

January 22, 2015 Industrial Insurance Medical Advisory Committee Meeting

Minutes for Meeting

(*actions taken)

Topic	Discussion & Outcome(s)
	<p>Members present: Drs. Bishop, Chamblin, Gutke, Harmon, Howe, Lang, Seaman, Thielke, Waring. Dr. Carter joined by phone.</p> <p>Members absent: Drs. Leveque, Friedman, Tauben, and Zoltani</p> <p>L&I staff present: Gary Franklin, Lee Glass, Leah Hole-Marshall, Teresa Cooper, , Joanne McDaniel, Hal Stockbridge, Diane Reus, Vicki Kennedy, Nicholas Reul, Simone Javaher, Karen Jost, Emily Stinson, Deborah Hale</p> <p>Public: Janna Friedly, Regine Neiders, Dan Perrow</p>
Welcome and approval of minutes	<p>Dr. Chamblin opened the meeting and attendees introduced themselves. Dr. Leveque, the newest IIMAC member, was briefly introduced although he was not present. The minutes of the October meeting were approved without changes.*</p>
ACHIEV update	<p>Leah Hole-Marshall summarized the morning ACHIEV meeting. Materials are available on the L&I website. Topics covered included:</p> <ul style="list-style-type: none"> • Washington State Health Care Authority received a State Innovation Grant from CMS (Center for Medicare and Medicaid Innovation) of \$65 million to improve and coordinate health care purchasing. L&I initiatives in Opioid reduction and COHE are cited as progressive innovations in the application, and L&I will participate in advisory meetings as HCA moves to purchasing for value, L&I will be consistent. http://www.hca.wa.gov/hw/Pages/default.aspx • ACHIEV reviewed and approved their charter • ACHIEV heard updates on the projects that IIMAC has sponsored on care of catastrophically injured workers and coordinated behavioral health. For projects where there is overlap between clinical best practices and program design, ACHIEV will be involved as well as IIMAC. • ACHIEV reviewed and advised on top tier provider criteria related to complex claims • Provided an update on progress of OHMS (Occupational Health Management System) • Dr. Mootz presented on Predicting high disability risk--Functional Recovery Questionnaire and Functional Recovery Interventions • L&I provided data on border state providers to begin to facilitate a discussion about appropriate criteria for whether to expand the Medical Provider Network
PMP Updated	<p>Chris Baumgartner, DOH, Program Director of the PMP, gave an update presentation. There has been an overall decrease in deaths and hospitalizations from prescription opioids in the past few years.</p> <p>Staff in the PMP program collaborated with professionals at UW, DOH and L&I to write an article on Washington's approach to prescription drug abuse, which was recently published in the American Journal of Public Health.</p> <p>PMP registration numbers—30% of DEA registrants are signed up with the PMP. This needs to increase, and ideas for doing this are being solicited. Note that the number of users could actually be higher than listed, because of delegation.</p> <p>List of most frequently prescribed drugs is somewhat different this year, because of the</p>



scheduling of tramadol. Note there is a slight decrease in hydrocodone prescriptions. Also zohydro prescriptions are increasing, despite warnings that this drug can be very dangerous.

Only 10% of prescribers are responsible for 55% of the opioid prescriptions.

Questions:

- How is PMP different from RxHub in the electronic medical record? A: the data in RxHub is a feed from Sure Scripts, and it may not be complete. Recommend using both.
- What about patients with multiple names? A: The system is built to handle some of this. Searches should start out as general as possible. Some may still be missed. Identification is not required when obtaining opioids at pharmacy.
- What is being done about integration with OneHealthPort? A: That has happened, and enhancements are still in process.
- What about connection with EPIC? A: May be doing a pilot with EPIC next month.
- Veterans Administration? A: two of the 5 VA facilities in WA are signed on so far.
- Are there geographical differences in provider use? A: that is not known.
- Differences by specialty or provider type? A: there are numbers and percents for provider type, but specialty information is very hard to get from existing datasets.
- Is interstate data sharing coming? A: That is difficult, but they are working on it. Oregon has a law which prevents data sharing.

Comments:

- PMP is heavily used in emergency departments; maybe they could be the lead in some outreach work.
- The new web interface is much better and easier to understand.

Simone mentioned a white paper that she and others recently wrote on why providers should use the PMP. Will email to IIMAC members.

UW PMP evaluation study. Ongoing till June 2015, study to evaluate the effect of the PMP on patient outcomes. Includes overdose push notifications to providers; study of buprenorphine use.

Chris also spoke to the IIMAC about the draft of the AMDG opioid guideline section on PMP which he wrote.

Comments and recommendations:

- Check what is written with the L&I opioid guideline
- Check PMP prior to all elective surgery
- Check PMP for *all* patients every year
- Include in regulatory physical exams, such as those for DOT
- Non-opioids should be monitored too
- Access to PMP is a problem; can't access from virtual computers (phones)
- Require for providers who prescribe suboxone
- More help is needed on what providers should do when they discover abuse
- Maybe we should style this section of guideline after the appendix on UDT—for example, include sample vignettes
- Work with county medical societies to increase use
- Does PMP do proactive reporting to medical board? The board has not wanted that yet.



<p>Opioid use and guideline implementation at L&I</p>	<p>Jaymie Mai, PharmD; presented data on L&I opioid use. Data indicates that since the guideline implementation, injured workers covered by the state fund have experienced a 32% reduction in high-dose covered prescriptions, and a 29% reduction in all opioids prescribed. Dr. Mai reviewed the approval process and the authorization forms. L&I is also undertaking two projects, both grant-funded by DOH:</p> <ol style="list-style-type: none"> 1. The UW PMP study as described above. Some possible implementation ideas are to send a prescribing “report card” to providers, to notify prescribers of non-fatal overdose events, and to work with DOH to make a non-fatal overdose event reportable. 2. The AMDG opioid guideline conference, which is taking place June 12, 2015.
<p>Upcoming subcommittee on knee surgery</p>	<p>Dr. Howe presented the subcommittee for the knee surgery guideline, which will meet for the first time February 18. He asked for new volunteers from the IIMAC membership; no one volunteered but they did ask questions. Explained that probably the biggest controversy and hurdle concerning the knee guideline is that so many knee conditions are degenerative, and their relationship to work is questionable. A member made a suggestion that we have a rheumatologist on the subcommittee, and we should check with the author of a chapter in the new AMA guide to causation. The subcommittee is taking this suggestion into consideration.</p>
<p>Catastrophically injured workers project</p>	<p>Dr. Reul presented an update on the catastrophic claims project, stemming from the report that was presented at the last IIMAC meeting. The ad hoc advisory committee of IIMAC members is meeting and has set a list of first priorities for improvement of management of these cases, for recommendation to IIMAC full committee. Prioritized areas are:</p> <ul style="list-style-type: none"> • Nurse case management (update referral criteria underway) • OHMS (potential to use to track cases) • Discharge planning (increase standard work and coordination underway, focus on medication authorization) • Reduce administrative barriers (e.g. streamline approvals of certain procedures or equipment) • Mental health care – (ensure nurse case managers trained to review and recommend services, coordinate with providers) • Early identification, tracking, and timely ROA completion • Center of excellence – exploration underway for prosthetics <p>IIMAC members expressed appreciation for this effort and didn’t have additional priorities. Advisory committee will continue to be consulted.</p> <p>Center of Excellence Example - Prosthetics</p> <p>Dr. Friedly, of the UW and Harborview, presented the components of a prosthetic specialty program. A successful program requires familiarity with common issues and phases of recovery for amputees, which Dr. Friedly summarized. A comprehensive, multidisciplinary and holistic rehabilitation of people with amputations across the continuum of care is needed, including:</p> <ul style="list-style-type: none"> ○ Early interventions for prevention and treatment of pain ○ Early access to mental health services ○ Access to peer support: support groups and peer visitation ○ Coordinated care between rehab physician and prosthetists to develop appropriate prosthetic plans <p>Questions and comments:</p> <ul style="list-style-type: none"> • What if this type of comprehensive care program is not available? A: the early interventions are the most important.



	<ul style="list-style-type: none">• This kind of program should be available to all our injured workers, we need an FAQ document with recommendations and resources• Should prosthetic prescriptions come from prosthetists? A: The prescription should always come from a physician, who works with a prosthetist to get all the components ordered correctly.• Discharge planning will be an important early step to improve care for catastrophically injured workers. <p>L&I advised the committee that there is current draft legislation, SB 5418, that would mandate L&I pilot partnering with a medical management firm. IIMAC members discussed differences from current approach and leadership agreed to write a letter to express, as L&I's medical advisory committee, their concerns.</p>
Ulnar neuropathy guideline re-review	<p>Bintu Marong, presented research for new evidence that might warrant updating or changing the ulnar neuropathy guideline, which is going through a five-year review. The department has also received a few letters from interested physicians advocating for changing some of the electrodiagnostic criteria. Three changes were approved to the current guideline (besides formatting changes):</p> <ul style="list-style-type: none">• Changed the amount of conservative care required, on page 2.• Removed an awkwardly worded sentence on the third paragraph of page 7.\• Changed the paragraph on nerve conduction velocity, page 6, to reflect different parameters with the most commonly used, newer equipment. <p>The IIMAC recommends that the department adopt the guideline with these changes*.</p>
Other updates and announcements	<p>The agency has published a health policy on Ebola, which is available on the public website.</p> <p>The beryllium policy is being reviewed by national experts before publication. Dr. Reul is working to formalize an agreement for the department to support a center for referrals for workers with chemically related illnesses.</p> <p>The DSM-5 rules are undergoing further stakeholdering before finalization.</p> <p>The department surveyed IIMAC members about having fewer materials printed on paper for their meetings.</p>
Adjourn	Meeting was adjourned at 5:00.