Journal of Occupational Rehabilitation, Vol. 12, No. 1, March 2002 (© 2002)

The Minnesota Health Partnership and Coordinated Health Care and Disability Prevention: The Implementation of an Integrated Benefits and Medical Care Model

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In the spring of 1996, the Minnesota Health Partnership (MHP) received a demonstration grant from the Robert Wood Johnson Foundation Workers Compensation Health Initiative to pilot a model of health care that was designed to combine the best practices of general health and workers' compensation medical care. This paper outlines the genesis of the MHP, and the relationship of its Coordinated Health Care and Disability Prevention model to traditional managed care and 24-h care models. In order to effectively implement disability prevention principles within a primary care clinical setting, it is essential to increase health care provider awareness that the disability relating to a specific impairment can be positively impacted by specific clinical strategies. The basis and specifics of these strategies are also discussed. Plans for the evaluation of this model will also be described.

KEY WORDS: disability prevention; integrated benefits; physician communication.

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1053-0487/02/0300-0043/0 © 2002 Plenum Publishing Corporation

INTRODUCTION

For centuries, patients with medical conditions have been advised by their physicians to rest and stay at home until sufficiently recovered to return to their duties. This time honored nostrum is now coming under increased scrutiny by patients, their employers, case workers, managed care organizations, and in some cases, the courts. This is due in part to 1) the growing recognition on the part of patients and other interested parties of the importance of daily physical activity as an important quality of life issue, 2) the creation of comprehensive short-term disability (std) and long-term disability (ltd) programs offered by competitive employers, and 3) social legislation such as the Americans with Disabilities Act and the Family and Medical Leave Act. At the same time, current epidemiological research emphasizes that prolonged absence from one's normal roles, including absence from the workplace, is detrimental to an individual's mental, physical and social well being (1).

As patient advocates, it is also important for health care providers to recognize the significant financial impact of disability on patients. The total lost income to the U.S. workforce in 1994 for disability-related absence was $81.1 billion, of which only $49.4 billion, or 60.9%, was replaced by wage protection programs. A disproportionate amount of the lost income was related to nonoccupational conditions, with $55.2 billion of lost wages, of which only $19.0 billion (34.5%) was replaced through wage protection programs (2).

With the passage of the American's Disabilities Act, employers are encouraged to extend accommodations once traditionally reserved for work-related injuries to general medical conditions (3). This requires physicians to become more familiar with the interaction between a patient's medical condition and vocational and avocational activities, and to be prepared to relate appropriate limitations if necessary, and the suitability of relevant accommodations. Physicians are now expected to be more fluent with functional assessment, and to be able to express their recommendations in a more exacting and formalized manner than previously required.

In the spring of 1996, the Minnesota Health Partnership (MHP), a coalition of private and public employers, health care provider groups, and health plans received a demonstration grant from the Robert Wood Johnson Foundation Workers' Compensation Health Initiative (WCHI) to pilot Coordinated Health Care and Disability Prevention (CHCDP). CHCDP was conceived as an innovative model of health care delivery, which would bring together the best aspects of the general health and workers' compensation care systems. The principal features of CHCDP include 1) employee choice of health care provider, 2) promotion of primary care physicians as the foundation of health care delivery, 3) continuity of care with the employee's personal physician regardless of causation of injury or illness, 4) incorporation of physician advice about appropriate level of activity into all patient encounters, and 5) employer implementation of similar disability management strategies for all potentially affected employees, regardless of impairment work relatedness. Within this paradigm, physicians and other health care providers encourage patients to attain and maintain optimal activity for their health conditions, while employers strive to accommodate their employees with both work- and nonwork-related disabilities whenever possible. This two-fold approach is intended to decrease morbidity associated with inactivity and worklessness (4), decrease long-term medical and indemnity costs, and improve patient satisfaction with their health care. In the spring of 1998, the MHP received an additional grant from the WCHI to evaluate clinical outcomes, participant satisfaction, health care costs, and the required organizational changes associated with the implementation of CHCDP.

The Genesis of Coordinated Health Care and Disability Prevention (CHCDP)

Over the past decade, employers have become increasingly aware of the advantages of disability management for their employees with compensable work-related injuries and illnesses. More recently, some employers have placed an increased emphasis on managing employee health in a more universal manner by attempting to prevent or minimize disability because of general medical problems as well as work-related conditions, in part by delivering medical and disability benefits in an integrated fashion. One such group of employers is the Buyers Health Care Action Group (BHCAG), a purchasing coalition of Minnesota corporations dedicated to health care system reform. BHCAG's efforts have stressed improved quality of care, increased provider competition, increased consumer knowledge and responsibility for health care decisions, and enhanced efficiency of health care delivery. BHCAG began exploring integrated benefits in 1993 with an assessment of problems within the current workers' compensation and disability benefit systems.

The employers identified many concerns related to those systems. For instance, employers frequently found minimal communication between workers' compensation risk management and general health and disability benefits personnel, which led to an internal lack of accountability for total employee health and productivity. Job accommodations for nonwork-related conditions often were not pursued as aggressively as for work-related injuries, and disability benefits sometimes were used to solve personnel problems. At the same time, employees directed to specific occupational health providers for workers' compensation conditions often voiced concern over lack of provider choice in comparison to the options available to coworkers with nonoccupational health problems.

Employers also perceived that, in general, primary care providers in the general health care system did not address disability prevention, or emphasize appropriate activity to their patients as a component of their health message. Other than in occupational health, employers reported that physicians and other health care providers seemed to believe that an effort to encourage early return to work for their patients, even in a modified work status, was contrary to their role as patient advocates. A lack of trust in the employer's ability to maintain a safe work environment, as well as a lack of understanding of the actual work place, appeared to be contributing factors. Meetings with physicians revealed that, as a group, they felt poorly trained to determine what is appropriate activity for patients, and were most comfortable with a "don't ask, don't need to advise" approach.

There was also a concern among employers and physicians that, in the current model of health care, patients do not often take an active role in facilitating their own recovery. Communication among patients, their employers, and health care providers was perceived as often fragmented and delayed. Furthermore, economic incentives created by workers' compensation, std and ltd programs vary widely. These differences can result in cost shifting, and create adverse incentives for return to optimal function.

This critique culminated in a new approach to the management of both workers' compensation and general health disability. Improving a patient's functional status, inside and outside of the workplace, regardless of the origin of the condition, became an important focus for BHCAG members. Continuity of medical care, patient choice of health care providers, a shift in physician orientation to acknowledge the role of optimal function as a cornerstone of good health, and consistent employer management of both work-related and general health disability, were considered key elements for a new health care paradigm. This "integrated benefits" model of health care was intended to encourage patients to see their

personal physicians or usual clinics for both work- and nonwork-related conditions. The primary care physician would provide consistent treatment along with objective reporting of the patient's functional status, regardless of whether the condition was considered "work-related." Typical clinical care within the CHCDP model would combine the employee choice and primary care focus favored in the general medical care environment with the functional evaluation and disability prevention activities found among occupational health providers. Similarly, the BHCAG employers would promote early return to work and provide equal accommodations for employees with work-related and general medical disabilities whenever possible.

In pursuit of this initiative, BHCAG joined in a collaboration with a broad group of stakeholders, including the State of Minnesota as an employer (the Department of Employee Relations), and many of the largest Minnesota health care organizations (Allina, Blue Cross and Blue Shield of Minnesota, Fairview, HealthPartners, and HealthSystem Minnesota) to form the MHP. A unique feature of the MHP is the comprehensive public–private partnership it represents. The MHP adopted the goal of implementing a pilot model of integrated medical care, CHCDP, and then evaluating its impact on clinical outcomes, health care and indemnity costs, and patient, employer, and health care provider satisfaction. The receipt in March of 1996 of the Robert Wood Johnson Foundation WCHI demonstration grant served as a catalyst for the implementation of the model.

The model is currently being implemented at test clinics in participating health care organizations across the Twin Cities metropolitan area. Patients who have health coverage through a participating pilot employer are given counseling, by their primary care physician, on appropriate physical activity for their work-related or general health condition at each clinical encounter. Patients also receive a written "activity plan" for their reference. The "activity plan" includes a copy with all confidential medical information deleted that can be used for communication with their employer, school, or other third party if accommodations are necessary. Pilot employers have agreed to accept this "activity plan" in lieu of all other paperwork requirements, and are committed to managing disability and providing accommodation in a consistent manner for both work and general health related conditions.

Current Health-Care Models and CHCDP

CHCDP as implemented by MHP represents a hybrid of 24-h care and managed care concepts, with an emphasis on reducing unnecessary disability for both general medical as well as work related conditions while providing cost-effective medical treatment consistent with established best practices.

Medical care within workers' compensation has traditionally been fee-for-service, open to all providers, and relatively unrestricted. While general medical insurance provides the insured access to health care for any medical problem, workers' compensation restricts access to those medical issues connected to an admitted or adjudicated work-related injury or illness. Conversely, general medical insurance limits payments to only those services received during the period of coverage, while workers' compensation insurance involves a substantial "tail" of coverage for all services rendered in the future for the work-related condition. General medical insurance can also set some limits on the types of healthcare services and healthcare providers covered, while workers' compensation pays for any service or provider whose care is "reasonable and necessary."

As medical care costs escalated sharply in the 1970s and 1980s (5), general medical insurance enacted a variety of cost control measures including financial incentives, demand controls (copays, deductibles), and limitations on access (closed panel HMOs, preferred provider networks, gatekeepers). Because of statutory provisions and judicial precedents, the majority of these interventions were not feasible in the workers' compensation environment (6). Not surprisingly, health care costs in workers' compensation rose even more rapidly than in general medical insurance.

Because of historical factors and the underlying assumptions of employer responsibility for work-related medical conditions, the reforms of workers' compensation in the 80s and early 90s focused on the price and utilization of services. Price has been addressed through the development of fee schedules. Utilization has been controlled through limitations on employee choice of health care provider, mandated utilization review programs, the development of treatment guidelines, and the institution of case management services. These strategies have been adopted singly or integrated into the broader concept of workers' compensation managed care.

Managed Care

A managed care organization in workers' compensation can be defined as an organization that delivers the required health care services in a manner which is cost-effective in terms of both medical costs and indemnity costs (wage loss and permanent partial disability payments) (7). It accomplishes this through the selection, training, support, and management of a network of health care providers. The emphasis is on providing quality care at a reasonable cost that promotes efficient return-to-work, thus minimizing indemnity costs. Communication between the parties to the claim is emphasized and facilitated, and the provider is supported by case management services. Treatment protocols or guidelines are used to assess the progress of treatment and determine appropriate services. These guidelines usually include specific expectations about progress in functional ability and return to work. Jurisdictions with managed care have differed in whether it is allowed, regulated, or mandated.

Where it has been evaluated, workers' compensation managed care has reduced costs from 9 to 54% (8). Overall patient satisfaction was lower in the managed care populations than in the traditional fee-for-service comparison groups. But there were few significant differences found in specific medical and functional outcomes between the managed care patients and the controls. In the majority of the studies, the overall savings are a combination of significant reductions in both medical and indemnity costs. The reduction in indemnity costs is attributed to early return-to-work prescribed by the treating physicians in conjunction with therapy to support functional rehabilitation (7).

General medical care is not usually attentive to the effects of treatment recommendations on the patient's ability to return to, or stay at, work. Almost all medical encounters involve nonwork-related medical problems and the vast majority of health care providers are unaccustomed to dealing with return-to-work issues. In addition, managed care protocols in the general health setting often emphasize triage, judicious use of medical services, and reliance on self-care whenever feasible and appropriate. Conversely, workers' compensation treatment protocols recommend early and vigorous intervention to maximize healing and quicken rehabilitation. Using workers' compensation strategies could markedly increase

the volume and cost of services, while taking the usual approach typical of general medical care might delay recovery, resulting in increased lost time at work. In addition, as already noted cost- and demand-control strategies used in the two systems are incompatible, given the different system goals and statutory environments.

The important difference in workers' compensation managed care is the explicit recognition of the effect of injury and illness on indemnity costs and how this relationship can be affected by health care. Managed care in the general medical arena has focused on cost-effective care, where all the target costs are medical expenses and where effectiveness has been measured by mortality and patient-reported quality of life, but without consideration of indemnity costs. For the participating health care providers, the CHCDP model attempts to blend the best elements of each perspective by making health care providers simultaneously responsible for care consistent with best medical practices and attentive to disability prevention.

Twenty-Four Hour Care

Twenty-four hour plans were widely discussed during the workers' compensation reforms in the late 80s and early 90s, though none were actually implemented. In fact, 24-h coverage is a wide rubric incorporating a variety of insurance products that attempt to eliminate some or all of the differences between insurance products for work-related conditions and nonwork-related conditions (9). Advocates believe that 24-h plans will reduce insurer and employer costs by eliminating overhead and duplication of services resulting from parallel administrative systems, reducing friction costs because of disputes about attribution of conditions, exploiting the benefits of expanded case management, and eliminating moral hazards derived from differing medical payment schedules. Similar wage benefit plans also reduce cost shifting and potential worksite friction costs (8).

The obvious difficulties of any 24-h proposal include the differences in the existing benefit schedules, the differing emphasis of cost-savings techniques between the systems, variable market penetration of medical and disability insurance products, and the different eligibility requirements and due process guarantees. In regard to medical coverage, should general medical insurance be expanded to the more generous coverage required by workers' compensation, then costs of general health care could increase. Expansion of general medical insurance coverage would add considerable expense, while restriction of workers' compensation insurance by introducing the cost sharing techniques of general health care (copays and deductibles) would seriously affect the delicately balanced political compromises between management and labor that is ensconced in current workers' compensation statutes.

Likewise, there are significant differences in wage loss benefits between workers' compensation and std/ltd policies, even when temporary wage replacement rates appear similar. Short-term or long-term disability plans do not offer permanent partial disability payments or temporary partial disability benefits. Workers' compensation payments are untaxed and can be collected in conjunction with other wage indemnity benefits, including Social Security (though some offsets do occur). Expansion of std/ltd policies to offer the same range of benefits as workers' compensation, particularly permanent partial disability payments and rehabilitation expenses, would certainly increase costs sharply. Conversely,

reduction of workers' compensation benefits is always a bitter legislative dispute, perceived as a rollback in entitlement to injured workers.

The most difficult issues in developing 24-h plans are the differences in availability, eligibility, and due process between the work-related and nonwork-related medical and disability systems. While nearly all employers are required to insure for workers' compensation, only some provide general medical insurance, and even fewer also have comprehensive std and ltd insurance. Workers' compensation insurance provides benefits for the duration of the claim for any injury or illness that begins during the policy period, while general medical insurance pays only for services that are received during the policy period with no obligation on the insurer for subsequent services. Preexisting conditions do not preclude coverage under workers' compensation but can be, and sometimes are, excluded in general medical insurance policies. Short-term disability and long-term disability policies can, and often do, have contractual limitations on the duration of benefits and do not provide for further payments after the contract period, even though the employee's disability might continue. Finally, employees in workers' compensation have extensive due process rights regarding the receipt, modification, or termination of benefits with guarantees of access to special courts, fees for legal representation, and timeliness of decisions.

Reducing the differences in availability, eligibility, and due process between the work-related and nonwork-related benefit systems would require extensive legislation. Some analysts believe that such fundamental changes in the structure of workers' compensation would invalidate its current status as the exclusive remedy of the employee against the employer (8). Breaching the exclusive remedy would expose the employer to potentially unpredictable costs in litigation by injured employees for damages in tort. These additional costs, currently precluded by judicial support of the exclusive remedy in workers' compensation, could easily be far in excess of any savings realized in reducing traditional wage loss benefits in workers' compensation.

Integrated Benefits

The proposed alternative to a formally enacted 24-h plan is the notion of integrated claims management. No changes are made in the current insurance and regulatory arrangements, and each system continues to pay out benefits as currently required. However, management of medical costs and indemnity benefits is combined into a single operation with complete sharing of information and common administration. Injuries and illnesses must still be properly attributed as work-related or not, but this is done by a single claims processing unit which receives all submissions from employees for benefits. This single administrator also authorizes payment for all medical bills and coordinates wage-loss benefits from workers' compensation, std and ltd, within a single information processing system. Case management services and return-to-work are provided to all injured or ill employees, regardless of attribution, in order to improve outcomes and reduce total disability costs. Integrated claims management is a "virtual" 24-h plan for employers who already have, or plan to offer, general medical insurance and comprehensive std/ltd policies, with benefits approaching or exceeding those guaranteed by workers' compensation. For the vast majority of employees, this "seamless" approach to medical and indemnity benefits will reduce administrative paperwork and "hassle," avoid unnecessary delays in delivery of the appropriate benefits, and enhance continuity and coordination of care.

For the participating employers CHCDP is an integrated claims approach and a virtual 24-h plan. No legislative changes are planned or envisioned. Each employer will continue to meet all obligations under workers' compensation and will provide general medical insurance and std/ltd insurance. Management of benefits and case management services, especially commitment to early return to appropriately modified work, will be coordinated by benefits administrators. The participating employers already provide comparable wage replacement benefits for work-related and nonwork-related medical problems. Claims managers will proactively work to correctly attribute work-related injuries and illnesses without embroiling the health care provider or employee unnecessarily in administrative decision-making, and without delaying or interrupting wage continuation payments. Health care providers will be encouraged to focus on implementing best practices for quality health care and determination of function, for all patients. Employers will accept uniform reporting from patients and health care providers regardless of attribution of injury or illness. Barriers to access for medical care will be reduced, employees will be encouraged to seek care from their personal physician without regard to the insurance status of their claim so as to avoid administrative delays in treatment. Disabled employees will have equal access to light and modified jobs to promote early and successful return to work whether or not the problem is work-related.

The CHCDP is also in part an evolution of managed care. It introduces disability management into the "best practices" used in a general medical insurance managed care product and explicitly combines the cost and outcomes goals used in workers' compensation with those typically found in general medical insurance. Instead of two networks of health care providers with potentially incompatible sets of treatment protocols, and mutually exclusive case managers with possibly incommensurate goals, the MHP uses one network of providers for all required health care, with common management goals and strategies. The participating health care systems are asked to provide training for their physicians in disability management, and to implement administrative support systems for return-to-activity planning. Employees will be encouraged to receive their care from their usual primary care providers. The physician, in turn, is encouraged to provide the same medical treatment regardless of attribution but will also be asked to discuss and prescribe appropriate activity for the patient. Case management services, promoting and supporting early return to work and job accommodation, will be provided for all employees regardless of whether or not the condition is covered by workers' compensation.

Disability Prevention

In order to implement CHCDP, it has become essential to articulate to the health care community the benefit of this care model. For a physician or other health care provider to implement disability prevention strategies, there must be a belief not only in the rationale but also in the clinical effectiveness of the model. An important step in the educational process begins with the appreciation of the difference between impairment and disability. Impairment is any observable anatomical or functional abnormality or loss. Disability is a reported or demonstrated curtailment of activities, which is due in part, to the impairment, but is also significantly affected by other nonmedical factors. Impairment is a medical fact; disability may have a significant subjective component. Disability can vary between individuals with the same impairment, and, as the medical literature demonstrates, is the

result of complex social and cultural interactions (10). Acquisition of sick leave (or temporary "disability") may in fact be due to such disparate factors as job stress and burnout (11) or the legitimate need to attend to a sick child (12). Sick leave is a patient-generated phenomenon with the patient as the promoting party in the physician–patient dialogue (13). Rates of sick leave vary widely between societies. For example, in Poland, the 1994 rate of sick absences averaged 25.1 days per female employee (14), as compared to 7.9 days for Minnesota state employees (unpublished data from the state of Minnesota Department of Employee Relations). Disability, therefore, is, at least in part, a social rather than a purely medical phenomenon (15).

There is growing recognition in the medical literature of the importance of the biopsychosocial paradigm in providing care to patients (16). The biological health of patients has long been a recognized area of responsibility for health care providers. Within the past 30 years, there has been an acceptance of the important role physicians have in promoting the psychological health of patients. With the increasing recognition of lifestyle issues in the development of organic disease, there is also a growing awareness of the importance of social issues in the health of patients, and the role of the physician in encouraging patients to modify lifestyle choices. If the disability process is examined within this model, it is immediately apparent that there are the biological manifestations of deconditioning, the psychological consequences of anxiety and depression, and the social consequences of isolation and lost opportunity that result from a prolonged separation from the work environment and other usual activities (4).

Physicians have an important role in facilitating early return to work, which can have a significant impact in preventing unnecessary disability (17,18). The risk of developing chronic pain was eight times lower for an early activation group with acute musculoskeletal conditions in first time sufferers (19). Early return to activity avoids illness reinforcers such as disability income, inappropriate family/community sympathy, reduced responsibility, and the use of disability as means to resolve conflicts (20). The Canadian Medical Association has formally recognized the vital role of the physician in facilitating early return to vocational activities by providing advice on an appropriate activity to the patient (21). The management of disability by health care providers is not only appropriate but essential in discharging their core ethical responsibilities of doing no harm (avoiding iatrogenic disability) and promoting health (encouraging optimal activity). This is sufficient justification for health care providers to implement disability prevention strategies within their daily practices.

A variety of strategies have been found to be helpful in promoting early return to activity for patients. The patient's own perceptions about disability can be more important than the nature and severity of the condition in determining the long-term activity level (22–25). Fear and the avoidance of activity on the basis of fear are strong predictors of poor prognosis (26,27). Education on the condition and its prognosis can be used to influence expectations for recovery with appropriate treatment and diffusing unfounded fears about future disability. Education on prognosis and the natural history of the illness or injury leads directly to recommendations regarding appropriate activity during recovery. Close follow-up is maintained to prevent unwarranted activity limitation in those at high risk for disproportionate disability (28–30). Risk factors for such a delayed recovery include a personal or family history of previous delayed recovery, prior abuse, chemical dependency, depression, job dissatisfaction or workplace friction, and economic or legal issues (31). These psychological and social health factors, if recognized by the physician, can be addressed with the patient and dealt with appropriately.

EVALUATION

One of the core principles of the MHP is a commitment to an objective evaluation of these health care and disability management innovations. The planned evaluation of the CHCDP model has four components: 1) organizational analysis; 2) a study of medical and indemnity costs; 3) an assessment of patient, provider, and employer satisfaction; and 4) an evaluation of clinical outcomes for selected conditions. The a priori hypotheses are that CHCDP will 1) improve patient functional status without adversely affecting clinical outcomes and quality of care; 2) enhance patient and employer satisfaction without adversely affecting provider satisfaction; and 3) reduce overall societal cost of illness as a consequence of improved functional outcomes.

The organizational study of CHCDP will be a broad-based evaluation of implementation and operational issues. Objectives include a description of the evolution of CHCDM from concept to operational status; an assessment of the impact on employers, health care organizations, and health plans; and documentation of CHCDP impact on the economic relationships between providers, health plans, and employers.

The cost study will evaluate both group and individual costs associated with CHCDP. Employees from pilot employers implementing integrated benefits management and receiving care from test clinics implementing clinical disability prevention will be compared to controls. The analysis will address how CHCDP affected societal health care and disability costs, who benefited financially from CHCDP and who did not, and what barriers this may represent to broader implementation. Costs will be evaluated for both general and workers' compensation health care, and indemnity benefits under both workers' compensation and the employers' std/ltd plans. The data will be compiled and analyzed from multiple sources, including medical claims, employer indemnity data, and patient surveys.

Clinical outcomes will be assessed by means of both cohort and cross-sectional studies. Employees at pilot employers receiving care at test clinics will be compared to controls. Data will be obtained using patient surveys and medical record reviews. Random selections of patients will be surveyed periodically during the evaluation period. In addition, cohorts of patients with low back pain, knee pain, and diabetes mellitus will be followed longitudinally with surveys and medical records reviews. These studies will assess the impact of CHCDP on functional status, quality of care, and satisfaction with care.

The major challenge for the evaluation will be the identification and control of the many independent and potentially confounding variables. Patients cannot be randomly assigned, and may not be equivalent in regards to variables that influence results. We will attempt to control for initial identifiable differences between groups using statistical modeling. Both pilot and comparison employers represent large corporations with attractive working conditions and wages, a factor that should reduce differences between employee populations. Employers and clinics are also distributed throughout the Twin City metropolitan area, as well as in some rural areas.

SUMMARY

The MHP, a coalition of employers, health care organizations, and health plans has implemented CHCDP and is planning to evaluate the impact of the model on the quality of medical care, participant satisfaction, and impact on health care and indemnity costs.

CHCDP combines an integrated claims management approach or "virtual" 24-h plan with a managed care strategy that combines the best elements of general medical managed care with workers' compensation managed care. Employers will attempt to provide seamless medical and indemnity benefits to employees through coordinated benefit management in cooperation with the employee's choice of care system, which is responsible for care for all medical conditions regardless of attribution. The care systems are committed to provide the best quality of medical care, which is now defined as one which includes interventions that promote return to optimal function in all settings, both at home and the work place.

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