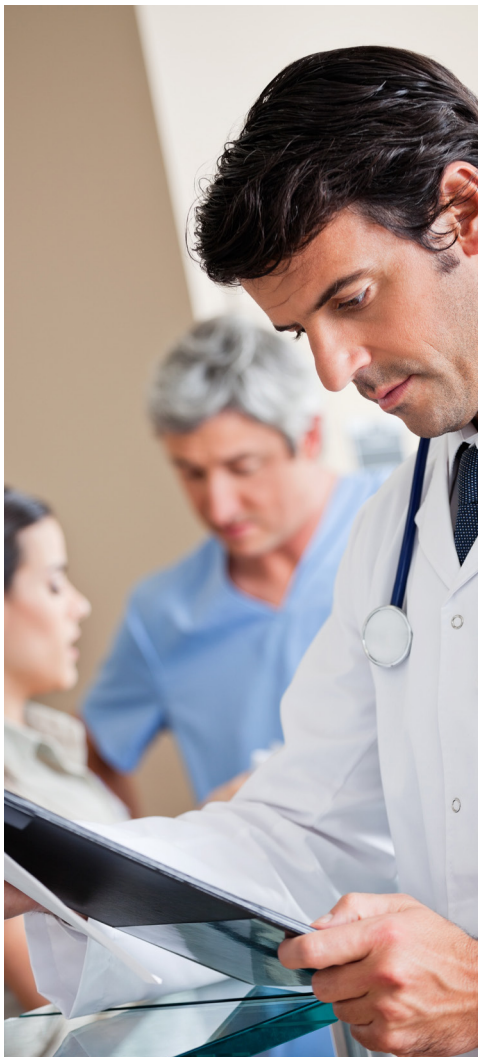
How to Maximize Your Occupational Health Investment

by Matt Koerlin

What is occupational medicine? According to Wikipedia, occupational medicine specialists work to ensure that the highest standards of occupational health and safety can be achieved and maintained. While it may involve a wide number of disciplines, it centers on the preventive medicine and management of illness, injury or disability that is related to the workplace.[1]



The interesting part of this definition is the last: "related to the workplace." What does that mean? The obvious meanings include injuries or illnesses that occur at the workplace (e.g. slipping on the shop floor, injury caused by malfunctioning work equipment, or a contagious disease acquired at a hospital). Some meanings might even include injuries that happen outside of work but impact the worker (e.g. an arm broken at a sporting event that prevents normal job duties). Ask most people about occupational medicine and you're likely to get an answer that somehow reflects back on these sorts of circumstances.

Increasingly, however, companies that manage workers are substantially broadening their definition of occupational medicine. These employers are providing employee benefits that carry a high and rapidly increasing cost and those benefits plans cover impactful health conditions that result from factors well beyond the traditional scope of work-specific medicine. Furthermore, research shows that an employee's overall health actually has a significant impact on the quality of their work productivity. Given the large investment companies are making in employee health and the causal link between overall health and quality of work, doesn't it make sense for companies to maximize the impact of their investment?

Many companies are concluding that the answer to that last question is an emphatic "Yes!" and many are re-evaluating how they choose occupational medicine providers. The goal of this paper is to explore some of the dynamics that have led to this change and to provide some perspective for companies considering new service partners to help with their employee health initiatives.

[1] https://en.wikipedia.org/wiki/Occupational_medicine, 26 August 2016

MASSIVE PROBLEM, EMPLOYER REACTION

Unless you've been living under a rock, it should come as no surprise that healthcare costs are enormous and rising rapidly.

- The United States spent $3.0 trillion on health care in 2014, which is more than $9,500 per person and 17.5% of GDP.[2]
- About 53% of U.S. health care spending since 2009 has been private (i.e. non-government).[3]
- In 2015, an average employee-sponsored plan for a typical American family of four cost $24,671 on average, up from $19,393 in 2011 (27% total increase, 6.2% annual increase). In 2015, the employer contributed 58% of the costs.[4]
- Studies show that the other impacts due to health conditions on the workplace (higher absenteeism rates, lower productivity while at work) are as costly to the employer as documented healthcare costs.[5]

If you put all that information together and consider all of the different ways that companies experience healthcare costs (e.g. health and pharmacy premium benefits, matching HSA funds, missed work due to doctor visits, injuries, or lower productivity because of an ongoing or temporary medical condition), the impact to these private companies is well over $1 trillion annually. That number is stunning and companies are increasingly doing what companies do for large expenses that are impacting profitability in a competitive environment: they're taking action to manage the costs.

While one of the largest expenses for companies as it relates to health care is their healthcare premiums, those premiums as well as any other costs incurred are based on a pretty straightforward calculation:

Total Healthcare Cost =
[Avg. Cost per service] ***x***
[Services consumed] ***+***
[Productivity Lost]

With this in mind, a pragmatic business person looking to reduce total expenditure due to health care can take one or more of three basic strategies:

- Reduce the cost per service and/or
- Reduce the number of services consumed and/or
- Reduce the loss to productivity

In fact, these basic strategies are all driving some current trends in occupational health: more employer sponsored clinics, more focus on employee wellness, and an overall culture of integrated employee health and safety, all of which impact the components of the above equation positively.

REDUCING THE COST PER SERVICE

Traditional employers incur healthcare costs through a variety of different avenues, but the primary vehicle for providing these benefits is insurance: health insurance, pharmacy insurance, and workers compensation insurance. In order to control these costs, companies have traditionally employed one or more of the following tactics:

1. Minimize the increase of the employer-paid premium
2. Increase the employee deductibles
3. Decrease the amount of wage increases to account for any rise in insurance premiums
4. Lower the benefit level to the employee
5. Negotiate better rates with the insurance carrier

Items 1-4 on that list all involve either reducing the benefit itself or shifting the cost to the employee. The following chart fuses together information about industry averages to provide a sample look at an individual employee. It looks at average employer and employee costs over the past five years from the perspective of the employer, the employee, and the healthcare system.

[2] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html (26 August 2016)

[3] http://apps.who.int/gho/data/node.country.country-USA?lang=en (26 August 2016)

The chart is not intended to show all expenses. Unemployment and workers compensation insurance, for example, are additional expenses to the employer that are not represented above. However, in the data presented, you can see the impact over the past five years of each of the first four strategies used by employees.

1. **Minimize the increase of the employer paid premium:** How can a 26% increase in employer premiums be considered a "minimization"? Look at the yellow cell for employee increases. They have gone up 37%! Could employers have pushed even more to the employees? Maybe, but likely not without impacting employees even more.
2. **Increase Employee Deductibles:** If employee deductibles increase, the employee usually will spend more out-of-pocket. The increase in deductibles is therefore visible in the out-of-pocket increase of 26%?
3. **Decrease the amount of wage increases:** Note the employee take-home net of healthcare pay: 4% increase over five years. This is true even though employer outlays have increased by 12% on a much larger cost basis.
4. **Lower the benefit level for the employee:** This one is less obvious. "Fewer benefits" does not appear directly on the table, but changes such as narrower provider networks and fewer covered services would tend to drive up employee out-of-pocket expenses up 26% over five years.

So the data show pretty clearly what is going on. Costs are skyrocketing. Employers are spending a lot more money than they have in the past, but almost none of these benefits are flowing directly to the employees. In fact, when you consider the Consumer Price Index (CPI) over the past five years, the real value of employee wages, net of healthcare expenses, has likely declined on average. Instead, all of the extra expense has flowed overwhelmingly into the health delivery system to the tune of a 27% increase over five years.

Employee View	2010	2011	2012	2013	2014	Net Increase
Gross Salary	49,276	50,054	51,017	53,585	53,657	
Federal Tax	4,928	5,005	5,102	5,359	5,366	
Medicare Tax	715	726	740	777	778	9%
FICA Tax	3,055	2,102	2,143	3,322	3,327	
Employee Premium Contribution	4,322	4,724	5,111	5,540	5,906	37%
Net Pay	36,257	37,497	37,922	38,587	38,281	
Employee Out-of-Pocket Healthcare	3,006	3,282	3,473	3,601	3,788	26%
Net-of-Healthcare Pay	33,251	34,215	34,449	34,986	34,492	4%

Employer View						
Salary	49,276	50,054	51,017	53,585	53,657	
Medicare Tax	715	726	740	777	778	9%
Employer Premium Contribution	10,742	11,386	12,149	12,890	13,522	26%
FICA Tax	3,055	3,103	3,163	3,322	3,327	9%
Total Employee Expense (Does not include other taxes)	63,787	65,269	67,069	70,575	71,284	12%

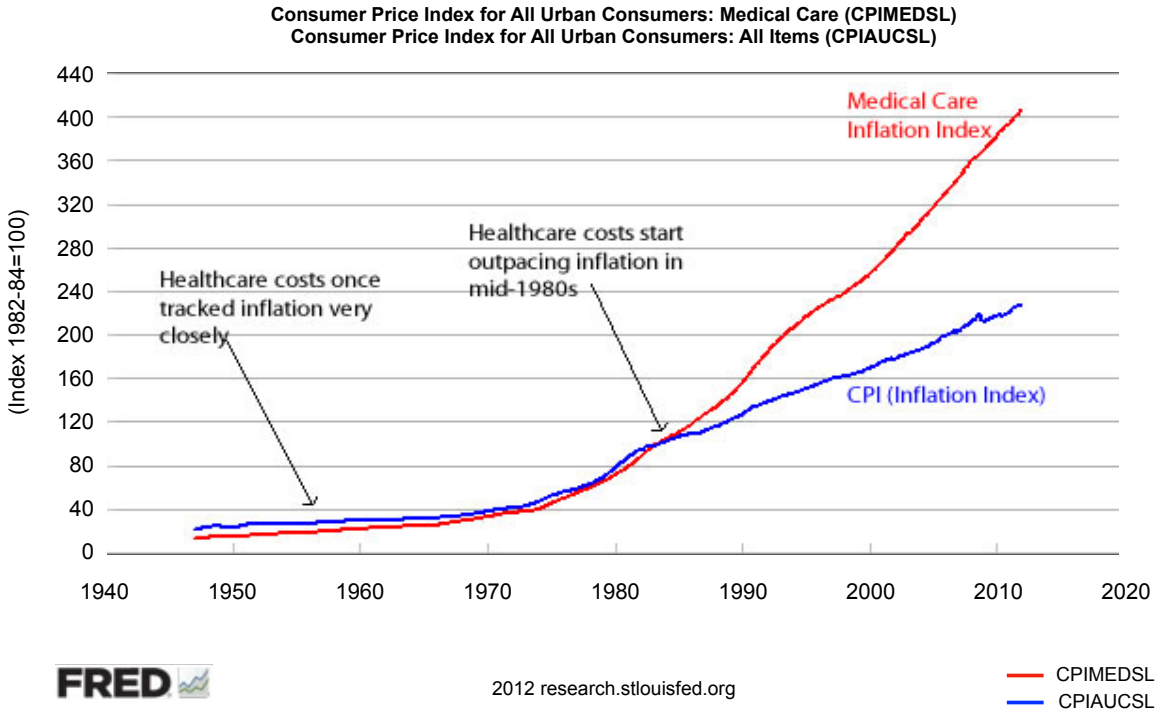
Health System View						
Total Insurance Premiums	15,064	16,110	17,260	18,431	19,428	29%
Total Medicare Taxes	1,429	1,452	1,479	1,554	1,556	9%
Total Share of Income Taxes Diverted to Health	986	1,071	1,173	1,216	1,325	34%
Employee Out-of-Pocket Healthcare Expenses	3,006	3,282	3,473	3,601	3,788	26%
Total Health Spend	20,484	21,915	23,386	24,802	26,098	27%

[4] http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf (26 August 2016)

[5] https://www.researchgate.net/publication/228798078_The_value_of_health_and_the_power_of_prevention (26 August 2016)

So what about the fifth strategy mentioned above, negotiating better rates from the insurance company? In theory, that would decrease revenue into the medical industry and leave more value to split between the employee and employer. The practical side, however, is a different matter altogether. Insurance companies employ an army of actuaries and are fairly accurate in predicting how sick your workplace is going to be. Additionally, if an insurance carrier is currently providing coverage, they have all of your employee health history for as long as they have fulfilled that role. Finally, of course, providing insurance at a profit is their business. Private industry does not willingly provide a service for free and these companies are constantly evaluating, pricing, and selling coverage to all of their customers. Conversely, a company negotiating with an insurer might only be concerned with this information once a year, during the negotiation of their one contract. The situation is a textbook case of information asymmetry. When you consider that in conjunction with the experience gap, negotiating favorable rates with an insurance company is almost an impossible task.

The following chart shows the healthcare CPI vs. the standard consumer price index as a proxy for the relative cost of a service with time. It strongly implies that the idea of negotiating lower rates has not been an effective strategy.



Traditional methods of shifting costs to employees and pushing back on insurers have been either ineffective or are reaching (or have passed) the end of their viability in the marketplace. As a result, more companies are deciding that the problem of rising costs goes beyond their own workforce and are rightly concluding that a big part of the problem is the way the current healthcare system is set up to deliver services.

A BROKEN SYSTEM

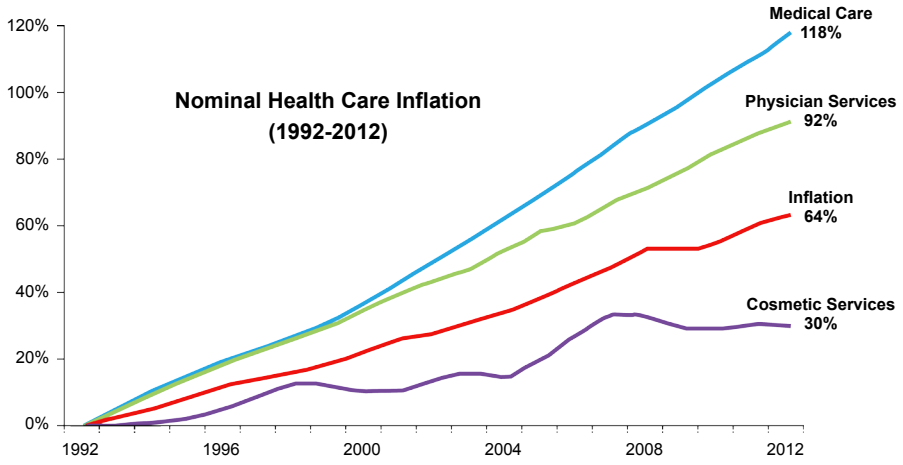
The current healthcare delivery system is geared toward handling insurance as a primary payment method. Insurers price services based on contracts they negotiate with their networks of providers, a process that happens well before anyone actually receives a service. The whole process makes understanding what a patient will need to pay for a service almost impossible to determine before the service is consumed since it requires that the provider understand

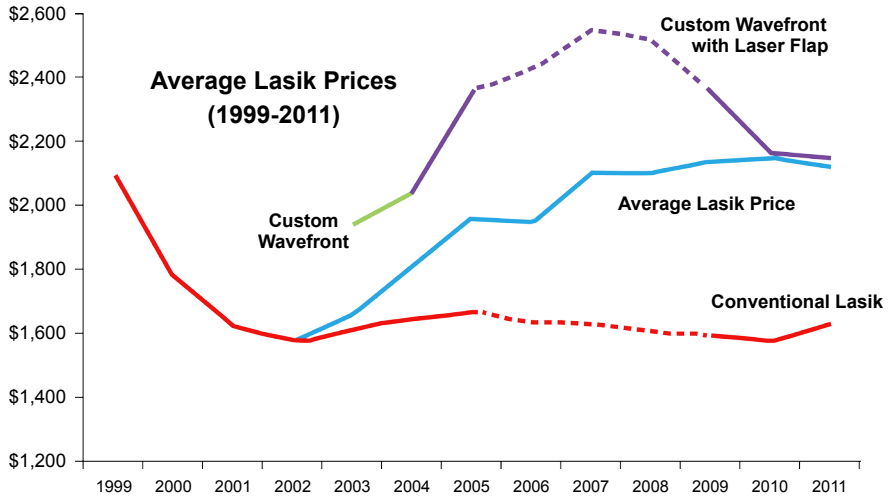
the insurance carrier that you have, the network you are in, the state of your deductibles, whether or not you have co-insurance, what procedure codes you end up receiving, and many other factors that are rarely understood before you receive care.

On the front end, price discovery is nearly impossible and the insurers take on the overhead of things like network formation, physician contracting, and credentialing. On the back end, the payment process is no less burdensome. Third party payment and fee-for-service require a complicated system of coding and pricing review. Providers then apply co-pays, co-insurance, and use the negotiated contract to understand which party gets billed for which portion of the service. After that, providers must pursue invoicing, payment, reconciliation, collections (in the event of non-payment), dispute resolution, and discussions with patients and carriers so that everyone can understand what happened and why the numbers are what they are. In the end, all of this overhead contributes almost nothing toward the problem the employer is trying to solve--getting healthier employees to be more productive at work--but layers on an incredible amount of cost.

The waste in the system is increasingly coming to light. The *Los Angeles Times* recently showed that some insured patients are better off paying cash for routine blood tests than using insurance, sometimes saving over 80%.[6] Stories such as this and Steve Brill's "Bitter Pill" article in *Time Magazine*[7] are causing employers to ask the right questions: If an employee is insured, uses the deductible, and then has a 20% copay on a service that he can get at a cash price discount of 80%, what exactly is the employer getting for his insurance premiums? In this sort of environment, is it possible for the employer to provide the service in a more cost effective manner?

This idea, in general, is nothing new. Entire businesses have had massive success doing what companies are considering in this very scenario. Disintermediation is the same business strategy that Dell used to sell computers directly to consumers (taking out the retailers), Southwest Airlines used to sell tickets directly to consumers (taking out the travel agencies), Tesla uses in selling its own cars (removing the dealerships), to name a few. You can even find examples in health care. Ever drive down the street and see an ad for Lasik eye surgery or a Botox injection on a billboard? These types of procedures are generally considered to be cosmetic and are therefore not covered by most health insurance coverage so there's rarely a third party intermediary between the consumer and the provider. Guess what? Prices





[6] http://www.latimes.com/business/lazarus/la-fi-lazarus-healthcare-pricing-20160610-snap-story.html (26 August 2016)

[7] http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/ (26 August 2016)

for these services haven't grown in the same way as other health procedures. The price trends for these services don't resemble those of other medical services, but are more akin to what you'd find in other consumer products, even while technology, at least in the case of Lasik, has improved.[8,9]

So, back to the problem of decreasing cost per service: if disintermediation is a way to potentially decrease the average cost per service, how does an employer accomplish that? To provide healthcare services directly, companies are taking generally one of two approaches: either they open up an employee clinic directly or they work with an occupational medicine provider. In either case, employers are in a position to directly control costs; they define the services to be provided and pay the provider on salary or they negotiate service prices with their provider directly.

When companies take on this sort of control, they open up areas of potential cost control that simply are not easily available to them when their employees are consuming services out "in the wild". Did you know that there are massive differences in the price of prescription drugs based on where employees choose to shop for them? The following chart from Consumer Reports demonstrates this with some relatively common prescription drugs.

How drug costs compare

In our pharmacies study, Costco had the lowest retail prices overall and CVS the highest for five widely prescribed generics.

Drugstore/store	Price [1]					Total
	Generic Actos, 30 mg (pioglitazone)	Generic Lexapro, 20 mg (escitalopram)	Generic Lipitor, 20 mg (atorvastatin)	Generic Plavix, 75 mg (clopidogrel)	Generic Singulair, 10 mg (montelukast)	
Costco [2]	$101	$7	$17	$15	$27	**$167**
Healthwarehouse.com	141	11	16	12	29	**209**
FamilyMeds.com	140	12	15	30	29	**226**
Sam's Club [2]	140	87	56	48	47	**376**
Independents [3]	180 ($37-$393)	52 ($6-$164)	42 ($8-$197)	48 ($8-$222)	58 ($10-$193)	**381 ($131-$1,073)**
Kmart	145	96	65	46	40	**392**
Walmart	160	84	68	58	57	**426**
Walgreens	158	105	65	50	55	**433**
Grocery stores [3]	252 ($48-$346)	115 ($12-$190)	84 ($10-$146)	99 ($5-$209)	108 ($15-$173)	**658 ($176-$1,018)**
Target	274	85	144	158	135	**796**
Rite Aid	286	119	134	137	144	**820**
CVS	295	126	150	180	165	**916**

[1] For walk-in stores, average price for one-month supply. [2] Nonmember, nondiscounted prices. At Sam's Club, prices could be up to 40 percent less.
[3] Prices in parentheses are the range across sampled stores.

[8,9] http://www.allaboutvision.com/visionsurgery/cost.htm (26 August 2016)

Certainly the most cost-conscious employees will seek out this information, but some or most employees will do what is most convenient for them. Most providers are more concerned with the treatment than cost. However, if the employer controls the prescribing provider or, at a minimum, provides access to a consulting physician that can offer this information to the employee, they can require or incent providers to make this information available to employees. Even better, providers can act as a sort of consultant, working with the employee to find a lower cost prescription or over-the-counter therapy, a cost savings that directly benefits both the employer and the employee.

All of these benefits (control, direct negotiation, competition, service consulting) naturally drive the price of services down and the quality of services up to the benefit of both the parties paying and the party receiving the service (the employer and the employee). Over time, the savings can be profound.

REDUCING SERVICES CONSUMED

It's all well and good to say that we are going to reduce the number of services that are consumed, but how? To understand the answer to that question, you first need to understand the underlying causation. That is, what conditions drive the number of services that are consumed?

The short answer is chronic disease. The Centers for Disease Control estimated in 2009 that 75% of all healthcare spending is related to chronic conditions.[10] By definition, a chronic condition is one that usually does not just go away. Over time, chronic conditions require more attention, care, and cost. In fact, according to the Partnership for Fighting Chronic Disease, the average person with a chronic disease spends about five times more on health care than someone without. The same study reveals that over 45% of the population has at least one chronic disease and 25% of the population has two or more conditions.[11] Those figures represent only those people who have been diagnosed. There are many more people who may very well have a chronic condition that has yet to be detected and is therefore having an impact, but is not being treated.

To drive home the point with a specific example, consider diabetes, a well-known chronic condition that is having an enormous impact on costs. According to Diabetes.org, about 1 in 5 dollars spent in the United States on Healthcare is directly attributable to diabetes.[12] And, according to National Public Radio, while there are 29 million people in the United States who have already been diagnosed, there are an additional 8 million people who have the disease, but haven't been diagnosed, AND 86 million more people who have pre-diabetes, meaning that they already have elevated blood sugar levels and are at high risk of becoming a type 2 diabetic.[13] While diabetes is one of the worst offenders, the same case can be made for obesity, certain types of cancer and respiratory disease, arthritis, and other chronic conditions.

The good news as it relates to these preventable, chronic conditions is that if we understand who is at risk, we can target programs toward those people to help them manage the risks. Most risky behaviors that drive chronic diseases are known and can be identified through Health Risk Assessments which identify risky behaviors, such as poor diet, insufficient exercise, and excessive tobacco or alcohol use. In sum, modifiable health risks are associated with about 25% of healthcare costs.[14]

So the formula for reducing service consumption goes something like this:

1. Determine which employees are exhibiting risky behaviors
2. Stop the risky behaviors
3. Prevent disease
4. Decrease the number of consumed services
5. Save Healthcare $!

If only it were that easy, the problem wouldn't be as big as it is. The problem compounds because people do not remain static in their level of risk. Dee Edington looks deeply at the relationship between risk and healthcare costs in his book Zero Trends. In the book, he explains that if you segment your employee population into low-, medium-, and high-risk groups based on the number of risk factors they exhibit and then you monitor that population with time, people will move between risk groups. Low-risk people will become medium- or high-risk, medium-risk people will become low- or high-risk, and high -risk people will become medium- and low-risk.

Therefore, a one-time survey of your employee population is not sufficient; any gains that a company makes in one area identified as a good target for intervention can be completely wiped out by losses in other areas. To move

[10] http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf (26 August 2016)

[11] http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC (26 August 2016)

[12] http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html (26 August 2016)

[13] http://www.npr.org/sections/health-shots/2014/11/20/365279289/what-diabetes-costs-you-even-if-you-dont-have-the-disease (26 August 2016)

[14] https://www.researchgate.net/publication/286219235_The_Portion_of_Health_Care_Costs_Associated_With_Lifestyle-Related_Modifiable_Health_Risks_Based_on_a_Sample_of_223461_Employees_in_Seven_Industries_The_UM-HMRC_Study (26 August 2016)

beneficially over time, companies must monitor both the stock of risk (who is in which pool now) and the flow of risk (who is moving between risk categories). Only by managing the flows of risk better with time can you can obtain the desired results.

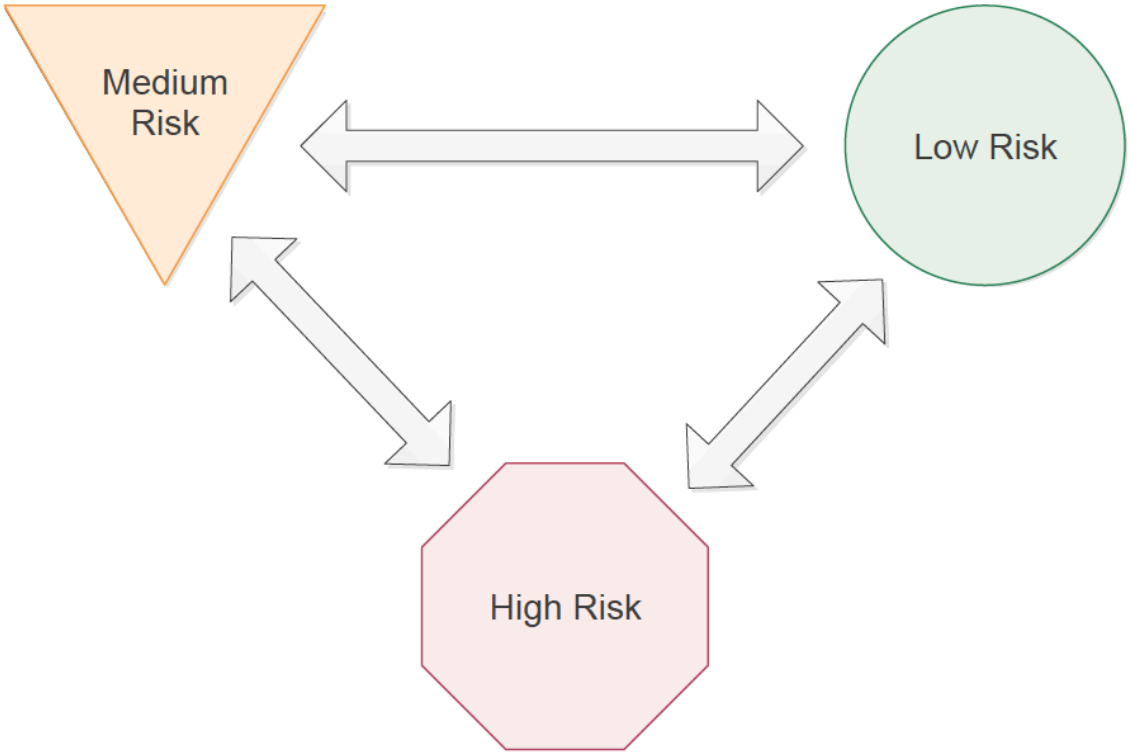


Diagram: To effectively manage the risk across your employee population and drive costs down, you not only need to understand who is in which risk category, but also how people move between risk groups over time. Ultimately, if the goal is to decrease the number of services consumed with time, a company needs to tilt toward a lower risk population, which means keeping lower risk people low risk, while moving higher risk people to lower risk.

It's this last part that most organizations do not understand or fail to implement, but it's the most critical component to the overall success with managing costs. To illustrate the problem, imagine you came to understand that many of your employees are smokers and that smoking was driving higher risk. A common response would be to invest in a smoking cessation program; if you did that and were successful a fair number of employees might actually quit. However, if you do not invest in keeping some people from starting to smoke, the net impact might not show any improvement.

The idea of "First, do no harm" is easy to understand, but often overlooked. Fundamentally, that's what we are targeting here. It's even captured as part of the Hippocratic Oath: "I will prevent disease whenever I can, for prevention is preferable to cure." [15]

How can an occupational medicine provider help with the process of risk reduction? First and foremost, providers can provide the tools and expertise required to help you understand your risks, which is the essential first step in the entire process. Beyond that, however, occupational medicine providers can help design programs that target individuals for specific health improvement initiatives. Is an individual in need of an active intervention like medication to move blood pressure down? Or, are they relatively healthy and just need some encouragement and monitoring for weight loss, exercise, and diet? Providers can provide this sort of individualized service while working under the privacy laws that an employer might not be able to do given the resources available. At the same time, a good partner will provide overall risk and cost guidelines so that

[15] https://en.wikipedia.org/wiki/Hippocratic_Oath (26 August 2016)

companies can be monitoring how effective their chosen partner is in improving overall health and reducing costs.

INCREASED WORKER PRODUCTIVITY

The third component of improving the overall health equation for companies is increasing worker productivity. While the term "productivity" is vague, there are some solid measures that can be tracked to demonstrate a return.

Chief among productivity measures are claims that are made due to health-related conditions, such as disability claims, worker's compensation claims, and sick days taken, collectively known as "absenteeism". If a worker is out sick or on disability, then they are not working and therefore not productive. According to a study in the Journal of Occupational and Environmental Medicine, high-risk individuals (those same individuals we described above) consistently exhibit higher rates of absenteeism overall than their low- and medium-risk counterparts. In general, the total time away from work increases with risk.[16]

Of course, absenteeism is itself a vague term and can be influenced by other external factors. For example, if an employee works at a remote site and needs to see a doctor in his office that is an hour away from his worksite, then just the ride time to the office will result in one or two additional hours off of work in addition to the actual time with the doctor. So something as fundamental as the location of the doctor can contribute to the overall absenteeism rate of employees and should be a factor in looking for a solution to reducing the overall absentee rate.

A second type of productivity loss is what some call presenteeism. For this sort of productivity measure, an employee may actually be at work, but is not capable of performing at peak performance. There are many types of presenteeism that present in different forms, making a universal measurement difficult if not impossible. One example might be sub-optimal performance due to a physical condition (e.g. headache

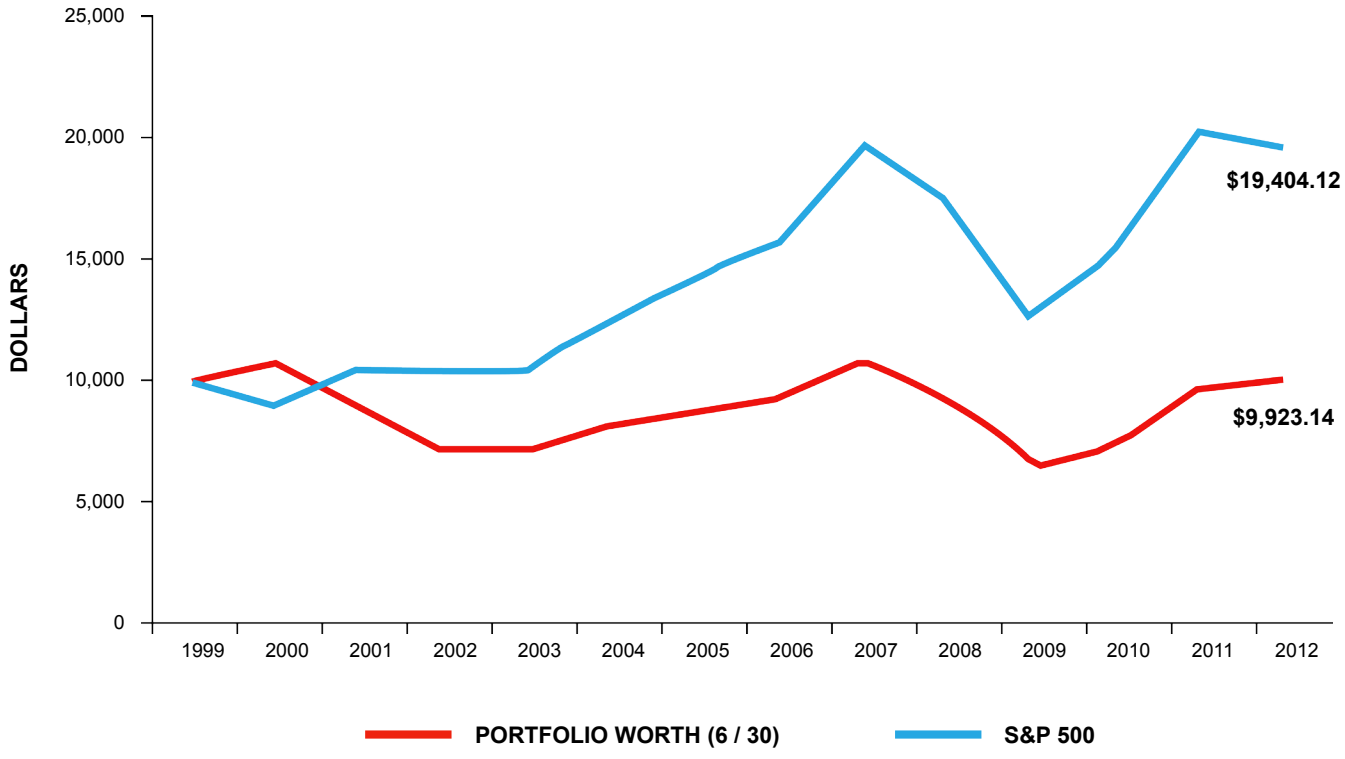


FIGURE 4. Portfolio excluding outliers versus S&P 500.

[16] http://umich.edu/~hmrc/tree/pdf/2002.pdf (26 August 2016)

or depression) or a production line shut down to deal with an injury. In these cases, the impact can be measured as a decrease in output per unit time. Another less obvious impact might be a decrease in quality or increase in defect rate. The unit output rate might remain unchanged, but the quality is degraded. In this case, the cost of presenteeism manifests in lost time and materials due to waste. While, direct measurement is not always possible, studies have indicated that the combined impact of presenteeism and absenteeism can be as much as 2.3 times as much as the actual costs to obtain the care.[17]

Solving the problems of absenteeism and presenteeism are not easy, but since the underlying causes are the same, the solution generally follows the same path as well. And that implies that companies need to focus on the health risk factors associated with their employee population. Most of the current research suggests that organizations concerned with these factors strive to obtain a "Culture of Health" and the work to date indicates that the results are well worth the effort. Probably the most prominent such study was published in 2013 in the Journal of Occupational and Environmental Medicine in which the authors compare the relative stock performance of a portfolio of companies that demonstrated a culture of health by being awarded the Corporate Health Achievement Award (CHAA) vs. the S&P 500. The relative results are shown below and demonstrate that the "healthy" companies severely outperformed the index.[18]

What exactly is a "Culture of Health"? At the highest level, however, it boils down to an executive-sponsored focus on the well-being of the employees as a core business strategy in order to create a competitive advantage. It is a proactive strategy focusing on prevention and early detection rather than a reactive posture that focuses almost exclusively on disease treatment. By taking this sort of approach, companies with a "Culture of Health" take control over health care costs and productivity losses and create organizations that are capable of performing at higher levels.

PARTNER SELECTION

A full-blown culture of health might not be your ultimate goal or even your first step. The above discussion was intended to outline some of the problems most organizations face, some of the underlying causes, and give ideas about how you can improve across whatever dimension is relevant for you. Regardless of where you are currently and where hope to be in three or five years, one of the most critical steps in getting to where you want to be is selecting both technology and service providers that understand the problems, your goals, and the means to get there. Such partners can efficiently collect, process, and report on health and safety data within an organization so that executives, healthcare providers, benefit managers, supervisors, and employees can process the information presented efficiently and use it to guide their decisions on a daily basis.

So what makes a good partner? While there is no one-size-fits-all answer to that question, there are many different characteristics that different companies will likely find useful depending on their perspective. This section will provide some food for thought for a conversation with the partners you're evaluating, whether they are technology partners, service partners, or any other partnership you might be considering.

WHAT SORT OF RELATIONSHIP DO YOU WANT WITH YOUR SERVICE PROVIDER?

Are you looking to fill a single specific role? Do you need a particular service in volume or do you need a variety of services to cater to a variety of unique circumstances? Do you need a visionary that can help develop a strategy that works for your organization? What roles are important to keep internal to your organization? Are you looking for one vendor or many? Do you need help filling a particular gap in expertise?

WHAT RESOURCES DO YOU HAVE AND WHAT ARE YOU GOOD AT?

Someone in your organization is, to some degree, already filling the needs you have today. That person has created a personal system or is using a commercial system that is designed for a purpose. What's good about what you have today and what can be done better? Are the people in place equipped with the right knowledge and tools to accomplish the goals? Can a partner supplement what you have effectively or do you need to find someone that can take on more of the responsibilities?

HOW WILL YOU INTERACT WITH YOUR PROVIDERS?

Even if you decide that most of your services will be outsourced, you still need to get data and to communicate. Do you understand what information you need and can you get it quickly? Who will be communicating processes, requirements, and results to your employees? How can you make sure that these communications are as seamless as possible? The

[17] https://www.acoem.org/uploadedFiles/Healthy_Workplaces_Now/HPM%20As%20a%20Business%20Strategy.pdf (26 August 2016)

[18] http://www.ndworksitewellness.org/docs/2016summit/link-between-workforce-health-safety-bismarck.pdf (26 August 2016)

default interfaces between organizations have been manual for a long time (e.g. physical mail, email, and fax). Are manual interfaces conducive to the level of reporting you require and your overall strategy of health for your organization?

Partnering with an occupational provider is very important. They can also be a resource for:

1. Recommending alternative (lower cost) treatments
2. Dispensing medications at a lower rate than retail pharmacies
3. Offer lab services that they've negotiated at a lower rate
4. Provide referrals to other specialists to get a lower rate

All of these services should come at a positive return to the company procuring them. The important choice comes down to picking an occupational medicine provider that can provide both the services you need and the technology that lets you recognize the full power of your return for taking control over your healthcare spend.

ABOUT THE AUTHOR

Matt Koerlin is the Director of Product Strategy for Healthcare at UL EHS Sustainability in Franklin, TN. Prior to UL, Matt spent 10 years at Emdeon (now Change Healthcare) and through his combined experience at UL and Emdeon has acquired a wealth of experience in addressing problems in healthcare for payers, providers, employers, and patients. With over 20 years' of technology experience and a background in Computer Science and Business, Matt brings a unique perspective to the problems faced by businesses and how technology can be used to address these problems in unique, productive, and profitable ways.