

**Advisory Committee on Healthcare Innovation and Evaluation**  
**ACHIEV Minutes for October 22, 2015 Meeting**

**Members present:** Dianna Chamblin (Chair), Ron Wilcox (Vice-chair), Andrew Friedman, Robert Waring, Lisa Vivian, Stephen Thielke, Teri Rideout, John Meier, Kirk Harmon, Mike Dowling, Clay Bartness, John Meier  
**L&I staff present:** Gary Franklin, Nicholas Reul, Vickie Kennedy, Leah Hole-Marshall, Diana Drylie, Noha Gindy, Brian Peace, Simone Javaher, Zachary Gray, Ellie Campbell, Barbara Braid, Carly Eckert, Karen Jost  
**AAG staff present:** Jessica Creighton, Kaylynn What  
**Public present:** Regina Nieders, Pacific Rehabilitation, Dave Threedy, Nichole Cushman, Nancy Vandermark, Amy Valdez, Jerri Wood

**Topic**

**Safety Message:** It's getting dark and Halloween is coming; put lights on early and dress to be seen.

**Healthy Worker 2020:** Leah Hole-Marshall gave a brief overview of the evolving L&I health care purchasing vision and five year plan. A key component is occupational health best practices, and the Top Tier will help provide incentives for providers to adopt them. PowerPoint available in meeting materials.

**Top Tier Proposal on Criteria and Incentives.** The primary meeting focus was to share a complete proposal for the Top Tier of the Medical Provider Network. The goal is for disability prevention. The timing goal is to finalize the Top Tier criteria by end of 2015; communicate to providers by spring 2016; and start accepting applications by fall of 2016. PowerPoint with criteria and incentive proposals available in meeting materials.

Noha Gindy, Brian Peace, and Bob Mootz presented and those present reviewed the vision, criteria, and incentive framework being recommended for the Top Tier program.

General criteria:

1. MPN approved provider; assessed by NPI
2. Follow treatment guidelines
3. Use technology when available to transmit data
4. Minimum claim volume ( at least 12 claims in past 3 years)
5. Sign up for quality improvement
6. Follow occupational health best practices (ROA in 48 hrs; APF at first visit and for claims with restrictions; two way communication) and JA returned in 5 days
7. Follow best practice prescribing (opioid and generics)
8. Use Problem Oriented Medical Record (POMR) chart notes.
9. Outcomes review – feedback on claims on time-loss and length; review of claims over 6 month for appropriate documentation of diagnosis and causation, charting, communication and tracking of pain and function.
10. Accept claims at L&I request
11. Care coordination – requirement not yet defined

Estimated potentially qualifying providers – about 300.

Feedback on criteria included:

- Need to know how COHEs fit in with the Top Tier program and goals.
- Hesitation expressed about having to attest to following guidelines 100% of the time because they are written for most general circumstances and do not always apply, e.g. to exceptional cases.
- Concerns expressed about required threshold of L&I claimants seen by providers to qualify for Top Tier. Estimate 1426 out of 11,500 providers (12%) will meet threshold; 70% of providers have only 2-3 IW claims per year.
- Be as inclusive as possible and allow providers to demonstrate their ability to follow best practices and prevent disability.
- Requiring attestation to use electronic communications could be a disincentive for joining top tier.
- Cost of setting up and customizing EMR systems needs to be considered; Connecting to the HIE and embedding the APF within the EMR is estimated to cost The Everett Clinic \$20-30,000.
- Top Tier criteria to submit 80% of ROAs within 2 business days is not always practical, especially for small rural providers. What will count? Date of mail or fax? As long as it was initiated by the provider (and documented), that's the indicator. How does new claim definition affect the ROA?
- Program needs to accommodate the different ways a clinic is structured and operates:
  - Providers who treat patients for a limited time period



- Providers who use staff to conduct best practices (ex: two-way communication)
- Prescribing best practices should get more feedback from IIMAC. Comments made that even though state rules and AMDG guideline for opioid prescribing limit is 120mg daily MED as a threshold, recent research shows risks can begin as low as 50mg daily MED; this warrants discussion. CDC guideline will be coming out in January and may have dose < 120mg. Currently, 92% of prescriptions are for generics (do not say, “dispense as written”).
- What does it mean to “resolve” a claim? Concern about provider role versus other issues (e.g. adjudicative rather than clinical).
- Complex claims are important and need to be a focus, but unsure of how to do so as part of Top Tier. Accepting complex claims criteria: not looking to “ding” a provider for not accepting them.
- Requested input on assessment process and how information will be transferred to the AP; they have a quarter to correct any errors.
- Suggestion made to give different weights to Top Tier provider acceptance criteria; some will be relatively easy to achieve while some will be more difficult.
- For chart documentation and review - consider automating any part of the process - such as identifying certain parts of the text?
- POMR is not a specific /new format (for individuals that currently have an EMR format) A critical factor in worker comp is identifying what the work-related condition; and does it include finite treatment goals. Are there new forms? Using the Problem Oriented Medical Record approach is the goal.
- Will there be any criteria for top tier related to injured worker feedback on the quality of care that they receive? Response: If it’s in the record, it will be considered. Providers concerned about their performance being measured based on patient feedback when provider may be following best practice but not meeting patient’s request (e.g. opioid prescription).

Incentives – reviewed different financial incentive approaches and list of potential non-financial incentives. Feedback on criteria included:

- Non-Financial incentives are very important. The most important of those is the provider being able to get the information and assistance they need from an L&I claim manager.
- Incentives need to be structured for the organization and the provider; for example provide organization with rewards/incentives that allow them to reduce RVU productivity thresholds for providers, which reduces their burden.
- Incentives need to be separated from regular billing and noted on provider reporting.
- Incentives should be compatible with all the programs in Healthy Worker 2020.
- Business and labor want Top Tier providers that can take the more difficult claims.
- Providers want a complex claim contact that is knowledgeable and always available. They don’t call all the time, but their sporadic calls are important.
- Providers need a hotline or concierge service. Providers need to communicate with CMs to move the claim forward.
- Providers need resources to assist them in implementing best practices. L&I will train providers about the top tier requirements.

Additional questions:

- How is the previously reported MPN number (approximately 23,000) different than the Top Tier number of about 17,000?
- How should GINA – Genetic Information Nondiscrimination Act – be handled as part of the POMR?
- How will self-insured employers participate in this program?
- Recommend that L&I get IIMAC feedback on Top Tier prescribing measures.

#### **Bio-psycho-social practice resource by Dr. Bob Mootz**

This is a joint IIMAC-IICAC subcommittee co-chaired by Dr. Thielke (IIMAC) and Dr. Lawhead (IICAC). Will address things like self-efficacy, fear avoidance, and early activation. These will be delineated from psychiatric disease and should be routine parts of care for every primary care provider. Goal is to build local skills in the PCP community so chance for optimal recovery is improved. The literature shows lots of promise with doing this. Another goal is to avoid making this into a long list of things the PCP has to do; should be easy to implement with no prior authorization requirements. Plans to have a draft ready by the end of the year and wants it to be available in early 2016. This will be considered a best practice. This will help document the worker’s functional improvement over time.

**Catastrophic Care Management RFP Update**

Dr. Reul presented an update on the five-point plan; there's opportunity to expand and improve outcomes with these best practices.

1. **Conduct RFP** for external value-based catastrophic care management services. RFP released and received five responses. Designed to increase nurse case management services and add life care planning together. Expected services will be delivered at any time throughout the life of the claim.
2. **Strategically reallocate internal L&I resources** for catastrophically injured worker care management. About 6 claim managers and 6 nurses have been assigned responsibility for new catastrophic claims. L&I will also be using information technology to coordinate communication - OHMS is the identified tool.
3. Establish a **catastrophic health services coordinator (HSC)** role within COHE – L&I is identifying current HSC roles and additional functions that are needed for catastrophic care coordination.
4. Establish **Centers of Excellence** for catastrophic injuries, first with amputees – the scope of services is currently defined.
5. Conduct a **prospective evaluation** of catastrophic management - IRB approval has been received for the first phase of data analysis.

Other activities: L&I participated in a House committee meeting last month where Vickie Kennedy gave an update on the implementation progress of the Catastrophic care management plan. L&I catastrophic work is a part of our health care purchasing vision contained in Healthy Worker 2020. From a state perspective, it is also important to note that it is consistent with the state's overall initiative "Healthier WA" which include a value based purchasing strategy.

Meeting wrap-up, including plans for the January agenda