Some Predictions for Occupational Medicine in the New Era of Health Care Reform

Paul J. Papanek, MD, MPH, FACOEM

Some Predictions for Occupational Medicine
In the New Era of Health Care Reform

Paul J. Papanek, MD MPH FACOEM
WOEMA Webinar
February 17, 2011

Legal - Educational Disclosures

- Dr. Papanek
  - Works in Los Angeles for Kaiser Permanente, which has an interest in increasing its base of Occupational Medicine practice.
  - Serves as Board Chair of WOEAMA (Western Occupational and Environmental Medical Association)
  - Consults for the UCLA ERC.
  - Has received honoraria for giving lectures for ACOEM on Occupational Medicine policy.

Acknowledgments

- Thanks to:
  - Drs. Pam Hymel and Ron Loeppke (ACOEM Board)
  - Drs. Douglas Martin, James Butler, Richard Johnson for their sustained leadership in the ACOEM Private Practice Section
  - Dr. Michael Levine (Co-Chair), and other participants in the ACOEM Private Practice Task Force

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Expanded Opportunities for OccMed (in a Time of Change)

1. National health care reform (PPACA)
   More workplace preventive services
   (including Health and Productivity Management / HPM services).

2. Expanded OSHA regulations may bring more opportunities for Health and Safety consulting.
   (Putting occupational physicians into the OSHA Standards)

Expanded Opportunities for OccMed (in a Time of Change) - cont.

3. GINA regulations will probably require sturdier information firewalls managed by medical departments, to allow HPM programs. Note: PPACA has a “GINA slipknot” for wellness.

4. Participation in Health Teams and the Medical Home, and grant writing for small employers.

Improving Occupational Medicine Practice - ACOEM Private Practice Task Force (2010) -

- Get more “paying patients through the door” (Clinical preventive services, HPM, compliance planning).
- Leverage PP-ACA for Occupational Medicine.
- Get Occupational Physicians more involved in OSHA compliance.
- Marketing - more awareness and respect for OEM among our potential customers.
- Improve OccMed fee schedules.
**Occupational Medicine - Lessons from Europe**

- Should Occupational Medicine be "inside the tent" -- part of the health insurance marketplace?
- British National Health Service (NHS) started 1946. - OccMed opted out of the NHS. Payment for OEM services would instead be through private contracts with employers.
- "Double coverage" by British employers.
- NHS-Plus (1989) - OEM gets back inside the tent.

**Occupational Medicine in Europe, a "new" speciality**

**Lessons from Europe**

EU Directive on Occupational Medicine, 1989

- EU Directive on Occupational Medicine 1989 specifies that all workplaces shall have Occupational Medicine services, at one of three tiers.
- Services to include:
  - Pre-placement and periodic examinations
  - Preventive planning
  - Delivery of general clinical preventive services
  - Injury care, including first aid

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1. All working people in Europe should have equal access to comprehensive occupational medical services.
2. In view of the importance in European economies of small and medium enterprises, a strategy must be developed to meet the needs of the large numbers of workers employed in this sector.
3. The unique contribution of the occupational physician in recognizing work-related ill health must be acknowledged in general health care systems. The occupational physician is aid in diagnosing and managing these conditions should be more widely sought by other medical specialties. His/her skills in advising on prevention programs, rehabilitation for work and implementation of appropriate measures to help employers meet their other legal responsibilities should be made more widely known to industry, in particular through effective multidisciplinary occupational health teams.
4. The social and economic costs of work-related ill health make it mandatory that there should be new efforts to expand occupational medicine in Europe. All doctors practicing in primary care and family practice settings should be encouraged to improve their competencies in the non-specialist occupational medicine arena.
5. Health promotion is an integral and important part of the occupational physician’s functions. Workers and their representatives should be effective partners in deciding upon health promotion programs in the workplace.
6. The European networks of occupational physicians must continue to work together to strengthen the profession and to train the substantial numbers of practitioners needed.

Lessons from Europe
EU Directive on Occupational Medicine, 1989

RESULTS -
• Compliance with this Directive varies by country, but overall is now estimated to be above 50%.
• In many countries, OEM physicians now comprise as high as 15% of all practicing physicians.
• How do Occupational Physicians get paid as a result of the Directive?
  - Sometimes 100% from employee’s insurer.
  - More typically, about 50% from employee’s insurer and 50% directly from employer.

Number of physicians* working in OCCUPATIONAL MEDICINE in Europe, by number of inhabitants

<table>
<thead>
<tr>
<th>Country</th>
<th>Per Inhabitants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>one per 4,000</td>
</tr>
<tr>
<td>France, Belgium, Holland</td>
<td>one per 5,000-10,000</td>
</tr>
<tr>
<td>Norway, United Kingdom</td>
<td>one per 30,000-70,000</td>
</tr>
<tr>
<td>Sweden, Denmark</td>
<td>one per 100,000</td>
</tr>
<tr>
<td>United States</td>
<td>one per 100,000 - 300,000</td>
</tr>
</tbody>
</table>

* includes specialists and non specialists

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Work-related death rates, approx 2006
Canada = 6.2
USA = 4.0
EU = 3.5
California = 2.6
(deaths / 100,000 workers)

Workplace Fatalities, California 2003 - 2005

Lost-time Work Injury Rates, EU 1995 - 2005
(Lost time 3 days or more, per 100,000 workers)

Note - these rates are much lower than in the US, but not directly comparable.
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Rates of Lost-Time* Work Injuries -
USA and California, 1987 - 2008

Disability Management -
Lost work days after various work injuries,
European Union - 2005

Disability Management - California, 2008

* Lost Time = at least one day
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ACOEM’s Healthy Workforce Now - Lobbying for workplace prevention

The Health Care Reform Bill
PP-ACA

Key ACOEM provisions are in the Healthcare Reform Bill

From ACOEM: HealthyWorkforce Now. Thanks to Drs. Hymel and Loepke.
GINA -
What’s at the door?

- GINA, the Genetic Information and Non-Discrimination Act, passed in 2008, prohibits use of genetic information for "underwriting purposes" - interpreted as prior to enrollment in a health plan.
- Information available at [http://www.genome.gov/Pages/PolicyEthics/GeneticDiscrimination/GINAINfoDoc.pdf](http://www.genome.gov/Pages/PolicyEthics/GeneticDiscrimination/GINAINfoDoc.pdf)
- Proposed regulations, now delayed, would preclude employers from including family history or other genetic information in Health Risk Appraisals. For treatment, physicians are permitted to get FH.

Employer-Sponsored Plans
- the “GINA Slipknot” (Sec. 1201)

- In general for Health Plans - no discrimination for pre-existing conditions (no exclusions or higher premiums).
- Premiums can vary only by age band and geographic area.
- Up to 50% higher premiums permitted for tobacco users.
- BIG EXCEPTION - wellness programs offered by employers
  - Applies only for employer-based plans
  - Permits premium discounts, rebates, or other cash incentives
  - Such incentives can be based on "health status factors" if certain requirements are met
- Starts in 2014.
- For the individual market, comparable wellness demonstration projects in 10 states, to start in 2014.

How will Employer-Sponsored Wellness Programs work?

- No restrictions at all on cash incentives for:
  - Re-imbursement for gym memberships
  - Participation in HRAs, if conditioned on participation rather than results
  - Obtaining preventive care for essentially ANY specific condition (the VALUE target) - waiver of copay or deductible
  - Smoking cessation materials
  - Getting health education.
  - Health conditions subject to preventive care are broadly conceived (examples - seasonal allergy meds, migraine prophylaxis, personal exercise programs for back or shoulder pain)
Employer-Sponsored Wellness Programs - “Programs Subject to Requirements”

- For other preventive programs, cash rewards permitted up to 30% of premium. (Can increase to 50% of premium on petition.)
- These incentives can be outcome-based
- Possible examples - weight control, fitness participation, medication compliance, BP control, HbA1c success, CPAP use, vaccine compliance.
- Programs will probably be subject to legal scrutiny to assure that they are “well designed” and “not a subterfuge for discrimination”
- Open enrollment at least annually
- Available to all without discrimination, with a “doctor’s note” exception

Wellness Programs and the “GINA Slipknot” (conclusion)

- These extra incentives and variations in premium will probably be closely scrutinized, but they allow employer-sponsored plans to give cash rewards (or discounts) for health factors associated with productivity, such as smoking status, fitness, CPAP use, and compliance with preventive measures such as vaccine compliance.
- Occupational physicians will have a role in creating and maintaining “firewalls” between the medical record and HR departments.

How Many Workers Will Be Covered by Employers vs Exchanges?

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The HEALTH HOME TEAM
for patients with certain chronic conditions
Optional by state - (Sec. 2703)

- Providers who are part of a “Health Home Team” get paid extra for coordinating care.
- Chronic conditions include:
  - Mental health conditions
  - Substance use disorder
  - Asthma
  - Diabetes
  - Heart disease
  - BMI > 25
- The team can include Occupational Medicine physicians.

Community Health Teams
To support the “Patient Centered Medical Home” (Sec. 3502)

- Grants available to states and local jurisdictions, to form “Community Health Teams” to provide preventive services to persons with the above chronic conditions
- New fee schedules
- Broad membership on the “team”
- Incentive for EHR and record sharing

New Guidance from HHS
Secy

- Model (HRA’s) Health Risk Assessments expected for Medicare recipients within 2 years (Sec. 4103).
- Model employer-based wellness programs, expected within 2 years (Sec. 4303)
- Community Transformation Grants to promote healthy living, including nutrition, fitness, smoking cessation (Sec. 4201)
Grants to small employers for “workplace wellness programs”
(Sec. 10408)

- Eligible, if < 100 employees
- Program to run from 2011 to 2015
- Amount - $200 Million available
- Can cover HRA’s, education, incentives, on-line, other behavioral tools
- PREDICTION - the Occupational Physician as grant writer

Preventive Services Are Covered with No Copay or Deductible

- All plans, including Medicare and Medicaid, to cover preventive services rated A or B by USPSTF without copay.
- New Preventive Services Task Force established to publish best practices.
- Incentives for participation encouraged

Conditions for which better control is proved to be associated with improved job performance

<table>
<thead>
<tr>
<th>Item</th>
<th>Assessment</th>
<th>Evidence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>History</td>
<td>Yes</td>
</tr>
<tr>
<td>Asthma</td>
<td>History</td>
<td>Yes</td>
</tr>
<tr>
<td>Migraine</td>
<td>History</td>
<td>Yes</td>
</tr>
<tr>
<td>Obesity</td>
<td>History</td>
<td>Yes</td>
</tr>
<tr>
<td>Smoking</td>
<td>History</td>
<td>Yes</td>
</tr>
<tr>
<td>Seasonal allergic rhinitis</td>
<td>History mainly</td>
<td>Yes</td>
</tr>
<tr>
<td>Inflammatory arthritis</td>
<td>H&amp;P</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetic control</td>
<td>Lab</td>
<td>Equivocal</td>
</tr>
</tbody>
</table>

... achieving value
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Prevention = Productivity Savings
Study of 500,000 HRA’s, with 77,000 repeated HRA’s

- After averaging across the health risks and chronic conditions included in the study, it is revealed that the modifiable health risks are nearly five times more costly than the chronic conditions ($212,577 per modifiable health risk vs. $42,695 per chronic condition).**
- ** per 1,000 employees per yr

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Low Risk</th>
<th>High Risk</th>
<th>Excess</th>
<th>Costs ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>7.83</td>
<td>18.50</td>
<td>10.75*</td>
<td>4,627</td>
</tr>
<tr>
<td>Stress</td>
<td>7.1</td>
<td>16.75</td>
<td>9.65</td>
<td>4,060</td>
</tr>
<tr>
<td>Glucose</td>
<td>9.25</td>
<td>14.00</td>
<td>4.60*</td>
<td>2,500</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>9.15</td>
<td>13.45</td>
<td>4.28*</td>
<td>1,380</td>
</tr>
<tr>
<td>Physical activity</td>
<td>7.38</td>
<td>11.20</td>
<td>3.82*</td>
<td>1,753</td>
</tr>
<tr>
<td>Weight</td>
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</tr>
<tr>
<td>Cholesterol</td>
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<td>1,576</td>
</tr>
<tr>
<td>Tobacco use</td>
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<td>11.24</td>
<td>1.96*</td>
<td>300</td>
</tr>
<tr>
<td>Nutrition</td>
<td>8.25</td>
<td>10.05</td>
<td>1.80*</td>
<td>980</td>
</tr>
<tr>
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<td>1.20*</td>
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</tr>
</tbody>
</table>

* = 0.0001

JOEM 2011-
HRAs and Impairment

TABLE 4: Productivity Impairment Rates for Individuals Classified as Low or High Risk for Each of the Modifiable Health Risks

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</tbody>
</table>

* = 0.0001

JOEM 2011-
HRAs and Impairment

TABLE 5: Estimates of annual loss in productivity by health factors for 1,000 employees

<table>
<thead>
<tr>
<th>Health Factor</th>
<th>Prevalence (%)</th>
<th>Prevalence Rate (%)</th>
<th>Annual Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetics</td>
<td>5.33</td>
<td>27.5</td>
<td>686,975</td>
</tr>
<tr>
<td>Physical activity</td>
<td>2.14</td>
<td>14.00</td>
<td>456,367</td>
</tr>
<tr>
<td>Depression</td>
<td>6.87</td>
<td>9.8</td>
<td>259,883</td>
</tr>
<tr>
<td>Weight</td>
<td>6.87</td>
<td>35.9</td>
<td>246,365</td>
</tr>
<tr>
<td>Poor nutrition</td>
<td>9.35</td>
<td>9.0</td>
<td>182,509</td>
</tr>
<tr>
<td>Asthma</td>
<td>7.96</td>
<td>9.0</td>
<td>123,657</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>1.40</td>
<td>11.4</td>
<td>70,275</td>
</tr>
<tr>
<td>Migraine</td>
<td>1.48</td>
<td>9.4</td>
<td>40,157</td>
</tr>
<tr>
<td>COPD</td>
<td>6.36</td>
<td>1.6</td>
<td>20,000</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.92</td>
<td>1.0</td>
<td>10,120</td>
</tr>
<tr>
<td>Current tobacco use</td>
<td>0.47</td>
<td>0.7</td>
<td>20,490</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>9.32</td>
<td>9.0</td>
<td>19,937</td>
</tr>
<tr>
<td>Chronic heart disease</td>
<td>1.75</td>
<td>0.7</td>
<td>6,103</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>5.62</td>
<td>0.2</td>
<td>2,880</td>
</tr>
</tbody>
</table>

Annual Cost due to decreased productivity, as a result of each risk factor
* For 1,000 employees, out of annual payroll of $50 million.
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The HPM Toolkit

Guidelines for HRA Use

Detailed Information on HRA's

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ACOEM Initiative, 2010 - 2011
ACOEM is in talks with Fed-OSHA for an enhanced Haz Com Standard

- Many European countries serve as a model.
- Possible adoption of a generic OSHA safety standard, based on California IIPP’s (Injury and Illness Prevention Programs).
- Put the OccDoc into the OSHA Standards.
- Include HPM in OSHA-mandated preventive planning.

Study in Process, 2011 - Do IIPP’s Work?

Evaluating the Effectiveness of California’s Injury and Illness Prevention Program and Compliance Officers’ Inspections
Partnership with RAND and the University of California, Berkeley

One of the recommendations of the Health and Safety Research Activity Committee was to rigorously identify the consequences of different regulations, policies, and practices with respect to job safety and health standards and enforcement through workplace inspections. CHSWC, RAND, and the University of California, Berkeley, are conducting a study to identify the recommendations with respect to the policies and practices that increase the effectiveness of the compliance officers’ inspections of ensuring injury and illness reporting. The research could help in the ability of occupational health and safety officers to prevent injuries, potentially preventing a significant number of injuries and illnesses. This study will identify the following:

- Whether firms that comply with Labor Code Section 6501 have lower injury and illness rates and better experience modification factors than similar firms which do not.
- Whether firms which improve their compliance with Section 6501 experience reductions in injury and illness rates.
- Which provisions, if any, of Labor Code Sections 6503 are most closely associated with reductions in injury rates. The rule includes seven substantive provisions, each of which can be cited separately.
- Whether there is any relation between the stringency of enforcement of Labor Code Section 6503 and reductions in injury rates.

Injury and Illness Prevention Programs - Cal-OSHA compliance is probably not so good.

Twenty-Five Most Frequently Cited Title 8 California Code of Regulations (CCR) Standards in 2008

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Total Violations</th>
<th>Severe Violations</th>
<th>Percent of Severe Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3208</td>
<td>Injury and Illness Prevention Program</td>
<td>3069</td>
<td>84</td>
<td>2.7</td>
</tr>
<tr>
<td>3295</td>
<td>Heat Stress Prevention</td>
<td>1128</td>
<td>160</td>
<td>14.2</td>
</tr>
<tr>
<td>3299</td>
<td>Construction Injuries Prevention Program</td>
<td>983</td>
<td>24</td>
<td>2.5</td>
</tr>
<tr>
<td>3294</td>
<td>Hazard Communication</td>
<td>787</td>
<td>13</td>
<td>1.7</td>
</tr>
<tr>
<td>3232</td>
<td>Electrical/Environmental</td>
<td>594</td>
<td>222</td>
<td>37.6</td>
</tr>
<tr>
<td>3233</td>
<td>Hand/Arm/Feet/Back Injuries</td>
<td>518</td>
<td>7</td>
<td>1.3</td>
</tr>
<tr>
<td>3247</td>
<td>Reporting and Investigation of Injuries</td>
<td>518</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3245</td>
<td>Records to Operate Air Tools</td>
<td>415</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>5344</td>
<td>Respiratory Protection Equipment</td>
<td>417</td>
<td>7</td>
<td>1.7</td>
</tr>
</tbody>
</table>

CHSWC has commissioned a study of the effectiveness of IIPP’s for 2010.
Source: CHSWC Annual Report 2009
Opportunities for Occupational Physicians after Health Care Reform

- HPM and benefits administration for employer sponsored plans, behind a GINA-compliant firewall.
- Participation in “Health Home” team
- Health and safety planning under a more stringent HazCom standard.
- Assist small employers to obtain grants for workplace wellness programs
- Market, design, and deliver preventive programs to employers.

Additional Discussion

- Other suggestions
- Personal experiences
- Prioritization