

Advisory Committee on Healthcare Innovation & Evaluation (ACHIEV)

Meeting Minutes for January 28, 2016
Port of Seattle – Central Auditorium, SeaTac Washington

Members Present

Dianna Chamblin, MD (Chair)
Ron Wilcox, DC (Vice-Chair)
Clay Bartness, DC
Mike Dowling, DC (alternate)
Kirk Harmon, MD
Neil Hartman
John Meier
Stephen Thielke, ME (alternate)
Lee Thomas, JD
Robert Waring, MD (phone)

Members Not Present

Andrew Friedman, MD
Joe Kendo (alternate)
Lisa Vivian

L&I Staff Present

Gary Franklin, MD, MPH
Vickie Kennedy
Leah Hole-Marshall, JD
Diana Drylie
Carly Eckert, MD, MPH
Ryan Guppy
Carole Horrell
Simone Javaher
Rose Jones
Karen Jost, PT, MS
Michael Murphy
Nicholas Reul, MD, MPH
Hal Stockbridge, MD, MPH (phone)
Jena Williams

Guests

Donna Egeland, Ombuds for Self-Insured Injured Workers (phone)
Tom Lehmann, Group Health Cooperative
Regine Neiders, Pacific Rehabilitation Centers
Terri Smith-Weller, University of Washington

All materials are available on the [ACHIEV website](#).*

Start: 8:35 due to traffic conditions.

Welcome and introduction of new members and staff. [ACHIEV website](#)

Safety Tip: When thunder roars, go indoors. Avoid lying or leaning on concrete, avoid taking a shower during lightning storms.

*lni.wa.gov/ACHIEV

The minutes from October 22, 2015 meeting were reviewed and unanimously approved.

Update on Top Tier (Karen Jost, PT, MS)

Vision: To be the quality leader in workers' compensation healthcare, achieving the best outcomes and quality of life for workers at the best value and using the simplest means.

Karen Jost continued the discussion around the requirements and vision of Top Tier provider status including reviewing feedback from the Top Tier presentation at the October 2015 ACHIEV meeting. Slides are included in the meeting materials on the [ACHIEV website](#).

L&I incorporated the feedback from the previous ACHIEV meeting and is moving forward with an approach that will allow providers to reach Top Tier using several pathways. One is through being a COHE high adopter and demonstrating certain best practices; another approach is through an application to Top Tier where equivalent high adoption of best practices occurs. These routes are primarily for primary care. More routes could be added for specialty, such as high adoption in the new combined surgical best practice program. L&I also confirmed that demonstration of an ability to work within a system and have care coordination is central to any Top Tier qualification.

L&I acknowledged the concern about requiring acceptance of complex claims and has decided that the willingness to take complex claims is important but not a requirement for Top Tier. To address the complex claims issue, Cheri Ward, L&I Chief of Claims, is launching a team to review complex claims with the goal of understanding what claims and provider needs are and what potential non-financial incentives for Top Tier providers to accept complex claims might be available.

The question was asked about how to evaluate and reward someone who specializes in complex claims and how this could be measured. It was suggested that peers could nominate individuals or the department could.

The Surgical Best Practices pilot should be completed and assessments performed by 2020.

Medical Provider Network Update and Access (Leah Hole-Marshall, JD)

Vision: To be the quality leader in workers' compensation healthcare, achieving the best outcomes and quality of life for workers at the best value and using the simplest means.

Update on Healthy Worker 2020, Medical Provider Network capacity and infrastructure. Handouts displayed a heat map of the Medical Provider Network care coverage and chart of injured workers and currently approved and provisional PCPs within a 15 mile radius. Also included was a table of providers by specialty. These handouts are available on the [ACHIEV website](#).

Of the four objectives of "Building on Workers' Compensation Reform Foundation," the most important objective is secondary and tertiary prevention of disability. (The slides and complete list of objectives are on the [ACHIEV website](#).)

Leah Hole-Marshall requested feedback on what other organizations think about provider capacity, why access and quality are related and what areas we should focus the day's discussion on:

- Approved providers
- Provider location
- Provider capacity
- Provider types
- Provider standards

Update:

- ~300 applications per month come through the Medical Provider Network.
- Washington Health Care Authority (HCA) got a large grant from Accountable Communities of Health for sustaining organization and defining priorities of communities. Requirements include:
 - Involving multiple industries to attain priorities such as clean drinking water or disease prevention.
 - Healthcare innovation by the Regional Extension Hub aligned with Dept. of Health goals. Collaborate with Medicaid to improve care.
 - Five year grants (3 years to implement improve care, 2 years to evaluate)
- One of the goals is the integration, coordination and purchasing of mental health services with behavioral services.
- PEBB benefits may align to these innovations eventually and two Business Labor Advisory Boards have similar structure.
- Currently over 23,000 providers are approved. Discussed why some providers are not in the network. (Per WA DOH, there are 64.2 healthcare providers per 100,000 population).
- There are about 87,000 injured worker claims per year filed in the state fund. 50% of those are initiated by a COHE.

The department has done well engaging COHE providers, surgeons, and chiropractors. Mental Health is an area of concern and interest and many providers don't have training in work-related mental health issues. Aside from potential paperwork and reimbursement concerns, there are system issues to be addressed. Mental health providers may not know much about workers' compensation. Long term claims could decrease if early mental/behavioral health services are available instead of resisted.

Overview of Susan Skillman, Deputy Director of the Center for Health Workforce Studies at the University of Washington view of the healthcare reform's impact on the healthcare workforce including emphasis on coordination skills, evidenced based care and paying for value instead of volume.

Discussion around Mental Health Integrated Behavioral Health Care (MHIB). There is considerable concern and interest that many providers don't have training in work-related mental health issues.



- Concept: L&I has done a great job partnering with and becoming an insurer of choice or preferred insurer for surgeons and occupational medicine providers (best practice programs). L&I can become an insurer of choice for mental health.
- Better communication needed – many parties involved with a disparate view or only limited view of the claim – not a complete picture. Need to collaborate and align with psych providers.
- Resistance to mental health issues early on makes for a snowball effect in the claim/recovery if not addressed.
- Workers comp is limited to workplace injury - cannot treat all illness/conditions (pre-existing).
- L&I is leading the way by having a payment policy that pays for team conferences and telephone calls.

The discussion needs to continue on the topics of:

1. Geographic location – Where do we need providers?
2. Provider capacity – How many do we need?
3. Provider workforce planning – Who do we need? Comment that better communication is needed as disparate information ends up in files, need better communication between providers.
4. Provider standards – What do we need?
(Timeliness, Quality, Panel Size, Patient Acceptance)

Comments:

More discussion/ideas needed about how to best apply effective incentives.

Surgical Best Practices – interactive session (Diana Drylie, MPA, Michael Murphy, Carole Horrell)

Today's goal is to open discussion and brainstorm on how to integrate surgical components with each other and integrate them across clusters. Slides are available on the [ACHIEV website](#).

Orthopedic and Neurological Surgeons Quality Project: Project is currently implemented. Goal is to provide timely access to high quality surgical care.

Surgical Best Practices Pilot: Three pilot sites have just completed the start-up year. Coordination and communication are key objectives.

Surgical Warranty and Bundle: Payment mechanisms are being explored by L&I. This model moves away from fee-for-service toward value-based purchasing.

All three of the above components have overlap and differences. Opened discussion around what should be considered in integrating these three components and when L&I should remain consistent with other health care purchasers or payers and across other HW2020 clusters.

Discussion:

- Consider including Utilization Review Group-A criteria in some fashion as part of the surgical cluster.
- Timeliness:
 - Reducing delay in the system is important. Currently incited in Ortho/Neuro
 - Can L&I measure “friction in the system” – if timeliness is an issue, how can we best measure where the delays occur (and whether to attribute to provider)?
 - Goal to compress time between events in the claim to achieve better outcomes and reduce cost. Consider a possible measure of time between steps in care.
 - Can surgeons in the community help set expectations for how long someone would be off work after a given operation? Establish guidelines for each condition. Pilot criteria/guideline. Let group vet it. Content experts see if they agree.
 - Time loss may not be the best measure for these programs; timeline for recovery might be a better measure.
- Compliance with Guidelines:
 - Adherence to guidelines can be a conflict if patient is outside the norm.
 - Sometimes patients that are outside of the norm need more care to recover fully.
 - 100% adherence isn’t realistic, need flexibility.
- Establishing expected goals for return to work are necessary and part of the Surgical Best Practices (SBP) pilot.
 - Tracked in Occupational Health Management System (OHMS) for SBP pilot. Discussion on whether a generic expectation is used by surgeon (e.g. standard recovery expectation can be 8-10 weeks). Patients are unique—there is no way to predict the day they’ll be recovered enough to return to work. Could create unintended disincentive for provider to use aggressive time or patient at risk for not enough recovery time.
 - It’s important for surgical health services coordinators to follow through with provider handling on-going care after surgical period is complete.
- Need care coordination across clusters. For example, how will COHE Health Services Coordinators (HSCs) & Surgical Health Services Coordinators collaborate?
- Medication Use – good best practice to measure
 - Consensus that minimal Dispense-as-Written may not be a relevant best practice because most providers have already surpassed this goal.
 - A threshold tied to opioids would be appropriate. This is an example of integration across clusters.
 - How can we monitor physicians who may still be writing prescriptions even if we aren’t paying?
 - How can we monitor if surgeons defer prescribing to the attending provider after surgery.

- Need training on how to taper off opioids.
- Consider opioid status of patients previous to surgery.
- Thresholds & criteria need to consider the whole person.

Catastrophic Care Transformation (Nicholas Reul, MD, MPH)

Slides were handed out and are available on [ACHIEV website](#).

Improving care of catastrophically injured workers is another part of the mission of Healthy Worker 2020.

Catastrophic claims are defined as: Hospitalized in acute care facility within 1 day and hospitalized for a minimum of 4 continuous days. This definition is flexible depending on context. Generally, head injuries, burns, amputations, multiple broken bones/multiple trauma, brain injuries, or spinal cord injuries are considered to be catastrophic claims.

Catastrophic claims are a small portion of claims, 0.3% (n=~200) of claims, however they account for 5.2% of costs to the workers' compensation system. Note that catastrophic claims are only a small proportion of L&I's highest cost drivers – about 8% of total claims drive 81% of total costs. This means that more than 7% of claims that drive about 75% of costs *are not catastrophic*.

5 Point Transformation Plan (presentation focus on points 1-3):

Unified by *focus on outcomes*

- Relies on clinically meaningful measures.
 - Incorporates overall recovery expectations into daily decisions.
 - Coordinates successful care transitions.
 - Evaluated need/facilitates timely delivery of mental healthcare.
 - Promotes patient and loved one satisfaction.
1. Strategically reallocate internal L&I resources for catastrophically injured worker care management (occupational nurse consultant/claim manager).
 - a. Prevention of reoccurrence with immediate DOSH notification (primary prevention)
 - b. Enhancement to the Occupational Health Management System (OHMS) that creates a worklist and information repository for information on catastrophic claims. The system demonstration shows how L&I staff can enter hospitalizations (even if claims are not yet established), and track progress on claim acceptance, injured worker location and demographics, and assignment of resources. This significantly enhances communication, supporting health services coordinators and speeding decision making. (Viewed a live demo of OHMS.)

Questions about whether claimants and attorneys can access OHMS?

Answer - No, however, claim data are updated into the core system and available through the Claim and Account Center (CAC). One piece of data not currently updated and available in CAC is the assigned external Nurse Case Manager, but this will be available.

- c. 100% of new catastrophic claims are being managed by the designated L&I team and tracked in OHMS.
 - i. Median time from date of injury to receipt of report of accident is down to 1 day.
2. Conduct Request for Proposals (RFP) for external catastrophic care management services
 - a. RFP – complete (3 contracts signed)
 - b. By Feb 2016, 90% of catastrophically injured workers will be assigned an external nurse case manager.
3. Establish Centers of Excellence – first for amputee care
 - a. Majority treated at Harborview Medical Center
 - b. working on bridging geography with telemedicine.
4. Establish catastrophic health services coordinator role.
5. Conduct prospective evaluation for catastrophic management.

Retrospective Analysis of Catastrophic Claims, 2002-2010 by Carly Eckert, MD, MPH

Number 5 of the 5 Point Transformation Plan is to “Conduct a prospective evaluation of catastrophic claims.” Dr. Carly Eckert is leading the analysis and described the methods and early findings. Slides were handed out and are available on [ACHIEV website](#).

2014 Gap Analysis revealed gaps in the areas of communication and coordination, data systems and access to care, so with IRB approval Carly Eckert linked L&I data to Dept. of Health Trauma Registry data.

Carly Eckert’s analysis defined catastrophic claims inclusion criteria. Dr. Eckert’s slides include charts with data on severity scores, injury type and mechanism, disposition after discharge, hospital days, etc.

- 2117 L&I claims were matched with WA state trauma registry data from 2002-2010,
- Based on injury severity scores, nearly 1/3 of L&I catastrophic claims are “severe”
- The breakdown of injury types remains consistent across severity levels, with orthopedic injuries the most common (>50%). Spinal cord injuries are the least common.
- The most common mechanism of these injuries is falls, which is also the most common cause of worker fatality among this subset of claimants.

The review should be complete in March. Next steps and domains for improvement are listed in the slides.



Meeting wrap-up

- Thank you to new members for participation.
- Reminder from those calling in to please use microphones.
- Agreement that “going green” by reducing handouts is working however participants need access to download the handouts earlier.
- We were over time so the chair will collaborate with L&I staff to produce the next agenda.

Adjourn: Noon

DRAFT