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Stay-at-Work/Return-to-Work
POLICY COLLABORATIVE

PolicyBRIEF

Keeping Workers with Medical Problems Employed: Can an Intervention That Succeeded Inside Workers' Compensation Succeed Outside?

Every year, more than 2 million workers across the nation lose their jobs or leave the workforce because of a medical condition. Many of them face economic hardship and become dependent on public benefits because they do not get the health care or support services that would allow them to continue working. Some states have adopted promising early-intervention strategies designed to help these workers stay employed, but the states could potentially do much more. This policy brief considers one option: making Washington State's Centers for Occupational Health and Education (COHE) program, a care coordination and quality improvement initiative that has been effective inside the state's workers' compensation system available to workers with non-compensable medical conditions.

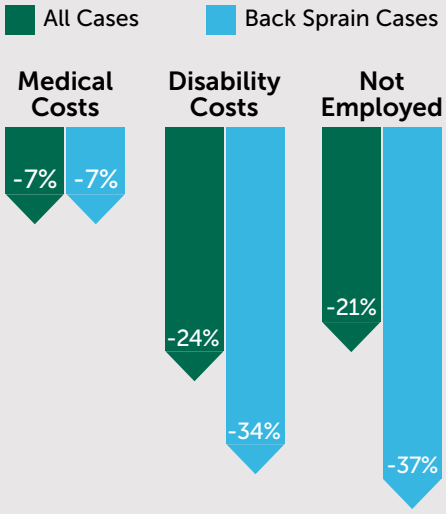
COHE INITIATIVE REDUCES COSTS, KEEPS WORKERS OFF DISABILITY ROLLS

In the early 2000s, Washington State's Department of Labor & Industries collaborated with industry and labor, health care providers, and other stakeholders to develop, pilot, and scale up the COHE program for workers' compensation claimants. These independent program centers:

1. Assign each worker a health services coordinator who, in the first three months after a claim is filed, monitors service delivery; identifies potential problems; and communicates with the worker, providers, employers, the Workers' Compensation Fund, and other parties to expedite the worker's recovery and return to work; if the worker remains on the road to recovery at the end of three months, services may continue for another three months.
2. Educate providers and other stakeholders on best practices for and emerging evidence on occupational health and return-to-work support.

A rigorous evaluation of the COHE pilot showed that, over 12 months, the program substantially reduced medical costs, disability payment costs, and the rate of workers not employed (see Figure 1). This is especially true in cases involving back sprains, which are common among workers who leave the labor force and enter Social Security Disability Insurance (SSDI). Preliminary follow-up results suggest that COHE reduced the number of workers who went on to receive SSDI in the next eight years by 26 percent.

Figure 1.
Estimated Reductions in Key Outcomes (At 12 Months)



Source for Figure 1
Based on results reported by Wickizer, T.M., G. Franklin, D. Fulton-Kehoe, J. Gluck, R. Mootz, T. Smith-Weller, and R. Plaeger-Brockway. "Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Healthcare: A Population-Based Intervention Study." *Medical Care* 2011, 49(12):1105–1111.

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There is a critical need to provide health care and other support for workers whose medical conditions would otherwise lead them out of the labor force and into SSDI. The Washington State COHE model for service coordination and quality improvement is demonstrably effective in providing such support in a fully integrated, public workers' compensation system.

REPLICATING COHE SERVICES

It would be easiest to replicate COHE services in other settings when one entity, like Washington State's Department of Labor & Industries, is responsible for financing and managing all services but does not offer COHE-like services. Examples include other workers' compensation funds and large employers such as the federal government and many state governments.

But the value of providing COHE-like services could be even larger in the fragmented systems to which millions of workers must turn for care, often falling through the cracks as they attempt to navigate the complex infrastructure on their own. However, the absence of an infrastructure that would support an integrated program like COHE makes it much harder to provide such services. Many public agencies and other organizations would have to join forces not only to develop an administrative infrastructure but also to address the privacy issues that are more problematic outside the workers' compensation system than within it.

Financing is also an issue. Health insurers and various public programs could fund the bulk of services, but the cost of services not covered by these programs would fall on workers and their employers. In addition, we know little about the extent to which other supports available to workers' compensation claimants and their employers in Washington State have been important to the success of the COHE program. These supports, which include wage-replacement benefits for workers and return-to-work assistance and incentives for employers, would not generally be available outside of the workers' compensation system. Although replicating COHE-like services seems like a promising approach, the best way to implement them and how successful they would be are open questions.

PILOT TESTING IS A SENSIBLE FIRST STEP

Several reasons make a strong case for pilot testing COHE-like services before scaling them up in a new setting. First, Washington State's experience shows that workers, employers, the state, and the federal government can all gain from a well-designed system that keeps workers employed, and there are good reasons to think that gains are not limited to when the worker is covered by workers' compensation. Second, states and other stakeholders should be aware of the challenges involved in putting these services in place. Third, the lessons Washington State learned from its pilot inside workers' compensation were instrumental to the success of the statewide scale-up.

We envision a pilot led by a state agency with support from existing COHEs and leaders in the public and private sectors, including a few large health insurers, health care systems, and other stakeholders. Health care providers would be randomly assigned to the "COHE-affiliated" group or to the "not-affiliated" group. Existing COHEs would train the former in how to use program services, and the workers served by these providers would be eligible for COHE services if they have a qualifying medical condition. As in Washington State's COHE pilot, data for tens of thousands of workers treated by hundreds of providers in both groups for up to two years would be needed to support the analysis.

THE WAY FORWARD

A pilot test outside of workers' compensation needs support from the federal government for two reasons. First, the costs of moving forward are likely to exceed the financial gains to a state or to any private organizations because there is no mechanism for compensating them for any share of the substantial savings expected to accrue to SSDI and Medicare. Second, a pilot will need the cooperation of federal agencies that have financing and oversight responsibility for state programs that would likely be involved in a pilot. But given Washington State's success, implementing and testing its workers' compensation model outside of workers' compensation seems worthwhile.

For more information about the Stay-at-Work/Return-to-Work Policy Collaborative, please contact R2WPolicy@mathematica-mpr.com.

Source document for this policy brief
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