Advisory Committee on Healthcare Innovation & Evaluation (ACHIEV)

Meeting Minutes for January 24, 2019

Members Present
Dianna Chamblin, MD (Chair)
Ron Wilcox, DC (Vice-Chair)
Clay Bartness, DC
Mike Dowling, DC (alternate)
Kirk Harmon, MD
John Meier
Stephen Thielke, MD
Lisa Vivian
Malcolm Butler, MD
Andrew Friedman, MD
Lee Thomas, JD

Vickie Kennedy
Cortney Melton
Zach Gray
Ryan Guppy
Cheri Ward
Morgan Young, DC
Jeana Weekley
Jaymie Mai
Sarah Holm
Nancy Vandermark
Rey Robertson
Emily Stinson
Joel McCullough
Susan Campbell, LM

Members Not Present
Joe Kendo (alternate)
Neil Hartman

Members of the Public
Bobbi Meins
Nicole Cushman, COHE Alliance
Jamie Hodge, COHE Alliance
Janice Lejos
Lissa Grannis, DC

L&I Staff Present
Gary Franklin, MD, MPH
John Boze
Karen Jost, PT, MS

All meeting materials are available on the ACHIEV website. These minutes are only a brief summation of meeting discussions.

The meeting began with a welcome, introductions, and a safety tip on traffic safety, with a note on the Seattle viaduct closure. The minutes from the October 25th meeting will be approved at the April 25th meeting.
**Acupuncture Pilot Update** presented by Zach Gray  
Zach Gray gave a brief update, explaining project status of the Acupuncture Pilot. Start date Oct 2017 and ongoing. Presentation was in regards to how bills were being paid, next steps in the pilot in regards to finalizing the proposed coverage decision, as well as noting the public hearings and public comment sessions to discuss proposed language. Proposed end date will be when CR-103 is filed, tentatively June 1st.

**FEEDBACK AND QUESTIONS:**
- Q: Will the rule include 10-session maximum?  
  A: Yes.
- Q: NIH study states older adults may need additional visits (up to 24).
- Q: How is study defining functional improvement?  
  A: Meaningful improvement 30%, also considering RTW and other functional goals.
- Q: Pilot providers have been successfully submitting documentation – how have they been so successful?  
  A: Unsure, believe that providers are motivated.
- Q: Number of referring providers?  
  A: No current data.

**Master Level Therapy (MLT)** presented by Zach Gray  
Zach Gray gave a brief update explaining the status of the MLT. To be discussed with stakeholders at 2/4/2019 meeting. Previous meetings (10/31/2018 and 12/3/2018) discussed providers’ training needs as well as implementation and timeline.

**FEEDBACK AND QUESTIONS:**
- Q: Is a mental health diagnosis necessary for referral, or can one make a referral with any diagnosis with a history of depression?  
  A: Yes, as it will help with coping skills and working through the IW’s injury.
- Q: Training is crucial to success. Will training classes be large & “101” (basic level) and will the number of providers signing up prove beneficial for them when they do not know how great the demand will be?  
  A: We will learn this information throughout the pilot.
- Q: Primary care has integrated behaviorists on their teams; how will this prove different from independent providers?  
  A: Visits may be shorter and may be able to be booked earlier as they do not have other in-house providers referring.
- Q: MLT Providers are incredibly busy, so having an additional extended training online may not work, as some may not have capacity. They may also bring up HIPPA concerns and may be uncomfortable conversing with employers; how will this be addressed?  
  A: VRC or HSC may be more appropriate for contact with employer, and access codes are already available for billing
Request for materials for attending providers (such as when to refer to a psychologist vs MLT) to determine scope of practice and what is included in the MH treatment from each mental health provider.

Q: How many MLT in network and what is the benefit – financial?
A: Currently zero, hoping pilot will highlight additional benefits aside from awareness and easier access.

Q: How will LNI encourage a goal-oriented approach?
A: LNI can encourage this by demonstrating best practices and highlighting that many providers already use evidence based treatment approaches.

**PCORI Opioid Grant update** presented by Gary Franklin, MD.

Dr. Franklin gave a brief update explaining current status and recent papers that have been published in regards to the grant. Included in the update was the department’s investigation into how opioids affect a claim based on when in the claim’s lifetime they are prescribed. Dr. Franklin also noted that discussions were happening about moving forward with a proposal and about how to work with Ohio while their state government was in transition.

**FEEDBACK AND QUESTIONS:**
- None.

**HW2020 update** presented by Karen Jost, as Diana Drylie was absent.
Handout is available on ACHIEV meeting website.

**FEEDBACK AND QUESTIONS:**
- None.

**Direct Entry APF Demonstration** presented by Noha Gindy.

Noha Gindy gave a walkthrough presentation on how the current direct entry APF form works – handout with full walkthrough, screen captures, and APF form is available on the ACHIEV meeting page.

**FEEDBACK AND QUESTIONS:**
- Q: Will there be the capability to self-populate?
  A: Header does already; restrictions have been a challenge so far.
- Q: How long did it take to do the form?
  A: Dr. Harmon finished in 2 minutes; the first time through, it took 4 minutes or so. Bringing the previous restrictions forward is time consuming, so pre-population is important. There is concern that providers will ignore the restriction section if it is pre-populated with prior restrictions and will not update.
Since accessing CAC has become more difficult with recent authentication sign on enhancement, it may be harder to access CAC – Dr. Chamblin often must go to her main computer to receive an access code, which can take ten minutes to arrive. This is not conducive for patient visit time and flow.

**Cloning Chart Notes** presented by Emily Stinson & Sharon Brosio. A new policy in cloning chart notes is in development; Stinson and Brosio presented it to the committee for feedback.

**FEEDBACK AND QUESTIONS:**
- **Q:** What is the department’s goal with this policy?
  **A:** To ensure clearly what is happening throughout the life of a claim and to prevent broad cut/past/carryforward of large chunks of pertinent information that should be regularly updated.
- **Q:** Recommendation for a “corrective feedback” process – some records can be particularly egregious.
- **Q:** This issue seems quite complicated – is there a way that widely known EMR systems could highlight what is new in each chart note?
  **A:** There is some functionality there to do it, but it does cost additional money, which providers may not be willing to pay for.
- **Q:** Could this be a COHE educational opportunity?
  **A:** Possibly.
- **Q:** A cloning records policy could be difficult to establish and ensure, as LNI is only one payer and other payers may have different policies.
- **Q:** This issue is sensitive and should have more time spent on it. Many providers no longer dictate their records – EMRs have the ability to create templates.

**Interpreter Services** presented by Susan Campbell.

Update on how interpreter services will be changing in the coming year, particularly for in-person appointments.

**FEEDBACK AND QUESTIONS:**
- **Q:** Is there a vision to move most of the interpreting to telephonic or video conferencing some day?
  **A:** Not necessarily.
- **Q:** Contact with representatives prior to contacting injured worker should be documented, especially if the worker is represented by legal counsel.
Some interpreters force their way into the lives of injured workers and turn it into a coercive relationship where they believe they have no other options but to use this particular interpreter. Scheduling system may help with this in the future.

- Q: Would it be possible to compensate practitioners who work with a second language differently?
  - A: It will be looked into

**Care Coordination** presented by Noha Gindy.

A three-part skit was presented to take the viewers through the life of a claim and what role a care coordinator can play at different stages. This skit highlighted what support could be given to the injured worker, and what duties they would be able to take on in order to make the claim move forward easier. The presenters broke this up by reviewing the handouts, available on the ACHIEV website, which further break down the care coordinator’s role.

**FEEDBACK AND QUESTIONS:**

- Q: What is the current period for allowance of a claim?
  - A: 4 days, longer for an occupation disease.

- Q: Claim manager turnaround time should be measured. Community based coordinators use CAC – what are delays in imaging documents? Some documents are prioritized higher (ROA, etc.). How will claim managers/providers be able to access the case note?
  - A: It will be available in CAC, indexed as HSC-COHE.

- Q: Can note be built to get rid of the extraneous material in the finale document (not including non-selected responses, etc.)?
  - A: It is a top ask for Maven, which is creating the document.

- Q: It is unclear how restrictions align with a “priority” claim (potential time loss) – does it include claims that look like time loss?
  - A: No, there will be training to focus on APF/restrictions.

- Q: Is this happening in the healthcare facility?
  - A: Usually delivered over the phone

- Q: Does the care coordinator screen for injured worker representation?
  - A: Yes. There is not currently a space for attorney on the list of contacts – that will be added. It was also noted that care coordinators would be good to have listed on the injured worker’s contacts in CAC – they have been there for the last 3 years (in claim file status).

- Q: Does this duplicate any work for the claim managers?
  - A: Claim managers will look at the care coordinator’s notes before contacting worker.
o Q: What are the requirements for a signed JA?
   A: The state requires them, and many employers will put them on record in event of a dispute.

o There is anticipation that Return to Work referrals will become less common as vocational referrals will hopefully happen earlier.

o Q: Who is taking care of quality assurance reviews, COHE or contract manager?
  A: Contract managers will be taking on reviews and are no longer limited to the first year of care coordinator’s tenure

o Q: What would deter doctors from having all care coordinators be lower-paid/trained staff such as medical assistants in order to make more money?
  A: The presenter states that audits will hopefully rule this out, and there are minimum qualifications for HSCs and HSCAs. There is concern that this may de-incentivize COHE participation, but the incentives team will be looking into this.

o Q: Where does multi-modal care fit in here? How are they ensuring these are well-coordinated? E.G getting PT to communicate, needing higher level of integration in the community?
  A: Part of the referral coordination, with care coordination monitoring. *Dr. Franklin requests that there be some sort of metric to identify and ensure that multi-modal care is being delivered and coordinated.*

**Meeting Wrap-Up & Further Plans**, by Diana Chamblin, MD.
Topics for further agenda items were mentioned here and are as follows:
  o Murray vs L&I
  o How to increase participation from Business & Labor.
  o Voc recovery

With no further comments, the meeting was adjourned at 12:00.