How total population health management transforms care coordination across health, workers’ compensation and disability
Workers’ compensation and health care professionals have discussed Integrated Disability Management (IDM) for years. Advocates define a successful IDM program as one that can manage conditions, coordinate care and reduce lost time at work, while avoiding duplicating compensation payments and oversight resources. This strategy would reduce expenses, coordinate benefits and better control administrative services. With a stronger focus on care coordination, more successful clinical and return-to-work outcomes could be expected across health, disability and workers’ compensation. The Affordable Care Act (ACA) has accelerated the need for new program opportunities as health care management and wellness are increasingly examined on a continual basis. These conditions require that medical management utilizes the best cost containment tools in health benefits and workers’ compensation. In addition, the ACA means that human resource and risk management teams must develop strategic plans and approaches that reexamine traditional corporate health care initiatives. As a result, medical management is the key to improving absentee outcomes. Health care and disability management are critical components in effective human resources for health insurance, STD and LTD administration, as well as workers’ compensation.¹

The healthcare industry is rich in opportunities to better manage the clinical and financial outcomes of individuals with both traditional health management concerns and a need for clinical support due to an occupational or disability related event. Coordinating care across the spectrum of health-related events is difficult from a clinical context. This is due to an inability to use coordinated care models that incorporate the clinical management of an individual’s health condition while integrating and engaging in return-to-work and disability programs.
Defining care coordination

Care coordination can be defined as the spectrum of activities across utilization management, case management, disease management and health and wellness that support the healthcare management of individuals. The process should provide optimal clinical outcomes in the most cost-effective manner. Care managers coordinate clinical management among different practitioners, facilities and services using pre-approved commercial and proprietary guidelines that minimize service duplication, promote patient compliance and reduce confusion in navigating the healthcare system.

There are significant similarities between conditions or diseases that require health care, disability or workers’ compensation programs. These similar risk factors offer opportunities to coordinate care across these products. This potential for positively impacting both cost and outcomes using care coordination has gone largely unused. Emerging sources of data such as electronic medical records and social media are just starting to be tapped for additional insight into managing the conditions leading to poor health outcomes, high cost claims and adverse experience ratings. The opportunity now exists to add additional data sets to improve the predictive analytics capabilities available for care coordination by using total population health management (TPHM) strategies across health, disability and workers’ compensation programs.

Care coordination provides appropriate points of contact for both patients and providers so that the plan of care can be implemented efficiently to achieve beneficial outcomes in the healthcare reform environment. Clinicians participating in care coordination are inundated with disparate requirements for documenting the provision of care to ensure quality outcomes and reimbursement. In order to provide a general overview of care planning and claims documentation, integrated disability management data input includes multiple sources such as electronic health records, lab, pharmacy, and administrative systems. The data collected across the various systems are
then used to identify underserved or at risk individuals and populations, drive evidence-based medicine compliance, identify gaps in care, address quality reporting measurements and minimize adverse events due to care omission or redundancy. One of the most important aspects of collecting the clinical and financial data is providing anticipatory guidance and predictive analytics to enhance care delivery and coordination across the continuum of the healthcare system. There are both benefits and challenges when integrating clinical care information within a TPHM structure to enhance clinical, financial and administrative outcomes.

Current impact of health, disability and workers’ compensation costs

The national healthcare expenditure is projected to hit $3.207 trillion, or about $10,000 per person. Care coordination can help manage these expenditures. However, the financial impact of direct health and workplace costs in disability and workers’ compensation is not often exposed as an important aspect of developing clinical cost containment programs.

Occupational injury and illness in the US

- Roughly $250 billion a year; the same amount exceeds the costs of several other diseases, including cancer, diabetes, and chronic obstructive pulmonary disease (COPD) for the same year.

Workers’ compensation carriers cover only 21% of total costs.

For medical costs only, other insurance (non-workers’ compensation) covers 48%, Medicare covers 24%, and Medicaid covers 18%, with the remaining 10% being picked up by injured workers and their families.

Occupational injury and illness costs are shifted from workers’ compensation carriers to workers and their families, non-workers’ compensation insurance carriers, and taxpayers.

Public health programs currently pay more than 40% of the $67 billion annual medical cost of the occupational injuries and illnesses.

The potential financial return on a greater public investment in prevention research is quite substantial.

Impact of disability on income/poverty

Facts and figures

› Median monthly earnings for people with any kind of disability were $1,961 compared with $2,724 for those with no disability; those with severe disabilities had median monthly earnings of $1,577

› 28.6% of people aged 15 to 64 with severe disabilities were in poverty compared to 17.9% of adults with non-severe disabilities, and 14.3% of people with no disability were in poverty

› Among those aged 65 and older, 11.7% of those with severe disabilities were in poverty compared with 6.7% for those with non-severe disabilities and 5.0% for those with no disability

› More than half of adults aged 15 to 64 with severe disabilities received some form of public assistance (59.0%)

Source: US Census Bureau

High disability rates are increasing the need for care coordination. By age 50, a male head of household has a 36% chance of having been disabled at least once during his working years. At this age, 9% of men also have begun experiencing a disability that will last at least four years and greatly limit or eliminate their ability to work. By age 60, one in four men will have some sort of disability. These disabilities have a negative economic impact. Two-thirds of those experiencing a chronic and severe disability never return to work, and are reported to incur a 79% drop in earnings. One-sixth of families whose household head has a chronic and severe disability will fall below the poverty line.³

The cost of occupational injuries and illness are likewise quite severe. The National Safety Council estimated the cost of fatal and non-fatal work injuries was $198 billion in 2012. For comparison with the cost of other healthcare conditions, the Rand Corporation estimated the annual cost of dementia was between $159 and $215 billion in 2010, while the American Diabetes Association estimated the annual cost of diabetes was $245 billion in 2012.⁴

Many conditions predisposing individuals to workers’ compensation and disability are the same as those which increase the risk for adverse health care claims. These include chronic conditions such as
diabetes, excess body weight, tobacco use and high-risk activities or behaviors including frequent alcohol consumption or substance abuse. These conditions can be used to calculate the chances an individual will face a disability at some point in their life. For example:

- A typical female, age 35, 5’4”, 125 pounds, non-smoker, who works mostly at an office job, with some outdoor physical activities, and who leads a healthy lifestyle has the following risks:
  - A 24% chance of becoming disabled for 3 months or longer during her working career
  - A 38% chance that the disability would last 5 years or longer
  - The average disability for this individual would last 82 months

- If this same person used tobacco and weighed 160 pounds, the risk would increase to a 41% chance of becoming disabled for 3 months or longer

- A typical male, age 35, 5’10”, 170 pounds, non-smoker, who works an office job, with some outdoor physical activities, and who leads a healthy lifestyle has the following risks:
  - A 21% chance of becoming disabled for 3 months or longer during his working career
  - A 38% chance that the disability would last 5 years or longer
  - The average disability for this individual would last 82 months

- If this same person used tobacco and weighed 210 pounds, the risk would increase to a 45% chance of becoming disabled for 3 months or longer

Based on this information, it is clear that using a care management strategy that incorporates chronic disease management with return-to-work principles could form the basis for a care coordination program that incorporates the principles of disease and disability management.
Key challenges in managing workers’ compensation and disability cases:

Incorporating the principles of TPHM into disability and workers’ compensation affords stronger care coordination based on risk identification and engaging with the participant in the interventional program. A best-in-class approach to TPHM would include optimizing clinical care coordination management, utilizing healthcare analytics, leveraging a care management platform and improving process management. Doing so would result in improved health outcomes and reduced operational costs across multi-product lines.

The four pillars of an effective TPHM approach are:

› Knowing your customers, inclusive of the disabled or injured worker and the disability manager and workers’ compensation adjuster

› Engaging patients to drive behavioral change that not only improve health status but encourage returning to work

› Involving and aligning providers to address a holistic approach to clinical and occupational status improvement

› Measuring process and outcomes to identify and reduce the risk of an adverse clinical or financial event

The goal of a TPHM program should be to incorporate risk management into health, disability and workers’ compensation programs. This requires data for managing the clinical, behavioral and lifestyle needs of the enrolled population, as well as those at risk for disability or occupational events. By incorporating tools such as natural language processing, social media and digital interventions, a holistic understanding of an individual or defined population can be developed that allows for personalized communication. Improved care coordination outcomes can be achieved by using this in-depth knowledge to identify and focus outreach efforts on individuals with a propensity...
to make sustained lifestyle changes. Due to the scale involved in integrating a TPHM framework, many companies choose to take a modular approach to its implementation.

Considering the key challenges in disability and workers’ compensation, care management is an important step when initially developing an integrated population health approach.

Cost effectiveness and quality of care delivery are the most frequently cited care management challenges in workers’ compensation and disability. In general, outcomes for work-related cases are poorer than those for non-work related claims due to the lack of both care coordination activities and access to qualified providers who are familiar with occupational medicine. Therefore, one part of a coordinated care management plan would be to provide care managers with access to a preferred network of participating providers to control costs and coordinate chronic disease supervision.

A pilot program conducted in the state of Washington over the course of one year assigned members to a narrow network of occupational providers to determine if their specific care direction improved outcomes and reduced costs. A two year follow-up period looked at "long term health and employment outcomes and the medical and disability costs of workers treated through managed care compared to workers treated in fee-for-service.
settings.” While cost of care was similar and claim costs increased for both groups, the magnitude of the increase was higher for the fee-for-service group. In addition, the study demonstrated the need to support those physicians who treat occupational conditions infrequently with treatment and return-to-work plans by promoting contracts that provide financial incentives to accomplish these objectives.6

Within the population health context, the area of engagement references the early intervention with the participant in a workers’ compensation and disability claim. Obtaining early care coordination and risk assessments for disabled individuals can facilitate cost reduction. Disability and return to work programs can use the principles of disease and wellness healthcare management programs to incorporate frequent inputs from predictive modeling, as well as utilizing digital and robotic capabilities to support a participant’s early engagement, enrollment and clinical interventions.

Disability and workers’ compensation programs often have difficulty in engaging at-risk individuals early in the course of the health related event. Due to the limited use of care managers, an injured or disabled individual’s case is often not referred before incurring substantial costs. This lack of coordination and integration of occupational health services can lead to prolonged work absences. Incorporating TPHM principles into risk identification, enrollment and engagement can improve outcomes for injured workers or disabled individuals. Implementing care management at the onset of care can reduce costs and minimize employee confusion with duplicative form submission and provider selection.

One of the important areas within TPHM is reporting to purchasing organizations and government entities in regards to compliance results and providing outcomes measurements on clinical and
Many employers use multiple vendors to manage their workers’ compensation and disability programs. This causes HR departments to manage reporting and tracking requirements despite lacking the ability to share information used on their benefits administration and care management platforms with the analytics vendors. Because of these data sharing requirements and the dearth of integrated platforms for data sharing, it is difficult to monitor the change of work-related injuries into disabilities over time, or the impact of chronic disease or mental health issues on return to work. This makes it difficult to determine the total administrative cost as well as cost of care as the reporting requirements differs on the basis of benefits.
Implementing a single point of contact with a TPHM 360 degree member view across case, disease and utilization management can coordinate provider and member contact as well as absence activities, reducing duplicated efforts. Further, both stay-at-home and return-to-work activities can be coordinated across different vendors, as well as coordinating broader health plan management on chronic illnesses and behavioral health issues. Due to the sensitive nature of this data, ensuring secure access is an absolute necessity. Data and member lists should be kept in one instance of whatever platform is used to share this information until it can be determined who can access medical management members or insured workers.

Lack of integrated care and data leads to poorer outcomes and higher care costs

The aging of today’s workforce means that older workers remain in the workplace for longer periods than in the past. In a research brief published by the National Council on Compensation Insurance, “claim severity and costs for older workers (45-64) is more than 50% higher than for younger employees for both indemnity and medical”. Older workers are more likely to incur claims related to comorbidities and obesity, which cost twice as much as other claims without these conditions. TPHM has a solid emphasis on predicative analytics focused on the senior age group, and on identifying and closing gaps in care that relate to quality metrics such as HEDIS and Stars. Closing these gaps can reduce the potential for workers’ compensation or disability claims, as the potential for short term and long term risks can be mitigated by focusing on regular health exams, laboratory testing, screenings and obesity management. Workers’ compensation claims may also be reduced through promoting eye exams, medication compliance, multiple drug use risk evaluations and chronic care evaluations for Medicare eligibility.
TPHM analytics also has a strong capability to identify mental health related comorbidities using telephonic or digital assessments. The aspects of early identification of a mental health issue are important, as depression has also been linked to almost 60% of all claims. Early mental health and behavioral risk identification through assessments can be used as an additional tool for accident and illness prevention. In addition, TPHM analytics can be used within pharmacy programs to identify the potential risks of drug interactions or address the current concerns around opioid prescribing and use in a work environment. A growing area for concern in disability and workers’ compensation is both the cost and safety in the increased use of opioids for pain management and their impact on moving an individual through the continuum from workers compensation to long-term disability. Long-acting opioid use quadruples the likelihood that a claim will cost more than $100,000 versus those for individuals without any prescriptions.

TPHM care coordination is better accomplished when integrated care managers are certified in disability management. This requires demonstrated knowledge of workplace interruption management, as well as the activities of tracking, reporting and coordinating care. In addition, certified disability managers must be adept in disability prevention services and benefits administration to assist all workers in accessing care when needed. When a worker requires time off for a short term condition or scheduled absence for a medical condition, the disability manager can assist in the submission of forms to ensure continuity of pay and other benefits.
The challenges to creating efficiencies in workers’ compensation and disability care management

Pay-for-performance and bundled payment strategies now incorporate clinical, financial, administrative and predictive data in an integrated manner to assure providers are reimbursed at the right levels for the clinical risk level of the patient. Injured and disabled workers receive clinical interventions from providers that are indistinguishable from those provided for non-occupationally related conditions. However, information is rarely integrated into a TPHM single care management system that incorporates and integrates clinical, administrative, reporting, and transitions of care associated with return-to-work activities or long-term disability management. Inefficiencies in care provision and administration can be more easily detected within integrated clinical applications and care management systems. Employers can gain the data necessary to predict long-term costs for managing at-risk individuals by utilizing a single management system to review all occupational and non-occupational conditions while assessing concomitant health risks and comorbidities. This type of system can also provide improved insight into reasons, patterns and costs of employee absenteeism.

Care management systems should focus on managing the individual through their utilization of services and referrals while monitoring results. This creates a longitudinal record of care throughout the period when service is required, regardless of payer source. Standardizing and recording care management processes is the key to evaluating care effectiveness and outcomes.
The results from a study of unionized janitorial workers in California demonstrated that integrating clinical data with reporting requirements for workers compensation claims helped to eliminate confusion over payer responsibility and identify conditions of occupational origin. These observations lead to the recommendation for modifying electronic health records to accommodate regulatory reporting while supporting the underlying documentation of clinical care, regardless of cause. Even definitions of medical necessity vary on the basis of benefit type being claimed. Understanding links to work-related conditions is not the same as cause. For example, a worker who struggles to manage his diabetes through medication, diet, and exercise may be compromised when his shift is extended and he is unable to eat at his regularly scheduled time. A fluctuation in his blood sugar may result in clouded judgment or dizziness that could lead to workplace accidents and injury. Having the ability to link this information allows companies to prevent workplace injuries from occurring in the first place.9

However, the reality is that there are few commercially available systems that support these relationships through the entire course of employment. Future strategies in combining TPHM with disability and workers’ compensation will require organizations to co-develop these capabilities. TPHM integrated care provides early intervention with the most qualified and appropriate treatment practitioners within a network. When occupational-related care is delivered through coordinated networks, improved outcomes can reduce claim costs as much as 20-40%. Integrated data improves efficiencies in care delivery and care planning by looking for patterns to expedite returning to work or care transitions associated with disability. Further integrated data allows for advanced claims analytics to identify best practices for providers, outcomes, and the potential for predicting underlying conditions and causes that compromise safety.
References


EXL (NASDAQ: EXLS) is a leading operations management and analytics company that helps businesses enhance growth and profitability in the face of relentless competition and continuous disruption. Using our proprietary, award-winning Business EXLerator Framework®, which integrates analytics, automation, benchmarking, BPO, consulting, industry best practices and technology platforms, we look deeper to help companies improve global operations, enhance data-driven insights, increase customer satisfaction, and manage risk and compliance. EXL serves the insurance, healthcare, banking and financial services, utilities, travel, transportation and logistics industries. Headquartered in New York, EXL has more than 24,000 professionals in locations throughout the United States, Europe, Asia, Latin America, Australia and South Africa.

© 2016 ExlService Holdings, Inc. All Rights Reserved.
For more information, see www.exlservice.com/legal-disclaimer