

# NECOEM Reporter

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### Events:

#### September 30

##### Dinner Meeting:

**“Challenges to Finding Solutions to the Health and Productivity Problem: Depression in the Workplace”**

#### December 3 & 4

##### NECOEM/MaAOHN 2009 Annual Conference

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**Save the Dates!**

## Citizen Ambassador Occupational and Environmental Medicine Delegation to China

By Dr. Robert K. McLellan and Dr. Robert Naparstek

From December 5, through December 15, 2008, a professional delegation of Occupational and Environmental Health clinicians had the pleasure of traveling to China together. The journey provided participants an unparalleled opportunity to meet with our professional counterparts to explore universal, critical components of protecting and promoting the health of workers including occupational health and safety regulation, epidemiologic surveillance systems,

occupational health research, systems of providing and financing health care to workers, labor rights, disaster preparedness, consumer and envi-

ronmental health issues.

The delegation achieved its overall mission of an intense, meaningful professional exchange combined with cultural activities that unquestionably furthered a deeper understanding and appreciation of Chinese and American participants for each other’s professional accomplishments and native culture. **Perhaps the most important take-home lesson for the state of occupational**

*(Continued on page 2)*



## Wellness in the Workplace:

### Why Bother?

By Dr. Larry Catlett

“Sick” care costs in the US may represent the difference between economic recovery and stability, and economic stagnation. We are now spending greater than 2/3 of what China claims as a GDP on health care each year, and the growth curve is beginning to take on logarithmic

characteristics. Much of this is due to the failure of the claims management model to significantly decrease “sick” care cost escalation. American business has been under the assault of a true pandemic of my own naming- Toxic Medical Premium Escalation Syndrome Complicated by Claims Management Fail-

ure. While adequate for dealing with the costs of acute or episodic illness, claims management as a strategy is not effective against the rising epidemic of chronic disease attributable in large part to the increasingly unhealthy

*(Continued on page 4)*

*OEM Delegation (Continued from page 1)*

**medicine in China was that its focus is tertiary prevention ... the treatment and rehabilitation of the sick and injured worker.** We were shocked to learn that large Chinese hospitals exist which specializes in the inpatient care of workers suffering from severe occupational diseases and injuries. **Most likely, the most common of the ailments treated in these facilities has been severe mercury poisoning treated with intravenous chelation. Common conditions include toxic neuropathies such as manganism; heavy metal poisoning; pneumoconioses and asthma.**

On the other hand, we amused our Chinese colleagues when we told them that the most costly and prevalent occupational health problem in the US is low back pain. Chinese society considers low back pain and cumulative trauma disorders as conditions of living and aging, not as occupational health problems. As in the US, China considers work-related health problems as either injuries or disease. The Chinese maintain a list of 107 Occupational Diseases last updated in 1987. Any disease not on this list is generally not considered work-related for purposes of compensation.

However, the condition may in some cases be considered an injury (e.g. a needle stick) and nonetheless be compensated. Other striking lessons for the US delegation were:

- Contemporary Chinese occupational health laws (many new since 2000) resemble those of the US in many ways; however they remain lofty ideals, without many detailed rules. Most importantly our professional hosts uniformly reported that they are poorly enforced. There are few inspectors

for a very large country with countless business establishments. Enforcement and occupational health and safety practices differ with the economic sector: State-owned enterprises and large multinational corporate businesses tend to have much better occupational health programs than the foreign investment enterprises and myriad of small, local township and village enterprises. Delegates recognize similar problems with enforcement in several economic sectors in the US as well.

- The ratio of physicians to nurses is dramatically different from the US and there are no physician extenders. For example in the No. 5 People's Hospital in Guiyang, there were 72 physicians and a total of 260 staff.
- There is no special training program for occupational health nursing; occupational health nurses learn on the job.
- Duty hours for Chinese house officers are capped at 48 hours a week. Occupational disease hospitals integrate traditional Chinese medicine



with Western medical interventions. Sophisticated industrial and environmental hygiene labs and consulting services, such as the Beijing Municipality



pal Institute of Labor Protection exist, but are not widely employed in China. Little workplace air monitoring is performed. Although our Chinese colleagues share the same hierarchy of industrial hygiene controls as ours, they expressed the opinion that workers' unmet training needs combined with their general disregard for correct use of personal protective equipment and proper work practice play a big role in occupational exposures. They note that the wide range of languages and dialects along with the staffing of industry with workers fresh from rural villages tremendously complicates training.

The American delegation compared these problems to those in our own home states and noted the amount of undocumented immigrants, contract employees, and other vulnerable labor segments that exist in our country. We also noted that there is no national health insurance in China and most of the elderly rely on their own families for support. Ironically, the "one birth" policy is eroding this cultural tradition. Young Chinese are more often choos-

*(Continued on page 3)*

(Continued from page 2)

ing not to live with their parents.

Our delegation also noted several parallels in the practice of occupational medicine in our respective countries:

Few physicians practice occupational medicine; it exists as an underappreciated specialty

Enforcement of occupational health regulations is hampered by few inspectors and is difficult to extend to smaller employers because of their sheer number.

Under-reporting of occupational disease is pervasive

Workers compensation laws share similar basic benefits:

Medical care

Wage replacement

Impairment rating

Vocational rehabilitation

Death benefits

Cultural programs greatly enhanced the value of the professional meetings. These programs, with the interpretations offered by our guides, provided the context to better understand the value of the worker and the place of occupational and environmental health in Chinese society. These activities also greatly extended the depth of our appreciation for the complexities and origins of modern China.

Another visit included the Occupational Disease Department of Beijing University, Third Hospital. Our delegation toured the hospital starting with the VIP ward for families that could afford the approximate \$1,000 per day price. Medical students and nurses were interviewed. The nurses noted that the typical inpatient staffing was one nurse to

two patients. We then engaged in an active discussion of OEM issues with four professors of the hospital. (We were treated to unlimited amounts of loose tea, so that throughout the discussion, the members of the American delegation were required to constantly remove tea grounds from their mouths!) In that discussion, the tragedy of melamine poisoning was brought up as well as causation analysis and challenges in the American



system. We asked our Chinese counterparts about their approach to new occupational diseases and how they handled sentinel cases. They reported that their records showed approximately 10,000 cases of pneumoconiosis annually, with tuberculosis being common.

The American OEM delegation also visited the Beijing Municipal Institute of Labor Protection, where a large billboard electronically welcomed us by stating "Welcome people to people, occupational and environmental health delegation." Dr. McClellan presented a brief overview of OEM from the American perspective and got a good laugh (via translation) when he noted, "it was somewhat easier to protect a duck than a worker from harm." We toured the laboratory that contained state-of-the-art equipment, although none of the machines were in operation at the time.

In the end, the delegation recognized the almost overwhelming challenge of protecting the workforce and community health of a rapidly industrializing country of over a billion people. While it is tempting to think that the practice and success of occupational health and safety in the United States is far advanced compared to China, a moment's reflection reveals that it is only since 1970 that our country has had comprehensive occupational and environmental health regulation.

And, as much as a third of the current US workforce is outside of the scope of OSHA regulations.

As a final note, something must be said of our group's amazing visit to the ancient Forbidden City in Beijing. Dr. Steve

McCloy of Pawtucket, Rhode Island, aptly summarized our trip to the Forbidden City in Beijing. He quoted a poem entitled "Purple Forbidden City," by Zijin Cheng: "Tell me what you see beyond the colors, the silks, the fine woods, the marble carvings, the five bridges, the curved roofs, the gable carvings, what do you see? Do you hear the falling trees of Vietnam and Cambodia? They fell to build me. Do you hear miner's moans, buried forever in the earth that yields me its golden jewels? Do you hear the echoes of Marco Polo's boots on my floors? Do you hear the frantic drawing of water from my cauldron to staunch yet another cooking fire? Can you feel my old bones and sinews? I am the Forbidden City."



*Wellness (Continued from page 1)*

western lifestyle and its attendant at-risk health behaviors.

This is a critical time in the maturation of wellness as a meaningful healthcare intervention. Fortunately, the new paradigm in healthcare – claims prevention replacing claims management as the predominant cost control effort – is beginning to be accepted in the place where it truly matters: American business. Even in the midst of this economic downturn, companies are looking for solutions to the burden of healthcare costs. Insurers, brokers, healthcare institutions, and even governments are rushing to subsidize or adopt programs and interventions for their market in response to the demand. For these reasons, now more than ever, it is extremely important that we get it right. Grabbing a wellness program from a vendor menu without critical evaluation may lead to the unwarranted rejection of wellness as a tool to improve quality of life, decrease medical expenditures, and improve productivity.

Most current wellness initiatives fit into three distinct categories: **health awareness**, **health education** and **health behavior change**. **Health awareness** initiatives are generally limited to short term events such as health fairs, biometric screening events, “biggest loser programs”, walkathons, or fresh fruit by the coffee machine. **Health education** initiatives may include a Health Risk Appraisal (HRA) offering a follow-up about the discovered health risks. They may also provide event-based forums on blood pressure, obesity, smoking, or better eating habits. These programs often include the event-based activities of the health awareness initiatives and education-based health coaching efforts. These initiatives are well-intentioned, but, according to the Wellness Councils

of America, result in little significant population effect (defined by Dr. Dee Edington at the University of Michigan as 70-80% sustained long term program participation, substantial decreases in at risk health behaviors, movement toward a 0 trend in cost escalation and ultimately the capture and maintenance of 70% of the population into the low cost risk category) on at-risk health behaviors and medical, pharmacy or lost productivity costs – the outcomes the CEO is looking for.

So how do we make the CEO happy? **Health Behavior Change** as the primary strategy is the remaining alternative. Such interventions are based on the fact that real change occurs one person at a time. What do health behavior change interventions look like? They are not about experts divulging their knowledge to non-experts in the hope that change will then be inevitable. Health education interventions rely on the principle that once a person knows what he or she can and should do, that person will choose to do what is “best.” Anybody would, right? It turns out that people will do exactly what they *perceive* is right for them – but they view what is “right” in terms of their own values, perceptions, experience and environment. As a result, there often remains a significant difference of opinion between the expert and the participant about just what is best – about what should be and can be done, and why. Health behavior change interventions are focused not on educating about what “right” thing should be done or can be done, but rather on what drives participants to keep *doing* the “wrong” things. Behavior change coaching helps participants develop acceptable alternative behaviors that, by reflecting the participants’ values and experience, can be sustained comfortably over time. Successful health behavior change interventions stress **collabora-**

**tion** instead of confrontation, **evoking** importance of change **from** the participant rather than educating and assuming importance will follow; and encouraging **autonomy** rather than relying on authority throughout the change process. People change because they come to believe they should, they think they can, and nothing else is a higher priority at the time. In short, people change because they become motivated from within.

An individualized health behavior change intervention using health coaches trained in a technique such as Motivational Interviewing is designed to guide participants in this process. Such a program invites cooperation because the intervention is always about the *participant*, not the *program*. People look forward to coming back and continuing to work with a non-judgmental health coach at their own pace, on issues that they are most interested in changing. These interventions are best delivered one-on-one to maximize individual change, and should be conducted on-site, in person, and on a continuous basis. Sustained healthy behavior, much like safe behavior – in individuals and in the culture – requires intense, sustained effort. And what better place to conduct such an intervention than the workplace?

The health coach is really a mirror that reflects what he/she learns about the participants’ perceptions, values, goals, life experiences, cultural influences, and capacity for self-direction to help enhance the participants’ value of, confidence in, and readiness for change in behavior. The arguments for change are the clients’ personal arguments rather than the rational health reasons experts promote. The coaches’ job is not to change the participants’ behavior, but to help the participant decide to change for their own reasons. Active listening, or evaluating the essential

meaning of what the participants say as well as the use of guiding skills (the directive component of this sort of counselor interaction) are essential to success. When done well, the client provides all the reasons required for change, obviating the usual defense of taking the other side of an ambivalently perceived issue.

Health behavior change interventions, at less than 2%-3% of the cost of “sick care” premiums, and designed to specifically achieve the outcomes of individual health behavior change and a subsequent decreasing “sick care” spending, should be part of any effort to control the health care crisis. Even patient-centered health plans such as HSA’s and HRA’s have demonstrated limits to their ability to control costs. Prevention of the progression of our population toward chronic disease must be halted to achieve lasting control of the problems confronting the health care system today.

**The following interview exemplifies the technique we have found to be most successful.**

Health Coach: Welcome. So you are new to the program. Can you tell me what you know about Wellness Works?

Patient: (*Leaning back, arms crossed with stern, challenging facial expression*) Well, I can tell you one thing. I think the idea is great for everybody else. The company is good to do this, but I eat right, I’m not overweight and I exercise almost everyday. I smoke a little but my grandfather smokes and he’s 86 now and doing great. I just don’t need this for myself. I don’t see how it can help me. (*resistance to change*)

HC: “*Wow, you are really doing some good things for your health aren’t you?*”

P: What?

HC: You’re eating right and exercising. Sounds good to me! (*active listening/collaborating*)

P: Yeah, but I smoke!

HC: Are you concerned about that? (*evoking*)

P: Well, most people say you shouldn’t.

HC: Why? (*asking*)

P: Well, they say it causes cancer and will give you a heart attack.

HC: What do you think? (*asking, evoking*)

P: Well, it can’t be that good for you I guess, but I don’t know what I’d do if I couldn’t smoke. It relaxes me and gives me a little time for myself.

HC: You may have concerns about smoking and your health but the positives about smoking are very important to you. (*active listening*)

P: Yeah. That’s right.

HC: What are some other positives for you about smoking? (*asking/elaborating*)

P: Well... uh, I can’t think of many. It stinks and makes my grandkids sick according to my wife. It sure costs a lot and I often wonder what I could do with the extra money.

HC: But still, smoking is something you don’t think you could give up, even though it’s affecting your grandkids and is really expensive. (*active listening/guiding*)

P: I don’t know. I really hate it. If I could figure out some equally good ways to relax I might try. I know I just use it for a crutch. I did stop once for 6 months.

HC: Could you quit again if you had better ways to handle stress? (*asking/guiding*)

P: Sure, but that’s the catch isn’t it?

HC: It seems to be with most people. Given the fact that you use it for a stress reliever, is it at all important for you to quit now? (*informing/asking*)

P: It is and it isn’t, I guess.

HC: Rank importance on a scale of 1-10. (*scaling client importance*)

P: Maybe 6 or 7. I really don’t want to get stuck on oxygen some day.

HC: Oxygen? (*active listening/guiding*)

P: Yeah. A couple of the older guys here at work have to tote a bottle around with them. They don’t look very good either. I’m not interested in that life.

HC: So your health and the quality of your life is really important to you and smoking is just going to make you wind up like them. (*active listening/guiding*)

P: Yeah, maybe you are right.

HC: Let’s play another game. You are the HC and I smoke, and you need to convince me to quit! What would you tell me? (*enhancing importance/guiding*)

P: Well your house and clothes stink, you waste enough money to pay for a Harley when you smoke and you might get lung cancer. What more would you have to know?

HC: You tell me.

P: Your family might leave you alone if you quit and you wouldn’t feel so much like you were letting them down. Your daughter would let you take the grandkids more and your wife wouldn’t turn away every time you spoke to her.

HC: So smoking is a waste of money, its keeping you from that Harley you always wanted, it sickens and alienates your family, and it may make you sick enough to wind up on oxygen.

(*mirror,mirror...*)

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## From Massachusetts:



### Workers' Compensation Rates to increase in Massachusetts

As of April 1, 2009, Workers Compensation rates will go up in the state of Massachusetts. The Massachusetts Division of Healthcare Finance and Policy approved an average 9% rate increase to the compensation rate paid to healthcare providers in Massachusetts.

*Note from Robert Naparstek who represented NECOEM (as a member), DIA (Healthcare Services Board), Mass Med Society (Comm on Env and Occ Health) and MassCosh (member):*

I would also like to see that the effort to increase rates is intended to support the access to care for injured workers. Additionally, that all members should be active in supporting the creation of a permanent structure to adjust rates. If interested, call Mr. Andrew Burton, executive director of the DIA Advisory Council at 617 727 4900 (ext 379).

### New UR Guidelines for Knee from Mass HCSB

A consensus group for the Department of Industrial Accidents' (DIA) Health Care Services Board (HCSB), the Board charged with the development of treatment guidelines for the appropriate and necessary treatment of Massachusetts' injured/ill workers, has revised the guideline for the conservative care of knee injuries (MA HCSB Guideline 14). The new guideline was effective as of January 29, 2009. The consensus group was chaired by Dr. Robert Naparstek, MD, a past president of NECOEM.

One of the major revisions is that

MRI/CT may be indicated at any time if any of the following: instability during any diagnostic maneuver during physical exam; palpable and reproducible click during physical exam maneuver; joint locking (intermittent or sustained); joint giving way; acute trauma or fracture resulting in immediate effusion; delayed recovery, i.e. recovery not meeting medical expectation by 4 weeks. Another change in the revised guideline is the inclusion of ergonomic assessments, which if indicated, makes it more likely to be covered by insurers.

These treatment guidelines or practice algorithms were developed and implemented in the early 1990's, and many have not been updated since development. The original guidelines were derived from multiple sources including, but not limited to, the American Academy of Orthopedic Surgeons, the state of Washington, Department of Labor and Industries and multi-disciplinary committees of the Health Care Services Board. UR reviewers in Massachusetts are required to reference these guidelines when applicable, before proceeding to secondary sources. For more information, please visit the website for the Executive Office for Labor and Workforce Development (EOLWD) of <http://www.mass.gov>.

**The American Association of Occupational Health Nurses, Inc.**, as the primary association for the largest group of health care professionals serving the workforce, is committed to healthy and safe work and community environments. Each year AAOHN honors outstanding individuals, businesses and chapters for excellence in activities that promote, advance, guide and protect the occupational and environmental health nursing profession. **Congratulations to the Massachusetts Association of**

## Occupational Health Nurses for being chosen the 2009 Chapter of the Year!



Terry Donahue, President of Massachusetts AOHN accepts the 2009 AAOHN Award

**Occupational Medical Consulting, LLC**, urges you to familiarize yourself with Sen. Tom Harkins' bill, S. 1753 as proposed under **The Healthy Workforce Act**. Under this bill, employers would be awarded a tax credit of 50% of the cost of a "bona fide" wellness program up to \$200 dollars for the first 200 participants and up to \$100 for the remainder of the employee population. The bill requires a health behavior change component be present to qualify. We urge you to contact your legislative representatives in support of this bill. More information at this website.

<http://www.thomas.gov/cgi-bin/bdquery/z?d110:SN01753:@@L&summ2=m&>

Also see ACOEM email from June 2 and [www.acoem.org](http://www.acoem.org) for news about ACOEM's "Healthy Workforce Now" advocacy initiative, which ACOEM has launched in Washington, D.C. ACOEM is working vigorously for new federal policies that will make preventive health in the workplace a much higher priority than it has ever been.

## Traditional Patients and Alternative Medicine: A Growing Trend

By Abe Timmons, D.O., MPH

A patient schedules a check-up with his doctor to discuss some possible health concerns. The patient has recently retired from a high-powered executive career and is greatly looking forward to spending more time with his family. In recent years, the patient has suffered the losses of several close friends, all male and all under 70, from sudden cardiac death, cancer and stroke. The doctor has known the patient for many years and knows him to be conservative in his values, politics, and religious beliefs. Imagine the doctor's surprise when the patient brings with him to the appointment a referral for chelation therapy from a natural health center, despite having no history or symptoms of metals toxicity! In addition, the patient expresses his desire to go off his cholesterol medication on the advice of a friend, who has convinced him that the potential side effects outweigh the proposed benefits of the medication. The patient wants to use natural red yeast rice instead.

This patient's attitude represents a growing trend in our aging population. The use of alternative medical remedies is on the rise among patients who do not fit the traditional mold of patients seeking herbal, "all-natural," or holistic medical practices. To find the reasons for this trend, we must ask what alternative medicine offers that traditional medicine does not. Ask people what they dislike about receiving regular medical care and many will answer that they don't know their doctor, couldn't choose their doctor, have difficulty getting timely appointments, or (the big one) never have enough time to speak with the doctor once they do get in for an appointment. The insurance forms are incomprehensible, the hospitals bewildering, the prescriptions and referral processes complicated and confusing. In fact, most patients' chief complaint is *not* pertaining to the state of their actual health, which despite our complicated healthcare system, is still better maintained than most

people in the world; but about the *experience of receiving* healthcare.

In this sense, traditional medicine cannot compete with alternative healthcare practitioners. Because they are paid in cash and don't have to deal with health insurance, alternative practitioners offer patients something the bureaucratic American healthcare system cannot: a semblance of control over one's healthcare choices, better access, and an overall more pleasant experience.

Patients can walk into a health food store and buy most any remedies they want without needing prescriptions. They can easily and quickly make appointments for an endless variety of services with no wait or hassle from their insurance company. Aging patients anxious to have more control over their health are looking for additional steps they can take other than recommendations from their annual doctor visit or their regular visits for ongoing concerns. Once they enter the alternative system, the choice seems clear: here are more options, much more easily obtained, from which patients can pick or choose at will.

Given this reality, the role of the traditional doctor is to educate their patients as thoroughly as possible when they do return for regular office visits. Patients are often under the mistaken impression that because a substance or procedure is labeled "natural," "herbal," or "holistic," it is completely safe. At the same time, patients complain of the side effects and risks that accompany prescription drugs or surgical procedures. It is the physician's job to educate patients of the reality of alternative medicine: that "natural" substances and alternative procedures can carry just as much risk as in mainstream medicine; and, that because they are unregulated and often relatively lacking in comparable research into safety and efficacy, the manufacturers, sellers, and practitioners of these products and services are not required to make these risks apparent to the patient. Using both traditional *and* alternative medicine puts the onus of understanding the possible inter-

actions between traditional and alternative medicines and procedures and informing their doctor of all their choices entirely on the patient. They often believe, or are told, that any ill side effects or poor results are solely a result of trusting in traditional medicine.

In the case of the retired executive, the outcome was favorable. The doctor scheduled a follow-up with the patient and presented him with data regarding safe levels of lead and mercury in the blood. He also gave a clinical description of chelation therapy and outlined the serious risks involved. The patient reversed his decision to undergo the chelation at the alternative clinic, and was surprised to learn that the level of metals in his system was over a thousand times lower than what is generally accepted as a toxic level that would require chelation treatment. As for the red yeast rice, the doctor pointed out to the patient that natural red yeast rice in fact contains the same active ingredient as his prescription cholesterol medication, but in varying unregulated amounts, and therefore potentially more dangerous form, especially if he decided to stay on his own prescription medication, which could cause overdosing. The patient was convinced to go on a different prescription to minimize his side effects.

This is not to say that all "alternative" therapies are ineffective, either. To the contrary, *all* treatments, traditional or alternative, have potential benefits and risks.

As long as our healthcare system is battling challenges on all fronts: cost-cutting insurance companies, government waste and misuse of funds, lack of centralized record keeping, crippling malpractice lawsuits, and the crisis of uninsured populace—patients with the means to do so will seek alternatives for care. Our task is to sift through the evidence, when available, and help our patients make the right choices.

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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.*

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**P:** I guess we should talk about quitting, huh?

### So, what have we learned?

All wellness interventions are not created equal. Client centered health coaching changes at risk health behavior. Population risk burden stabilization approaches 0 trend over time while risk burden reduction can result in a negative trend. Looking only at medical/pharmacy cost trends does not reflect total wellness impact.

Combining a bona fide wellness program with safety efforts is a great fit and can produce a synergistic response. Reducing individual health risk burden increases individual quality of life. You can't tell people what to do and why they should do it! They have to tell you what they will do and why!

Health behavior change interventions, at less than 2%-3% of the cost of "sick care" premiums, and designed to specifically achieve the outcomes of individual health behavior change and a subsequent decreasing "sick care" spending, should be part of any effort to control the health care crisis. Even patient centered health plans such as HSA's and HRA's have demonstrated limits to their ability to control costs. Prevention of the progression of our population toward chronic disease must be halted to achieve lasting control of the problems confronting the health care system today.

*For more information see Dr. Catlett's PowerPoint slides in the library section of [www.necoem.org](http://www.necoem.org) or contact Jennifer Ridley at Occupational Medical Consulting, LLC, 207 524 2410 or 1 800 575 6537, email , [drcatlett@omcwellness.com](mailto:drcatlett@omcwellness.com)*