

**Workers' Compensation Advisory Committee (WCAC) Special Meeting
Labor & Industries Tumwater, WA
Meeting Minutes
June 1, 2009**

Business Representatives

Kris Tefft, Association of Washington Business, Rebecca Forrester, Group Health, Rick Anderson, Sakuma Bros, Nancy Dicus, TOC Management Services

Labor Representatives:

Terry Tilton, Washington State Building & Construction Trades Council; Karen Gude, United Food & Commercial Workers Union Local 1439; Jeff Johnson, Washington State Labor Council; Owen Linch, Joint Council of Teamsters No. 28

Labor & Industries:

Judy Schurke, Director; Bob Malooly, Assistant Director of Insurance Services

Recorder:

Sharon Avery

Guests:

Glenn Hanson, Brad Reckord, Katrina Zitnik, Dave Kaplan, Karen Nilson, Greg Kabacy, Tina Coakley, Melissa Johnson, Mike Barron, Lloyd Brooks, Naomi Goodman, Donna Egeland, Dennis Kelley-Jones, Christina Lombardi, Nancy Ziegler, Carolyn Logue, Ann Jarvis, Dan Hansen, Ellen Hull, and Dr. Tom Wickizer

L&I Staff:

Bob Mootz, Diane Doherty, Jason McGill, Brenda Heilman, Mary Shatto, Jean Vanek, Susan Campbell, Cheri Ward, Cassandra Smith, Mark Mercier, Karen Peterson, Russell Frank, Joshua Ligosky, Jessica Nau, Diana Drylie, Dr. Gary Franklin, and Vickie Kennedy

Opening Comments and Safety Message:

Mr. Malooly presented a safety message to the committee. The meeting continued with an introduction of the attendees.

The minutes of the April 29, 2009, meeting were not ready for review and approval.

Copies of the presentation, *Update on the Occupational Health Services Project*, were distributed.

Background of the Centers of Occupational Health and Education (COHE) Project: Diana Drylie

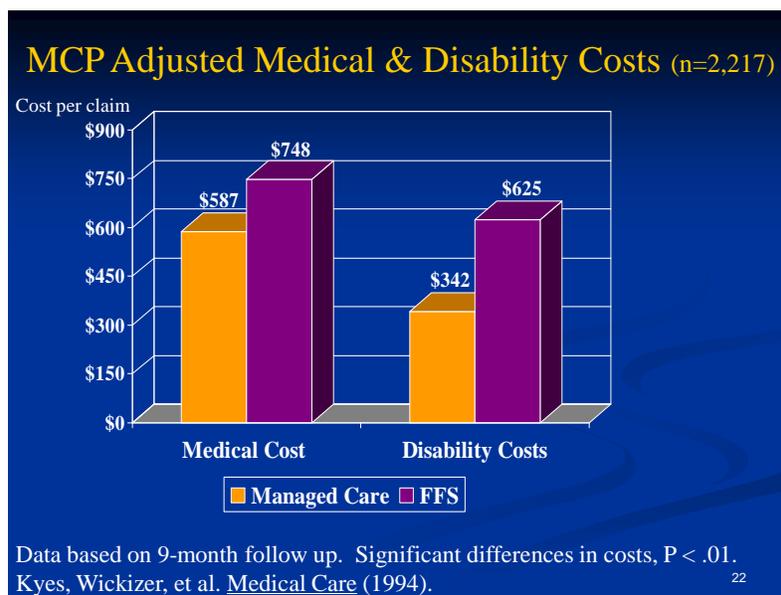
The goal of this presentation was to update the WCAC on the work completed by the WCAC- Health Care Sub-Committee (WCAC-HC), specifically related to Centers of Occupational Health and Education (COHE).

Regarding the best practice design on slide 10, it was asked why carpal tunnel syndrome (CTS) was selected. Dr. Franklin answered that carpal tunnel is the most prominent and objective of the upper extremity repetitive motion disorders. Ms. Drylie added that the COHE best practices are applied by participating providers regardless of condition. Any injured worker who receives care from a COHE participating provider gets the best practices.

Dr. Franklin was asked if the department has seen a decline in CTS claims. He observed that the CTS diagnosis is not used as frequently as it was pre-2000 and remarked that all injuries have declined in recent years, including CTS. He offered to discuss this decline in more detail at a later time.

Findings of UW COHE Evaluation: Thomas Wickizer

Mr. Malooly introduced Dr. Thomas Wickizer to the committee. Dr. Wickizer provided a summary of the main findings from the evaluation of COHEs.



In a brief mention of the earlier Managed Care Pilot (MCP), Dr. Wickizer noted that both medical and disability costs declined even though the principal payment incentive was for medical cost control. The 1993 MCP replaced the fee for service system with capitation (or a per claim charge). It paid designated occupational health care networks for coordinated care, on-going follow-up, and adherence to treatment guidelines. In addition, worker satisfaction was lower. The satisfaction survey conducted about six months after claim receipt included a variety of questions regarding worker satisfaction with access to care, their primary physician and access to specialty care.

Primary COHE Evaluation Findings: Renton and Spokane Pilots, Years 3 & 4 after Implementation*

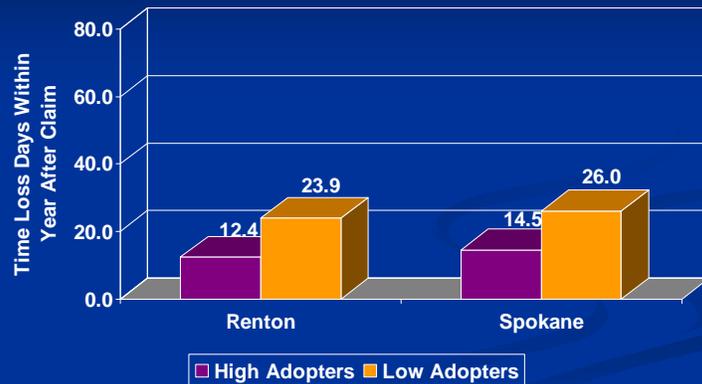
- The most recent detailed analysis shows COHE associated with:
 - 4.1 day reduction in time loss per claim
 - \$347 reduction in time loss payments per claim
 - \$245 reduction in medical costs per claim
 - Estimated combined (gross) cost saving per claim: \$592
 - Net gross savings per claim: \$480

* The outcomes are based upon 2 years follow up.

28

A question was asked regarding slide 28—did the net gross savings per claim of \$480 include Retro and non-Retro? Dr. Wickizer confirmed that savings accrued to both Retro and non-Retro claims.

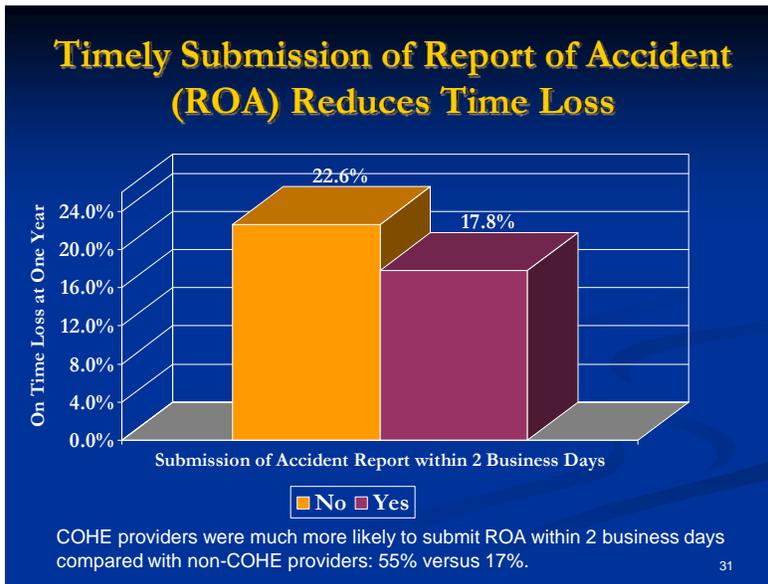
Adjusted Mean Disability Days for Back Sprain Cases: Is Performance Associated with Adoption of Best Practices?



Differences are statistically significant ($p < 0.05$)

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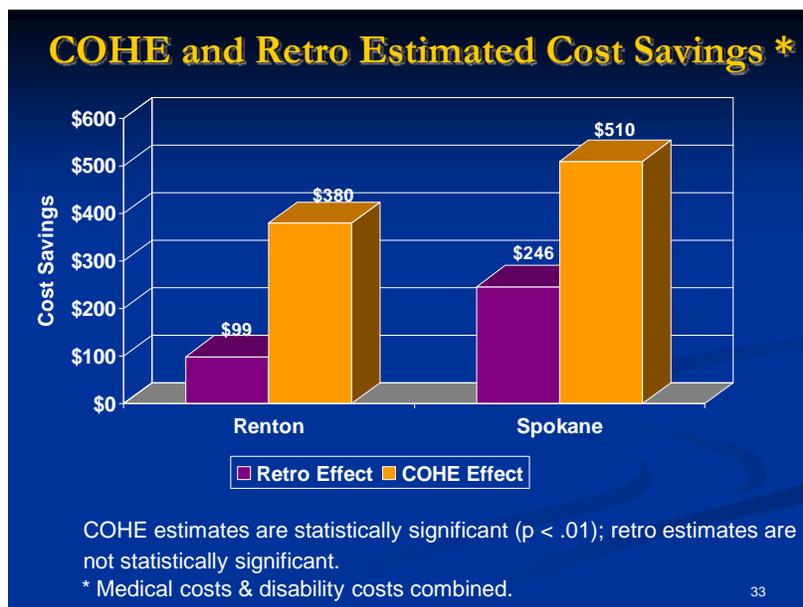
The COHEs achieved a substantial reduction in time-loss days per claim. When looking at strictly back sprain cases at the Renton COHE, patients who were treated by low-adopter physicians had roughly 24 days of time-loss versus about 12 days of time-loss for patients who were treated by high-adopter physicians. The same pattern occurs at the Spokane COHE (26 days for low-adopters versus 14.5 days for high-adopters). High-adopters are physicians who were above the median value on two out of three of the best practices (ROA in two days, Activity Prescription Form, and phone calls to employer). All other physicians (physicians who were above the median on zero or one of the best practices) were defined as low-adopters.



Within the COHEs, timely submission of Reports of Accident (ROA) was associated with reduced time-loss, favoring workers whose ROA was submitted within two days.

In response to a question, Dr. Wickizer commented that the principal analysis related to time-loss reduction was adjusted for injury type.

Dr. Wickizer also conducted an analysis of the COHE effect compared to any potential effect of Retro status. The COHE represented an effort to change the nature of interaction between the physician, worker and employer from within the health care system, and under the control of physician leaders. Another intervention that is more similar to an insurance administrative intervention is represented by the Retro program. Thirty percent of COHE claims are also Retro claims. The UW evaluation team took the opportunity to compare the Retro (insurance) effect versus the COHE (health care delivery) effect. This was completed to better understand what value is added to the health care system through the COHE intervention, as opposed to not changing the delivery system and providing only an insurance-based administrative intervention.



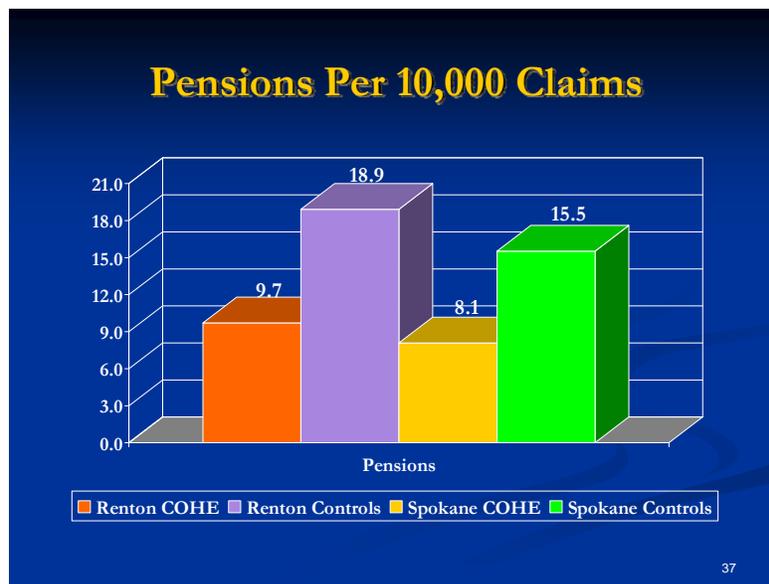
The relative COHE versus Retro estimated cost savings:

Renton: Retro Effect= \$99 COHE Effect= \$380

Spokane: Retro Effect= \$246 COHE Effect= \$510

When the standard statistic model is used, the findings show some cost savings associated with the Retro program, although these savings were not statistically significant. There was a much greater degree of savings associated with the COHE program independent of the Retro program.

It was asked why the group compared the Retro and COHE programs, when the purposes of the two programs were different. Would using Retro and COHE have an additive effect and reduce the total cost of a claim? Dr. Wickizer agreed that it would be an additive but explained the goal was not to get an overall combined effect of Retro and COHE, although this could have been done with a statistical model, but simply to compare the two groups. He agreed that the information indicates if there was a Retro claim and it was subjected to COHE, there would be an additive effect.



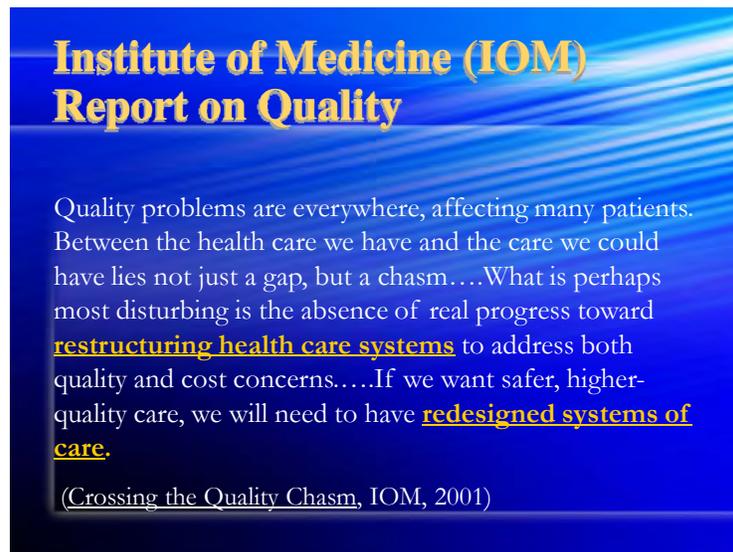
The COHE evaluation also studied other potential beneficial effects of the COHEs, for example on claim acceptance rates, on protests, on pensions, and on attorney involvement. The COHE results demonstrated less claim rejections, fewer protests, fewer pensions, and less need for attorney involvement. For example, the pension rate (per 10,000 claims) was approximately half when compared to the control groups in both the Renton (9.7 vs. 18.9) and Spokane (8.4 vs. 15) COHEs.

Dr. Wickizer reviewed the overall conclusions of the COHE evaluation.

A question was asked if a report regarding the best practices that promote disability prevention is posted on the website. It was answered that all of the UW COHE evaluation reports are posted on L&I's website in date. The website is: <http://www.lni.wa.gov/ClaimsIns/Providers/Research/OHS/default.asp>

Innovating Improved Quality in WA Workers' Compensation Health Care: Dr. Gary Franklin

Mr. Malooly introduced Dr. Franklin. Mr. Malooly remarked that Dr. Wickizer and Dr. Franklin discovered that the department was paying for utilization reviews (UR) for doctors who never had their treatment requests denied by the department. These URs delayed surgeries for injured workers and created more administrative work for the providers. Dr. Wickizer and Dr. Franklin developed a “Class A” doctor approach for outpatient surgeries. If providers follow department guidelines consistently over a period of time, they no longer need to complete UR; instead, these physicians still notify the UR vendor, Qualis, of the intent to conduct a procedure, but these requests are usually approved within hours without additional review. This saves the department money and it allows the best doctors to provide needed surgeries sooner for injured workers, with much less administrative burden for the physician offices. The results were positive. The number of providers following treatment guidelines more than doubled, for a net savings for the department and reduced administrative costs for the “A” physicians.



The COHE, through financial and non-financial incentives, innovated a novel method to improve the delivery of occupational health care to injured workers. The redesign related to COHE is a good example of using financial and non-financial incentives to improve the use of best practices and health care outcomes.

The Health Services Coordinators (HSC) are the “go to” staff within the system for the doctors. They are considered the “glue” of the community and are improving the coordination for COHE. It was expressed by the doctors’ focus groups that this feels like a team effort. One committee member asked if the HSC work for the department or for the COHE. All HSCs work for the participating COHE providers, within the health care delivery system. Thus, the providers see these HSCs as part of their own health delivery network, not as part of the workers’ compensation insurer’s system.

The HSCs and other aspects of COHE have led participating providers to report high levels of satisfaction with COHE. It was commented that, in contrast, a study being done for the California Workers’ Compensation System shows that approximately 70% of chiropractors in California plan to substantially scale back treating injured workers. Of primary care physicians, the majority said they plan in the next two years to substantially reduce their practice involving injured workers because there is so much frustration with the California system.

This is in strong contrast with the COHE physicians in Washington who are willing to treat more injured workers.

In response to a question regarding the method of reimbursement for HSC services:

- All time spent conducting administrative functions, such as reviewing and determining which claims would benefit from their services are paid under a contract. This is part of the infrastructure cost of a COHE.
- Once an injured worker is identified who needs their assistance with return to work, they bill L&I for the time spent coordinating the claim. The fee schedule allows them to bill in six minute increments. This is a cost to the claim.

Dr. Franklin reiterated the importance of timeliness in delivery of the COHE best practices. In the past, for example, it would take up to one month to receive a ROA from Harborview Medical Center; it is now received within two days.

Dr. Franklin also explained that a large proportion of workers, up to 40%, begin their treatment at the emergency room or urgent care center. These are workers who may be far from their own doctors, or they do not have a doctor. One of the innovations of COHE has been to connect the occupational doctors and the COHE provider with emergency rooms so it would not take an additional week for the worker's next visit to occur. Thus, the same timeliness benchmarks apply to workers visiting an emergency department as to those who do not.

Dr. Franklin also briefly addressed the acute problem related to increasing disability, morbidity and mortality associated with overuse of prescription narcotics for chronic pain. His UW research group will have published five papers in peer-reviewed journals by the end of 2009 addressing these problems in the workers' compensation system. In addition, a statewide opioid dosing guideline was implemented as an educational tool for Washington providers in April, 2007. This is helping change the manner in which physicians use opioids for chronic pain, and appears to be helping reduce the large doses previously provided injured workers.

**Washington Workers' Compensation
Disability Risk Identification Study Cohort
(D-RISC)***

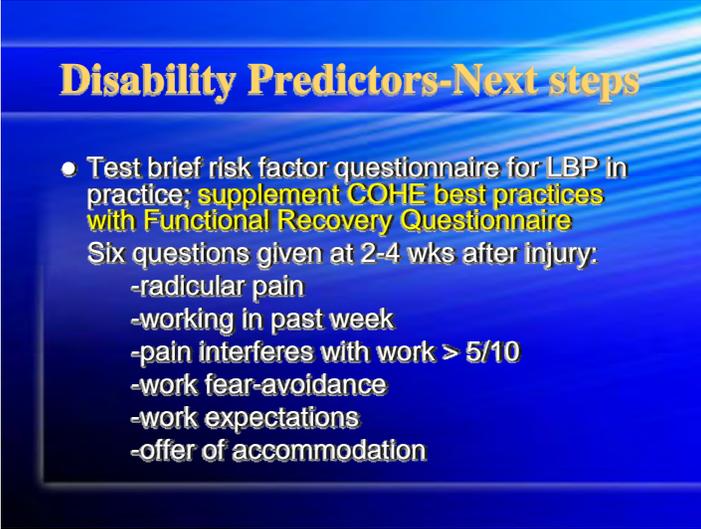
- Prospective, population based
- Low back injury and carpal tunnel syndrome
- For LBP, N=1885 workers enrolled and completed baseline interview (median 18d)
- Predictors of disability at 1 year

CDC/NIOSH RO1 OH04069-end 8/31/2007
*Turner, Franklin, Wickizer, Fulton-Kehoe et al. ISSLS Prize Winner; Early Predictors of Chronic Work Disability: A Prospective, Population-Based Study of Workers With Back Injuries. Spine 2008; 33: 2809-2818

Dr. Franklin also explained there has been a longstanding interest in how disability can be predicted. The department received a five-year National Institute of Occupational Safety and Health grant seven years ago and has been able to track 2,000 low back cases and 2,000 carpal tunnel cases over several years. Workers were surveyed a median of 18 days from the time they first sought treatment. A recent research paper on the overall findings for the low back cohort received an international prize for the best paper related to low back care. This will be extremely useful for the department to translate into a practical tool to identify workers early on that may be at a greater risk for disability, and to deliver to them effective services that address barriers to recovery.

Some examples of information learned in the disability prevention study grant: the department developed an injury severity scoring method by reviewing the first visit. This method reliably identifies whether the injury is a mild or severe sprain or whether the injury is more severe, such as radiculopathy. With the increasing severity of injury, there was a dramatically increased percent of workers that were disabled one year later.

Another example: If the worker received a job accommodation offer within several weeks of being first seen for a new low back injury, they were more than twice as likely to be back at work.



Disability Predictors-Next steps

- Test brief risk factor questionnaire for LBP in practice; **supplement COHE best practices with Functional Recovery Questionnaire**
Six questions given at 2-4 wks after injury:
 - radicular pain
 - working in past week
 - pain interferes with work > 5/10
 - work fear-avoidance
 - work expectations
 - offer of accommodation

The disability prediction data was used to develop a Functional Recovery Questionnaire that has six questions which can be used as a disability screening instrument early in low back cases. If these six questions are asked within two to four weeks after the injury, the answers could help determine whether the worker is likely to be disabled within a year.

The department has also done extensive work with Dr. Judy Turner at the UW to review the best available evidence for types of treatments that could be offered related to the problems uncovered by the screening questionnaire. If targeted and graded exercise, education regarding fear avoidance for return to work and low work expectations, and workplace accommodations can be applied within two to four weeks, disability can be reduced for injured workers. This model would help improve the application of one COHE quality indicator, identification of barriers to return to work by four weeks of lost time, which has been underutilized in the COHEs. The department is working to apply the questionnaire and to apply practical interventions that could be added to the workers' care between two to six weeks following injury.

Where Are We Going? Diana Drylie

Ms. Drylie explained the COHE project was designed by business, labor, and the department with assistance from the University of Washington. As we learned more about the benefits of the COHEs, we started a collaborative process with business and labor to determine how to define the future of the COHE project.



Guiding Principles

- Expand capacity and improve quality of occupational health best practices for both primary and specialty care.
- Improve provider accountability for delivery of efficient and effective care.
- Enhance satisfaction of workers and employers by continuously improving the medical care provided, coordination of health care, and the processes developed by the Occupational Health Services project.

Guiding Principles (cont.)

- Retain the voluntary nature of the worker's current ability to select providers.
- Increase satisfaction of providers with the workers compensation system. Use incentives to encourage and enhance the use of occupational health best practices and increase participation by providers.
- Improve injured worker and overall system outcomes using continuous quality improvement.

A question was asked regarding the Project Guiding Principles. Was there an increase in accountability of providers and were employers' satisfaction levels surveyed? Ms. Drylie answered that there are several places where provider accountability is part of the system. The department has scorecards at both the COHE and participating provider levels. COHEs show each provider where they fall on each of the best practices compared to benchmarks and their peers. A comment was made regarding provider accountability. The Eastern Washington COHE is working on a quality improvement project to identify providers who adopt fewer of the best practices so that the COHE can provide focused training.

Dr. Wickizer responded to the question regarding employer satisfaction. The UW conducted a limited survey of employers a number of years ago. More recently, a focus group was conducted with employers for the Spokane COHE. Research staff met with the employers and had a productive conversation. Those employers confirmed some of the findings found from statistical analysis, such as the importance of the HSC. They felt the communication to providers improved due to the HSCs. Their general response was favorable to COHE.



Transition Goals

1. End the pilot phase of the COHEs
 - a) Implement COHE model as standard practice

2. Role of WCAC-Health Care Subcommittee
 - a) Continue subcommittee
 - b) Review and provide feedback on implementation details
 - c) Regular reporting to WCAC

A question was raised concerning whether the WCAC-HC subcommittee was still needed. Ms. Drylie felt it would be extremely useful to continue the subcommittee, especially as the department is developing the implementation details and figuring out how the COHEs can work in a standard process.

A member of the WCAC agreed and said they would like to continue meeting with the subcommittee until the roll-out of these new processes is complete. The parent meeting often has other agenda items, where the subcommittee focuses solely on COHE issues.

A comment was added that the representatives from the Renton and Spokane COHEs are on the subcommittee and they bring the local perspective.



Implementation Details

- Develop with WCAC-HC feedback

- A. Disciplined expansion of best practices
 - Funding mechanism/amount for COHEs
 - COHE accreditation process and standards
 - At least 2 new COHEs by 2013
 - Criteria to implement best practices statewide

The implementation details are from the transition goals developed by the subcommittee.

- A. Disciplined expansion of best practices: The department wants to be careful on the expansion of separate best practices to ensure they can achieve the same outcomes achieved by COHEs.
- When discussing the COHE model as a whole, the department must determine how best to fund the model. The hope is to have a clear funding mechanism that is equitable for COHEs across the state. The funding formulas have not been developed yet, but the department would like to continue working with labor and business on this issue.

A question was asked regarding recent funding. How much per year is spent on the Renton COHE versus the Spokane COHE? Ms. Drylie answered that the numbers vary dramatically due to the sizes—Renton COHE: \$230,000 per year; Spokane COHE: \$540,000 per year. Additionally, each of the smaller COHEs receives \$100,000 per year.

It was asked when the pilot is over, how will the current COHEs be funded? Ms. Drylie answered that the COHEs will continue to be funded through the current contracts for the next two years.

It was asked how the department accounts for legislative unpredictability when trying to apply a disciplined expansion. Ms. Drylie answered that there is no way to control legislative decisions or what bills are introduced during session, but the collaborative process allows labor, business, and the department to respond together to any issues that are raised. During the last legislative session, all of the caucuses were well prepared, understood the transition plan, and were able to respond quickly to a bill that was dropped.

- COHE accreditation process and standards: The department wants to provide clear minimum standards for future COHEs. The department plans to determine the minimum level of service that must be provided for an entity to become a COHE and a handful of performance measures that we can apply to determine whether or not a COHE is continuing to achieve success.

Mr. Malooly remarked that the design problem is challenging because of the differences in conditions in the medical community and the different parts of the state. Developing a model that can be effective given the wide range of conditions poses a challenge. Ms. Drylie added that flexibility will need to be built into the process to ensure that minimum standards for all of the varying COHEs can be met while allowing them to be flexible to meet their communities' needs. Dr. Franklin added the new standards should not have an adverse impact on the innovations that have already occurred, such as the connection between the emergency room and doctors in a community or between US Health Works and Valley Medical Center.

- At least 2 new COHEs by 2013.
- Criteria to implement best practices statewide.

A question was asked regarding the goals for measuring success of the overall program. Ms. Drylie answered that, as COHE expands, the opportunity to use control groups in evaluations is lost. The department must figure out the role of University of Washington and L&I in future evaluations and performance measurements.

It was commented that, while control groups may diminish or disappear, when more providers are brought into the COHE system we gain an opportunity to focus on quality improvement activities within the COHEs.

One of the challenges for developing clear performance measures is linking them to the outcomes that the current COHEs have achieved.

It was asked if L&I has a target for total number of future COHEs. Ms. Drylie answered there are currently no targets.



Implementation Details

- Develop with WCAC-HC feedback
 - A. Disciplined expansion of best practices
 - Funding mechanism/amount for COHEs
 - COHE accreditation process and standards
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On slide 68, Ms. Drylie continued to review the implementation details.

B. Continue current COHEs through June 2011

It was asked whether L&I will terminate the original COHEs in 2011. Ms. Drylie answered the current COHEs would continue until the design work is completed. By the 2011-2013 biennium, we can transition to the new process and our current COHE partners can choose whether to participate.

It was asked if the new COHEs are intended to be in new geographic areas. Ms. Drylie explained that we currently do not know. They could be community-based COHEs or institution-based COHEs.

C. Work with self-insurance community to make best practices available to self-insured employers and workers. The plan is to have a forum to allow L&I and self-insured employers to share best practices.

Ms. Drylie had two requests for the WCAC:

1. Does the committee approve of moving toward COHE becoming a standard way of doing business as opposed to a pilot?
2. Requested clarification of the role of the WCAC-HC subcommittee for the next two years.

It was asked to clarify the value of community-based HSC versus the department providing these services. Could the department provide the same quality of interaction with providers? Ms. Drylie felt that the quality of service would not be the same. The HSC and the COHEs have a relationship with the providers. The providers view the HSC as their resource and work closely with them on care coordination and return to work. Dr. Franklin added that claim managers at the department cannot change the way health care is delivered; only the doctors can.

A comment was added that the department and Retro associations both have claim managers who manage claims. The HSCs outperform both of them in reducing costs. They work with the physician community in a unique way.

A question was asked concerning information about claims managers working with the COHEs. Has a survey been completed? Ms. Drylie answered that a survey has not been completed. Recently, claim managers participated in focus groups and expressed positive feedback on having the HSCs available to help them communicate with providers. This has been a useful tool for the claim managers.

It was asked if a claim manager could easily identify COHE cases. Ms. Drylie answered that all COHE providers mark "COHE" on the top of ROA forms. The HSCs also meet with claim managers assigned in their geographic area once a year.

It was asked how many HSCs are available. Ms. Drylie answered there are a total of eight HSCs with all of the COHEs.

It was asked if employers receive the full copy of the ROA forms from COHE. Ms. Drylie responded that the employer receives an abbreviated copy from L&I. For COHE, the best practice is for the provider to share the worker's work status, restrictions or capabilities, and talk with the worker and employer about return-to-work options, so they can develop a return-to-work plan together.

In closing, Mr. Malooly commented that the two decisions needed today concern transitioning COHE from a pilot and continuing the WCAC-HC subcommittee. Based on the discussion today, the WCAC-HC subcommittee should continue to meet as the plan is to move forward. Mr. Malooly suggested that the next step should be to develop a proposal on how the department would like to proceed and to review it at a future WCAC meeting for input.

It was commented that at the Quarterly Building Trades meeting, a request was made for a SHIP grant for Labor Radio. They are looking for updates to provide to the labor community and it was asked if they could be contacted to educate labor about the COHE experiences and how to access it.

It was asked how much detail will need to be in the proposal. Ms. Drylie responded that she will draft a high level work plan that includes high-level tasks, the time range when the department can achieve them, and when data will be available to present to the WCAC and WCAC-HC. The WCAC-HC will work with the department to create the work plan and will report to the WCAC when an agreement has been made.

Meeting Adjourned