

Occupational Health in Primary Care

30 years in the trenches

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Imperatives for Primary Care Based Occupational Health Service

- Workplaces are everywhere
- Primary care physicians are mostly everywhere
- Supply of occupational physicians limited in numbers and geographically
- In US 80,000 physicians provide occupational health services
- About 4500 belong to ACOEM, 1/2 of those are board certified in Occ/Preventive Med

Occupational Physicians in NZ

- 56 physicians registered in occupational medicine
- 3109 registered GPs
- 12646 physicians with active licensure

The Math(s)

- 35 physicians practicing occupational medicine for every 1 board certified occupational physician in US
- 138,000 people for every board certified occupational physician in US
- 56 GPs for every occupational physician in NZ
- 79,000 people for every licensed occupational physician in NZ

Other Imperatives

- 25% of life is at work
- At work status correlated with longevity
- Prevention work / Health screening 95% compliance when done at worksite, 75% in a good medical practice

Occupational Epidemiology

- Workplaces many and varied
- Work activity changing rapidly
- Millions of chemicals in use today
- Tracking exposures very difficult
- Measuring outcomes even more difficult
- Information glut, but paucity of good data

Are GP's Trained to Provide Occupational Health Services?

- No

Average Occupational Health Training in US Medical Programs

- 1 freshman epidemiology course
- 2 hours of lectures on occupational health
- 2 or 3 days of precepted clinical work in an occupational health setting (FP residents)
- 6.7 hours annually from one study

Average Annual Occ Med Training in Australia and NZ Medical School

- 12.8 hours
- 10.5 Topics
- Increased if faculty included occupational medicine trained physicians
 - Shanahan, Murray, et al, Occup Med, Vol 50, No 4, 2000

The Big Problem

- Incentives for health care delivery are driven by delivery model and pay for services paradigm—docs get paid for injury care but not workplace prevention (how about getting paid for visits that don't happen???)
- Primary care docs have many competing agenda

Group Health a model?

- Salaried physicians
- Incentives to deliver cost-effective care rather than more care/procedures
- Incentives to keep patients/workers happy
- Capitation rather than visit-based reimbursement for the most part
- Strong preventive medicine focus
- 30-50% care “touches” electronically

Group Health—A model but...

- If Group Health has a better mousetrap, “why isn’t the world beating a path to your door?” ... “Why is the whole U.S. health care system not dominated by organizations like Group Health?”

– Robert G. Evans, PhD

Award winning Canadian economist

Answer: I don't know....

- Market imperatives drive us/GHC to deliver some unnecessary care
- Bureaucracy inefficient in many cases
- Hard working medical staff certainly not the issue (:>)

Interesting...

- The per-physician cost of dealing with payers was \$22,205 a year in Canada and \$82,975 in the U.S.

- American Medical News, 15 Aug 2011

System disconnect example: Medical Clearance for Drivers

- Commercial drivers need medical clearance examination every 2 years or more often if “indicated”
- Clear standards for hypertension, seizure disorder, use of opiate pain medication, use of insulin to control diabetes
- Family docs/GPs and multiple other providers do most of these exams

Work as a GP Provider— Too Many Mandates

- As mentioned, every business school grad knows how to make a GP more efficient...
- However, how many business school grads know what a pediatric neuroradiologist does during the day?

Example, new mandates for US 65 year old examinations

- Required Screening

- AAA if > 100 cigs in lifetime
- Lipids
- Colorectal Cancer
- Breast
- Prostate

- Immunizations

- Tdap, PPV, Zoster, Flu

- Required Counselling

- EtOH
- Bladder control
- Calcium, Vit D
- Home Safety
- Living Will
- Physical Activity
- Safe Sex
- Tobacco
- Weight management

REQUIRED testing for US Medicaid Patients, subject to audit

- COPD—spirometry
- Osteoporosis—bone density and Ca study
- Fracture—follow up function, xray
- Documentation of discussion for
 - Fall prevention
 - Incontinence
 - Mental health

Some/much of the pressure
can/will improve practice but...

At what price to the general
practice of medicine?

Is something missing??

- What about occupation (s)?
- What about exposures?

Occupational History

- Sadly lacking in most medical records
- Coding systems cumbersome, difficult to integrate into automated systems
- With rapidly changing work and workplace exposures, no data = no problem!

Family Physicians/GPs Squeezed

- US: reimbursements constantly being scrutinized, lowered
- Every lawyer knows what needs to be covered in each medical exam
- Documentation requirements increasing
- Physician autonomy under constant attack
- Hard enough to do the job without adding the complexity of workplace issues...

So what do we (you!) do?

- Educate your colleagues
 - GPs in your community
 - Precept medical students & registrars
 - Work/partner with medical associations
- Educate the community
 - Government: needs to insist on occupational coding for reimbursents
 - Talk to employers, worker groups, schools

“Those who cannot remember
the past are condemned to
repeat it.”

George Santayana

Thanks!
(Tui thanks
you, too...)

