**Managing Chronic Health Problems at Work:**

New Study Assesses Strategies to Address Functional Issues Proactively

William S. Shaw, Ph.D., Glenn Pransky, M.D., M.Occ.H., and Bob McLellan, M.D., M.P.H.

One significant and growing problem in occupational health and safety is the increasing number of employees reporting chronic health conditions. This is explained by a combination of factors: the aging workforce, rising obesity rates, more life-saving medical treatments, and an increase in the population prevalence of several common chronic diseases. Now, nearly one-third of the US workforce reports one or more chronic health conditions affecting their ability to work, and this percentage is likely to increase [1-2]. This is an important worksite wellness issue that can easily fall between the cracks of injury prevention, health promotion, traditional disease management, and disability benefit systems, so occupational medicine practitioners may increasingly find themselves being asked to address this problem of “walking wounded” employees through new worksite programs and policies. As a result, we have been pursuing a line of research to understand the nature of this problem better and to offer potential solutions.

What kinds of problems do workers with chronic ill-

1. New Study Assesses Strategies to Address Functional Issues Proactively
2. Managing Chronic Health Problems at Work
3. What kinds of problems do workers with chronic ill-
One important distinction is that this study focuses on preserving function at work rather than restoring function or facilitating return-to-work after a period of disability or prolonged sickness absence. In this way, this intervention program represents a proactive strategy for employers to prevent disability before it occurs. Also, the group workshops in this study are being offered within existing EAP provider frameworks and with a standardized provider manual, so the program could be easily adopted by other employers if shown effective in this randomized trial. Introducing such programs in the workplace may be one way to expand occupational health to address broader issues of worker health affecting productivity, turnover, and healthcare costs.

If you know of an employer who might be interested in this novel wellness strategy, please contact Glenn Pransky at (508) 497-0253 for more information about the study. The methodological details of the study design are posted at www.clinicaltrials.gov (NCT01978392). The intent of this research is to focus more attention on the functional difficulties of workers with chronic health conditions, who represent a growing proportion of the US workforce. The essential premise is that affected employees may be more functional at work if they are encouraged to self-manage their workplace challenges through pacing, problem-solving, thoughtful communication, and an appropriate use of job flexibility and leeway. This study addresses an important gap in worksite wellness activities and represents a possible new direction in occupational medicine practice.

References:

Bill Shaw is the Principal Research Scientist at the Liberty Mutual Research Institute for Safety.

Glenn Pransky is the Director of the Liberty Mutual Center for Disability Research.

Bob McLellan is the Medical Director and Section Chief of OEM at Dartmouth Hitchcock Medical Center.
We Need You!

On any given day, about one-third of the U.S. population is working, making the workplace a prime setting for health interventions. “We cannot fill the need for trained occupational medicine specialists,” said Arch Chip Carson, M.D., Ph.D., associate professor and program director at the University of Texas Education and Research Center, UT School of Public Health in Houston. “There is more clinical work in occupational health than we can handle. So, we have to share that task with others who are not specifically trained in occupational medicine principles and practices.”

According to Dr. Carson, an estimated 4,000 physicians who are either board-eligible or board-certified are practicing OEM in the U.S. Approximately 10,000 more physicians (e.g., internists, family and emergency medicine, general surgeons) have “substantial” OM practices. There also are related sub-specialists such as physiatrists, neurologists, ophthalmologists and orthopedic surgeons, as well as occupational health nurses and nurse practitioners, physician assistants and other allied professionals making significant contributions.

Challenges Abound

OEM physicians share a desire to provide excellent care, save lives and improve the health of working populations. However, they are subject to a number of challenges, starting with the nature of the health care delivery system as a whole. “We have a health care system run amok,” Dr. Carson said. “The system we have created essentially eats 60 to 90 percent of the resources we put into it, leaving the rest for actual care. This is a shameful situation and one that I hope we are beginning to correct.”

Other challenges for medical professionals cited by Dr. Carson include:

- Increased regulation by governmental entities, insurers and “risk-shy” institutions
- An ongoing need to justify treatment recommendations to obtain reimbursement
- Litigious practice environments
- More strict licensure and certification requirements
- Challenges specific to OEM include:
  - Low specialty recognition
  - Insufficient output of new trainees
  - Fewer opportunities to expand practice into traditional preventive medicine areas, the roots of the specialty
  - An estimated 200 to 500 positions for physicians available each year at organizations that would prefer to employ individuals with formal training in OEM, corresponding with lack of funding for recruitment-related activities

Residency Training Conundrum

While the need for trained specialists continues unabated, occupational medicine residency program numbers are shrinking. There were 47 OEM residency programs in 2000; today there are 27 producing 54 to 61 graduates a year. Consequently, a growing number of medical schools have added OEM training competencies to some residency programs in an effort to provide “rudimentary knowledge,” reports Jeff Levine, M.D., M.S.P.H., who is affiliated with the University of Texas Health Science Center in Tyler, Texas.

Dr. Levine said that the Accreditation Council for Graduate Medical Education (ACGME), the leading accrediting body for allopathic physicians, has made some important changes in preventive medicine and OEM residency requirements over time. “The council’s goal is to train physicians, and there needs to be a clear demonstration of the traditional medical model – individual physicians taking care of individual patients,” Dr. Levine said. However, “the residency review committee recognized the need for a population health component, so they have worked hard to ensure a balance. Some significant changes have been made through some greater clinical requirements as the house of medicine sees it. Fundamentally, occupational medicine is more than just a workers’ compensation or injury management specialty. Without a population and injury prevention focus, we sort of disappear into the other specialties across the board.”

He said changes in preventive medicine residency requirements effective July 1, 2014, reflect a shift to a more outcomes-based approach in terms of how residents are trained and residency program performance is measured overall. Periodic progress reports featuring information obtained through an accreditation data system are among the requirements. “The days of old when review was every five years have gone away; we are now developing dashboards for the accrediting body to evaluate annual performance based on certain milestone metrics and competencies,” Dr. Levine said.

Areas targeted for increased emphasis include hours on duty, alertness management and fatigue mitigation; care transitions; supervision; professionalism and personal responsibility; and patient safety.

“We don’t do this in isolation. It requires working with disciplines outside of medical practice to do excellent work,” Dr. Levine added. “There have been workforce changes over time that affect practice and training, and there is an increasing emphasis on social-behavioral factors that influence risk.”

Tee Guidotti, M.D., M.P.H., an international consultant in OEM and former chair of the Department of Environmental and Occupational Health in the School of Public Health and Health Services at George Washington University, believes universal adoption of a five-year OEM residency would help ensure longevity for the profession. “One thing that could basically be done overnight would be to declare that occupational medicine is a five-year residency,” he said. “Why? Because everyone gets about five years of training anyway. Another option would be to declare it as...”
Put on Your Shades

The future may not be so bright that physicians have to don sunglasses, but there are a number of reasons to feel encouraged about the prospects of the specialty, several speakers said. First, there appears to be renewed interest in corporate medical practice – both occupational and personal health management-related – following an era of outsourcing. In a related trend, recruiters say jobs for younger physicians are opening up as older physicians take pay-outs and early retirement. “This trend will likely continue in the near future,” Dr. Carson said. “In the past two years I have seen more requests for occupational medicine practitioners to enter positions in corporations than I have in the last 15 years. Practitioners are returning to practice in large corporations that understand medical in-house consultation is critically important to their business model. There is still a huge number of businesses that have not yet received the message, but they will. They will see their competitors doing it, and they will start doing it, too.”

Second, there are emerging opportunities for OEM physicians to respond to prevention provisions in the Affordable Care Act in collaboration with employers who are interested in population health management and worker wellness initiatives. “The ACA has elevated prevention services to a level equivalent to other medical provider services,” Dr. Carson said. “We can now get paid for things we used to do for free. We can also take advantage of our skills to create centers of excellence for illness prevention in schools, communities and workplaces so it has to be considered for reimbursement. Wellness promotion flows naturally from that. Research and evidence is beginning to pour out now – some from ACOEM’s own health and productivity group – that every dollar spent through a properly designed program returns a larger amount of cost savings in the future. Our problem in the past has been how to present those numbers and make them understood.”

Third, Dr. Levine points to positive aspects associated with working in a field as dynamic as OEM. He alluded to topics on the National Occupational Health Research Agenda, for example, and said that researchers at the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health (NIOSH) and academic institutions are investigating serious public health threats (e.g., potential terrorist attacks, natural disasters, pandemics). NIOSH also supports Total Worker Health, a strategy aimed at integrating occupational safety and health protection with health promotion.

Fourth, Dr. Carson mentioned that while the much-anticipated transition from ICD-9 to ICD-10 coding has been delayed in the U.S., ICD-11 is already on the horizon in some other parts of the world where ICD-10 is in use. “It will hit here eventually,” he advised, “and it has specific sections built into it for coding (and billing) of occupational health services and population health practice activities that have never been included in that coding system before.”

Fifth, surveys show that compensation and job satisfaction rates are higher than average in OEM when compared to other types of medical practice. “We do better (salary-wise) than most primary care physicians, and we still mostly have a better lifestyle, so that’s very attractive,” Dr. Carson said.

In summary, he offered this advice to his colleagues: “Our future is what we make of it. Every OEM physician should stretch his or her comfort zone to some extent.” For example:


2. Engage a stakeholder in an educa-
The Federal Motor Carrier Safety Administration (FMCSA), US Department of Transportation now requires that all commercial (truck and bus) drivers operating in interstate commerce whose current medical certificate expires on or after May 21, 2014 must be examined by a certified medical professional listed on the National Registry of Certified Medical Examiners (NRCME). NECOEM has offered 13 in-person training courses in New England to its members and interested non-member healthcare providers so that they could meet the training requirement for NRCME certification.

Our NECOEM faculty – Drs. Ron Blum, Robert Swotinsky, and myself - have provided training to 754 healthcare professionals at NECOEM training courses. As of May 21, 2014, 68 of 754 course attendees (9%) are current NECOEM members and 455 of 754 (60%) have become NRCME certified medical examiners (MEs). NECOEM has provided training for 34% of certified MEs in New England states. The two tables below summarize attendance and certification by state and profession.

Members should be aware of some recent changes in the NRCME program:

- The NRCME homepage URL has been changed to: https://nationalregistry.fmcsa.dot.gov/NRPublicUI/home.seam
- NRCME has a map of the locations of all 21,373 certified MEs throughout the US: https://nationalregistry.fmcsa.dot.gov/NRPublicUI/ResourceCenterMELocations.seam
- Certified MEs are required to complete an online database entry for each exam performed (Form 5850) at least monthly, or indicate that they have not performed a CDL exam in the past month.
- There are now three training organizations offering the certification exam to healthcare professionals who have completed the training course and are eligible for certification: PSI Online, Comira Testing, and Prometric.

At this time two additional courses are planned for 2014: Waterbury, CT in October and Newton, MA in December. Details are available on the NECOEM website. Information about the certification process can be found in the “Complete Guide to Medical Examiner Certification” at https://nationalregistry.fmcsa.dot.gov/NRPublicUI/documents/Complete_Guide_to_ME_Certification_revised_032513.pdf.

Our faculty offers special thanks to:
- Deborah Halbach, Executive Director of the Maine Academy of Family Physicians, for her efforts in partnering with NECOEM for the 4 training courses in Maine. We are pleased that 64% of certified MEs in Maine have attended our NECOEM courses.
- Dianne Plantamura, NECOEM Executive Director, for her key role in arranging these successful courses as well as her tireless and cheerful responses to questions from NECOEM members and course attendees.

- Safe driving!    Jay Poliner, MD, MPH, FACOEM, West Hartford, CT

### Summary: NECOEM NRCME training courses

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<th>TABLE 1</th>
<th>Training course attendees</th>
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ANSWER TO “WHAT IS IT?”

The settlement shown in the Spring issue’s “What Is It?” is the Hull House located in the near west side of Chicago. Dr. Alice Hamilton, a pioneer in occupational medicine was one of its notable residents.

Congratulations to Joan Balkus RN, COHN-S, CCM and Jay R. Poliner, MD, MPH, for correctly identifying the structure!

“What Is It?” is a section on trivia, facts, figures, etc. related to the field of occupational medicine. If you have any such interesting or fun-filled material, please e-mail it to the associate editor at dr_abhik@yahoo.com. All material should be related to the specialty of occupational and environmental medicine and have an educational, inspirational, historic or other relevant value.
Congratulations to the new ACOEM Fellows!
The new fellows from New England are:

Bernard M. Bettencourt, Jr, DO, MPH;
Michael D. Lappi, DO, PHD;
James E. Mazo, MD, MS;
Ben Hur P. Mobo, Jr, MD, MPH;
Rick Snyder, DO, MPH;
Marcelo Targino, MD, MPH.

(Continued from page 4, Occ. Med. Goes)

3. If you are not already, consider becoming board eligible.

4. Routinely collect numbers that demonstrate value to yourself and others. (ACOEM and NECOEM can help facilitate this.)

5. Be part of efforts to reach a common consensus on individual contributions and the role of OEM, in general. “As we increase our recognition, and as we move forward as a group and as individuals, this is where our expert practitioners will come from,” Dr. Carson said.

Karen O’Hara is Director, Marketing and Communications, at WorkCare, Inc., the nation’s largest physician-owned and managed occupational health care company.

Her previous positions include Managing Editor and Communications Specialist at UL Workplace Health and Safety, and Senior Vice President and Editor-in-Chief, RYAN Associates and the National Association of Occupational Health Professionals. Based in Santa Barbara, Calif., she has specialized as an industry journalist, consultant and curriculum planner in occupational health since 1990.

Related resources:
1. American College of Occupational and Environmental Medicine (ACOEM) 10-point advocacy Agenda for Change; http://www.acoem.org/AdvocacyAgendaForChange

In Collaboration with Dr. Tony Tannoury, NECOEM Is Proud to Announce Our Exciting New Mini-Fellowship Program!

What is it? Spend 1 to 2 days shadowing Dr. Tannoury, alongside other industry-leading specialists, in surgery, the clinic, or both to learn anatomy, surgical procedures, patient symptomatology, and terminology

What specialty areas are covered?
- Minimally Invasive Spine Surgery
- Hand Surgery
- Pain Management
- Upper Extremity
- Long Bone Fractures
- Sports Medicine (shoulder, knee, etc)

What are the benefits to participating?
- Improve your understanding of clinical presentation and pathology
- Master new skills in physical exam
- Improve skills in reading and interpreting diagnostic studies (x-rays, MRIs, CT scan, nerve conduction studies, etc)
- Observe and meet patients before and after surgery
- Learn the complex process involved in workers’ compensation cases

For More Information:
Please visit www.bostonmis.com
Letters to the Editor:
Hello, Dr. Karandikar
The Hull House in Chicago was the intermittent residence of Dr. Alice Hamilton, a pioneer in occupational medicine in the US as well as a strong support of the settlement house movement. Her experiences as a resident of Hull House, especially those with the health hazards faced by immigrant workers, were instrumental in her decision to pursue a career in occupational medicine. Among Alice Hamilton’s many professional accomplishments was her appointment as the first female faculty member at Harvard Medical School. She also had many ties to Connecticut: a graduate of Miss Porter’s School in Farmington, CT, she retired to a house in Hadlyme, CT with her older sister Edith Hamilton, a classics scholar. I encourage any NECOEM members not familiar with her professional life to read “Exploring the Dangerous Trades,” an autobiography first published in 1943. Many thanks for adding this “trivia quiz” to the REPORTER!
Best regards – Jay Poliner

Dear Dr. Karandikar,
Hull House was founded by Jane Addams and Ellen Gates Starr. Jane Addams served as the first woman president of the National Conference of Social Work. Because of the work of Alice Hamilton, I always considered Hull House as a symbol of the union of my two careers - social work and occupational health. Check out the history of Hull House at its official site:
www.uic.edu/jaddams/hull/hull_house.html
Thank you for choosing this historic site for the first “What is it.”
Dianne Plantamura, CSS, MSW