

# Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV) 7/23/2015 Meeting Minutes

All handouts referenced in these minutes are in the 7/23/2015 meeting handouts or slides located at <http://www.Lni.wa.gov/ACHIEV> . Headers below indicate the name of the related file(s).

**Safety message:** During this hot, fire season. Keep yourself and your property safe by moving wood piles, brush, and propane tanks away from homes and structures.

**Minutes:** The 4/23/2015 meeting minutes were approved as written.

## SSB 5801 Wrap Up

This interactive section covered a brief synopsis of the status of each of the legal mandates:

- Medical Provider Network (MPN)
- Risk of Harm
- Occupational Health Management System (OHMS)
- Centers of Occupational Health and Education (COHE) Expansion
- Best Practices Expansion
- Top Tier

### Comments from the advisory committee:

- Encourage measuring the success of outreach to attract more access to care for workers. Recreate access maps to indicate location of providers who have injured workers on their caseloads and specialists.  
**Response:** It's difficult to identify providers who are treating workers or have had a claimant. This still wouldn't address the small population of workers doctors screen out because they have longer, complex claims or are difficult to work with.
- Incentivize providers to take complex claims.
- The focus is to improve care to injured workers. It's nice to see the savings associated with SSB 5801 implementation, but most was in time loss compensation not medical care. This may indicate better care, shorter claims, and, hopefully, return to work.
- Is more analysis comparing pre and post MPN? Consider actuarial analysis of subgroups, like psychologists and providers on the Oregon and Idaho borders.  
**Response:** The actuarial analysis is now moving toward providing measures of access and quality of care.

### **Risk of Harm from prescriptions and reoperations**

#### Comments from the advisory committee:

- Opiates are often paid for in cash or other means. How does L&I track it or look at related data?  
**Response:** L&I uses monthly data from the PDP matched to medical recommendations, looks for poisoning or other clues, and performs individual claim reviews. The DOH Quality Assurance Commissions would also have access to this same information.

### **OHMS**

#### Comments from the advisory committee:

- How will the knowledge management function be used beyond policy and guideline development?  
**Response:** Hopefully, we can build it so providers and claim managers are in the same system and access the same information. The test mode is designed to be both an internal and external enterprise approach.

- How can Self-Insured employers learn which providers are in COHE? Do self-insured workers who go to a COHE provider receive the same services?

**Response:** Find a Doctor identifies individual doctors as COHE. In OHMS, users can look at all doctors and identify whether they are COHE providers. The Health Services Coordinators (HSCs) do not work on self-insured claims being treated by COHE providers, however, they often help out, if they can.

- As more workers are treated by COHE providers, there is a real opportunity to address and resolve issues and barriers early to avoid claims becoming complex, unless the worker doesn't want to stay in the program. COHEs do not discharge workers at specified times, rather works with them for six months or more, if needed.
- 46% of time loss claims are currently handled by HSCs. What is the plan for the future?  
**Response:** The goal is 65% of time loss claims will receive HSC assistance in medium and high adopter provider offices. It's important to make sure the right workers get the right service at the right time. We're working on the metrics to assure we are correctly meeting the need.
- There is interest in reporting high adopters separately from medium adopters, as they achieve better outcomes.
  - How can workers and employers access the names of high adopters?
  - The Everett Clinic COHE providers do not call employers; HSCs do. By not performing one of the four Occupation Health best practices (OHBP), the providers cannot be identified as high adopters. However, their outcomes may not be less than the high adopters because the best practices are still being completed.
- Look within a COHE to identify high-medium-low adopters.
- Would it help doctors if companies entered their correct return to work contact information into OHMS or Claim and Account Center?

#### **PGAP:**

##### Comments from the advisory committee:

- Some self-insured employers and employer representatives are having difficulty locating doctors who support PGAP. The employer/employer rep will champion PGAP for select workers who are likely to benefit. Their nurse case managers coordinate between PGAP, attending provider, and the worker. However, attending providers are not highly accepting of the recommendation.
- Financial incentives work. If provided, most providers would become high adopters.
- Is PGAP an OHBP?  
**Response:** Not officially, it is an emerging best practice. HSCs discuss this option with workers who seem to be good candidates for the program.
- Through a focus group with doctors, query their use/non-use of PGAP to determine how to improve the program, develop criteria and protocols, etc.

#### Best Practice Programs

Best practice programs were reviewed and some OHMS functionality was demonstrated and discussed.

#### **COHE Innovations:**

This overview covered program innovations each of the six COHE's implemented, tested, and presented during the past year. Discussion followed on what ACHIEV would like each COHE to present in 2016. The following suggestions/topics were mentioned:

- Self-insured access to best practice programs

- Identifying high adopters
- COHE access measures
- Outcome comparison (high adopters vs. low and medium adopters)
- Provider access to a database of employers' contact information
- Continue to build on the COHE Executive Summary with priorities discussed by ACHIEV
- Is COHE achieving the program's overall goals? Need data. Need to discuss what the right data is to determine this question.
- How is the community/service area doing?
- How do we get all injured workers to go to high adopters?
- Can a provider choose not to join any best practice program?
- % of providers by specialty and provider type information.
- Can we develop COHE ACHIEV metrics?
- How do we incorporate injured worker feedback?
- What are the advisory boards' learnings?
- How do we change provider behavior?
- How many providers are non-adopters?
- COHE communications: what are COHEs communicating about? COHE Director meeting agendas. Is it enough?
- Panel of COHE Directors/HSCs could be helpful to highlight how each COHE is different
- Synergy of messages
- ACHIEV role is to look at performance and priorities (not open ended discussion)
- Need clarification of what the ACHIEV role is with COHEs

ACHIEV members agreed that there are three main next steps:

1. To discuss what data they need.
2. To review the data that is provided.
3. To determine a topic focus for a COHE panel.

### **Healthy Worker 2020 Future Purchasing:**

This introductory overview covered nine key areas of interest. Team members indicated the priority of topics they would like to have presented at ACHIEV. They noted that topics number 3 to 8 relate to complex claim issues and cover both secondary and tertiary prevention and rehabilitation.

#### Prioritization outcomes per numbered topic:

1. Chronic Pain and Behavioral Health Collaborative Care Services (13 votes)
2. Core Occupational Health Best Practices (11 votes)  
Structured Physical Medicine Best Practice (11 votes)
3. Core Occupational Health Model/System (8 votes)
4. Surgical Best Practices (4 votes)
5. Structured Multidisciplinary Pain Evaluation and Program (3 votes)
6. Opioid Prescribing Best Practice Cluster (2 votes)
7. Catastrophic Services and Centers of Excellence (1 vote)
8. Operational Support (0 votes)

### **L&I Updates**

The new Agency Medical Director Group's Opioid Guideline conference last month was exceedingly well received by over 300 participants. The Bree Collaborative just voted to adopt the guideline statewide. The AMA is also working on education for doctors to encourage

ACHIEV recognized Stephen Thielke, MD, Andrew Friedman, MD, Dianna Chamblin, MD, Gary Franklin, MD, and many, many others who worked diligently to develop this important, far reaching guideline. Well done.

Dr. Franklin also provided an overview of outcomes from the recent legislative session.

## **Promoting OHBP**

The new logo and tagline to promote OHBP was developed by a marketing company after consulting with doctors. The individual body part-shaped icons are easily identifiable, eye-catching, and can be used separately on specific guidelines or educational pieces. "Working together to keep people working" is the tagline option that all parties identify with. Expect to see the new logo and tagline at future meetings.

## **Catastrophic Injuries**

The 2015 5-point plan:

- Establish a dedicated L&I Occupational Nurse Consultant and claim manager to work with catastrophically injured workers.
- A request for information or request for proposal will seek external catastrophic care management services. Recognizing different models may exist, services may include life care planning, connections to community resources, and others.
- COHE will establish Catastrophic Health Services Coordinator(s).
- A Center of Excellence (COE) will be established for amputees.
- A prospective evaluation of catastrophic management will be designed.

### Comments from the advisory committee:

- MSWs may be a key element to rehabilitation of catastrophically injured people. They help set people up for successful healthcare transitions in outpatient or community care after they leave the hospital or rehabilitation center.
- Those workers treated at Harborview Medical Center (HMC) need assistance locating care in their communities. They find it nearly impossible to get back to HMC or downtown Seattle for appointments.
- If one Center of Excellence is selected, share "lessons learned" or "pearls" with other providers in WA to bring up their level of care for workers treated external and separate from the COE.

The 2016 agenda includes: Multiple COE's for burns, spinal cord injuries, traumatic brain injuries, and multiple trauma.

### **October agenda planning:**

- Top Tier
- Updated on the prioritized future purchasing topics, above

## **Appendix:**

**Participants**

- On the phone: Brian Peace, L&I
- In person:

<b>Members</b>	<b>L&amp;I</b>	<b>Public</b>
Dianna Chamblin, MD, Chair	Gary Franklin, MD, MPH	Ben Doornink, E WA COHE
Clay Bartness, DC	Vickie Kennedy	Grace Casey, VMC/COHE
Mike Dowling, DC, Alternate	Leah Hole-Marshall, JD	? Creighton, AAG
Andrew Friedman, MD	Diana Drylie	Nichole Cushman, COHE Alliance
Kirk Harmon, MD	Noha Gindy	Scott Green, UW/HMC COHE
John Meier	Simone Javaher, RN	Melodie Maerz, Amplifon Hearing Health Care
Teri Rideout, JD	Rose Jones	Regina Nieders, Pacific Rehab Center and Pain Interest Consortium
Stephen Thielke, MD, Alternate	Karen Jost, PT, MS	Amy Valdez, UW/HMC COHE
Lisa Vivian	Scott McConnell	Nancy Vandermark, COHE Alliance of Western Washington
Robert Waring, MD	Joanne McDaniel, MA	Kaitlyn Watt, AAG
Ron Wilcox, DC, Vice Chair	Nicholas Reul, MD, MPH	
	Hal Stockbridge, MD, MPH	