Building on a tradition of excellence from recent Western Occupational Health Conferences it is a pleasure to present you with a preview of the upcoming WOHC ’05 being held in Monterey. Our conference dates are September 15 through 17, with room blocks at the Monterey Plaza Hotel and Portola Plaza (formerly the Doubletree). Pre- and post-conference programs are scheduled on September 14 and September 18.

The Portola Plaza has been beautifully remodeled and will host many of our postgraduate sessions and workshops while the Monterey Plaza hosts our plenary sessions. Occupational and Environmental medicine is changing at a whirlwind pace with new science, new politics and new challenges to our careers. Your WOHC ’05 Planning Committee has named the conference: “New Horizons in Occupational Medicine.” Our endeavor this year is to look to the horizons of our profession and at the world in which we practice.

Our conference coincides with a national treasure: the 48th annual Monterey Jazz Festival. This is America’s oldest Jazz festival and on Thursday night we’ll have the “WOEMA Ribs & Chicken Barbecue” including a full, all-night gate pass to the Jazz festival. Get hip, listen to the beat and groove on!

WOHC ’05 will begin on Wednesday, September 14 with three “warm up” events. Join your WOEMA colleagues for a tour of Monterey Mushrooms, the largest mushroom farm in the world, growing, packing, and shipping over 100,000 pounds of mushrooms a day. Meet the scientists involved in the mycology of new spore research and taste Shiitake, Portobello and other exotic products.

Also on September 14, we offer a behind the scenes tour of the Monterey Bay Aquarium. Meet the scientists and veterinarians who care for tens of thousands of aquarium fish, reptiles and mammals. See the control rooms where water is regulated and meet the safety staff that supervises visitors and employees.

The annual WOEMA golf tournament will also take place on September 14. Dr. Peter Greaney is this year’s “WOEMA golf commissioner,” so tee off with Peter at Poppy Hills — a world class course as only the Monterey Peninsula can offer.

Our hope is to offer a facilities tour to all WOHC ’05 participants, so we plan to duplicate the Mushroom and Aquarium tours on September 15. Also on September 15, WOHC ’05 presents our popular postgraduate sessions including “Power Orthopedics,” an all day review of radiology, physical examination and pathology of the back, knee and shoulder. Other postgraduate sessions will include an OEM Journal Club moderated by past WOEMA and ACOEM president Bob Goldberg. Thursday will also feature a practical update on bracing, strapping, and taping techniques, “Be the Best Expert Witness and Master your Deposition” will be a

Continued on page 3
President’s Message

BY ROBERT ORFORD, MD

This year marks the 65th anniversary of the Western Occupational and Environmental Medical Association. It will be an exciting year, with challenges, opportunities, and most importantly, intellectual stimulation and fun ahead of us.

A recent NIOSH-funded study estimated that the costs of occupational illness in America total more than $171 billion per year, five times greater than the cost of AIDS and equal to the economic cost of all cancers.

With WOEMA’s five states including 15% of the US population, the costs attributable to occupational illnesses in our region alone are between 25 and 30 billion dollars annually.

Occupational medical practitioners are also increasingly responsible for health care and productivity management, and in this way we have the potential to influence an even larger segment of the economy. In doing so, it is important for us to work collectively towards the goals of our association and the broader aims of occupational medicine.

In the legislative arena, your Board and the WOEMA Legislative Affairs Committee continues to work closely with Mr. Don Schinske (telephone (916) 444-3568, email dschinske@am-group.us), is our legislative advocate. Please contact Mr. Schinske, or Legislative Affairs Committee Chair Steve Schumann, if you have any concerns in the legislative area, or intelligence that could help us.

Our educational initiatives continue to grow, with Occupational Medicine Grand Rounds planned in Los Angeles on May 17, 2005, and Phoenix on June 11, 2005. Also, the Western Occupational Health Conference, from September 15-17, 2005, is in an outstanding location, Monterey, during the annual Monterey Jazz Festival. Dr. Walt Newman and his committee members have been doing a tremendous job of planning.

Our relationship with our national organization, ACOEM, continues to strengthen, with both Dr. Pam Hymel and now Dr. Warner Hudson (replacing Susan Cassidy) on the ACOEM Board. Dr. Paul Papanek has agreed to lead WOEMA’s Delegation to the ACOEM House of Delegates. Many thanks to Warner for his efforts as our Delegation leader in the immediate past, and for his continuing support in this area.

In January, 2005, your Board met in Glendale, CA to discuss future directions. We heard excellent presentations by Dr. Peter Greaney, Dr. Bill Lewis, Dr. Phil Harber and our legislative advocate Don Schinske. These reports are the basis of articles that appear in this newsletter and in future issues. I hope you enjoy this exchange of ideas.
WOHC 2005
Continued from Page 1

popular seminar. A workshop on Workers Compensation Reimbursement will round out the seminars.

Once again, the Durand Media Group from Tennessee will host our Welcome Reception at the Monterey Plaza on Thursday evening. Libation, good food and sea lions will welcome us to Monterey Bay at this annual event outside on the deck.

Friday, September 16 we kick off the day with greetings from the Mayor of Monterey, Dan Albert and begin the plenary session with our keynote topic: “The Environmental Science and Human Ecology of Monterey Bay.”

Oceanographic and public health scientists from the Monterey Peninsula will help us examine the marine and human ecology issues of the region. Other important plenary session topics will include a clinical, evidence-based symposium on hand injuries and pain syndromes, a “point-counterpoint” debate on surgery vs non-surgery past the ACOEM guidelines, a seminar on Workers’ Compensation fraud both by employees and providers, and an overview of the use of the 5th edition of the AMA Disability Guidelines.

Special presentations will include an address by Dr. Cheryl Barbanel, president of ACOEM, the annual Johnstone address, and a Saturday keynote address by Dr. Ron Leopold, medical director of Metropolitan Life on the aging workforce. Saturday’s plenary session will conclude with a lecture entitled “Healthy Pleasures: Science and Evidence for a Life of Sensuality, Optimism, And Altruism” presented by Dr. David Sobel. Dr. Sobel will help us examine the scientific evidence encouraging us to eat well, be happy, dance and enjoy life.

No WOHC would be complete without WOEMA’s now-famous hospitality events. For spouses and guests we feature a day’s journey called “Moments with John Steinbeck” Our guide will read Steinbeck to us on board our bus down Cannery Row followed by a small group tour of the magnificent National Steinbeck center in Salinas. This will be followed by a special private lunch near Steinbeck’s boyhood home — a once in a lifetime opportunity not to be missed.

The signature event of WOHC ’05 will be the gala Jazz Dinner Dance Saturday evening, September 17 at the Monterey Bay Aquarium. We’ll take over this amazing world landmark for dinner, socializing with our lecturers, more mushroom tasting, and dancing to jazz music. Once again, an event not to be missed.

WOHC ’05 promises to be an overwhelming success, and will definitely sell out. We are limited to a block of 300 rooms and other rooms will be scarce or impossible due to the Jazz Festival. Please book your reservation NOW at the Monterey Plaza (800) 334-3999 or Portola Plaza (888-222-5851). We want WOEMA members to have first priority for rooms, and NOW is the time—before the conference gets publicity at AOHC and elsewhere.

See you in a few months at Monterey Bay for WOHC 2005!

For additional information about the Western Occupational Health Conference, please visit our website, www.woema.org, or call 415-927-5736.
Predicting the future is always challenging if not impossible. By tracking what happened in the past one could provide a glimpse of what might happen in the future.

Without going into detailed research, we know that there are a few downward and upward trends in the practice of OEM. The delivery of OEM services is tied to the practice of OEM and medicine in general.

The downward trends include:
- Decrease in significant chemical workplace exposures
- Decrease in the traditional industrial work environment
- Decrease in reimbursement for industrial medical services
- Decrease in autonomy of medical practice in general

The upward trends include:
- Increase in ergonomic related conditions
- Increase in demand for comprehensive health care delivery
- Increase in non traditional OEM practices
- Increase in legislative mandate for standardized care

What do these trends implicate in the future delivery of OEM? I believe that there are four components:
- More electronic connections
- More one-stop shop requests
- More consultative services on UR, med-legal and disability cases
- More demand for quality of care and patient satisfaction

Delivering cost effective and quality OEM services in the future almost requires the implementation of an Electronic Medical Record (EMR) system. The benefits of EMR are multiple. EMR facilitates proper documentation of services, maximizes coding and promotes e-billing. EMR can provide practice guidelines for medical providers at the time of office visit. Drug interactions and side effects are automatically revealed when medications are prescribed. Work status and other pertinent workers’ comp and occupational health related information can be documented and shared with the employer and/or claims examiner who may access specific parts of the database via a secured system. Provider profiles on quality and economic indicators can be monitored on a going forward basis. Future data mining on the disease trends and utilization of services can be done relatively easily.

Preventive, safety and industrial hygiene programs are important to the practice of OEM. As company resources are limited, these

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Workers’ Compensation: Legislative and Regulatory Trends

BY DONALD SCHINSKE, WOEMA’S LEGISLATIVE ADVOCATE AND POLICY ANALYST
ADVOCACY & MANAGEMENT GROUP, INC., SACRAMENTO, CALIFORNIA

The last time California’s Workers’ Compensation system was “reformed” was in 1993, when two major changes were added: the standard of treatment was based on the presumptive correctness of the treating physician, and the floor on insurance rates was moved. Those two changes, along with expansive legal interpretations and inconsistencies and ambiguities in the program itself led us to where we were by 2003, with almost seven cents of every payroll dollar going to workers’ comp premiums.

That year, 2003, saw the Legislature approve and the Governor sign two pieces of reform – AB 227 (Vargas) and SB 228 (Alarcon) – that did several things: 1) Changed the fee schedule, to be discussed later, 2) utilization of certain services was capped, and 3) presumptive correctness was transferred from the treating physician to the ACOEM Practice Guidelines.

The Governor and the business community were not overly impressed. Under threat of initiative, the Legislature scrabbled together SB 899 (Poochigian), which the Governor signed in April 2004. The bulk of details of SB 899 were delegated to the regulatory process. No one knew what to expect on this. Then, Governor Schwarzenegger appointed Andrea Hoch as the Administrative Director of the California Division of Workers’ Compensation, a state lawyer with no background in workers’ comp, insurance, or healthcare. She did have a reputation as being a good administrator and for “moving the freight” and she has done that. As of January 1, the statutory deadline, at least emergency regulations were in place for most of the major sets of regulation.

Emergency Regulations

Treatment Guidelines to be used for utilization review – At the moment, emergency regulations remain in effect that give primacy to the ACOEM guidelines. Last summer, CHSWC (Commission on Health and Safety and Workers’ Compensation) commissioned a RAND evaluation of ACOEM along with the existing specialty and industry guidelines. ACOEM nominally fared the best. CHSWC then made a series of recommendations to the AD, endorsing the use of ACOEM but also recommending that the AAOS (American Academy of Orthopedic Surgeons) guidelines on spinal surgery replace ACOEM on that subject. All indications are that the AD will do just that. But it’s tricky, obviously, to stitch one set of guidelines onto another.

There’s also the question of how to deal with injuries and illnesses not covered by ACOEM (about 70-80 percent of medicine) that isn’t “evidence-based.” ACOEM is viewed as having shortcomings in several areas: pain management, psychiatric illness and injury, and the physical modalities. Questions remain too about exactly how far evidence-based medicine can go. For instance, how many times do you order a blood test or x-ray simply because you know, given your relationship with a patient, that the test itself will make the patient feel better? Are you not “curing and relieving?”

Medical Provider Networks – Regulations are in the last phase, with a final hearing set for February 2 in San Francisco. Questions remain about whether direct contracting requirements between MPNs and providers are strong enough. Also, there continue to be questions about whether everyone who is willing and qualified to be in a network can get into one. The statute itself is pretty skeletal regarding MPNs, and this is one area where we might expect future legislation.

Permanent disability ratings – Emergency regulations became effective January 1; the main element was a switch to the AMA disability guidelines. Before the latest draft, the AD removed the apportionment requirement, which seemed unworkable. This part would have required physicians to guess as to which part of a disability comes from a current injury versus...
Workers’ Comp
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which part from a prior injury or condition.

Independent Medical Review – Emergency regulations were in place January 1st, with a formal comment period underway and then a formal hearing on March 16. IMR is essentially the fourth (and final) opinion available to an employee, and a reviewer outside of the network. An earlier draft required IMR physicians to be in an “alternate” specialty to the treating physician, which was odd. The latest language, more appropriately, says “appropriate.”

In early 2005, as expected, a bill has introduced to regulate insurance industry rates, as the Democrats have wanted to do. SB 46 (Alarcon) calls for the Governor, Insurance Commissioner and Attorney General to appoint a panel that would set maximum rates.

Worker’s comp reform will also be in the courts. The CAAA (California Applicant Attorneys Association) filed suit in November specifically claiming that MPNs disrupt for care. There was no plaintiff so the case was thrown out, but they will find plaintiffs now. Additionally, the CAAA has filed suit challenging the permanent disability rating system. The suit is based on a UCD study showing that payments to workers could drop as much as 70 percent. The intent of the change was to add consistency to the ratings, not to seek savings, and the fact that savings may be generated is the basis for the challenge.

Network Discounts – There are key areas that will require discussion and consideration in the coming year. We need physicians to say, “We can’t provide discounts at these levels.” The discounts jeopardize access and quality of care. Regarding the new law around causation (the former AOE and COE determination) one board member said, “We are now no longer able to turn an injury ‘off.’” They go back to the QME system and the QMEs have been well trained to “split the baby in half” and will never say it is not workers’ compensation. Employees are claiming work injuries just because their pain is felt at work. A denied claim is then sent through the QME process and then the claim is accepted. This has expanded our coverage of workers’ compensation injuries. The basic distinction is that IMR is the process for challenging treatment for accepted claims and QME is the process for denied claims.

Fee Schedule – The reforms of 2003 called for a new fee schedule by 2006 that pegged the aggregate for medical services to 120 percent of Medicare. The AD is allowed to pick any system that hits that aggregate mark. In the interim, the Evaluation and Management codes have been raised to at least 100 percent of Medicare, while the procedural and surgical codes took a five percent hit. However, huge disparities remain between reimbursement for cognitive and procedural codes. One problem with the statute is that if the AD does not take action, the fee schedule will stay the same. Another large order of business – and one that all physician organizations probably agree – is that the fee schedule must be detached from Medicare. Medicare payments are set to go down five percent in 2006 and down five percent again in

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Workers’ Comp
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2007. We have to detach the OMFS (Official Medical Fee Schedule) from Medicare.

CIGA – There are some other possible tweaks to the system that have been talked about and which CHWSC has explored at various times. One involves CIGA (California Insurance Guarantee Association), which pays the claims if an insurer is bankrupt or insolvent. Two percent of every policy goes into the CIGA fund to pay compensation claims, but the problem with this funding is that many employers use high deductible policies. In essence, the amount of the deductible escapes the two-percent tax, which shifts some of the costs onto other policies.

More Issues in 2005 – The concern regarding broker’s fees is another area that must be resolved. The question is: how do we moderate what the middlemen make? There are larger questions as well: How well will the ACOEM guidelines fill their appointed role? What process will ACOEM adopt to fill in its own gaps, and to what extent will it reshape the guidelines to serve as a practicable UR tool? ACOEM is attempting to tackle issues involving mental health. Four-hour training seminars for adjusters are being implemented, and an attempt is being made to get non-clinicians to understand the guidelines.

WOEMA can generate excitement by generating knowledge.

problem solving. For example, New Zealand has had a combined system of workers’ compensation and we would benefit from learning the details of how this system has succeeded. Closer to home, there is a bill in Arizona this year to approve a ballot measure that would amend the state constitution to prohibit alcoholically impaired workers from receiving benefits. The courts long ago ruled that while it’s possible to determine that someone is impaired on the job, it’s not possible to show that alcohol caused the accident. Additionally, there are proposed changes to the Administrative Rules in Hawaii. The ODG (Official Disability Guidelines) have been adopted as the treatment guidelines, with ACOEM chapters 1-7 to be referenced as an “expression” of appropriate treatment “philosophy.”

Over time, we will likely see greater use of treatment guidelines in workers’ compensation systems around the country, with a greater push toward incorporating outcomes data, quality measures and pay for performance.

Cedaron Medical, Inc. offers software fully integrated with the “Guides to Evaluation of Permanent Impairment—5th Edition”. Designed to simplify your work by providing concise and accurate documentation for Workers’ Compensation, personal injury and disability cases.

For product information, contact Cedaron at 800-424-1007 or via email at cedaron@cedaron.com.
Fasting serum glucose levels and a diagnosis of diabetes are independent risk factors for several major cancers per a ten-year prospective cohort study of 1,298,385 Koreans (829,770 men and 468,615 women) aged 30 to 95 years. Using Cox proportional hazards models and controlling for smoking and alcohol use, the stratum with the highest fasting serum glucose (> or =140 mg/dL) vs. lowest level lowest level (<90 mg/dL) had higher death rates from all cancers combined (hazard ratio [HR]=1.29 overall; =1.22-1.37 in men; and = 1.23 in women). For pancreatic cancer, HR= 1.91in men; =2.05 in women. Significant associations also found for cancers of the esophagus, liver, and colon/rectum in men and of the liver and cervix in women. JAMA. 2005 Jan 12;293(2):194-202

The CDC issued Guidelines for Nonoccupational HIV Prophylaxis that call for a 28-day course of a three-drug regimen of highly active antiretroviral therapy, but only if a high-risk exposure occurred within 72 hours of treatment initiation. The CDC guidelines cited studies and a recent study of 700 patients evaluated 12 weeks after nPEP was initiated. Of the seven hundred, 7 individuals seroconverted (6 of the 7 seroconverters reported other high-risk encounters in the prior 6 months). These guidelines are for the first time issued covering accidental exposure to the virus outside of the health care workplace. MMWR 2005;54[RR02]:1-20

Effective weight loss was achieved in morbidly obese patients after undergoing bariatric surgery and substantial majority of associated conditions experienced complete resolution or improvement was the conclusion of a meta-analysis of 136 fully extracted studies with a total of 22,094 patients, (19% men, 72.6% women; mean age = 39 y/o). Mean percentage of excess weight loss was 61.2% (47.5% w/ gastric banding; 61.6% w/ gastric bypass; 68.2% w/ gastroplasty; and 70.1% w/ bilipancreatic diversion or duodenal switch. Operative mortality (< or =30 days) was 0.1% to 1.1% for various procedures. Diabetes was resolved in 76.8% of patients; Hyperlipidemia improved in 70%; Hypertension was resolved in 61.7%; Obstructive sleep apnea was resolved in 85.7% JAMA. 2004 Oct 13;292(14):1724-37.

Working no more than 75% of the work time with the computer was a prognostic factor for musculoskeletal symptoms in the neck/shoulder and elbow/hand, and a high influence on the speed of work was a prognostic factor for symptoms in the low back, a multivariate logistic regression analyses questionnaire study of 5033 office workers in 11 Danish companies, over an approximately 18 month period (3361 respondents) indicated. Occup Environ Med. 2005 Mar;62(3): 188-94

Nearly one in five scientists (18%) said that they have been pressured to approve or recommend approval for a drug despite reservations about the safety, efficacy or quality of the drug and more than one-third (36%) of scientists were not at all or only somewhat confident that “final decisions adequately assess the safety of a drug” per a late 2002 survey conducted by the HHS Office of Inspector General (OIG) and polled 846 FDA scientists, with (47%) completing the survey. http://www.oig.hhs.gov/oei/reports/oei-01-01-00590.pdf

One-year cardiovascular event-free survival was 88% in the exercise group, which was significantly better than the 70% rate among stented patients per a study of 101 men with stable CAD and an indication for percutaneous intervention (PCI) who were assigned to angioplasty plus stenting or to a regular physical exercise program. This was also associated with a highly

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News You Can Use
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significant 36% reduction in high-sensitivity C-reactive protein from a mean baseline value of 4.2 mg/L in the exercise group. Also, After VO2 max, rose by a mean of 16% in the exercise group, vs. 6% in the PCI group. Internal Medicine News February 1 2005 • Volume 38 • Number 3

Higher infant sibling exposure in the first 6 years of life was associated with a reduced risk of multiple sclerosis (MS) when duration of contact with younger siblings aged less than 2 years in the first 6 years of life, based on 136 cases of magnetic resonance imaging-confirmed MS and 272 community controls, matched on sex and year of birth and measured using infant-years of contact. 1 to <3 infant-years, odds ratios (OR) = 0.57; 3 to <5 infant-years, =0.40; > or =5 infant-years, = 0.12. The “hygiene hypothesis” was discussed. JAMA. 2005 Jan 26;293(4):463-9.

The age-adjusted odds ratio OR for cataract for men in the highest vs lowest quintile of tibia lead level was =2.68. Blood lead levels were not significantly associated with cataract. The mean age = 69 years and cataract was identified in 122 of the men 642 aged 60 years and older in the Normative Aging Study (NAS). Tibial (cortical) and patellar ( trabecular) bone lead levels were measured by K x-ray fluorescence between 1991 and 1999 and eye examination data (collected every 3-5 years) for the period after the bone lead measurements were taken. JAMA. 2005 Jan 26;293(4):425

Acupuncture seems to provide improvement in function and pain relief as an adjunctive therapy for osteoarthritis of the knee when compared with credible sham acupuncture and education control groups. The study included 570 patients with osteoarthritis of the knee (mean age 65.5 years) who received 23 true acupuncture sessions over 26 weeks (controls received 6 two-hour sessions over 12 weeks or 23 sham acupuncture sessions over 26 weeks). 6-minute walk distance, health inventory, WOMAC pain scores and patient global assessments were measured. Ann Intern Med. 2004 Dec 21;141(12):901-10

Clinical Occupational Medicine in an Academic Setting

The University of California, San Francisco (UCSF) School of Medicine in partnership with UCSF Medical Center is pleased to announce the availability of a fulltime clinical faculty position in Occupational Medicine. The faculty member will serve as medical director of one of the nation’s largest university-based employee and occupational health services, and will lead our multidisciplinary occupational medicine teaching practice. In addition to these clinical responsibilities, there are multiple opportunities for collaborative teaching, consulting, and clinical research within the UCSF Division of Occupational and Environmental Medicine. The incumbent must be board certified in Occupational Medicine, and three to five years of clinical and/or occupational health management experience is preferred. An academic appointment is anticipated in the clinical series at UCSF (Division of Occupational and Environmental Medicine, Department of Medicine).

UCSF is recognized as one of the most distinguished healthcare institutions in the world, renowned for its integration of medical research and clinical care for the benefit of patients. We offer comprehensive resources for career development, competitive salaries, and a comprehensive benefit package that starts on the first day of hire and includes a generous vacation and lucrative retirement plan.

For immediate consideration, please email your CV to: Janice.Schwartz@ucsfmedctr.org or mail CV to UCSF Medical Center Human Resources, 2233 Post Street, Suite 302, Attn. Janice Schwartz, San Francisco, CA 94115.

UCSF is an affirmative action/equal opportunity employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for Vietnam-era veterans and special disabled veterans.
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apprehension of the medical facts of
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lack of lenity regarding your
patient’s situation? As the coin of
the realm seems to be Evidence-
Based Guidelines, there is a place
on the web sponsored by the
Colorado Division of Workers’
Compensation that may help you
turn contention into progress. To
access, go to www.coworkforce.com
/dwc/rules%20pdf/rulescontents.asp
and scroll down to “Rule XVII
-Medical Treatment Guidelines.”
Guidelines in PDF or Word format
are available for review (.pdf files
seem to be the more detailed) and
categorized by subject. [Note: An
easier path to these is to: (1) go to
the main page, “http://www.cowork-
force.com/search.asp,” (2) type into
the Search Area: ‘RULE XVII
Exhibit F’, (3) pick the top choice
(‘rulescontent.asp’) from the search
results that come back and then (4)
scroll down to the “Rule XVII-
Medical Treatment Guidelines”
section].

The Medical Treatment Guidelines
cover low back pain, UE, LE, CTS,
thoracic outlet syndrome, shoulder
Injury, CTD, CRPS/RSD, C-Spine
Injury, Chronic Pain Disorder, and
traumatic brain injury. Some are
a few years old but the wealth of
detail will inform and help support
your opinions. Most of the topics
covered in depth are those that
come into contention in UR
(epidurals, discograms, etc.) and the
depth and focus of information
contained in these is quite helpful
in articulating a position. These
Guidelines do not, of course, have
California legislative sanction as do
ACOEM’s, but for areas where the
ACOEM Guidelines are tenuous or
silent, these Guidelines provide a
wealth of quality information and
are worth checking out.

Bonus Site:
If Medical Guidelines are your
meat, you can gorge yourself on the
metaphorical Atkin’s diet of sites at
www.guideline.gov – this is the
NGC (National Guidelines
Clearinghouse) and is a
comprehensive database of
evidence-based clinical practice
guidelines and related documents
that contains abstract/summaries of
each guideline, links to full-text
guidelines, Palm-based PDA NGC
summary downloads, a guideline
comparison utility, “Guideline
Syntheses” (includes NCG
comparisons of guidelines
developed in different countries), an
annotated bibliography database
and an electronic forum, NGC-L,
for exchanging information on
clinical practice guidelines. Lot’s of
good stuff well organized.

WOEMA Sets Legislative Priorities for 2005

1. WOEMA will support legisla-
tive and regulatory efforts in its
five Western states to promote the
use of the highest quality level of
evidence-based medicine in their
respective Workers’ Compensation
insurance programs.

2. WOEMA will work with allies
and coalitions to detach the
Official Medical Fee Schedule
(OMFS) in the Workers’
Compensation Program from the
Medicare Fee Schedule.

3. WOEMA will work with allies
and coalitions to encourage adoption
of an RBRVS-based Workers’
Compensation Fee Schedule that
uses a single conversion factor.

4. WOEMA will support legisla-
tive or regulatory proposals that
thwart the practice of requiring
physicians to accept discounts to
provide services through an MPN
(Medical Provider Network.)

5. WOEMA will support
California legislative and adminis-
trative proposals to separate and/or
elevate health functions and
administrative structure relative to
other government health programs.

6. WOEMA’s Legislative Affairs
Committee will review emerging
legislation, regulations, or adminis-
trative proposals in all five states
that affect the practice of occupa-
tional and environmental medi-
cine.

Adopted by the WOEMA Board of
Directors at their January 23, 2005
meeting.
Delivery of OEM Services
Continued from Page 4

programs are eliminated or down sized. Small to medium size companies cannot afford these in-house programs. When these services are needed, they are needed almost immediately to avoid bad publicity and expensive consultative fees. As Americans become weightier, wellness and fitness programs are becoming attractive. OEM programs and departments that provide a menu of services such as preventive medicine, industrial hygiene, safety, wellness and even lifestyle counseling as “optional” items will be leaders in the delivery of OEM services.

With occupational health service reimbursements being regulated in most states, non-traditional practices will become important aspects of OEM services delivery. California’s workers’ compensation reform encourages the use of Utilization Review. Many OEM physicians are working part-time on UR services due to better reimbursement rates. Furthermore, med-legal cases and disability evaluation claims not limited to workers’ compensation may be taken up by OEM physicians who render evidence-based medical opinion and have better understanding of the judicial system. A friendly personality with willingness to educate attorneys, adjusters, union members, human resources, corporate decision makers and juries using down-to-earth language will fare well in the med-legal consultative practice.

Workers’ compensation has been a significant cost driver in OEM services. Not only are current workers’ compensation system not effective in managing injured workers’ medical conditions, excessive wastes due to over utilization and litigation are common. The State of California passed sweeping reform bills that include SB 899 and implementation of Medical Provider Network. OEM programs that can recruit and retain good primary care clinicians who are not confrontational, are willing to practice medicine based on Guidelines, and are willing to communicate with claims people, employer representatives and specialists to ensure patient satisfaction will come out ahead. Reasonable, fast access to specialty services will be an important component to ensure quick return to work when such referrals are medically appropriate.

Welcome new WOEMA Members

WOEMA continues to be the largest component of ACOEM, now with over 750 total members thanks to the following new members who joined this winter……

Robert G. Aptekar, MD Los Gatos, CA
Gary L. Baker, MD Lakewood, CA
James G. Beauchene, MD Phoenix, AZ
Washington G. Bryan, II, MD Los Angeles, CA
Michael D. Butcher, MD Los Gatos, CA
Craig A. Clark, PA-C Riverside, CA
Gerald A Coniglio, MD, FACS Mt. Morris, NY
William H. Dillin, MD Los Angeles, CA
Mary Dunning, FNP, MHS Napa, CA
Becky Foster, MPH South San Francisco, CA
Sally J. Glunt, MSN, FNP, COHN-S Windsor, CA
Jennifer A Hackwith, APRN, BC, MSN Las Vegas, NV
William C. Janss, MD El Paso, TX
Hannah H. Kim, MD Loma Linda, CA
James A. Lemus, MD City of Commerce, CA
Kevin Maher, MD Richmond, CA
Steve Novak, MD Indio, CA
Stephen B. Prepas, MD Newport Beach, CA
Thomas M. Reilly, MD, APROF Pasadena, CA
Kurt A. Spurgin, DC Indio, CA
Oscar C. Tuazon, MD City of Industry, CA
Diane Vogelei, RN, MSN, OHNP San Francisco, CA
Robert C. Walker, DO Indio, CA
Philip Westbrook, MD Carlsbad, CA
Norman P. Westhoff, MD, MPH San Francisco, CA
Erik Won, DO Fullerton, CA
Grand Rounds in Occupational Medicine

WOEMA / Mayo Clinic Grand Rounds
Saturday, June 11, 2005 – 8 am – 12 noon
Mayo Clinic Hospital, 5777 E. Mayo Boulevard, Phoenix, AZ

Sponsored by: Mayo Clinic College of Medicine, Mayo School of Continuing Medical Education, and Western Occupational and Environmental Medical Association

Topics:
- The Future of Occupational Medical Services
- Cardiovascular Diseases in the Workplace
- Update on DOT Exams and Transportation Medicine

Faculty:
Natalie Hartenbaum, MD, Chief Medical Officer, OccuMedix, Dresher, PA
Robert R. Orford, MD, CM, Chair, Division of Preventive and Occupational Medicine, Mayo Clinic, Scottsdale, AZ
Peter Schnall, MD, MPH, Center for Occupational and Environmental Health, University of California, Irvine, Irvine, CA
William R. Lewis, MD, Regional Medical Director, Concentra Medical Center, Phoenix, AZ

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