

Providers Target Captive Audience at the Workplace

PHYSICIANS, NURSES FILL ROLE AS ON-SITE CONSULTANTS TO BUSINESS AND INDUSTRY.

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This is the second part of a two-part article on worksite-based occupational health services. Part I appeared in the November/December 1998 VISIONS.

The vast majority of the working population is captive during a significant part of the day. So it makes infinite sense to deliver occupational health services at the workplace.

Mobile medical units, nurse placement programs, and on-site physician consulting and clinical oversight are among forms of outreach that are growing in popularity. However, these services must be carefully planned, targeted to appropriate industries and marketed wisely in order to succeed.

Mobile Medical Services

When a provider-based program with one or more clinics considers introducing a mobile medical or other on-site program, it's advisable to start out slowly, says Bruce Davis, vice president of sales for Health Examinetics, a national mobile medical company with headquarters in San Diego, CA. Starting out small may mean focusing initially on offering one or two services that are commonly required, such as audiometry and spirometry, and expanding from there.

"Lots of people go in and out of this business," Mr. Davis said during a presentation at RYAN Associates' recent conference on *Developing and Providing Effective On-Site Occupational Health Services*. "Rather than buying a mobile unit at the outset, leased or rental units, or subcontracts with experienced vendors, are a good way to start. Remember, your lines of communication and supply stretch the farther afield you go."

Restrictive federal and state standards also are an important consideration; compliance violations can quickly lead to lawsuits and put a mobile unit out of business.

For the provider, mobile services have a number of benefits. For example, mobile units act as a feeder to other product lines and services. Mobile services can be developed as a profit center and used to increase visibility in the marketplace. Many hospitals and health systems find that mobile units also can be jointly shared with other programs and used to support community service missions.

The benefits to the customer are obvious: mobile medical services represent a cost-effective and convenient alternative to sending workers off site. In addition, most companies benefit from the relationship because mobile medical providers are attuned to their regulatory compliance need. "Very few companies are truly in compliance," Mr. Davis said.

However, before committing resources to the development of a mobile program, it is essential to first conduct a market needs assessment. Components of such an assessment include:

- ♦ defining the territory to be served;

- ◆ identifying the nature of business and industry and number of workers within that territory;
- ◆ determining whether there is an adequate concentration of business within a reasonable driving distance to support the unit, or units;
- ◆ pilot-testing of selected services with a few clients before introducing services to the broader market.

Whether a program decides to buy, rent or lease a unit, it is important to recognize that it will be an extension of the fixed site. "Image, quality and flexibility are critical," Mr. Davis said. Health Examinetics' large corporate clients typically pay \$5,000 to \$7,000 per day for the unit, and have expectations to match those figures.

Other considerations include the following:

1) If purchasing a mobile unit, it may be more practical to buy a tractor-trailer model rather than a fully contained vehicle like a motor home; if the tractor goes in for maintenance or repairs, it may be possible to keep the mobile clinic on the road using a substitute tractor.

2) The mobile unit and equipment in it must be durable and able to withstand climatic changes. Calibration of equipment is essential.

3) Personnel who staff the unit should be certified in all relevant areas and also have the personality for the job. "For the client, a mobile unit can be impersonal and feel like a production line, so it's especially important to have personable, well-trained staff," said Mr. Davis. (His company uses commercial driver's license holders to drive the unit.)

4) Federal and state regulations should be thoroughly reviewed before launching a mobile service. When crossing state lines, be aware that regulations vary by state, with some states more restrictive than others.

5) Equipment and information systems in the mobile unit should be compatible with those used at fixed sites. The use of on-board information management systems and specialized software is strongly recommended for data management and quality assurance. Electronic transmission of data to a home base or clinic at the end of each day also is advisable.

6) Scheduling is key. Patient flow rates, distance and travel time, and shift work are among factors that must be considered. Scheduling can become a relatively complex undertaking. For example, in a large company, a mobile unit may have to cover the equivalent of 50 shifts in order to reach the majority of employees when days off, absenteeism, flex schedules, 24-hour operations and other issues are added into the equation.

7) On-site locations should be evaluated prior to the mobile unit's arrival with regard to the setup, including the availability of water and power. If a generator is to be used, be aware that low-level vibrations can affect hearing test results.

8) Employers expect prompt results. Specimens should immediately be sent to laboratories for testing. Results should be reported as soon as possible—no later than within two weeks. Employers also appreciate aggregate reports to assist them with employee training and compliance tracking from year to year.

Nurse Placement Programs

Company nurses have long been a mainstay of on-site medical programs. However, trends indicate that employers are becoming more inclined to outsource this important function to local provider organizations or national companies such as Meridian Corporate Healthcare, a Nashville-based firm that provides on-site medical services and information management technology to clients.

"In occupational health nursing, you serve many masters," said Pam Dulaney, a nurse who is vice president of operations for Meridian, with responsibility for on-site medical health units. "The patient comes first, but you also need buy-in from the safety department, human resources and front-line supervisors."

She applies the following rule of thumb to staffing nurse placement programs:

300+ employees=1 FTE RN.

For each additional 750 employees, add one RN.

In addition to nurses:

1,000+ employees = 1 part-time physician

2,000+ employees = 1 full-time physician

For the provider sponsoring a nurse placement program, one of the foremost considerations is the selection of appropriate candidates. Experience, certification and expertise must be evaluated in the context of the company's needs. For example, a heavy industry would be likely to require a nurse with recent experience in emergency medical care. The choice of nurse should also be influenced by the corporate culture, the regulatory/workers' compensation environment and the state of labor-management relations.

"It depends on what the client really needs," Ms. Dulaney said. "The more services you can provide on-site, the less expensive it is for the company. We do as many modalities with an RN on site as we can."

Meridian has a formal orientation program for nurses entering new work assignments. "You don't just plunk people into a new setting," she said during her presentation at the on-site services conference. "They need both a clinical and a regulatory orientation. I want them to get a feel for what it's going to be like to function one-site." The orientation typically lasts 3-5 days.

At Meridian's on-site clinics, the key person in management is the nurse. Policy, procedure and protocol manuals are available to the nurses as a resource. Since the nurses operate under standing orders for emergency care, they must develop a bond with the company's medical director (usually a community physician). In addition, Meridian has a corporate medical director who is just a phone call away.

At the on-site locations, case management is handled as a three-tiered process: nurse review, physician review and medical review. To date, medical review has not been necessary, Ms. Dulaney said.

With 73 on-site medical units in 17 states, Meridian has had the opportunity to develop an operations model applicable to multiple settings. Its infrastructure is supported by nurses at its corporate office who function as client operations manager. Each manager handles five to seven on-site contracts apiece.

One of the goals of the operations manager, as well as the nurses on-site, is to develop productive relationships with off-site providers. "We can't do it all ourselves, although we retain control of the relationship, including the billing," Ms. Dulaney noted.

Meridian assesses its performance in a number of ways. Ms. Dulaney said the number of patient visits per day isn't the best indicator of the work being done by an on-site clinic. The on-

site provider should monitor lost work days, restricted duty days, injury/illness frequency rates and severity. Client satisfaction surveys are done quarterly; patient satisfaction surveys are completed in the clinics on a daily basis. Continuous clinical quality improvement is also part of the Meridian model. Nurses seem to respond favorably to documentation about their performance as long as it's a non-punitive system.

"Total workers' compensation costs, temporary total disability, medical and indemnity costs should all go down if you are doing a good job," Ms. Dulaney said.

On-Site Physician Services

Cost-effective management of in-house health care professionals has proven to be a challenge for many American companies. Consequently, more employers are entering into contracts with physicians and other medical professionals who are associated with outside organizations to provide internal health care services on either a part-time or full-time basis.

"On-site (medical service) contracts allow more flexibility because the employer can reduce staff hours, and subsequently costs, at will," said Bruce Dalton, M.D., senior vice president of health affairs for U.S. HealthWorks, an occupational health practice management and preventive medicine company based in Alpharetta, GA. "Never accept a client so far from your fixed facility that you can't meet their needs. Trust, confidence and respect are the basis of the relationship."

Based on his own experience, Dr. Dalton said companies typically pay physicians \$115-\$255 per hour for on-site work; nurses and physician assistants, \$45-\$65; registered nurses, \$35-\$50; LVNs/LPNs, \$22-\$28; medical assistants, \$15-\$20, and clerical assistants, \$12-\$18. Typically, the clinician's employer is responsible for medical benefits, vacation pay, training and other costs.

Aside from monetary considerations, other potential benefits to the employer include:

- ◆ opportunities to leverage existing resources;
- ◆ renewed focus on core business activities;
- ◆ reduction in confidentiality constraints, and
- ◆ improved access to information systems and technology.

However, when a physician begins a relationship with a company as a consulting on-site medical director, he or she should also be prepared to address what the employer and the workforce may perceive as disadvantages in moving from an internal medical model (or lack thereof) to one that is managed by an external source. These concerns include:

- ◆ weakened internal capabilities, e.g., loss of availability, responsiveness;
- ◆ divided loyalties;
- ◆ impacts on employee morale;
- ◆ reduced access to senior management;
- ◆ increased need for "vendor" management, and
- ◆ loss of "company" spokespersons.

In addition, for the physician, a contract to provide on-site services is likely to change the nature of the relationship he or she may have had with the company as a clinic-based physician.

"Once you are on-site, the lines between the organization you represent and the company become more blurred," Dr. Dalton said during a presentation at the on-site services conference. "You start to make decisions for your corporate client.

"A contract for on-site services should take effect at the point where the physician becomes an agent for the company, or where the physician takes exposure on behalf of the

company. For example, the physician should help maintain the OSHA-200 log, but he or she should never warrant to the client that the company is in compliance.

"A systems approach is very important. The physician does not provide services in a vacuum. The company will expect the physician to interface with corporate assets."

A physician working under contract to a company also has to change his or her perspective in terms of provider relations. As an "insider looking out," the physician is suddenly in the position of asking colleagues why they are treating or managing an employee's case a certain way. Dr. Dalton said he has found it helpful to use specialists as third party consultants in certain cases.

He identified four integrated components of an on-site medical program:

1) **Program management:** Examples include on-site clinic management, vendor network management, medical direction, compliance and surveillance oversight, coordination of on-site prevention and educational activities, and the defensible use of internal and external resources. "The value of the program to the client must be documented," he said. "This hinges, to a considerable degree, on the availability of intellectual talent."

2) **Information management:** Examples include medical records database integration, compliance support, corporate decision support and performance metrics. The external provider and the client must agree on what success is going to look like in order to measure it. "Information is the value-added to the relationship; it makes you, the provider, worth keeping around," Dr. Dalton said. "Information is power. Become indispensable to the client by bringing data to their information set. Tailor the information to the target audience—to the CFO in economic terms, the CEO in business terms, the vice president of human resources in human capital terms. Same data, different presentation." If there is not enough information to share quarterly, the provider is probably not meeting expectations.

3) **Productivity management:** Examples include medical release and absence management, return to work and temporary alternative duty management, impairment assessment, rehabilitation, and Family and Medical Leave Act certification. Productivity management, and all the elements associated with it, is "the hottest topic on our stove right now," Dr. Dalton said.

4) **Clinical services:** Examples include physical exams, injury care, drug testing and MRO services, independent medical examination consultations, critical incident response, medical surveillance and travel clearance. The physician plays an important role in this component by leading the clinical team. It is incumbent on the provider organization to "enable and manage" the physician. "On-site work is like a foreign assignment for that physician," Dr. Dalton said. "He is your communicator. He has the credibility. He is the case manager deciding what is or isn't important for that employee. To a great extent, the physician is a problem-solver."

In summary, Dr. Dalton offered these words of advice: "When developing an on-site strategy, make sure you clearly understand the client's requirements. Be creative, but stay within reasonable parameters. Watch out for the 'since you're already here' syndrome and learn to say 'no' when it is appropriate. Have a vision, and lastly, use resources wisely."