WOEMA

Western Occupational & Environmental Medical Association

A VISION FOR A HEALTHY WORKFORCE AND HEALTHY COMMUNITIES

Anticipating Healthcare Reform in California, Legislative Goals Related to Occupational and Environmental Medicine

[Adopted by the Western Occupational & Environmental Medical Association on 1/9/2019]

Executive Summary

Following the recent mid-term elections, California anticipates a new state Administration and legislative action on comprehensive health care reform in our state. WOEMA (the Western Occupational and Environmental Medical Association) urges adoption of the following policy goals, related to the practice of Occupational and Environmental Medicine (OEM) and improvements to California's healthcare system. These proposals focus on disease and injury prevention, health care value, and the promotion of environmental quality in the state.

WOEMA recommends that an improved California healthcare system should:

1. Cover the entire California workforce, and assure access to high quality, affordable healthcare for all workers and their families.
2. Cover all of the ACA's "Essential Health Benefits," as well as dental benefits. For the California workforce, the list of "essential health benefits" should be expanded to include access to occupational health services.
3. Pay for clinical preventive services at every opportunity, including in the workplace.
4. Integrate the care of ill and injured workers, currently treated under Workers' Compensation, with the delivery of general healthcare services to the extent possible.
5. Deliver high-value care aimed at maintaining and improving patient function, while providing for continuous quality improvement.
6. Update and incorporate specific policies to address the opioid crisis.
7. Adopt policies to assure an adequate number of trained professionals in the field of preventive medicine, including occupational and environmental medicine.
8. Provide incentives for energy efficient ("green") healthcare facilities, systems, and processes, consistent with established statewide energy goals.
9. Promote the widespread adoption of high-quality, high-functioning electronic health record (EHR) systems, and encourage use of EHR data to drive optimal health outcomes for Californians.

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Introduction:

As California anticipates a new state Administration after the fall elections of 2018, expectations grow for legislative action in Sacramento on comprehensive health care reform in our state. WOEMA (the Western Occupational and Environmental Medical Association) believes these key policy goals, related to the practice of Occupational and Environmental Medicine (OEM)[1], should be considered by legislators and other leaders as they design an improved health care system for California.

WOEMA is a professional medical association, representing five western states including California, with a membership of over 600 occupational medicine physicians and other health professionals who champion healthy workers, safe workplaces, and a healthy and sustainable environment.

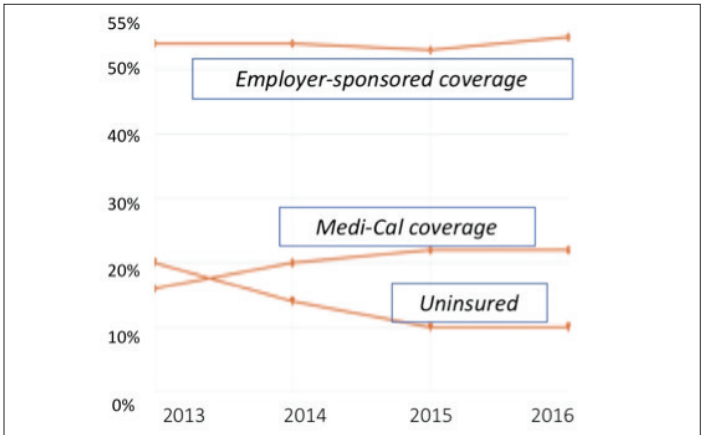
Because OEM is inherently a preventive medicine specialty, our recommendations emphasize opportunities to improve preventive health care and the value of medical services delivered to California workers, while promoting health-related environmental quality and sustainability.

WOEMA recognizes that California has been a national leader in a number of policy areas where national leadership has lagged, such as expansion of health care coverage, moderation of greenhouse gas emissions, promotion of energy efficiency, improvements in workplace safety, and control of environmental health hazards. Accordingly, WOEMA urges California to continue to lead the nation in building on the successes of the Affordable Care Act (ACA), and to consider the following policy goals aimed at improving our state's health care system.

1. The entire California workforce, and their families, should have access to high quality, affordable health care.

About 1.8 million working Californians still lack health insurance, despite improvements following enactment of the ACA. Of note, as of 2017, about 62% of California's uninsured adults were employed.[2] Furthermore, too many California workers, particularly migrant workers and other minority populations, live in areas where access to health care providers remains limited.[3] A wealth of literature supports the concept that a healthy workforce is essential to a healthy society and a healthy economy. Furthermore, WOEMA would emphasize the old adage: "no health care, no health,"[4] — a concept that applies to our California workforce.

The following graph shows the percentage of California workers under age 65 whose health care coverage comes from their employers or from Medi-Cal, and the percentage who remain uninsured.[5]



Health insurance coverage among California workers

A promising approach to assuring that all workers have health care coverage is illustrated by the policies of "Healthy San Francisco," a local initiative aimed at providing health care coverage for San Francisco residents age 18 or older with income up to 500% of the federal poverty level who are uninsured and ineligible for Medi-Cal or Medicare.[6]

Hawaii was the first state to require employers to offer health insurance for all employees. Under the Hawaii Prepaid Health Care Act of 1974, employees working twenty or more hours per week or more are covered, with dependents covered ag the option of the employer.[7]

2. Coverage for the California workforce should include all of the ACA's "Essential Health Benefits." To those benefits should be added dental coverage, and worker access to occupational health services.

High quality health care coverage, by definition, should include all "essential health benefits," as defined under the requirements of the ACA. Such coverage would preclude so-called "skinny" plans, or "short-term" plans. Furthermore, WOEMA recognizes that dental coverage serves an important preventive role,[8] and salutes the state of California for bundling dental benefits under Denti-Cal, with Medi-Cal benefits. Among small and medium-sized employers (< 50 employees), fewer than half offer dental coverage to their employees.[9]

WOEMA believes that workers will further benefit from a specific addition to the list of "essential health benefits," namely, access to occupational health services. In 1994, the World Health Organization (WHO) launched a global effort to assure that all workers have access to essential occupational health services,[10] and it continues to refine its recommendations for the types of services. that should be offered to all workers, including:

a) **Medical surveillance for populations** with particular risk factors (including at safety-sensitive jobs or jobs with anticipated exposures to hazardous materials or serious safety risks);
b) **Training of workers and supervisory staff** about hazard recognition and in the reporting and follow-up of identified work-related illnesses, injuries, and "near-misses";
c) **Creating a "culture of health" in the workplace,** with on-site delivery of preventive services, including services aimed at improving lifestyle choices.

To that end, WOEMA believes that employer-sponsored plans should retain provisions to incentivize healthy lifestyle choices, using as a model the 2016 EEOC Guidance Document (to the extent that employer-sponsored health care coverage will persist in the state).[11] Furthermore, legislators are urged to explore mechanisms to incentivize employers to maintain and improve the safety of workplaces, and to carry out proven health promotion programs, in order to achieve a broad concept of worker wellbeing.[12]

3. An improved California health care system should incentivize and pay for clinical preventive services at every opportunity, including in the workplace.

Currently, ACA requires "qualified health plans" to pay for all preventive services identified by the US Preventive Services Task Force (USPSTF)[13] as earning an A-grade or B-grade for quality-of-evidence. The Act further prohibits co-payments or deductibles for such services.

Despite this provision, which has been in place for the last 8 years, busy clinicians continue to miss far too many opportunities for prevention, especially during episodic treatment visits, whether in the Emergency Department, outpatient setting, or consultation suite. Some of these well accepted interventions include counseling for smoking cessation,[14] hypertension,[15] risk detection for alcohol and drug abuse,[16] control of other risk factors for cardiovascular disease,[17] diabetes control,[18] and vaccinations.[19] During the care of injured workers under workers' compensation, WOEMA physicians have often found it difficult to obtain insurer authorization for administering the combined vaccine for pertussis and tetanus (Tdap), or influenza vaccine, despite the high likelihood that these immunizations will prevent the spread of disease in the workplace.

Missed opportunities for prevention cost the nation billions of dollars,[20] and represent an exigent opportunity to pursue such "low-hanging fruit." WOEMA urges the legislature to assure that proven preventive services will receive "first dollar" coverage, that is, dependable coverage without copays or deductibles, perhaps through a statewide clinical prevention fund that would stand apart from any specific pool of insurer dollars.

Many California workers have difficulties obtaining medication to prevent worsening of potentially disabling health problems, which in turn might trigger costly Emergency Department visits or hospitalizations. WOEMA recommends that certain medications that serve as "secondary" preventive interventions should be covered at zero, or very low,

cost. Such medications include, but are not limited to:

a) Certain diabetes medicines, including insulin and basic oral diabetic drugs;
b) Anti-hypertensives;
c) Anti-coagulants;
d) Medications to control hyperlipemia;
e) Bronchodilators;
f) Injectable epinephrine for patients allergic to hymenoptera venom;
g) Injectable naloxone, when prescribed by a provider for patients taking narcotic doses in excess of 50 MED (morphine equivalent dose), following established pain protocols.

4. The medical care of ill and injured workers under Workers' Compensation should be integrated, to the extent possible, with the delivery of general health care services.

The California Workers' Compensation system is expensive, fragmented, and adversarial, and is too often frustrating for injured workers and other stakeholders. WOEMA encourages the California legislature to create incentives for health care providers to bundle general health care with care for work-related illnesses and injuries. A pilot program involving the concept of so-called "24-hour" care, briefly attempted over 20 years ago in California, was shown to deliver considerable value without sacrificing patient satisfaction.[21]

A recent RAND Corporation study lists a number of barriers to be overcome in effecting an integration of these two systems, and also makes a number of recommendations for improving both the California Workers' Compensation system and its relationship to group health plans.[22]

5. An improved California health care system should deliver high-value care and should provide for continuous quality improvement.

In order to further the worthwhile ACA goal of promoting "outcome quality" rather than "service quantity" in health care delivery, WOEMA believes that an improved California health care system should measure and incentivize clinical processes that have been shown to improve quality outcomes in the OEM sphere, and which are likely to improve quality outcomes for group health recipients as well.

Quality outcomes might be improved through the following key steps:

a) Clinical "outcome" measures should include the *functional status* of the patient, including whether the patient is continuing to go to work and participate in activities of daily living in a fruitful and satisfying way.[23, 24, 25] Too often, so-called "functional assessments" focus on intermediate markers of improvement (such as range of motion of a particular joint or the strength of a set of muscles), rather than on whether the patient's daily activities reflect successful function.[26] To that end, WOEMA recommends that the legislature explore capturing quality measures reflecting actual function, including successful return-to-work.
b) Payment for health care providers is currently carried out using badly flawed CPT codes,[27] including the Evaluation and Management codes, which "reward" providers for useless churning of services and meaningless documentation. ACOEM has proposed alternate payment and coding schemes, aimed at incentivizing providers to document clinical findings that correlate with high quality outcomes, including functional status.[28]
c) Recognizing that the quality measures mandated under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), aimed at incentivizing outcomes over process, including the MIPS criteria, represent a complex, often proprietary, and so-far unsatisfying set of burdens on providers, WOEMA urges legislators to explore alternate incentive systems for California providers, with improved quality metrics emphasizing both preventive and functional success.[29]
d) Price transparency is a key goal of efficient health care systems, both for medications and clinical services.[30, 31] WOEMA urges California legislators to explore mechanisms to increase price transparency in an improved California health care system.

6. An improved California health care system must incorporate specific policies to address the opioid crisis.

The OEM medical community was among the first to adopt comprehensive evidence-based guidelines for the use of chronic opioids for the treatment of pain, and has identified a number of best practices for opioid prescribing that might be exported to the rest of the medical community. In particular, we encourage the legislature to incorporate the following elements related to opioid prescribing into an improved California health care system:

a) Opioid prescribing by medical providers should follow published evidence-based treatment guidelines, whether in an OEM setting or under group health coverage.[32]

b) Providers should be paid for the extra work required to utilize "opioid contracts," to screen for adverse effects, and to review periodic urine drug screens.[33]
c) California's prescription drug monitoring system (PDMP), the CURES system, should be improved, according to recent guidelines by Brandeis and ACOEM.[34]
d) The availability of mental health services and other treatment for opioid-addicted patients is currently far too limited and should be expanded.
e) California should consider adopting a number of other recommendations contained in the CMS publications under the heading of: A Roadmap for the States.[35]

7. The supply of trained health professionals in the fields of occupational and environmental health, including the supply of Board Certified / Board Eligible OEM physicians should be significantly increased through increased funding for training institutions.

California is facing a shortage of trained OEM physicians, as well as a shortage of primary care physicians.[36, 37] California has only three OEM residency programs dedicated to training Board-certified OEM physicians at this time, graduating about 6 to 8 new Board-certified OEM physicians per year — a number far too small to keep up with current demand. WOEMA urges the legislature to explore mechanisms to increase the training of both OEM physicians, and primary care providers in our state.

8. An improved California health care system should provide incentives for energy-efficient ("green") health care facilities, systems, and processes.

Designing energy-efficient health care facilities and health care processes has the potential to save billions of dollars in California over the next decade.[38] On average, hospitals and health care facilities consume twice as much energy as comparably-sized commercial buildings.[39] Furthermore, there is compelling evidence that well designed health care facilities also contribute to the health of both workers and patients.

Consistent with California's commitment to curtail the emission of greenhouse gases under the Global Warming Solutions Act (AB 32, 2006)[40] and the state's recent commitment to achieve 60 percent renewable energy by 2030 and 100 percent carbon-free energy by 2045 (SB 100, 2018),[41] WOEMA urges the Legislature and the new Administration to take advantage of this opportunity to improve energy efficiency in the health care sector.

9. California should take the lead in promoting the widespread adoption of high-quality, high-functioning electronic health record (EHR) systems.

Recognizing that the Office of the National Coordinator for Health Information Technology has achieved considerable progress in driving the adoption of electronic health records (EHRs) at the national level,[42] WOEMA believes that further improvements are needed in California and around the nation. To that end, WOEMA encourages the legislature to explore establishing California-specific standards for "credentialed" EHR systems. WOEMA believes that a highly functioning EHR system will incorporate the following functionalities:

a) Record and time-stamp a coded field for the patient's industry and occupation;
b) Encourage interoperability with other credentialed systems, such as the "care everywhere" system used by EPIC,[43] or other interoperability allowing exchange of information with a patient's Personal Health Record (PHR); [44]
c) Contain the ability to exchange messages with credentialed correspondents, including health departments receiving notifications of reportable diseases or vaccine status;
d) Allow rapid exchange of information with CURES (California's Prescription Drug Monitoring / PDMP program);
e) Enable user-specific "firewalls" for users authorized to view only certain data fields;
f) Enable decision-support algorithms.
g) Include population management tools to target interventions for specific subgroups.

WOEMA urges the legislature to explore how a "California Coordinator" for Health Information Technology might drive more efficient and functional EHRs in the state and might increase the uptake of EHRs by essentially all health care professionals, with much more robust inter-operability. WOEMA looks forward to the day when widespread sharing of de-identified clinical data might also be used to drive improvements in health care quality and value.

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Western Occupational & Environmental Medical Association (WOEMA)
575 Market Street, Suite 2125
San Francisco, CA 94105
P: 415/764-4918
Email: woema@woema.org
http://www.woema.org