendments. This has been a long time in coming and is the culmination of a lot of hard work by many of our Massachusetts members, including our past presidents Tom Gassert and John Burress, Robert Neparstek, and the late Bill Patterson. Thanks to all of you who helped make this happen!

Reid Boswell, MD, MPH

Testimony in Support of Increasing Medical Rates for Treatment Under Workers Compensation

by Marcy Goldstein-Gelb, Executive Director, MassCOSH

Doctors receive far less than most other states for treating patients with work-related injuries – and workers are suffering the consequences, according to more than a dozen doctors, labor representatives and MassCOSH staff who testified on February 10 before the state's Division of Health Care Finance and Policy. The state was seeking comments on proposed increases to reimbursement rates for physicians who care for patients through workers compensation.

"Let me tell you about the severely disabled worker who searched for weeks to find a doctor to treat his injured back through comp," Marcy Goldstein-Gelb, MassCOSH's executive director, told the panel. "He finally found a doctor 40 miles away, traveling from New Bedford to Brockton to obtain treatment."

The doctor who saw this patient, Dr. Robert Naparstek of Good Samaritan Occupational Health Center in Brockton, testified on behalf of the Massachusetts Medical Society (MMS). According to Naparstek, a recent survey

of MMS members found that for more than 90 percent of doctors

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***Solutions for OEM** (Continued from page 1)*

which teaches just that, at the Harvard Business School (HBS). The course, "Value-based Health Care Delivery," is a brainchild of HBS Professor Michael Porter, a giant in "competitive strategy." "Why 'value-based'?" one might ask. Here, I attempt to describe and critique some concepts and the logic behind them in the space below.

In order to fully comprehend the need to look at healthcare delivery from the perspective of creating "value," we must first refresh in our minds the current model of competition and the scope of problems in the US healthcare system. The United States spends 16% of its GDP on healthcare, yet 25% of the US population remains uninsured--both figures are the highest among the developed world. Clearly, spending more does not mean better quality of care! On the other hand, the classic HMOs in the 1990's pursued a universally applied strategy of cost-reduction, which meant more bureaucracy *and* lower quality of care. Patients complain of poor access to physicians, and of higher deductibles and co-payments. Physicians despise the insurmountable paper work demanded by the insurance. The insurance companies blame the pharmaceutical lobby for higher drug cost. The government points fingers at the insurance industry's intention for monopoly. All stakeholders involved seem to only focus on maximizing their own short-term gains, detaching themselves from each other and from patients, mistaking "lower cost" as "higher value". The business of health care delivery becomes a game of shifting cost, restricting service, and scraping for revenue. In other words, no net benefit comes out of this type of competition, or "zero-sum competition." At the end, patients suffer, and everyone loses. While many Americans grow increasingly cynical about HMO style insurance plans, few solutions are currently on the table.

Along with his co-authors, Porter offers a groundbreaking solution--or a foundation for a solution—which seems like common sense at first. He argues that every player involved in health care delivery must strive for a "positive-sum" competition. Meaning, rather than breaking down the delivery chain into truncated business entities, stakeholders seek to create "value" for patients. For example, the aim for this new kind of competition focuses on the full cycle of a medical condition rather than centering on a single procedure or symptom. The competition can be regional or even national, but not local. Furthermore, the competitors must also gauge themselves by measuring results. And such results, indicative of quality, must be widely available and comprehensible to the general public. Porter's delivery model places "patients" back at the center of discussion, seeks value in preventive care as well as innovative technology, encourages more transparency and affirms an integrated model of health care delivery. As the US begins to look at its health care delivery problems from the "value" perspective, OEM physicians must recognize that we are entering a new era of employer-based health care delivery and that we play a pivotal role in the "positive-sum" competition. OEM physicians need to appreciate the advantages our unique training affords us, and ACOEM must seize this opportunity to place OEM physicians at the center of this reform.

No stakeholder has as much vested interest in health care delivery to the US population as the employer. Employer health plans in the US cover 160 million, or 54% of the population. In comparison, Medicare covers only 14%, Medicaid and other public funds, 12%, with private insurance (non-group), only 5%. As of 2008, 60% of US employers offer health care to their employees, including nearly all employers with 200 employees or more. In addition, one-third of large employers also insure retirees and family dependents. Such a large coverage makes the employer a critical player of Michael Porter's new model of delivery.

For instance: a large employer commonly negotiates with different insurance groups through open bidding to create a "Self-funded Plan," or SFP, tailored to its own needs, making its employees the risk pool of the SFP. An employer is, therefore, both an insurer *and* a payer. This means it has the bargaining power over the insurance companies to push for a "value-based" health plan rather than a one-size-fit-all HMO-style cost-cutting plan.

Furthermore, the additional training in quality measure, epidemiology and public health sets OEM physicians apart from the other physician groups and situates us in a unique position to evaluate and promote an evidence-based, value-generating innovative health care delivery system. For example, many large employers already offer health promotion/wellness programs onsite, hoping to create greater "value" for their employees. Rather than the traditional model of targeting the extreme tail end of the bell curve for preventive care, which is often too little, too late, some employers have begun to broaden their preventive efforts to a larger employee base. In the process of creating "value" for the employees, those employers successfully reduce the expense of health care cost. It is a win-win situation. Some employers have also demonstrated that co-payment reduction in medications dispensed at the workplace can result in a higher medication adherence by their employees for

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***The New ADA** (Continued from page 1)*

and other terms, conditions, and privileges of employment. The ADA covers employers with 15 or more employees, including state and local governments. It also applies to employment agencies and labor organizations.
An individual with a disability is defined as a person who:
Has a physical or mental impairment that substantially limits one or more major life activities;
Has a record of such an impairment; or
Is regarded as having such an impairment.

A qualified employee or applicant with a disability is defined as an individual who, with or without reasonable accommodation, can perform the essential functions of the job in question. Reasonable accommodation may include, but is not limited to:

Making existing facilities used by employees readily accessible to and usable by persons with disabilities.

Job restructuring, modifying work schedules, reassignment to a vacant position;

Acquiring or modifying equipment or devices, adjusting or modifying examinations, training materials, or policies, and providing qualified readers or interpreters.

An employer is required to make a reasonable accommodation to the known disability of a qualified applicant or employee if it would not impose an "undue hardship" on the operation of the employer's business. Undue hardship is defined as an action requiring significant difficulty or expense when considered in light of factors such as an employer's size, financial resources, and the nature and structure of its operation.
An employer is not required to lower quality or production standards to make an accommodation; nor is an employer obligated to provide personal use items such as glasses or hearing aids.
Title I of the ADA also covers:

Medical Examinations and Inquiries

Employers may not ask job applicants about the existence, nature, or severity of a disability. Applicants may be asked about their ability to perform specific job functions. A job offer may be conditioned on the results of a medical examination, but only if the examination is required for all entering employees in similar jobs. Medical examinations of employees must be job related and consistent with the employer's business needs.

Drug and Alcohol Abuse

Employees and applicants currently engaging in the illegal use of drugs are not covered by the ADA when an employer acts on the basis of such use. Tests for illegal drugs are not subject to the ADA's restrictions on medical examinations. Employers may hold illegal drug users and alcoholics to the same performance standards as other employees.
It is also unlawful to retaliate against an individual for opposing employment practices that discriminate based on disability or for filing a discrimination charge, testifying, or participating in any way in an investigation, proceeding, or litigation under the ADA.

ADAA Expands Terms of ADA's Coverage

The ADAA expands the interpretation of several key terms of the ADA's coverage which has been narrowly construed by case law since the law was enacted in 1990.

New Definition for "Substantially Limits"

Over the years, tort law (Toyota Motor Manufacturing v. Williams, 2002) and the Equal Employment Opportunity Commission (EEOC) have defined an impairment as a disability under the ADA if it substantially limits, prevents or significantly restricts one or more major life activities. The amendment rejects this interpretation and mandates the interpretation of the term: "substantially limits" in a manner that encompasses a broader scope of protection for individuals. This action will make it easier for an individual to prove that an impairment qualifies as a ADA disability.

ADA Broadens Major Life Activities

The ADAA broadens the definition of a "major life activity," specifically describing it to include, without limitation, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction.
By broadening the definition of major life activity, the amendment makes protection under the ADA available to a larger group of employees, as a wider range of physical and mental impairments will now meet this definition.

Mitigating Measures

The ADAA will prohibit consideration of any mitigating measures, other than "ordinary eye glasses or contact lenses," when determining whether an impairment is "substantially limiting." Mitigating measures such as hearing aids and medications cannot be considered when determining if someone has an ADA-recognized disability. Again this broadens the scope of employees that can be protected under the ADA.

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Solutions for OEM *(Continued from page 3)*
chronic diseases such as diabetes and hypertension, potentially reducing future medical complications.

In addition to the common health care costs described above, which result mainly from workers' compensation expenses and absenteeism, the *indirect* cost of poor health and low morale in the workplace, or "presenteeism", can be as much as two to three times more expensive for large employers. An increasing number of employers are now using HRA, or Health Record Assessment, to describe an aggregate health profile of their employees: chronic disease, mental health as well as high-impact-low-profile symptoms (i.e. migraine, asthma and flu). Some onsite clinics are serving as a platform for innovative preventive care delivery--both traditional and alternative. Other large IT firms have even tested their latest technologies in creating a first-class electronic medical record (EMR) for the employees or a high-tech integrated employee primary care center as a showcase. A recently published study also suggests that environmental changes to the workplace can achieve modest improvement in employee's health risks such as obesity and BMI measures. More creative ways to add value to employees are on the table. As the nature of our economy evolves, the ways with which OEM physicians deliver health care at the workplace can transform it accordingly.

Clearly, Porter's proposal for a value-based care delivery serves more as an inspirational calling rather than a concrete roadmap. Many questions remain, particular pertaining to its assumptions and the execution. One of the obvious theoretical questions is "value to whom?" Unlike other commodities, high quality health care does not seem to have a clear price tag. The price only caps at what the consumers want, and often time what the consumers want is not what they need. So, can consumers/patients become educated decision makers, however personally interested they may be? As we all know, not all consumers are rational. For example, would advertising the excellence of the hospital's food attract more customers than advertising the hospital's high standards of care? How to measure "quality" is yet another challenge. Most of the current metrics measure process, not outcome. Some also worry that certain outcome measures are too long a cycle to measure--not instant enough to catch up with the fast-changing technological innovations that alter the standards of care.

Administratively, OEM physicians face yet another potential obstacle: they traditionally serve under the HR department of a large employer. Such structure hinders execution of value-based innovations because it often conflicts with the cost-cutting framework under which HR and employee benefit departments operate. Successful corporate health care delivery models seem to have been achievable only after gaining the whole-hearted support from the corporate boards. Therefore, OEM physicians, and ACOEM as a professional group, need to educate the CEO-level decision-makers to buy into the plan, and also understand the unique nature of employee health care delivery from the "value" perspective. The current reimbursement model, which incentivizes more procedures as well as highly complex procedures, must also change in order to support the delivery of a "value-based" health care. Medical school education and residency training need to catch up with the concept and integrate health care delivery into the standard curriculum.

Great potential challenges lie ahead on the road to "value-based" health care delivery. Many players involved may still instinctively withdraw to their old comfortable mentality of "zero-sum competition" whenever problems rise. Yet, only with a concerted effort can such a movement galvanize a significant momentum. Employer and OEM physicians need to recognize the urgency for change in the current health care system, as well as the excitement for their whole new roles in the value-based delivery model. We ought to take the lead at this critical junction of the value-based reform, and seize the opportunity, once and for all.

*About the Author: **Chunbai Zhang M.D.** is a graduate of Haverford College and Dartmouth Medical School. After completing an internal medicine residency at Tufts, he is currently a first year resident in OEM Residency program at Harvard. Chunbai is a recipient of the OPSF scholarship and an MPH candidate at Harvard School of Public Health. He also serves as a resident tutor in medicine at Adams House, Harvard College.* Dr. Zhang can be contacted at
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Rhode Island Comings and Goings. Dana Sparhawk, MD, MPH has moved from Concentra to Lifespan. Dr. Sparhawk was the first physician hired by a nascent Occupational Health + Rehabilitation Inc. to run its flagship office in Pawtucket, RI. OH+R eventually became a leading provider of occupational health services in New England, the mid-Atlantic and elsewhere. It was purchased in 2005 by Concentra.

Dr. Sparhawk is a clinical physician in Lifespan's expanding Occupational Health Services program. Lifespan is the product of mergers of four hospitals in Rhode Island and has 19,000 insured lives in its self-insured health plan.

He joins Dr. Philip Parks. Dr. Parks graduated from Tulane University School of Medicine, completed his Masters in Occupational Health at Harvard in 2007 and his residency in Occupational & Environmental Medicine in 2008. Dr. Parks is the Medical Director for Lifespan Health and Occupational Health Services. Drs. Parks and Spawhawk's practice focuses on Medical Center Occupational Health and Lifespan has recently begun offering onsite episodic care for employees.

At a presentation in October 2008 Steven G. McCloy MD joined with Attorney Gary Levine to discuss CAUSATION as a medical and legal challenge. Several NECOEM members provided cases that were blended into the presentation. The Powerpoint® slides can be downloaded from the Donley website. Dr. McCloy is the medical director of AXIOM Occupational Health and a former member of the NECOEM board.

The John E Donley Center is a division of the RI Department of Labor and Training. http://www.dlt.state.ri.us/donley/ It is an outpatient facility for the treatment of work related injury. In addition to its wide variety of creative programs in rehabilitation, Donley offers periodic seminars to clinicians, attorneys, insurers and judges associated with the injured worker.

The New ADA *(Continued from page 4)*

"Regarded" as Having a Disability

The ADAA provides that an individual can meet the requirement of being "regarded" as having a disability if they have been subjected to an unlawful employment action because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity. For example, if an employee is fired because they are perceived to have an impairment, the employee meets the requirement of being regarded as having a disability under the amendment.

Episodic Impairments

The ADAA clarifies the law surrounding episodic impairment to state if an employee has an impairment that when active would substantially limit a major life activity, they have a protected disability under the ADA, even if in remission or when not suffering from an episode. Examples include multiple sclerosis, epilepsy or cancer.

Summary

In summary, under the amendment more employees will fit within the definition of disabled, either by a mental of physical impairment and in turn more employers will be required to make reasonable accommodations. Steps employers should consider to minimize complaints and legal action include

Revising policies related to the ADA;

Establishing procedures for responding to requests for reasonable accommodations;

Revising medical certification forms;

Ensuring job descriptions spell out essential job functions;

Training supervisors and managers on the new law;

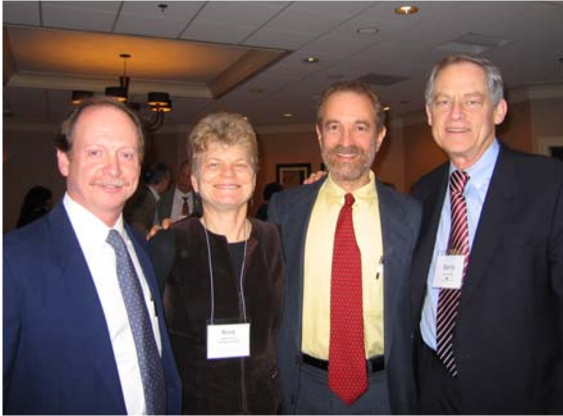
Consider including disability within diversity training, for all employees.

About the authors:

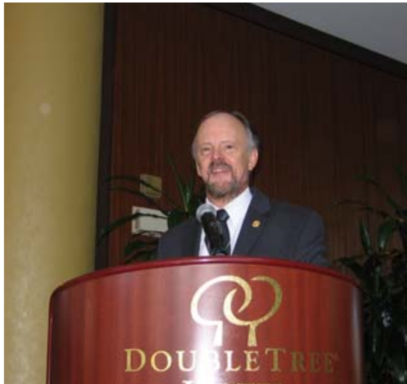
Tanya Robinson has been with Occupational and Environmental Health Network (OEHN) located in Marlborough, MA since 2006. She works collaboratively with OEHN Senior Management and Program Managers in Employee Health across New England to deliver Client Relations and Account Management initiatives. Tanya is a graduate of Babson College and recently earned her designation as SPHR (Senior Professional Human Resources).

Thomas H. Winters MD, FACOEM, FACPM, is the Medical Chief of the Occupational & Environmental Health Network (OEHN) and the New England Baptist Hospital Occupational Medicine Center. He is currently a visiting lecturer at Harvard Medical School. Dr. Winters has over 25 years experience in occupational and environmental medicine. Dr. Winters was recently recognized by the Occupational & Environmental Medicine Residency Program at the Harvard School of Public Health (HSPH) as the "Clinical Professor of the Year" for 2007-2008.

NECOEM/MaAOHN Annual Conference 2008



Friends congratulating Howard Frumkin, the Harriet Hardy Awardee (from left to right: Tom Gassert, Rose Goldman, Howard Frumkin, Barry Levy)



ACOEM President, Bob Orford addressing the NECOEM Annual Membership Meeting

NECOEM President Reid Boswell congratulates the Moore Medical Scholarship recipient, Neil Haas.

Calling all writers!!

As the new editor for the NECOEM Reporter, I would like to take this opportunity to introduce myself. My name is Abe Timmons, and I am a medical director at Occupational & Environmental Health Network in Marlborough, MA. I recently returned to the Boston area after completing my active duty service commitment in the Air Force. Prior to my time in the Air Force I completed the Occupational Medicine Residency at the Harvard School of Public Health. It is a real thrill to be home in New England once again, and an honor to have been selected as the new editor for the Reporter.

I recently received feedback from past editors regarding suggested content, and have several ideas of my own. However, I wanted to take a moment to solicit from the members and readers out there any ideas or articles you might have to share with us. If you or any colleagues you know have any articles written, ideas for articles, case reports, interesting news, or just a burning desire to get something into print, please don't hesitate to contact us by email or phone at:

Email: NECOEM@comcast.net
Phone: 978-373-5597

Thank you in advance for your ideas and submissions, and I look forward to seeing you at the upcoming dinner meetings and the 2009 Annual Conference.

Abe Timmons, DO, MPH

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NECOEM

NECOEM is a not-for-profit, regional component society of the American College of Occupational and Environmental Medicine, the pre-eminent organization of occupational and environmental physicians, associate and affiliate clinicians.

NECOEM has 200 physician, associate and affiliate members and is dedicated to preventing and treating occupational injuries and illnesses. NECOEM provides continuing medical education for its members and other clinicians in order to enhance the care that they provide to men and women in the workplace. NECOEM is an advocate for workplace safety, occupational health research, raising public awareness of occupational and environmental health issues, providing guidance on public health policy, and recognizing outstanding achievement by individuals in occupational and environmental health.

The editorial board welcomes letters to the editor. Write or email to NECOEM at the above address. The editor reserves the right to edit letters for publication purposes.

WC Rates *(Continued from page 2)*

who no longer accept workers compensation, "denial of reimbursement, low reimbursement, and excessive paperwork [were] important or very important in their determination about whether or not to accept worker's compensation patients."

According to the testimonials, delays in treatment are costly – it means that what might have been a minor injury can become a serious potentially crippling injury. Most often it means that workers won't end up receiving treatment through workers compensation at all, instead turning to their private insurance or, more often, the state.

"And for the workers we work with – many of whom are very low income – that sometimes means inadequate treatment, once more putting workers at risk of worsening their injury," said Goldstein-Gelb.

A 2002 report by the non profit Workers Compensation Research Institute based in Cambridge found that the average Medicare fees in Massachusetts were 13 percent higher than the median rate for Medicare nationally. By contrast, the Massachusetts workers' compensation fee schedule was 26 percent lower than the median state. This disparity between medical fee levels and provider costs, they warned, raises concerns that states may be creating incentives to under-utilize medical services in their workers' compensation systems.

"How many ... days out of work are spent waiting for the insurance company to find a physician willing to accept the paltry payments provided in Massachusetts to provide care?" asked Evie Bain of the Massachusetts Nurses Association. "No one really knows. This board has an opportunity ... to improve compensation rates to doctors, nurse practitioners and others who provide restorative care for injured workers."