

The Workers' Compensation Health Initiative: At the Convergence of Work and Healths

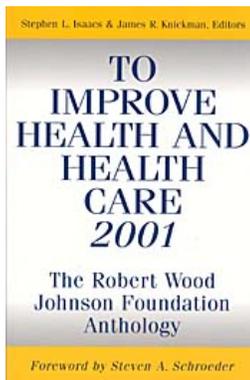
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Editor's Introduction

In 1910, New York enacted the country's first workers' compensation law. Wisconsin followed a year later, and by 1949 every state had passed a workers' compensation statute. The theory behind workers' compensation is simple—both employees and employers trade risk for certainty. Employees exchange the risk of going to court—which could result in a financial bonanza but more likely will return nothing—for the certainty of receiving limited compensation for their work-related injuries. Employers agree to pay job-related injury claims, whether or not it was their fault, and in return are assured that they will not be sued.

Although workers' compensation was created to simplify claims and avoid lawsuits, it has evolved into an expensive, complicated, legalistic system that all-too-often pits an injured worker against an employers' insurance company. In 1998, about \$16 billion was paid out to provide medical care for job-related injuries and illnesses through the workers' compensation system. Although this represents just 1.3 percent of all health care spending, at its best high-quality workers' compensation care can promote the well being and employability of workers and improve the productivity of American businesses.

In the late 1980s and early 1990s, many states reformed their workers' compensation systems, allowing managed care organizations to provide medical care for injured workers and encouraging the integration of workers' compensation and other health care systems. President Clinton included similar changes as part of his health reform proposals in the early 1990s. These developments piqued the interest of the Robert Wood Johnson Foundation, which in 1995 funded a national program called the Workers' Compensation Health Initiative to better understand the workers' compensation system and to promote innovations in how care is delivered to injured workers.

This chapter by Allard Dembe and Jay Himmelstein explains the workers' compensation system, the research undertaken by the 21 grantees supported by the program and key findings from their work. It places the findings in the context of other efforts to improve workers' compensation, and concludes with a discussion of the emerging trends and policy implications.

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The numbness and pain in Lidia Fernandez's hands began in the spring of 1996 and grew steadily worse. Like many immigrant female workers in Manhattan's garment district, Lidia had worked for years in a small, congested factory operating sewing machines, tending equipment for making button holes, and, most recently, as a "floor girl" involved in inspecting wedding gowns, clipping off excess thread and hanging the finished dresses on elevated racks. Many of Lidia's co-workers—predominantly young Italian, Chinese and Latin American women—experienced similar hand and wrist discomfort. Her pain and numbness progressed, but Lidia kept working. "I didn't have a choice," Lidia said. "I have to continue working. I live by myself. I need the money." When the pain finally forced her to see a doctor, she was distressed to learn that her union's health insurance plan would not cover the costs of her medical care: "They said my problem is caused by my job and should be covered by workers' compensation. They wouldn't have anything to do with it." When she filed a claim with her employer for workers' compensation, she was similarly disappointed. "They denied coverage," she said. "The claims adjuster didn't believe that it was work-related." In a desperate attempt to get the matter resolved, Lidia hired a lawyer, who pursued the case through the adjudication process of the New York State Workers' Compensation Board. More than three years have now passed, and Lidia's claim is still pending. "The judge's decision is expected next month," Lidia said. "It's been a nightmare."

Unfortunately, Lidia's experience is not at all uncommon. Recent studies by investigators from the Mt. Sinai School of Medicine found that 79 percent of claims for work-related carpal tunnel syndrome in New York are denied by workers' compensation insurance carriers.¹ Of those cases adjudicated through the state's administrative justice process, more than 96 percent are eventually decided in favor of the injured worker. But the researchers found that the length of time between claim filing and the judge's decision averages 429 days. Since all work-related disorders are supposed to be covered exclusively through workers' compensation insurance, most general health plans will not pay for medical treatment once a workers' compensation claim has been filed. Consequently, injured workers are often left without access to effective medical care, despite the presumably comprehensive and full coverage guaranteed to

virtually all workers under state workers' compensation laws. Similar barriers to access for medical care involving occupational conditions have been verified in numerous other studies.²

In one respect, Lidia was lucky. Her union, the Union of Needletrades, Industrial and Textile Employees, or UNITE, operates a special occupational clinic at the Union Health Center in New York City. With grant support from the Robert Wood Johnson Foundation's Workers' Compensation Health Initiative, UNITE has developed a financing plan that allows a worker to borrow money from the union's benefit funds to pay participating physicians while workers' compensation claims are being adjudicated. Through this plan, Lidia was eventually able to obtain diagnostic testing and therapeutic surgery for her carpal tunnel syndrome. "If it weren't for the UNITE program, I wouldn't have received any care," she said. "I would have been helpless." With continued funding from the Robert Wood Johnson Foundation, researchers from Mt. Sinai and the New School University's Center for Health Policy Research are now systematically examining the impact of the UNITE program on patients' medical and vocational outcomes and the quality of care.

Three hundred miles to the north, in Clinton County, New York, near the Canadian border, Daniel Devito remembers his encounter with the workers' compensation medical care system. Devito, a 31-year-old employee of a local bottling company, fell over a pallet while delivering cases of bottled soda. Two weeks later, his resulting backache had gotten worse, and pain appeared along the sciatic nerve in the back of his leg. "One night, the pain in my leg was so intense I couldn't sleep," he said. "By five in the morning, I couldn't move my leg and the pain was unbearable. All I could think about was getting to the emergency room. I called for an ambulance."

The ambulance brought Devito to the Champlain Valley Physicians Hospital Medical Center in Plattsburgh, 15 miles away. The area around Plattsburgh, like many rural areas in the United States, has few medical providers who specialize in occupational medicine or are well-versed in workers' compensation insurance and rehabilitation for injured workers. Clinton County has virtually no penetration by traditional health maintenance organizations or managed care service providers. The region has few of the resources needed for aggressively managing the medical treatment of work injuries. The 1995 closing of a local Air Force base had resulted in the loss of 2,500 jobs, delivering a devastating blow to the region's economy. In an attempt to revitalize the area's employment base, a local group of business and health-care leaders identified the improvement of workers' compensation medical care as a key component in attracting new industry. A community coalition was established—the North Country

On the Job Network, or NCOTJN—with representatives from the Chamber of Commerce, local employers, health care providers, labor organizations, city and county government and the Champlain Valley Physicians Hospital Medical Center.

When Devito reached the hospital, a nurse case manager from NCOTJN was there to meet him. During the next four weeks, the NCOTJN case manager stayed with Devito at every step of his treatment and recovery, making sure that he received appropriate care and was quickly referred to qualified specialists, expediting office visits, ensuring that no delays in treatment occurred and acting as a liaison to facilitate communication and planning between the patient, his employer, the workers' compensation insurer and a variety of health care providers. Unlike typical workers' compensation arrangements in which the case manager works directly for a compensation insurer or the employer, the NCOTJN case manager is officially an agent of the community coalition, representing the patient's and the community's interests. In the contentious world of workers' compensation medicine, which often pits employers and their insurers against workers and their lawyers, the objective perspective of the NCOTJN case manager was welcomed.

"I trusted her better than I trusted the doctors," Devito says of his case manager. When Devito twice suffered a severe allergic reaction to medication prescribed by his doctors, the NCOTJN case manager suggested that Devito discuss the situation with a local pharmacist and have the pharmacist call the doctors to work out a change of medication. "It was a brilliant idea that I wouldn't have thought of myself," he says—one of several good ideas that he credits with achieving his successful recovery. "She found a physical therapist right in my town, because I was having difficulty making the trip to Plattsburgh. She even got me hooked up with a chiropractor, which would have been almost impossible to get approved without her help."

Case management is only one of several services offered by the NCOTJN community coalition. It regularly sponsors educational seminars on occupational medicine, bringing in national experts to meet with local providers. The coalition employs a telemedicine system for consultations with providers in remote areas who are treating workers' compensation cases. Through a grant provided to NCOTJN by the Workers' Compensation Health Initiative, researchers from the Duke University School of Medicine are conducting studies to assess the impact of the coalition's efforts on the cost and the quality of care, along with the workers' experiences in getting appropriate medical treatment and attaining full recovery. For Daniel Devito,

the efforts of the NCOTJN and its case manager are easy to summarize. In his opinion, "She was on my side."

OBTAINING CARE FOR WORK-RELATED CONDITIONS

These case histories illustrate some of the many challenges individuals face in seeking treatment for work-related injuries and illnesses, and a few of the new approaches being taken to improve workers' compensation medical care. Although workers' compensation insurance was originally intended to ensure prompt access to medical care for all injured workers, significant barriers to obtaining appropriate care abound. For example, to qualify for workers' compensation coverage, a patient's condition must be clinically determined to have been caused in the workplace. In the early twentieth century, when workers' compensation laws were first enacted, most job-related cases involved acute, traumatic injuries that were relatively easy to identify and trace to workplace accidents. But the majority of today's cases involve nonspecific back pain, hand and wrist discomfort, musculoskeletal ailments, respiratory illnesses and other disorders for which there is an indistinct connection with job activities and a range of reasonable medical opinion about the degree of work-relatedness.

Few medical schools provide extensive training in the recognition and treatment of occupational ailments. Practicing physicians have little time or incentive to visit patients' workplaces or fully investigate possible occupational causes of illness. Many clinicians dislike the adversarial nature of workers' compensation and the extensive administrative procedures required in some states when treating occupational cases. As a result, some physicians either avoid seeing injured workers altogether or fail to evaluate adequately suspected work-related conditions. A recent study by researchers from Harvard University found that physicians at a large health maintenance organization failed to diagnose properly and report cases of occupational asthma 21 percent of the time, in part because they did not obtain detailed work histories.³

Medical care delivered to injured workers often requires specialized services that go beyond what would be customary in the typical primary care setting. For example, to prove that a patient's condition is work-related, and thus eligible for payment through workers' compensation, special diagnostic testing may be required. Moreover, to qualify patients for the wage-replacement benefits that are also provided through workers' compensation insurance, medical providers must often perform additional tests and procedures, including the evaluation of impairment and vocational function, and the assessment of job demands and work limitations. Medical practitioners are expected to consider the patient's needs for retraining and job

accommodation and to work closely with physical therapists, occupational therapists and rehabilitation specialists to achieve a speedy recovery of vocational function and minimize work disability. These medical actions are often surrounded by controversy in the combative workers' compensation system. This can complicate the medical care delivery process and embroil all parties, including doctors, in legal actions and lengthy administrative procedures. These factors can delay, and possibly jeopardize, the provision of needed services.

Medical care for workplace injuries and illnesses is one element in the broader context of management-labor relationships. The employer generally selects the workers' compensation insurance carrier and determines medical care arrangements. In most states, employees are restricted in their ability to alter the plan or choose their own medical care providers. In many cases, injured employees are not permitted to obtain care from their regular primary care practitioner, and this restriction may result in discontinuous care and incomplete medical records. The recent introduction of managed care and restricted provider networks into the workers' compensation setting is seen by some workers as part of a concerted campaign to strengthen employer control over care and further restrict employee choice.

Indeed, in many states, managed care provisions were first introduced as part of broad workers' compensation reform legislation enacted between 1992 and 1994. This legislation aimed at curbing the escalating cost of workers' compensation medical care in the late 1980s and early 1990s. During that period, average workers' compensation medical care costs grew at an annual rate of 14 percent, exceeding by 30 percent the rise in total national health expenditures. In response, more than twenty states passed laws to contain costs. These laws contained provisions that reduced wage-loss benefits, tightened eligibility requirements, and introduced the use of restricted networks, utilization review, discounted fee schedules and mandatory treatment guidelines. Until recently, few studies had been undertaken to assess the impact of these reforms on the costs and quality of care.

IMPROVING WORKERS' COMPENSATION MEDICAL CARE

The Robert Wood Johnson Foundation's involvement in workers' compensation was sparked in 1993 when it received several proposals from state workers' compensation agencies to evaluate pilot cost-control and managed care programs. Its interest was further stimulated that same year by the Clinton administration's call for integrating workers' compensation and general health care into a single "twenty-four hour" coverage scheme under the proposed Health Security Act. In 1995, the Foundation established the Workers' Compensation Health Initiative, or WCHI, a national grantmaking program

supporting demonstration and evaluation projects to test new models for improving quality and containing the cost of workers' compensation medical care. A national program office was created at the University of Massachusetts Medical School to direct this six-year, \$6 million initiative.

In the mid-1990s, other agencies also launched efforts to study and improve health care for injured workers. In April 1996, the National Institute for Occupational Safety and Health, or NIOSH, designated occupational health services research as one of 21 priority areas in its National Occupational Research Agenda, and instituted two rounds of grant awards in 1996 and 1999 for investigators studying the delivery of medical services to workers with occupational injuries and illnesses. At about the same time, the nonprofit Workers' Compensation Research Institute, in Cambridge, Massachusetts, began a multiyear effort to create a national research database for studies of workers' compensation medical care and to conduct analyses of the impact of provider networks and other new health care developments.

Since its inception, the Workers' Compensation Health Initiative has awarded 21 grants to a variety of institutions and agencies. Projects supported through the Initiative have included 24-hour medical care plans that cover both work-related and non occupational cases, the creation of new techniques for managing work disability, the development and evaluation of medical practice guidelines for work-related disorders, the formation of community- and union-based coalitions to enhance workers' compensation health care, innovative approaches to case management for workplace injuries, and a nationwide effort to develop standardized performance measures for workers' compensation managed care organizations. Recipients of grants have included state government agencies, community coalitions, private health care systems, professional societies, labor unions, employers and research organizations. A complete listing of grant recipients is provided in Exhibit 6.1.

RECENT RESEARCH ADVANCES

Through the efforts of the Workers' Compensation Health Initiative, NIOSH, the Workers' Compensation Research Initiative, several state workers' compensation agencies and independent researchers, new information is beginning to emerge that provides a better picture of the key factors determining the cost and the quality of workers' compensation medical care. Some findings from the new research are:

IMPACT OF MANAGED CARE

Studies from Florida, New Hampshire, Oregon, Washington and other states have indicated that the use of managed care techniques in workers' compensation saves money, but that patient satisfaction with care

is diminished.⁴ The evidence is inconclusive as to whether the use of managed care in workers' compensation affects medical and functional outcomes. Studies suggest that managed care can save as much as 20 to 30 percent, mainly through the introduction of discounted fee schedules, decreased utilization of medical services, and a lower incidence and duration of indemnity claims. For example, investigators in a WCHI-sponsored evaluation of Washington State's managed care pilot program found that the mean medical cost per injury declined 21.5 percent, but that 11 percent fewer patients expressed satisfaction with their care, particularly access to their medical providers.⁵ Preliminary results of data from research conducted by the Workers' Compensation Research Institute indicate that restricting care to designated networks of medical providers can decrease medical costs by 15 to 40 percent.⁶

COST DRIVERS

Considerable effort has been directed toward gaining a better understanding of what drives the costs of workers' compensation medical care. Several studies have documented that such costs are greater than costs for similar disorders treated under general health care plans.⁷ The difference has been attributed to the greater utilization of health care providers and medical services in workers' compensation cases—a utilization that is presumably linked to the need for supplementing traditional care with therapies and treatments that facilitate functional recovery and hasten the employee's return to work. Economists have identified other factors that may account for the cost differential, including the lack of patient cost sharing, the tendency for HMOs under capitated payment plans to shift cases and costs to the more lucrative fee-for-service reimbursement normally available for workers' compensation cases, and financial incentives motivating workers to exaggerate their symptoms or extend their disability periods.⁸

COMMUNICATION

A variety of studies have documented the importance of communication among patients, employers, providers, and workers' compensation insurers throughout the course of treatment for occupational injuries and illnesses, including rehabilitation and the return to work.⁹ Breakdowns in communications have been shown to result in delayed treatment, increased litigation, inappropriate care and unsuccessful return to work. New communications tools and procedures, such as the standardized Uniform Workability Reporting Form, developed by the WCHI-supported Mid-America Coalition on Health Care, in Kansas City, are showing promise in improving communication between parties and eliminating barriers to care. The use of specially trained nurse case managers has been touted as an effective way of improving communication and the coordination of care in workers' compensation.¹⁰ A new investigation of "enhanced" case management protocols for federal employees—involving patient education, improved communication with the employer, and a coordinated effort to redesign jobs to fit the restricted abilities

of injured workers—has recently been launched in a WCHI-funded study led by researchers from Georgetown University.

INTEGRATION OF WORKERS' COMPENSATION WITH OTHER MEDICAL CARE AND DISABILITY PROGRAMS

Pilot programs in California, Maine, Oregon and other states have explored the feasibility of coordinating or integrating medical care and wage replacement benefits available through workers' compensation with other private and public health insurance and disability benefits programs. The effort to establish such state-regulated "24-hour coverage" programs has proved to be technically challenging and politically difficult. Low enrollment in pilot programs impeded WCHI-sponsored research projects in California and Maine. At the same time, market-driven private sector initiatives blending disability and medical care plans for both work-related and nonoccupational conditions continue to evolve. The Minnesota Health Partnership, another WCHI grant recipient, has implemented a project of this type at several primary care clinics in the Minneapolis area. Employers participating in the project have established a coordinated plan in which medical providers evaluate the limitations on patients' work activity and offer disability management guidance, whether the condition is work-related or not. For example, physicians assess the ability of patients with diabetes, arthritis, asthma and other common conditions to perform vocational activities like lifting, carrying, operating machinery and working in proximity to industrial chemicals. They then advise employers and employees about limitations on work activities and appropriate job modifications. Research studies to assess the impact of this program on patients' health status and vocational performance are now under way.

EXPANDED ASSESSMENT OF HEALTH CARE OUTCOMES

Traditional investigations of workers' compensation medical care have focused relatively narrowly on evaluating direct medical costs and the amount of time needed for return to work. However, several recent studies have demonstrated the inadequacy of relying on these limited conceptions of medical care outcomes in workers' compensation cases.¹¹ It has been argued that how quickly a patient returns to work is a misleading indicator of health care effectiveness, because the first return to work is often followed by subsequent episodes of work disability; one study estimated it occurred 61 percent of the time.¹² For these reasons, suggestions have been made for new methods to assess not only the direct economic results of work injuries but also their indirect consequences on vocational and social function, quality of life, psychological well-being and satisfaction with care, risk of reinjury, subsequent labor market experiences and other functional outcomes.¹³ NIOSH recently awarded grants for a variety of studies that have examined an assortment of such indirect outcomes.¹⁴ Numerous new research instruments have been

developed to measure these outcomes, including adaptations of standardized tools for assessing health status and quality of life; questionnaires on work limitations; devices to evaluate functional capacity; and approaches for evaluating residual pain, impairment and impact on vocational performance. In the spring of 1999, NIOSH and WCHI cosponsored a national conference on these issues entitled "Functional, Economic and Social Outcomes of Occupational Injuries and Illnesses: Integrating Social, Economic and Health Services Research."¹⁵

REHABILITATION AND RETURN TO WORK

Significant strides have been made in identifying many of the factors that contribute to a successful recovery and return to work following occupational injuries and illnesses. Some recent studies have suggested that a "sports medicine" approach featuring early intervention and aggressive physical therapy is effective in facilitating a shortened course of disability.¹⁶ Other studies have found that workplace accommodations and transitional duty assignments represent an effective strategy for a successful return to work. Scientists have recently described numerous predictors for the recovery of vocational function, including personal motivation and job satisfaction, social support mechanisms, mental health status and organizational factors like job stress, supervisory support, work pace, employer size and employment practices.¹⁷ An increasing number of medical authorities have suggested that early return to work and a prompt resumption of limited physical activity following low back injuries and other musculoskeletal disorders can help maintain functional capacity and minimize long-term impairment.¹⁸ This approach has been incorporated into the new treatment guidelines for the management of work-related musculoskeletal conditions recently released by the American College of Occupational and Environmental Medicine.¹⁹ Similar guidelines have been promulgated by several state workers' compensation agencies. WCHI-funded research studies are being conducted to evaluate clinicians' acceptance and use of these guidelines, and the impact on quality and functional outcomes of the mandatory practice guidelines issued by the Minnesota Department of Labor and Industry.

UNDERREPORTING AND OTHER BARRIERS TO ACCESS

Despite the promise of a no-fault system offering comprehensive medical benefits with no patient copayments, many injured workers face significant difficulties in obtaining appropriate and timely care. Recent research has begun to document the extent and nature of the problem. A growing body of evidence suggests that many injured workers may be reluctant to report work-related ailments owing to fear of employer reprisal, concern about losing their jobs, employer safety incentive programs that reward low claims frequency rates, language and cultural barriers and lack of knowledge about the availability of workers' compensation benefits.²⁰ In some states, low fee schedules discourage doctors from accepting

workers' compensation cases. Several studies have shown that despite the full benefits supposedly available, workers often incur significant out-of-pocket expenses in order to obtain treatment for workplace injuries.²¹ Many jurisdictions do not provide coverage for all occupational diseases. The federal Department of Energy, for example, has advocated federal legislation that would provide for treatment of workers suffering from beryllium poisoning contracted at government weapons sites. Preliminary evidence from several states indicates that barriers to workers' compensation care do not affect all workers equally, and that ethnic and racial minorities, the working poor, immigrants and migrant workers and teenagers are particularly vulnerable to workplace health hazards and inferior access to care.²²

EMERGING TRENDS AND POLICY IMPLICATIONS

As more information is acquired, concerns have mounted about whether cost containment strategies and recent legislative reforms jeopardize the quality of care provided to injured workers. Mistrust and litigation still pervade the system, and workers, employers, health care providers and policy-makers remain confused and frustrated about how to identify and obtain the best possible care. Several approaches are being considered for continuing to improve workers' compensation medical care.

ACCOUNTABILITY

Considerable interest has been expressed in devising ways to hold managed care organizations accountable for providing high-quality care to workers receiving treatment for occupational disorders. Some states, such as California, Florida and Oregon, have adopted certification requirements for managed care organizations that have established contracts with purchasers (employers or insurers) to provide medical services for injured workers covered under workers' compensation. Industry groups have developed accreditation standards for workers' compensation provider networks and utilization management programs. Model language to ensure the quality of care for use in contracts between purchasers and managed care organizations providing workers' compensation medical care were recently proposed in a study sponsored by the National Association of Insurance Commissioners.²³ The American Accreditation Health Care Commission, in a new project funded by WCHI, is leading an effort to develop a set of performance measurement standards for managed care organizations treating patients covered by workers' compensation, similar to the health care standards developed for health maintenance organizations by the National Committee for Quality Assurance. Most authorities contend that no single strategy for assuring quality-of-care will be sufficient by itself, but that a multifaceted approach drawing on market mechanisms, regulation and self-regulatory methods will be needed.

DEFINING THE QUALITY OF CARE

All such efforts to ensure quality are impeded by the lack of agreement about what constitutes high-quality workers' compensation medical care. Unlike the general health care arena, there are few generally accepted clinical measures by which to quantify the effectiveness of treatment in the most common workers' compensation cases. Employers and workers still argue about the relative importance of cost control and expedited return to work, and medical authorities are split about basic aspects of care, such as the advisability of rest or activity for recovery from low back pain. More research is needed that will broaden the assessment of outcomes beyond cost and return-to-work to include a wide range of health status and functional indicators, indirect social and economic consequences and medical services utilization.

INADEQUACIES OF EXISTING DATA

Until recently, the paucity of available data limited the research options. Historically, there have not been any standardized data collection protocols or instruments available for use in this field. Most studies have relied on claims administration databases maintained by insurers or state workers' compensation agencies. These were restricted primarily to basic payment and transactional information. Few data sources contained detailed information on utilization of medical services, health status, or workers' experiences with care.

During the past few years, prompted in part by the grant initiatives described above, state agencies and research institutions have launched studies that incorporate worker self-reported survey data, medical records review and expanded reporting by health care systems. Projects have been initiated to enlarge the use of computerized accident reporting and electronic data interchange, and to compile the resulting information into usable research databases. A large consortium of researchers directed by investigators at the University of Texas-Houston School of Public Health was recently awarded a WCHI grant to conduct a planning and feasibility study aimed at devising a standardized research methodology for use in the creation of a national database for the study of workers' compensation medical care.

DISSEMINATION OF INFORMATION TO KEY INDIVIDUALS AND GROUPS

It is difficult for injured workers, employers, insurers, health care systems, medical providers and state policy-makers to obtain information about workers' compensation medical care. Although some insurers, state agencies and health care institutions provide information about workers' compensation medical care, there are currently no centralized agencies or clearinghouses (other than the WCHI) focusing on this issue. To address this need, the WCHI awarded two grants in 1999 to establish model resource

centers in Rhode Island and California to collect and disseminate information about how to improve workers' compensation medical care. These centers, housed in state workers' compensation agencies, will help form broadly based stakeholder interest groups; acquire and release relevant state-specific data; conduct educational workshops and conferences; and disseminate information through Internet websites and other media. These models could help stimulate the creation of similar resource centers in other states and nationally.

INTERACTION OF WORKERS' COMPENSATION AND OTHER HEALTH CARE PROGRAMS

Recent studies suggest that care delivered under workers' compensation is not independent of care provided through other health care systems.²⁴ For example, the working poor, especially transient and part-time workers, may fluctuate between participation in workers' compensation and Medicaid programs. Individuals suffering chronic disabilities as the result of work injuries may end up receiving disability benefits from Social Security. As many as 11 percent of patients receiving care at community-based free clinics may be there because of work-related conditions.²⁵ Although many small employers do not offer health plans to their employees, most have to carry workers' compensation insurance, thereby creating a potential incentive for otherwise uninsured employees to frame their medical problems as work-related. These cross-system effects could have significant implications for health care policy and the design of health and disability insurance systems. To date, however, these issues have received limited attention from researchers and government policy-makers. They constitute an important area for research that needs increased consideration.

AT THE CONVERGENCE OF WORK AND HEALTH

Workers' compensation medical care is part of a larger dynamic involving the interplay between workers' employment experiences and their health. The occurrence of occupational injuries and illnesses is a clear indication of how work can affect health. But evidence is accumulating that job conditions and workplace demands may also play a role in coronary heart disease, hypertension, asthma, psychological disorders, and a variety of other common conditions.²⁶ Likewise, workers' health status and physical impairments can affect their productivity and job experiences.²⁷ Little is currently known about the complex connections between work, health and workers' health care.

Further study is needed to investigate working conditions as one of many interrelated social determinants of population health. Because of the inherent linkages among occupational disorders, health care and the management of work and functional disabilities, the workers' compensation system can shed light more

broadly on methods for enhancing chronic care and supportive services for people with restricted functional capacities.

New knowledge about the ways that work affects health (and vice versa) challenges old notions about the supposed rigid distinction between occupational and nonoccupational disorders, upon which the workers' compensation insurance system is based. If employment conditions can influence and help determine a wide variety of common ailments, then an integrated insurance plan and medical care arrangement covering all employee maladies, regardless of cause, might help foster greater continuity of care and decreased fragmentation of prevention, health promotion and rehabilitation efforts. Likewise, techniques that have been honed in the occupational medicine field for managing workers' disabilities and facilitating job accommodation for persons with physical and functional impairments have great promise for transference into the general health setting and stimulating new employment-based public health initiatives. Experience gained through the Workers' Compensation Health Initiative is helping to open the door into this new area of potentially great significance for employers, policy-makers and all those interested in the promotion of workers' health.

Notes

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EXHIBITS

6.1 Workers' Compensation Health Initiative Grantees