

Advisory Committee on Healthcare Innovation & Evaluation (ACHIEV)

Meeting Minutes for April 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)
Andrew Friedman, MD
Kirk Harmon, MD
Joe Kendo (alternate)
John Meier
Stephen Thielke, ME (alternate)
Lee Thomas, JD
Lisa Vivian
Robert Waring, MD

Members Not Present

Neil Hartman

L&I Staff Present

Susan Campbell, MES
Diana Drylie, MHA
Carly Eckert, MD, MPH
Ryan Guppy, CDMS
Leah Hole-Marshall, JD
Simone Javaher RN, BSN, MPA
Nicholas Reul, MD, MPH
Morgan Wear, MPA
Jena Williams

Guests

Ben Doornink, COHE Community of Eastern Washington
Kari Isaak, COHE Community of Eastern Washington
Tiffany Grabowski, HealthSystems (phone)
Tom Lehmann, COHE at Group Health (phone)
Sarah Reyneveld, JD, Assistant Attorney General (phone)
Nicole Cushman, COHE Alliance of Western Washington
Nancy Vandermark, COHE Alliance of Western Washington

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

Start: 8:02

Welcome and introductions.

*lni.wa.gov/ACHIEV

Safety Tips

Flooding: Spring flood waters can be dangerous. Do not walk or drive in flood waters.

Drug Take Back Day: Saturday, April 30th, is the designated day to safely dispose drugs. See takebackyourmeds.org.

Today is Worker Memorial Day: We are reminded of why our work is important as the state and nation remembers workers who died of injuries and illnesses acquired on the job.

Minutes

The minutes from January 28, 2016 meeting were reviewed, moved for approval by John Meier, seconded by Dr. Harmon and unanimously approved by vote.

Provider access and standards and COHE best practices (Leah Hole-Marshall, JD, Susan Campbell, MES, Morgan Wear, MPA) (Slides are included in the meeting materials on the [ACHIEV website](#).)

Goal of this presentation: (1) provide context on current ways L&I measures provider access and potential additional approaches; (2) present draft additional approached to measure access to high quality providers for discussion and input; and (3) present current measures of “high quality” and outcomes of those providers for discussion.

Leah Hole-Marshall reviewed the Healthy Worker 2020 “An Occupational Health Home for the Prevention and Adequate Treatment of Chronic Pain” diagram. A core feature is the center circle, which includes the system and people to coordinate care. Our focus is to understand how to identify best practices and incentivize best practice providers in 3 areas:

- Primary Occupational Health Best Practices
- Specialty Best Practices
- Chronic Pain & Behavioral Health Best Practices

We need to ensure we have and are monitoring the supply of providers who work in systems that support coordinated care and will use best practices. At the January meeting we discussed the ways we currently monitor where and how many providers are needed, and that we need to expand these measures. We continue to look at ways to measure provider types that are needed, quality of care, timeliness and access for new patients.

Susan Campbell presented the Gap Analysis for COHE providers. We continue to use GIS maps to see the proximity of injured workers to providers – and from that data, we know most injured workers (94%) live within 15 miles of a COHE provider, and 93.5% live within 15 miles of 5 providers. There are only 3

counties where all workers live more than 15 miles from the nearest COHE provider, but expansion will cover 2 of the 3. 50% of state fund claims are now initiated by a COHE provider.

In addition to those statistics that we will continue to collect, what data do we need and how will we measure COHE's effectiveness in an ongoing way?

- Can a COHE be too big? Can a COHE be too small?
- What is our target for COHE access in counties and/or regions? Which providers should we target?
 - Can we get to 80% of claims initiated in COHEs?
- Consistency with purchasers other than L&I (HCA).
- Which providers to include in COHE measures (e.g. only primary care; care coordinators; which specialty types?)

If our goal is 80% or more of claims initiated by COHEs – how are we doing? Analyzing data by 9 regions of the state that correlate with Accountable Communities of Health, 3 of the regions have over 80% of claims initiated by COHE providers; 3 are around 50%; and 3 are between 14% and 21%.

Committee provided input and discussion. No committee action required. L&I will use the feedback as we determine the best data/measures to look at for COHE effectiveness. Committee indicated use of the Accountable Communities of Health regions could be useful, but would like more information about if it would impact decisions. Morgan Wear continued the discussion by presenting on data and measures of adoption of best practices by the COHE providers.

The COHE contracts will be renewed with contract edits July 1, 2016.

The 4 best practices of COHE providers that we track are:

1. Report of Accident completed & submitted within 2 days (65%)
2. Activity Prescription Form completed in first 12 weeks of claim (80%)
3. Provider contacts employer when patient has restrictions (25%)
4. Identify patient barriers to return to work & document plan (info only)

High adopters adopt 3 or more best practices. Medium adopt 2 or more and low adopt zero to 1. (Note: emergency departments are measured differently). Low adopters need more training and education. We are continuing to show improvement with over 29% of providers becoming high adopters of best practices.

COHE providers continue to save money on claims with most recent data showing a savings of \$1300 per claim.

Currently looking at refining measures for best practices adopters over the long term considering how these requirements might fit in with Top Tier, especially if requirements are added (ex. opioids).

Committee discussion/feedback: There were questions about how #3 is tracked. A phone call or discussion with an employer (CPT code 99441) is included in the count for this best practice when billed with modifier -32. Also, when a COHE Health Services Coordinator bills for an Initial Evaluation & Coordination service, because that service includes contact with the employer, it counts towards the best practice. Feedback is that it is best to make the call in real time while the injured worker is in the office with the provider, and that mobile phones make this easy to do.

Question answered that COHE works with all providers and helps the ones that need it. There is an educational process built into the COHE structure to train low performers. Comments that glad to see emergency departments pulled out in data.

Action item: Request was made to show the COHE claim cost comparison using a loss triangle. L&I will investigate.

Self-Insurance Risk Analysis System (SIRAS) (Jim Nylander)

(Slides are included in the meeting materials on the [ACHIEV website](#).)

Vision: Create a new data collection system that:

1. Informs the work of the Self-Insured Employer community
2. Transforms the way L&I does business with Self-Insurers

The Self-Insurance Risk Analysis System (SIRAS) was developed by working with business and labor to make a positive change for the self-insured community. Self-insured employers tend to be some of the largest employers in the state and may also self-insure in other states. Many of the 360 self-insured employers don't track medical claims data. The SIRAS system would provide one place for all self-insured employers to keep their claim data. Improved tracking will improve care, outcomes and costs.

The self-insurance program oversees and performs audits on self-insured employers to make sure they are staying within the parameters of the program. Tracking data will help the program target audits and watch for risk.

SIRUS will track and incorporate many data sources including:

- Nationally Standardized Medical Electronic Data Interchange (EDI)
- SICAM Application (claims adjudication)
- SIAMS Application (wage audits)
- LINIIS (existing claims data)
- Web Complaints

SIRUS will include medical and claim data dictionaries. Self-insured data will help inform and improve collaboration to improve medical outcomes for injured workers.

Q&A

Q: When can we look at claim notes?

A: Currently SI and Third Party Administrators keep their own files, but the SI program is working on a pilot to get claim files submitted to the department.

Lisa Vivian responded that IT is behind in Self-Insurance but are asking L&I for help. They are tracking and mapping to show how improving the infrastructure will improve claims.

Q: Does SIRUS connect to OHMS?

A: There is not a direct connection at this time, but we're working towards getting into the data warehouse.

Healthy Worker 2020 Care Coordination (Susan Campbell, MES)

(Slides are included in the meeting materials on the [ACHIEV website](#).)

Susan Campbell led an interactive discussion beginning with the story of a fictitious injured worker and how coordinated care would help him to recover. We discussed what success would look like and what barriers would look like.

Discussion question:

1. *What does successful care coordination look like to you?*
2. *What are activities included in comprehensive care coordination?*
3. *How does care coordination fit into the big picture of Healthy Worker 2020?*

Success:

- Would include 3 parts:
 1. Coordination of care plan
 2. Outreach, treatment, engagement
 3. Interface with someone designated to manage claim including interface with the employer.
- Assistance for the claim manager to move claims forward.
- Care plan coordination between multiple providers.
- Outreach & communication with injured worker especially between visits.
- Interface with insurer.
- Designated coordinator.
- Employer inclusion.
- Ability to work with all players.
- Early timely communication – not through billing.
- Help regardless of claim status (adjudication).
- Team includes everyone involved on claim.
- Relationship with claim manager – help with “moving claim forward.”
- Proactive communication of medical plans:
 - Of all providers treating the injured worker.
 - To claim manager & other providers.
- Coordinator is proactive – doesn't wait for request from provider.
- Immediate access to coordinator.



Barriers:

- Delay in adjudication, especially causing claim to not be allowed.
- Employer is missed in care coordination.
- Increase number of players: Local third party administrators vs. national third party administrators requires navigating/communicating difference messages. Washington-based third party administrators are good, but other states' TPA are hard to deal with.
- Funding – in a team conference, some participants are not paid, such as physical therapists.
- Not enough/overworked claim managers/health services coordinators, CM retention.
- Self-insured paper billing causes delays.
- Institutional coordination is easier than cross-institutional where sometimes information doesn't transfer.
- Lack of information from providers in real time.
- Too much workload for claim managers and care coordinators.
- Delayed access to decision makers.

Health Services Coordination is at the center of the “An Occupational Health Home for the Prevention and Adequate Treatment of Chronic Pain” diagram. Understanding best practices in care coordination is key to improving injured worker recovery and reaching the Healthy Worker 2020 goal.

Care coordination has been broken down into 10 topic areas. The topics were discussed and members filled in missing pieces.

Care Coordination Spectrum (handout) discussion

1. Provider Referral Coordination:

- Done by doctor/doctor's team.
- Review at follow-up appointment with patient.
- Done through electronic medical record when possible to facilitate records sharing.
- Things fall through the cracks if patient doesn't come for follow-up appointment.
- Claim manager provides oversight for no-shows.
- Tickler system for referral tracking.
- Everyone waiting – provider, insurer, patient.
- Scheduling staff to track.

2. Return to work coordination:

Done by provider (easy cases) or by COHE health services consultant (for more difficult cases).

Issues:

- Large employers.
- L&I stigma (“Why are you calling me?”)
- Unclear point of contact.
- Sitting on the phone wastes times.
- Light duty options can be unclear.



- Clarify restrictions/capacities.
- Do HSCs have some vocational training?

3. Assess unmet health care needs:

Care coordinators provide treatment expectations

4. Transitional care:

Issues:

- Attending provider status changes when worker needs surgery.
- History of poor communication from surgeons.

5. Care Plan Development:

- Coordinator qualified?
- Need specialized person in the role.
- Communication with people doing the task.

6. Care Plan Monitoring & Evaluation:

Issues: Provider “blind” to the need for this to happen.

7. Community Services- employer based

- What benefits are available at the employer? (ex. childcare)
- Other sources
- Educate employers about benefits and opportunities for more help/services.

8. Self-care and patient engagement

- Who does it? (provider, PCP, HSC (COHE), other?)
- Language/translation services
- Cultural barriers (cultural competency)
- Addressing sensitive issues (ex. HIV, drug addiction)

9. Medical Management

Provider feedback when practice out of guidelines, especially when L&I is not the payer.

10. Brief Interventions by Coordinator

Discussion in July

Committee asked the following to be added:

11. Ability to change coordinator if having problems working together.

12. Coordinator who assesses barriers globally.

13. Look at all work that is happening throughout L&I. Don't duplicate/recreate work.

14. Services regardless of insurer – workers' comp is workers' comp. Keep self-insurance in the dialogue as it is the biggest gap in COHE.

Action item: Susan Campbell will send out the link for motivational interviewing information. This feedback will be used as we develop the role(s) of care coordinators in the chronic care and behavioral health module and review the roles for the future of COHE HSCs and Surgical HSCs.

Catastrophic Care Transformation (Carly Eckert, MD, MPH)

Slides are available on [ACHIEV website](#).

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

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.

Catastrophic claims are defined as: Hospitalized in acute care facility within 1 day and hospitalized for a minimum of 4 continuous days with categories of: burns, amputations, multiple broken bones/multiple trauma, brain injuries, or spinal cord injuries.

Provided update on overall plan, and focused on Number 5 of the 5 Point Transformation Plan is to "Conduct a prospective evaluation of catastrophic claims." Dr. Eckert is leading the analysis and described the methods and early findings.

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

Specific Aims: To describe long-term disability following catastrophic injury

- A) to evaluate predictors of long-term disability in a severity adjusted analysis
- B) to evaluate modifiers of long-term disability in a severity adjusted analysis



Findings:

Predictors: Injury Severity Score (ISS) correlated with likelihood of being on time loss, 12, 24, and 36 months from date of injury. Data regarding time loss could also be examined by groupings of injury severity. Concerning findings included high percentage of time loss across all injury severity groups. Even injuries that may be considered minor (ISS of 1-4 and 5-8) had time loss at 36 months of 25% and over 40% respectively. Discussion among committee members included if all injury scores should be included in a prospective evaluation or if only the more serious (based on ISS scores) as is commonly seen in the trauma literature. The general consensus among the members was that there is something going on with these injured workers, regardless of injury severity, that is leading to significant time loss and begets evaluation.

Next steps:

- Continue to discuss details of study design
- Will likely be a prospective randomized controlled trial
- Involving arms of different approaches / intensity of care
- A variety of interventions with smaller sub-studies to focus on specific interventions or issues are possible, potentials include:
 - Enhanced case management
 - Mental health
 - Activity coaching
 - Opioid use

Legislative Update by Leah Hole-Marshall, JD

Handout with more thorough summary than listed below is available on [ACHIEV website](#).

The Health Policy Unit tracks bills in the legislature to prepare for potential impact to L&I. This session there were few of impact, but some that may be of interest to the members were discussed:

SHB 2730 Concerning the prescription monitoring program – permits facility access when facility has 5 or more providers. The original bill included a requirement for providers to check the prescription drug monitoring program when prescribing controlled substances, however this language was removed and L&I did not update summary accordingly. .

Comments/questions (regarding provision that post-meeting was determined to have been removed from final bill):

- How is it enforced?
- Where do you document that you checked?
- L&I checks at 6 weeks.
- Is there a reference in EPIC with a link to PMP?



SSB 6519 Expanding Patient access to health services through telemedicine and establishing a collaborative for the advancement of telemedicine.

Dr. Reul was a significant resource for this bill.

Budget provisos

L&I asked for funding for catastrophic workers (Dr. Eckert's' research) and evidenced-based best practices research (3 staff to look at risk of harm and new best practices).

Meeting wrap-up

- Thank you to everyone for participation.

Adjourn: 11:50

DRAFT