

Advisory Committee on Healthcare Innovation & Evaluation (ACHIEV)

Meeting Minutes for July 28, 2016
Port of Seattle – Beijing room, SeaTac Washington

Members Present

Dianna Chamblin, MD (Chair)
Ron Wilcox, DC (Vice-Chair)
Clay Bartness, DC
Mike Dowling, DC (alternate)
Andrew Friedman, MD
Stephen Thielke, MD (alternate)
Lee Thomas, JD
Lisa Vivian
Robert Waring, MD

Members Not Present

Kirk Harmon, MD
Neil Hartman
Joe Kendo (alternate)
John Meier

Guest Speakers

Jessica Creighton, JD
Dawn Ehde, PhD
Deborah Fulton-Kehoe, PhD

L&I Staff Present

Barbara Braid, RN, MSN, CNS
Susan Campbell, MES
Barbara Davis
Diana Drylie, MHA
Carly Eckert, MD, MPH
Greg Fisher, MCP
Gary Franklin, MD, MPH
Ryan Guppy, CDMS
Aaron Hoffman, MBA
Leah Hole-Marshall, JD
Simone Javaher RN, BSN, MPA
Karen Jost, PT, MS
Jessica Laboy Pratt
Bob Mootz, DC
Brian Peace, MHA, FACMPE
Nicholas Reul, MD, MPH
Hal Stockbridge, MD, MPH
Morgan Wear, MPA
Jena Williams

Guests

Nicole Cushman, COHE Alliance of Western Washington
Brian Chin, University of Washington
Ben Doornink, COHE Community of Eastern Washington
L. Rachel Kaufman, GHP
Sarah Reyneveld, JD, Assistant Attorney General (phone)
Terri Smith-Weller, University of Washington

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

Start: 8:05

*lni.wa.gov/ACHIEV

Welcome and introductions.

Safety Tips

It's the time of year for insect repellent.

- There are many types including Oil of Lemon Eucalyptus, DEET products, and Picaridin products.
- If you need both sunscreen and insect repellent, apply sunscreen first.

More info: <http://wwwnc.cdc.gov/travel/yellowbook/2016/the-pre-travel-consultation/protection-against-mosquitoes-ticks-other-arthropods>

Minutes

The minutes from April 28, 2016 meeting were reviewed, moved for approval by Lee Thomas, seconded by Ron Wilcox and unanimously approved by vote.

Healthy Worker 20/20 – Today's Topics (Diana Drylie, MHA, New Program Director for Healthy Worker 20/20)

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

Goal of this presentation:

This presentation introduced a model of the Healthy Worker 2020 Vision, targeted best practices and supporting structure. The 5 core components are:

1. Primary Occupational Health Care
2. Surgical Care
3. Chronic Pain and Behavioral Health Care
4. Physical Medicine
5. Catastrophic Care Services

Each of these components has a team devoted implementing the work plan. A list of the leads was included in the slides.

Today's presentations will address Physical Medicine, Primary Occupational Health Care, and Chronic Pain and Behavioral Health Care.



Physical Medicine/Therapy (Deborah Fulton-Kehoe, PhD, University of Washington)

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

Deborah Fulton-Kehoe presented data on the costs of physical therapy (PT) and total medical costs for patients with back sprains. The data included a detailed analysis of percent of back sprain patients with physical therapy codes, number of physical therapy visits, timing between injury and first PT, percent of active PT versus passive PT. Data included accepted workers' comp claims from 2005-2012. She noted that L&I has a daily cap for PT at about \$120 per day. This means that sometimes only 2-3 procedures are paid even if more (5 for example) were performed. The team looked at all procedures whether they were paid or not if at least one unit of PT was paid for that date.

- The proportion of per person medical costs from PT stayed steady at 12-13%.
- About 33% of patients with back sprain had any form of PT. Time loss (54%), medical-only (23%)
- Most PT starts within the first 6 weeks after injury.

Comments/Discussion:

- Literature shows return to activity is effective therapy for most people, however active PT is recommend for those afraid to return to activity.
- Massage therapy (delivered by massage therapists) was not been analyzed, but massage can be billed by PTs and is included in some of the passive codes.
- Passive physical therapy is not shown to be effective, and may be appropriate only during acute phase.
- Comments on timing for PT: Does early PT reduce timeloss? Is there evidence for best practices for optimum timing for PT (e.g. right away, two weeks, 6 weeks). Current standard of practice for some providers is to wait for 2 weeks before starting PT.
- Is Kept on Salary included in timeloss?
- Include mean and median for both TL and non-compensable.
- Is the timing data from claim acceptance or date of injury? (Response: claim acceptance).
- Is work conditioning and work hardening included? (Response: Currently no work hardening, but work conditioning is included because it isn't billed under separate code.)
- It would be helpful to develop a template to help attending providers know what type of PT to request or refer to. (Response: IICAC developed some: <http://www.lni.wa.gov/ClaimsIns/Files/OMD/IICAC/ActiveRehabWkRelatedLowBackCond.pdf>).
- Does well timed active PT prevent surgery? (Response: This is hard to analyze as more severe tend to be the ones getting surgery).
 - Adjust for back surgery received. (Response: This study is very time-consuming but can be done. If this were to be done, Gary Franklin recommends targeting 2 types of surgeries and the relevant codes.)



- Separate out PT vs. PT assistants (Response: This cannot be done for the entire cohort because it is not on bill, but has been done for a small sample of claims where medical records were reviewed, if it was included in the notes.)
- What are the definitions of active and passive? (Response: the codes used in each group are in the slides)
- Can cognitive behavior therapy be incorporated into PT in a more defined way? Are there principles/criteria?
- Look at organizational patterns. Great to get info by clinic. Do a relatively small number of providers account for a large percent of units or of passive modality?
- Has the PT community seen this data yet? (Response: No, they will be included as a stakeholder in the Physical Medicine Best Practices work under Healthy Worker 2020.
- Look into PT by region to see if there is clustering.
- If we reduce PT, what will patients use instead? Focus of optimum PT is better function and patient outcome, not solely on PT visit counts. Alternatives need to be considered.
- There is a complex relationship between PT and provider. In some cases, a provider may keep referring to PT because no alternatives. The PT does not believe further PT helpful, but also doesn't want to lose that provider's referrals so they may continue with treatment.
- Therapy reports often do not consistently address function as needed to consider return to work.

COHE Update: Results of Three-Year Review (Morgan Wear, MPA)

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

This 3 year review supplements the annual review to help highlight achievements and look for opportunities to improve. This review also preceded the three-year contract extension offers (2016-2019). All the COHEs signed the next extensions. There are 3,000 providers total in the COHE's.

The team gathered stakeholder input on COHES by surveying or interviewing (n=306) providers (268), employers (11), COHE advisors (10) and COHE staff (17).

Provider themes included:

- Health Services Coordinators are highly valued.
- They like their connection to COHEs
- They want more timely feedback/data. (The Occupational Health Management System (OHMS) should be able to provide this information.)

Employer themes:

- Health Services Coordinators are highly valued.
- Want more focus on return to work.
- What COHE services to last more than 3 months.



- Want more communication.

COHE advisor themes:

- The engaged advisors feel they are making a difference.
- Some wanted to be more involved.
- Advisors are chosen by the Medical Director of the COHE with input from the contract manager.

Staff feedback largely focused on the working relationship with the L&I Contract Manager. While valuable information, it wasn't focused on improving the COHE per se.

Summary – overall themes:

- General “awesomeness” of HSCs.
- Timely communication is crucial
- More performance feedback is requested.
- More opportunities for COHE advisors to help them.

Committee Feedback:

- Question on minimum requirements to be a COHE advisor.

Action Item: Morgan Wear will look up the requirements to be a COHE Advisor and send it out.

[Post meeting follow up from Morgan Wear: Here is standard language from the COHE contract:

3.3 Advisor Requirements

The COHE Advisor program will be led by the COHE Medical Director. The COHE Advisors should have regular group meetings.

The COHE Medical or Program Director must recommend each COHE Advisor in writing as part of the application process. Upon approval, COHE Advisors will need to complete an L&I COHE Advisor Supplemental Application. This will entitle them to access COHE resources such as special billing codes and free training.

COHE Advisors have special billing codes for some of their COHE work. (See Budget & COHE Program Fee Schedule, Attachment C).

When the Top Tier of the medical provider network is implemented, COHE Advisors must either meet the requirements for Top Tier participation or successfully complete Top Tier training modules.

The COHE will confirm COHE Advisor participation in the Annual Provider Enrollment and Training Report which is due June 1. (see Deliverable 7).

The COHE will:

- a) Ensure all COHE providers have knowledge of and access to COHE Advisors.*



- b) Develop a process for COHE Staff to access COHE Advisor assistance on specific claims.*
- c) Act as a liaison between the COHE providers and COHE Advisors on claims with unresolved barriers to return to work.*
- d) Develop training for COHE Advisors that is focused on their needs and interests.]*

- No patients were stakeholdered. The plan is to get feedback from some patients (injured workers) next time. There are still some concerns to work through before surveying patients. Lee Thomas offered help from Washington State Association for Justice that represents injured workers.
- Request that HSC name and contact information be available so parties can see when an HSC is assigned. The information is already included in CAC.
- Gary Franklin provided some additional information on long term COHE outcomes. A new follow-up study is about to be published:
 - 28% decline in permanent disability.
 - Cohort is doing better than most.
 - Early interventions like COHE prevent transition to SSDI.

Chronic Pain & Behavioral Health – Stepped Care (Dawn Ehde, PhD, Psychologist, Rehab Medicine & Pain, University of Washington)

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

Dawn introduced the team members and noted that some content was adapted from the UW AIMS Center: <https://aims.uw.edu>.

This project works to integrate care for behavioral health into primary care to prevent pain & disability to injured workers. The collaborative care model is a patient centered approach that is increasingly being incorporated into health delivery settings. . It was initially used with care for depression but is spreading into other areas including diabetes and multiple sclerosis.

The Collaborative Care Team includes a Care Manager that coordinates with providers and specialist resources (e.g., psychologist, psychiatrist, pain expert) to assure all the needs of the patient are being met. The Care Manager works directly with the patient and their provider and may provide brief interventions to help the patient to set goals, address recovery expectations, facilitate returning to normal activities, and help motivate the patient's continued engagement with their care plan.

Care Managers in MHIP can handle up to 100 patients, depending on the level of care needed. A stepped approach is used and the care manager assesses and monitors progress to facilitate appropriate behavioral interventions. For more complex patients (e.g., chronic pain) their case load may drop toward 25-50 patients depending on the level of interventions the care manager

provides directly. For chronic pain, the care manager may help the patient understand and use cognitive behavioral skills.

Cost studies have shown a 6:1 return on investment due to lower downstream health care utilization. However, there can be significant startup costs to implementing a collaborative care model.

A major challenge to implementing collaborative care often comes from perceptions related to behavioral health interventions, practice variation, and inadequate understanding of the evidence of effectiveness and cost savings for many behavioral health approaches in various conditions.

Comments/Feedback:

- If piloting, include self-insurers.
- Where does this effort fit within COHE
- How will it be funded
- Which patients is this most effective for – early on or for chronic pain
- Because behavioral interventions could be construed as psychological intervention, there will be employer concern of “buying” an unrelated injury or illness

Chronic Pain & Behavioral Health – Reducing Disability: Psychosocial Determinants Influencing Recovery (PDIR) (Bob Mootz, DC)

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

Full PDIR report is at:

<http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/IICAC/Resources.asp>

Reducing Disability: Psychosocial Determinants Influencing Recovery (PDIR) is a new occupational health best practices resource for attending providers to help understand, identify, and manage common psychosocial issues injured workers must deal with during their recovery. The resource was a collaboration between the Industrial Insurance Chiropractic and Medical Advisory Committees. Everyone has stress-related reactions to an injury. Some people are better at managing their responses to stress than others. The attending provider can play a key role in recognizing and guiding the patient in addressing their psychosocial issues. There is increasing evidence that timely management of psychosocial factors is associated with decreased long term disability.

The PDIR resource defines a firewall between diagnosed mental health conditions and psychosocial issues that impact everyone to varying degrees. Most psychosocial factors that are identified can be managed by attending physicians themselves through better understanding of these PDIR best practices and screening tools. Some workers may need referral for more structured behavioral health interventions depending on their own coping skills and the attending provider's expertise.



About 90% of IWs get improvement without any specific screening or attention to psychosocial interventions. However for the small percentage of workers at risk of becoming chronic, early identification and attention to psychosocial factors that have been shown to be correlated with long term disability appears to be critical to preventing the worker from becoming a chronic pain patient.

The PDIR screening recommendations emphasize routinely taking an appropriate psychosocial history at the beginning. If a large number of psychosocial factors are identified, exploration of the workers ability to handle them is encouraged. Going ahead with usual care is recommended if it looks like they can cope effectively. If these workers are not back to their jobs within a couple weeks, reassessing psychosocial issues is recommended. For those workers who appear to be overwhelmed by psychosocial factors during their initial examination, the PDIR resource provides detailed information about screening and managing various psychosocial factors, including the types of specialist and support referrals that might be considered.

Comments/Feedback:

- Is this billable or how to fund? These are a toolkit for providers who are already doing evaluation and management, including conversations with their patients about recovery. These are resources to improve outcomes in those E&M visits.
- Great resource – where is it available

Overview of Open Government in Washington State: Open Public Records and Open Public Meeting Training (Provided by Jessica Creighton, JD, Washington State Attorney General's Office)

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

Effective July 1, 2014, the Open Government Trainings Act (ESB 5964) requires many public officials and all agency records officers to receive training. Refresher training is required at least every 4 years. (RCW 42.30.205)

- Open Public Records governed by RCW 42.56.
- Open Public Meeting governed by RCW 42.30.

Members not at today's training will need to log in to: <http://www.atg.wa.gov/open-government-training> to take the training and print a copy of the Certificate of Completion. This needs to be completed before the October meeting. Forward a copy to Jena Williams at Jena.Williams@Lni.wa.gov.

The handouts were briefly discussed [*Included in the meeting materials on the [ACHIEV website](#).*]



- **The Mercier-Franklin Opioid Boomerang, 1991-2015** shows the projected percent of loss and percent of claims with opioids compared to all claims. It shows that in 1991 about 15% of claims had an opioid Rx and accounted for nearly 70% of losses. This peaked around 2010 with nearly 30% of claims having an opioid Rx accounting for about 78% of loss; and then falling back in 2015 to about 16% and 65% of loss.
 - This shows the work that ACHIEV/IIMAC does to intervene in the opioid epidemic is making a difference. We are saving lives. L&I has been on the forefront of preventing less-competent physicians from treating injured workers.
- **Catastrophic Care Case Management Project – Update July 2016** summarizes work to date.

Meeting wrap-up

- Chair and vice chair elections will occur at the October meeting.
- Thank you to everyone for participation.

Adjourn: 11:55