Implementation of the Medical Provider Network & Expansion of the Centers for Occupational Health and Education

2016 Report to the Legislature

December 2016
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Executive Summary

Introduction

The Department of Labor & Industries (L&I) is pleased to provide this report to the legislature on implementing requirements of RCW 51.36.010, an important piece of workers’ compensation reform legislation passed in 2011. This law requires L&I to report progress on implementing the law’s requirements starting December 1, 2012 and continuing annually through December 1, 2016. This is the final report from L&I to the legislature on implementation of the law.

The law aims to reduce disability among injured workers by improving the quality of medical care they receive. To accomplish this, the law requires L&I to increase access to high quality health care for injured workers by establishing a medical provider network (MPN) and expanding the number of centers of occupational health and education (COHEs).

L&I has implemented key provisions of the workers’ compensation reform law, and has completed actuarial analysis demonstrating reductions in disability for injured workers and the related costs. With resources provided in the 2015 budget, L&I is building on this success by expanding data analytics that identify lower quality providers, automated data exchange with providers, and COHE initiated claims; and by developing and launching a top tier. Key results include:

COHE savings

A 2011 study found that injured workers treated by COHE-affiliated health care providers were away from work 20 percent fewer days than other injured workers. COHE care also reduced disability and medical costs by $510 per claim during the first year. These savings are expected to increase because the number of injured workers treated by COHE providers is steadily increasing (from 30 percent of claims at baseline to 51 percent now). The savings per claim for fiscal-accident year 2015 (most recently analyzed claims) is estimated to be approximately $3,175 per subject claim, and is mostly from accident fund savings. The costs analyzed include payments made from the Accident Fund and the Medical Aid Fund. The mix of cases analyzed is adjusted to enable comparison of similar risk classes.

MPN savings

In 2015, L&I actuaries finalized a comparison of claim costs for injured workers treated by providers who did not apply or were denied admission to the medical provider network. The final analysis shows the program is successful in improving patient outcomes, preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

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2 The accident year is any 12-month period for which savings from claims taking place during that 12-month period are tracked.
L&I’s comparison of claim costs and time-loss shows reduced disability. The legislation projected that removing lower quality providers would save $16.5 million the first year and $33 million annually thereafter. L&I estimates the actual savings as $34.7 million annually. Patients of providers in the medical provider network averaged 36 percent less time loss (109 fewer days per claim) than patients of providers not in the network.

**2016 Outcomes**

To improve the quality of medical care for injured workers, the law required L&I to:

- **Create and manage a statewide medical provider network (MPN) by establishing standards** for medical providers who treat injured workers and ensuring providers meet those standards.
- **Expand the number** of COHEs to support medical providers’ use of best practices.
- **Create a top tier** within the MPN and incentives for providers who demonstrate best practices.
- **Implement an automated system** to track best practices, support care coordination and give feedback to providers.
- **Identify and pilot** emerging best practices.
- **Adopt and implement** risk of harm rules.
- **Convene an advisory group** of clinical, business and labor representatives to help develop policies and give input about these activities.

**Create and manage the statewide MPN (Complete)**

In 2013, L&I launched a robust medical and care provider network for injured workers covered by both L&I and self-insured employers. Since the last reporting period in December 2015, L&I has enrolled another approximately 1,400 providers, for a total of about 25,200 providers in the network. Ninety-nine percent of injured workers statewide live within 15 miles of at least five primary-care network providers. The network also includes a broad range of medical specialists.

**Expand the number of COHEs (Complete)**

L&I was required to provide at least 50 percent of injured workers access to COHEs by December 2013, and to provide all injured workers access by December 2015. L&I has agreements with six health care organizations that sponsor COHEs, which provide services in all 39 counties. Ninety-six percent of injured workers have access to five or more COHE providers within 15 miles of their home. While expansion of COHEs is complete with coverage throughout the state, L&I will continue efforts with COHE-sponsoring organizations to increase access within a 15-mile radius of the injured worker, and to increase provider adoption of occupational health best practices.

L&I expected the number of COHE-participating providers to more than double from about 1,800 to nearly 3,500 by September 2016. This contributed to the dramatically expanded access to COHE
providers for injured workers. In 2016, COHE providers are initiating or treating about 62 percent of current claims.

**Figure 1: Actual and projected increase in COHE providers**

<table>
<thead>
<tr>
<th></th>
<th>Number of COHEs</th>
<th>Number of providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2012</td>
<td>4</td>
<td>1,770</td>
</tr>
<tr>
<td>September 2013</td>
<td>6</td>
<td>1,880</td>
</tr>
<tr>
<td>September 2014</td>
<td>6</td>
<td>2,470</td>
</tr>
<tr>
<td>September 2015</td>
<td>6</td>
<td>2,730</td>
</tr>
<tr>
<td>September 2016</td>
<td>6</td>
<td>3,218</td>
</tr>
<tr>
<td>September 2017</td>
<td>6</td>
<td>3,490</td>
</tr>
</tbody>
</table>

Source: L&I’s Occupational Health Services Unit

L&I is committed to continuing the expansion of evidence-based purchasing by recruiting interested providers to participate in COHEs. Current COHE providers number over 3,200. L&I continues to lead both the state and the nation on evidence-based purchasing, which uses objective research about medical treatment to make better purchasing decisions.

**Create a top tier (Underway)**

The law directs L&I to establish a second tier (top tier) within the MPN for providers who demonstrate occupational health best practices. Top tier providers will be eligible to receive financial and non-financial incentives, such as streamlined authorizations for treatment.

Initially, in consultation with the statutory Advisory Committee on Health Innovation and Evaluation (ACHIEV), L&I made its network stabilization and COHE expansion efforts a top priority and postponed significant work on top tier. The reasons for postponing the top tier work were the large number of L&I program changes underway; other reforms affecting health care providers; and the additional time needed to further develop data, systems support and provider education programs.

In 2014, staff resumed work with ACHIEV on top tier, creating a work plan and establishing work groups. L&I continued this work in 2015 and completed a gap analysis to identify innovative market practices for paying for value.³ The research, data analysis and stakeholder outreach to create a solid incentive program is a larger effort than initially expected. L&I requested and obtained additional resources in 2015, and presented a preliminary program model with best practice criteria and

³ Paying for value is part of a strategy to achieve the triple aim of better health, better care, and lower cost by shifting reimbursement strategies away from a system that rewards volume of service to one that rewards quality and outcomes.
incentives to ACHIEV in October 2015. With the additional resources, work was completed in 2016 (see Create a Provider Top Tier, page 23), and L&I is on track to launch the top tier program in 2018.

**Implement an automated Occupational Health Management System (Complete)**
L&I has completed all five phases of a new computer system, the Occupational Health Management System (OHMS). This new web-based information system supports care coordination, tracks providers’ use of occupational health best practices and provides feedback to doctors. Currently, the health services coordinators at the COHEs use OHMS to perform and bill for coordination activities. OHMS is capable of storing and tracking training for providers and other users, and training modules are now being created for inclusion in the system.

L&I had planned to finalize provider feedback reports by December 2015. New resources were brought on board in late 2015; however, the transition was delayed to some extent by staffing changes. Provider feedback reports and other reporting requested from OHMS have been re-prioritized and are expected to become available by mid-2017.

The OHMS project also developed an enterprise-wide infrastructure to support use of a statewide health information exchange (HIE), OneHealthPort, by COHEs. The HIE allows users to automatically send data to or receive it from providers’ Electronic Medical Record Systems (EMRS). In 2015, L&I completed the first two connections with health care providers to enable automatic exchange of data through the statewide Health Information Exchange (HIE). This has resulted in a huge reduction in processing times and delays associated with paper, fax or direct entry solutions.

**Identify and pilot emerging best practices in occupational health (Ongoing)**
In 2016, L&I continued two projects to test emerging best practices in occupational health: functional recovery and surgical best practices. More information about these pilot projects is in the “Progress and Achievements in 2016” section of this report, beginning on page 8.

The pilot projects that are underway have addressed best practices within the acute and sub-acute phases of injury recovery (generally up to the first six months). In 2016, L&I turned its attention to initiating work on chronic disability best practices. L&I requested and obtained resources during the 2016 supplemental legislative session that will enable the department to take a key final step toward establishing an integrated delivery system that is rewarded for value and outcomes rather than volume.

**Adopt and implement risk of harm rules (Complete)**
L&I has adopted the nation’s first “risk of harm” rules. Risk of harm rules define a pattern of lower quality care that leads to harm or risk of harm to injured workers. To use data as the basis for potential action against a provider (such as allowing them provisionally for one year or removing them from the MPN), the department needs proven data methods such as standards and measures agreed on by the medical community. With the assistance of external advisory groups, L&I established processes to use data to monitor quality of care issues and identify providers who present a risk of harm to injured workers by prescribing dangerous levels of opioids that result in deaths and hospitalizations. The department reviews providers who have two or more opioid deaths or overdose
events. Providers who meet risk of harm criteria are reviewed by a medical director for appropriate action, which includes feedback to the provider about department concerns and guidelines through a referral to a credentialing review panel for a recommendation about network participation. L&I will use this established process for future topics.

Another indicator of risk of harm may be high rates of reoperation for back surgery. The department worked with a researcher to establish benchmarks for providers who have very high rates of reoperation for back surgery and presented the findings to the Industrial Insurance Medical Advisory Group (IIMAC). IIMAC requested additional data be added to the analysis, and the updated report is scheduled to be complete by December 2016. In the supplemental session, L&I received a permanent resource to fully deploy these analytics and develop the next analysis and benchmarks on other types of lower quality care.

**Convene an advisory group (Complete)**
The Advisory Committee on Health Care Innovation and Evaluation (ACHIEV), which includes representatives of business, labor and health care providers, has met at least quarterly since July 2011 and continues to meet. The group gives policy input on MPN status and implementation issues.

**Joint Legislative Audit and Review Committee study**
A performance audit of L&I’s claims management practices issued in 2015 by the Joint Legislative Audit and Review Committee (JLARC) highlighted the need for additional progress in identifying and implementing best practices. While the JLARC audit consultants complimented L&I’s leadership on evidence-based standards, it also concluded that L&I should rapidly expand and enforce its best practices.

To continue these successes, L&I is committed to making more progress in 2017 on improving outcomes for injured workers through the MPN and COHEs by:

- Continuing to review new applications to the MPN and ensuring that all participating providers meet network standards
- Continuing to improve application processing and turnaround times
- Continuing to develop criteria, processes and data analytics to monitor quality-of-care issues and remove or provisionally approve providers who present a risk of harm to injured workers
- Continuing to monitor injured workers’ access to care and recruit providers in needed specialties and underserved areas
- Supporting COHE expansion into new areas
- Supporting new providers using the Washington Health Information Exchange portal to automatically exchange data with L&I.
- Completing development of top tier criteria, incentives and system needs, and beginning implementation within resources
Convening a focus group in coordination with the University of Washington to develop criteria, measures and outcomes for the next set of COHE best practices

To support these activities, L&I requested and received additional resources from the legislature. A separate description of those efforts is provided in L&I’s 2016 report “Reducing Long-Term Disability.”
Introduction

Washington’s workers’ compensation system provides benefits to workers who are injured on the job or who suffer from an occupational disease. It pays for medical treatment and partial wage replacement, and provides disability benefits.

As part of the workers’ compensation system, L&I oversees:

- A statewide medical provider network (MPN) of health care providers who meet minimum standards and are eligible to treat injured workers
- A network of centers for occupational health and education (COHEs) that provide injured workers more access to occupational health best practices

The goal of Substitute Senate Bill (SSB) 5801 in 2011, codified as RCW 51.36.010, was to reduce disability among injured workers by improving the quality of medical care they receive. The law directs L&I to:

- Create and manage a statewide medical provider network (MPN) by establishing standards for medical providers who treat injured workers and ensuring providers meet those standards.
- Expand the number of COHEs to support medical providers’ use of best practices.
- Create a top tier within the MPN and incentives for providers who demonstrate best practices.
- Implement an automated system to track best practices, support care coordination and give feedback to providers.
- Identify and pilot emerging best practices.
- Adopt and implement risk of harm rules.
- Convene an advisory group of clinical, business and labor representatives to help develop policies and give input about these activities.

This report is the last of five annual reports required by the law. It describes actions L&I took in 2016 to achieve the above key objectives of RCW 51.36.010, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies, and any needed changes to further improve the occupational health best practices care of injured workers.
Progress and Achievements in 2016

This section of the report describes actions L&I took in 2016 to meet the key objectives of RCW 51.36.010, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies, and any needed changes to further improve the occupational health best practices care of injured workers.

CREATE THE MEDICAL PROVIDER NETWORK

Research shows that health care providers using best practices for occupational medicine generally have better outcomes with injured workers. The medical provider network (MPN) helps ensure high quality medical care by setting standards for network providers and encouraging use of best practices. The Centers of Occupational Health and Education (COHEs) work with medical providers, employers and injured workers in a community-based program to improve injured worker outcomes and reduce disability by training providers and coordinating cases.

Establish standards for medical providers who treat injured workers

L&I adopted rules in 2012 (Washington Administrative Code [WAC] 296-20-01030 through 01050) establishing:

- Standards and requirements for provider participation in the MPN
- Criteria for determining when a provider can be removed from the MPN for “risk of harm”

L&I’s criteria and processes for reviewing MPN applications are modeled after those used by most health plans. The providers submit a Washington Practitioner Application – the same form used by most Washington payers and hospitals – plus a signed L&I Provider Network Agreement and federal tax forms. All forms and instructions are available online at www.JoinTheNetwork.Lni.wa.gov.

Providers required to be in the network to deliver ongoing treatment include:

- Physicians (medical and osteopathic)
- Chiropractors
- Naturopathic physicians
- Doctors of podiatry
- Advanced registered nurse practitioners
- Physician assistants
- Dentists
- Optometrists
L&I pays non-network providers only for a worker’s initial visit when their injury claim is filed.

In 2015, L&I consulted with the Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV) on whether out-of-state providers and provider types not listed above (such as psychologists, physical therapists and occupational therapists) should be required to submit their credentials to continue treating injured workers. L&I presented data on border-state providers to ACHIEV. Based on the number of providers, lack of evidence of major practice variation and resource requirements, L&I (with ACHIEV’s recommendation) has decided not to pursue expansion of the network at this time. ACHIEV recommended continuing to explore how to better manage physical therapists, but agreed that the credentialing requirements would not resolve concerns about continued treatment without objective improvement. L&I is pursuing this recommendation as part of its overall quality purchasing initiatives.

In 2016, L&I worked with the University of Washington (UW) to analyze physical therapy data. The research team presented preliminary data on use of physical therapy to ACHIEV for input on how to use the data to guide discussion on development of best practices for physical (and occupational) therapy services. ACHIEV provided robust input regarding the data analysis and potential additional data, as well as feedback on possible areas for best practice. The next steps will be finalizing the data analysis with UW and beginning best practice identification. This work will continue as part of L&I’s quality purchasing program, with continued input from ACHIEV regarding best practices and expansion of MPN provider types.

**MANAGE THE MEDICAL PROVIDER NETWORK**

Since January 1, 2013, injured workers must use network health care providers for all care beyond an initial office or emergency visit when their claim is opened. The MPN is the same for workers covered by L&I and by self-insured employers. Workers may choose any MPN provider for their care.

Ongoing operations to manage the MPN include processing new applications and change requests, and monitoring MPN providers for compliance.

**Initial surge of provider applications**

Initially, over 20,000 providers applied to the MPN. This exceeded expectations and resulted in a very robust network with access to care and to a wide range of medical specialties. However, the volume of applications strained L&I resources for processing applications.

L&I took a number of actions to improve the efficiency of processing and acting on provider applications, and to prevent workload issues from disrupting care for injured workers:

- Screened applications to see if providers met criteria for *provisional* status, allowing them to treat and be paid while L&I finished verifying and reviewing their credentials.
- Adopted an emergency rule allowing any provider who applied prior to January 1, 2013 to continue to treat while L&I reviewed their application. This emergency rule has now expired.

- Hired temporary staff and prioritized network applications against other work (for example, non-network applications, delegates, change management).

- Processed all applications from providers who submitted a complete application prior to January 1, 2013.

The number of approved provider applications continues to rise steadily. There are currently over 25,200 approved providers in the MPN.

**Applications**
L&I continues to monitor and oversee MPN providers for compliance. The department’s goal is to process applications within 90 days, which is the credentialing industry standard, so that providers can quickly begin treating injured workers. L&I is generally reaching this goal, though not every month.

The high initial volume (now over 25,200) of providers resulted in more work than expected both for initial set-up and to maintain changes on accounts. The number of new applications per month in 2014 remained high – about 1,900 total. In 2016, L&I continued to receive about 1,200 applications per month – about 300 new applications from MPN providers and 900 new applications from non-MPN providers. L&I’s application processing time is currently about three months per application. Change requests are completed in less than two months for MPN providers and less than seven days for non-MPN providers.

**Calls**
In addition to application volumes, calls from providers to L&I’s dedicated provider lines (Provider Hotline and Preferred Drug Line) swelled beyond expectations. This is largely due to the increased number of MPN providers and the roll-out of evidence-based treatment guidelines. The robust provider network and compliance with guidelines that prevent harm are both contributing to higher quality care. This is a positive development, but has had unplanned impacts on workload; for example, in 2014, calls to the Preferred Drug Line spiked by 58 percent.

In 2015, provider calls stabilized at about 1,200 calls per month for the Preferred Drug Line and 12,000 for the Provider Hotline.

Process improvement work was undertaken in 2015 and 2016 for both the Preferred Drug Line and the Provider Hotline, resulting in additional reduction in call volumes. In 2016, the Preferred Drug Line averaged 1,150 calls per month, and the Provider Hotline has seen an additional decrease to 10,200 calls per month.

**Response to challenges**
Recognizing that resource constraints and the focus on reducing application processing time prevented MPN management efforts from being as robust as they could be, L&I shifted priorities,
hired additional temporary staff and conducted Lean 4 process improvement events to streamline processes. L&I documented its “new normal” operations based on actual workload and prepared a request to the legislature for six additional MPN staff in 2014, which was approved in 2015. Results include:

**Application processing:** Based on the approved budget request, L&I hired two additional credentialing staff in 2015 and now has permanent funding for the associate medical director overseeing credentialing decisions. As a result of these actions and Lean efforts, processing time for applications is meeting the 90-day goal. Turn-around time for change requests is down to less than two months for MPN providers and less than seven days for non-MPN providers. New applications per month have leveled to a projected “steady state” of about 300 MPN provider applications and 900 non-MPN provider applications. L&I will continue efforts to consistently meet turn-around time goals in 2016.

**Hotlines:** Also based on the approved budget request, L&I hired three medical treatment adjudicators to manage provider call volumes, and continues to re-prioritize resources and improve process efficiencies.

**MPN approval and denial/termination**

Since the start of the MPN through July 2016, L&I has approved over 25,200 provider applications – 99.9 percent of all applicants. The remaining 189, or 0.01 percent of provider applications, were either denied, terminated or withdrawn by the provider in lieu of denial or termination.

**Screening new applications**

L&I staff verifies information on applications using public databases and other sources, including the National Practitioner Data Bank (NPDB). The NPDB collects information on health care practitioners such as malpractice awards, loss of license or exclusion from participation in Medicare or Medicaid, and discloses this information only to authorized users.

Staff checks all information related to an application and reviews an applicant’s L&I file, if available, for potential quality issues. Based on standards or criteria in L&I’s rules, 5 staff may flag applications for further review and discussion at a meeting of L&I’s credentialing committee. The credentialing committee is a panel of practicing health care providers contracted by L&I to review providers’ qualifications. After reviewing applications, the credentialing committee recommends approval or denial to the L&I medical director. If the medical director decides to deny an application, L&I sends the provider a letter summarizing the issues and quality concerns that led to denial.

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4 Lean is a business philosophy used, along with methods and tools, to create and deliver the most value from the customer’s perspective while consuming the fewest resources.
5 WAC 296-20-01030 and WAC 296-20-01050
Monitoring providers approved in network (continuous monitoring)
L&I, with agreement from the ACHIEV advisory committee, decided to review provider qualifications using a continuous monitoring approach rather than a three-year review cycle where every provider is required to renew their application and each renewal application is reviewed. The main reasons for this decision are:

- Over 99 percent of providers met network standards at initial review, and L&I expects very few already-approved providers would be denied during a re-review.
- L&I can use data from continuous monitoring sources to drive focused reviews and take action rather than using a cycle that would review all providers.
- This approach reduces provider and staff rework and is consistent with Lean processes.

L&I now monitors providers on an ongoing basis, which increases the focus on monitoring changes and reduces paperwork for the vast majority of providers who are compliant. Continuous monitoring means providers continue to participate in the MPN unless they are notified of issues. While L&I staff was already accessing data from the sources below, it was not automated. Much of the work needed to fully implement this process required data system and process changes to accept regular “feeds” from information sources, including:

- Office of Inspector General (OIG): The data source for providers excluded from federal programs was linked in the spring of 2015. Staff electronically compares the OIG exclusion list to MPN providers. To date, there have been 12 provider matches with this exclusion list.
- Drug Enforcement Agency: L&I receives federal data on active prescribing licenses, and is working toward directly mapping\(^6\) this data into its credentialing system to enable automatic updating. This is expected to be complete by December 2016.
- Washington State Department of Health: L&I receives Washington state license numbers, effective dates and status changes for mapping directly into the credentialing system. This connection was successfully completed in August 2016 and data will be shared with DOH on a monthly basis.
- NPDB: Starting in 2016, L&I enrolls MPN providers in continuous monitoring through the NPDB. Staff reviews the incoming updates and takes action when indicated. This is a change from the previous process of running the NPDB report once during the initial credentialing process and every three years after the initial application. This process is now complete.

**Final Review**
Any adverse decision, including a one-year provisional approval, denial or termination, is communicated in writing to the provider. The provider may request reconsideration of the adverse decision. Each reconsideration request, and any supporting information submitted by the provider, goes back to the credentialing committee for a recommendation. Final decisions are made by L&I’s

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\(^6\) Data mapping is a process used to link different data models to each other.
medical director. A denial or termination takes effect 60 days after the provider receives notification of the final decision.

L&I must report denials and terminations to the NPDB. If a provider appeals L&I’s decision to the Board of Industrial Insurance Appeals (BIIA), the provider cannot provide ongoing care for injured workers while the appeal is pending. However, L&I will report the appeal to the NPDB so that this action becomes part of the record. The issue of treatment during appeal has been litigated, and L&I successfully defended the statute and rule prohibiting treatment by providers that are not network-approved.

Quality of care issues addressed
As noted above, 99.3 percent of providers are approved and remain in good standing within the network. This percentage has remained stable since network inception. However, as demonstrated by the actuarial analysis, a small number of lower quality providers have had a negative impact on injured workers’ recovery.

Since network inception, about 460 providers have been referred by L&I’s associate medical director to a panel of peer reviewers for a review and recommendation. Upon reviewing the recommendations of the panel, L&I’s medical director has denied or terminated a total of 179 providers, or the provider withdrew in lieu of a final denial or termination decision. Under continuous monitoring, an additional 15 credentialed providers have been referred to the panel of peer reviewers for a review and recommendation. Of those 15, L&I’s medical director has terminated 10 providers, or the provider withdrew in lieu of a final denial or termination decision.

Multiple reasons or issues trigger review, and these are not changing substantially. As shown in Appendix A, there are six categories of review criteria that lead to a denial or termination. The most common issue triggering a review (about 80 percent) is a licensure action. In addition, most providers have more than one review issue.

Some issues regarding providers’ network eligibility were initially disputed, and some individual providers challenged L&I’s decisions to deny their applications to the network. As expected, the number of appeals peaked in 2014 with 14 cases, totaling 24 since 2011. L&I successfully defended cases before the BIIA, and only one case remains open. There have been very few new appeals filed in recent months, and the ongoing annual volume is expected to be very low – about one or two per year.

L&I anticipated that some workers may need special assistance in transitioning their care because their provider either did not apply to the MPN, or was not approved. As noted in 2014, care transition occurred smoothly and is now a normal course of operation.

The MPN lowers health care cost trends
L&I’s implementation of the MPN, combined with innovative purchasing strategies, is keeping health care costs low while improving quality of care for injured workers.
By focusing on achieving high quality health outcomes through evidence-based purchasing\(^\text{7}\) policy, L&I not only improves injured workers’ ability to heal, but leads nationally in innovative purchasing and cost constraints. As shown in Figure 2, annual medical cost growth in the workers’ compensation system has been under four percent since 2010. The projected growth for 2016 is at 4.5 percent, which still represents moderate growth and is under national trends. This low rate of growth includes small increases to the fee schedules in 2014, 2015 and 2016. Even with these exceptional results, L&I continues to monitor, spend, and proactively engage with providers and other health care consumers to ensure the lowest possible medical cost growth.

**Figure 2: Cost trends in Washington’s workers’ compensation system**

![Cost trend graph](image)

Source: L&I Actuary

L&I’s innovations, such as guidelines for physicians prescribing opioids to treat pain in injured workers, are being replicated nationally. These innovations were highlighted in the recently submitted [Washington State Health Innovation Plan](#) as evidence that Washington is an innovation leader (COHE is cited as a currently implemented evidence-based purchasing strategy).

**The MPN reduces disability**

Beginning in 2014, L&I actuaries analyzed claim costs for injured workers treated by providers prior to creation of the network and who were never part of the MPN. The final analysis is consistent with the preliminary results shared last year: it shows the program was successful in preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

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\(^{7}\) Evidence-based purchasing uses objective research on and assessments of medical devices and health care solutions to make better purchasing decisions.
The primary network goal is reduced disability for injured workers; however, that outcome is difficult to measure. L&I analyzed claim costs and time-loss duration to determine whether disability was reduced, and the comparison showed reduced disability.

Claim costs
Workers’ compensation reforms were intended to increase the quality and effectiveness of health care and stabilize or reduce costs. The fiscal note for the MPN projected that removing lower quality providers would save $16.5 million the first year and $33 million annually thereafter. The actual savings is estimated at $34.7 million annually, slightly more than expected.

L&I’s actuarial analysis compared the costs of 135 providers not in the network (but treating injured workers prior to network launch) who were treating four or more claims. The providers not in the network had 10 percent higher costs and were involved in 18.6 percent of claims. This results in an annual savings of 1.9 percent of the Medical and Accident Fund ($34.7 million for 2013). Savings are based on injury date and the date the provider was involved in the claim, and include actuarial estimates of ultimate claim costs (total paid out for a claim) for claims that are still open.

Time-loss
In addition to analyzing claim costs, L&I actuaries analyzed the impact on duration of time-loss. L&I’s analysis compared average time-loss days of workers seen by providers not in the network and workers seen by all providers. The analysis controlled for the severity of injuries by selecting the 30 highest cost time-loss groups, matched by the nature of the injury and the injured body part. The analysis looked at time-loss as of the date of the report (not estimated to ultimate numbers) and compared data for the time period 2003-2008. As shown in Figure 3, patients of MPN providers averaged 36 percent less time-loss than patients of providers not in the network – an average of 367 days of time-loss for providers not in the MPN compared to 280 days of time-loss for those in the MPN.

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8 Duration of time loss is the days an injured worker is paid for lost wages resulting from time off work or time doing lower-pay work due to work-related injury or illness.
Figure 3: Days of time-loss paid

<table>
<thead>
<tr>
<th>Fiscal Year (FY)</th>
<th>Days paid: Non-MPN providers</th>
<th>Days paid: All attending providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>420</td>
<td>267</td>
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<tr>
<td>2004</td>
<td>322</td>
<td>261</td>
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<tr>
<td>2005</td>
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<td>259</td>
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<tr>
<td>2006</td>
<td>327</td>
<td>259</td>
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<tr>
<td>2007</td>
<td>382</td>
<td>269</td>
</tr>
<tr>
<td>2008</td>
<td>367</td>
<td>280</td>
</tr>
</tbody>
</table>

Source: L&I Actuary

Access to care issues

Primary care
Throughout implementation of the MPN, L&I sought to ensure injured workers continued to have access to primary care providers by monitoring the number of injured workers in each county who lived within 15 miles of at least five network primary care providers. The department then compared this to a 2012 baseline. This information was used to target provider recruitment and ensure an adequate geographic distribution of providers. In 2012, 99 percent of workers had access to at least five primary-care providers within 15 miles. By September 2013, the distribution was within two percent of the 2012 baseline in 34 out of 39 counties. This number has remained stable, and as of June 2016, the distribution was within two percent of the 2012 baseline in most Washington state counties.

Underserved populations
In 2016, L&I focused on underserved communities and populations – in particular, increasing service to Latino workers, increasing access to telehealth⁹ services, and improving mental health services delivery. Results include:

- The eastern Washington COHE now has three bilingual (Spanish) health services coordinators.

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⁹ Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services.
Three new providers are available to workers’ compensation patients in the Yakima area – two psychiatric advanced registered nurse practitioners (ARNPs) and one ARNP with pain management experience.

L&I staff researched and are recommending adoption of Culturally and Linguistically Appropriate Services (CLAS) health care standards. These are national standards to advance health equity, improve quality of care and eliminate health disparities. The standards are endorsed by the Washington State Governor’s Interagency Council on Health Disparities. Prior to making a formal recommendation to the Language Access Steering Committee, program executives are discussing implementation strategies.

L&I began collaborating on telehealth services by connecting two Yakima clinics with psychologists providing therapy in western Washington, including three multi-lingual therapists.

L&I is working with a large eastern Washington health care organization to determine the feasibility of delivering teletherapy (online therapy) in COHE offices in Wenatchee, Kennewick and Yakima.

L&I continues to monitor Washington legislation and the activities of a new work group on telehealth, and analyze payment policies to remain consistent with state and national trends.

L&I formed a stakeholder workgroup to explore issues regarding access to mental health services. In response to feedback from the work group, the department made process improvements and conducted provider outreach resulting in increased availability of providers (see the above bullet related to psychiatric ARNPS and psychologists).

**Outreach to injured workers**

To increase knowledge about and use of MPN providers, L&I informed injured workers about the MPN and helped them find a network provider through:

- Informational mailings to all workers with open claims, letting them know about the network and offering to help them find a provider.
- Letters and phone calls to workers who did not have a network provider, offering to help them find one.
- Enhancement of an online provider directory (FindADoc) to support searches by driving distance (www.FindADoc.Lni.wa.gov). While the FindADoc tool was a substantial upgrade to the previous web directory, L&I significantly enhanced it in 2014 to address navigational limits, increase usability and add easy-to-use search limiting functions.
- Targeted recruitments for dentists and a special information campaign for anesthesiologists, as both groups were underrepresented at the network launch. These efforts have been successful at gaining provider participation.
EXPAND THE CENTERS OF OCCUPATIONAL HEALTH AND EDUCATION

The Centers of Occupational Health and Education (COHEs) began as a pilot project in 2002 to support medical providers’ use of best practices with injured workers. Initial COHE best practices focus on the first 12 weeks post-injury, which is a critical period for preventing disability. COHE participation is voluntary. Network providers are not required to join COHEs and injured workers are not required to use COHE providers.

The law directs L&I to extend access to health care providers participating in COHEs with two milestones: first, expand access to COHE services to 50 percent of injured workers by December 2013; and second, expand access to 100 percent of injured workers by December 2015.

Ninety-three percent of injured workers now have access to five or more COHE providers within 15 miles of their home, and 96 percent of injured workers live within 15 miles of at least one COHE provider. L&I will continue to work with COHEs to identify and recruit active providers in the small number of areas that are currently not served. By late 2016, COHE providers are expected to be available to workers in all 39 counties.

How COHEs help injured workers return to work sooner

In 2011, a University of Washington study found that workers treated by COHE-affiliated providers heal and return to work sooner, with 20 percent fewer time-loss days. COHE care also reduces disability and medical costs by about $510 in the first year of the claim.10

In 2015, the Joint Legislative Audit and Review Committee (JLARC) audited the workers’ compensation system. They made several observations about the system:

“Major Observations
L&I has several other initiatives in planning or early stages, such as incentives for “Top Tier” providers to demonstrate best practices in occupational medicine, qualifying providers to be in the approved Medical Provider Network, based on performance, and further enhancements to COHEs. These all have great promise for improving outcomes and should be vigorously pursued.” 11

“A particularly successful program pioneered by Washington is the “Center for Occupational Health Excellence” (COHE), which has shown clear evidence of greater success in disability management than non-COHE providers. COHEs are community-based centers that undertake a more collaborative and integrated approach to occupational medicine. COHEs receive certain support from L&I and are recognized for their success. The State, in close cooperation with the medical community, continues to refine and strengthen ways to promote good occupational medicine... “The second initiative to address timeliness of reporting is the creation of Centers for

10 Wickizer, “Improving Quality, Preventing Disability,” 1105 (see n.1).
11 2015 JLARC Audit Team performance audit
Occupational Health and Education (COHE). COHEs are designed to apply best practices in occupational medicine; they have gradually expanded throughout the state since 2002….COHE providers have a much better record than non-COHE providers in timely reporting of claims and related reports (e.g. the Activity Prescription Form, or APF) on functional restrictions for the claimant during healing….. More needs to be done as early as possible in the life of a claim to identify issues that will complicate claim management and prolong disability.”

**COHE sponsors**

COHEs are run by health care delivery organizations such as clinics or hospitals (referred to as sponsors). COHE sponsors enroll health care providers, who are asked to use occupational health best practices with all their injured workers. With funding from L&I, COHE sponsors provide:

- Health Services Coordinators
- Clinical leadership and mentoring
- Provider outreach and training in occupational health best practices
- Community outreach to business and labor groups
- Support for participation in other L&I initiatives (such as pilots of emerging best practices)

Sponsors give providers feedback on how well they are following best practices. Providers receive financial incentives for demonstrating use of the following best practices:

- Submitting the Report of Accident to L&I within two business days
- Completing an activity prescription form at the first visit and when the patient’s status changes
- Conducting two-way communication with the patient’s employer on return-to-work options
- Developing a plan to address barriers that prevent patients who are still off work from returning to their jobs

Six health care organizations began participating in COHEs with new contracts in the summer of 2013. Figure 4 shows sponsoring organizations, the areas they cover or will expand to during the contract term (through September 2016), and the year they began participating.

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12 2015 JLARC Audit Team performance audit
Figure 4: COHE sponsors

<table>
<thead>
<tr>
<th>Sponsoring organization</th>
<th>Coverage</th>
<th>Year sponsorship began</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valley Medical Center (the Renton COHE)</td>
<td>Enrolled community providers in parts of King and Pierce counties.</td>
<td>2002</td>
</tr>
<tr>
<td>Harborview Medical Center</td>
<td>Includes providers in Harborview’s trauma center and several outpatient clinics.</td>
<td>2007</td>
</tr>
<tr>
<td>The Everett Clinic</td>
<td>Includes providers in nine Snohomish County clinics operated by the Everett Clinic.</td>
<td>2007</td>
</tr>
<tr>
<td><strong>Franciscan Health System</strong>, lead for a coalition of 12 health care organizations</td>
<td>Will enroll COHE providers in all western Washington counties. Health Services Coordinators will be located in Tacoma with an office in southwest Washington.</td>
<td>2013</td>
</tr>
<tr>
<td><strong>Group Health Cooperative</strong>&lt;br&gt;Patients do not need to be Group Health members to see providers in these clinics for work-related injuries or illnesses.</td>
<td>Will provide services to injured workers at 11 Group Health clinics in western Washington and one in Spokane.</td>
<td>2013</td>
</tr>
</tbody>
</table>

Source: L&I’s Occupational Health Services Unit

In addition to areas served by the two COHE sponsors that began providing service in 2013, the eastern Washington COHE is expanding services to providers in Benton, Franklin, and Kittitas counties. With the addition of Klickitat County to the COHE Community of Eastern Washington’s portfolio, COHE service areas now cover all 39 counties in the state. The map in Figure 5 shows the coverage of COHE organizations and providers identified in the contracts.
Figure 5: Injured workers within 15 miles of five or more COHE providers

All Injured Workers With 15-mile Radii From Current Active COHE Providers
As of June 2016

Source: L &I analysis using Esri Geographic Information Systems software.

Current activity in COHE expansion

The department continues to work to expand the COHEs so that more workers can benefit. As shown in Figure 6, the number of COHE providers has grown steadily since 2012. This extensive coverage provides injured workers additional choices in COHE-sponsored providers, resulting in better outcomes.

Figure 6: Actual and projected increase in COHE providers

<table>
<thead>
<tr>
<th></th>
<th>Number of COHEs</th>
<th>Number of providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2012</td>
<td>4</td>
<td>1,770</td>
</tr>
<tr>
<td>September 2013</td>
<td>6</td>
<td>1,880</td>
</tr>
<tr>
<td>September 2014</td>
<td>6</td>
<td>2,470</td>
</tr>
<tr>
<td>September 2015</td>
<td>6</td>
<td>2,730</td>
</tr>
<tr>
<td>September 2016</td>
<td>6</td>
<td>3,218</td>
</tr>
<tr>
<td>September 2017</td>
<td>6</td>
<td>3,490</td>
</tr>
</tbody>
</table>

Source: L&I’s Occupational Health Services Unit
L&I facilitated two business and labor advisory boards, one in western Washington and one in eastern Washington, to gather community input on COHE expansion and operations. Regional COHEs host these boards and take an active role in coordinating them and responding to board recommendations. The boards did not recommend any specific expansion of the number of COHE-sponsoring organizations. They have provided ongoing input on the enrollment efforts and other initiatives of current COHEs. As shown in Figure 6, most injured workers have five or more COHE providers within 15 miles. This level of access remains consistent.

**COHE expansion status**

L&I’s COHE expansion has met legislatively established goals. Additional recruitment is an ongoing operational activity as L&I remains committed to ensuring all workers are able to benefit from providers trained in best practices. The department expected about 3,000 COHE providers to handle 52,000 new claims in FY 2016, and is likely to exceed that. Currently, there are over 3,200 COHE providers and slightly over 50,000 new claims initiated by COHE providers.

**CREATE A PROVIDER TOP TIER**

The law directs L&I to establish a second tier (top tier) within the MPN for providers who demonstrate occupational health best practices. Top tier providers will be eligible to receive financial and non-financial incentives, such as streamlined authorizations. L&I has worked with ACHIEV to discuss eligibility criteria and incentives for top tier providers. The department has also held provider focus groups on top tier criteria and is reviewing the infrastructure needed to implement it.

**Preliminary eligibility criteria for top tier**

Following focus group discussions, ACHIEV and L&I began to develop preliminary eligibility criteria for top tier providers. The criteria include:

- Minimum number of workers’ compensation patients
- Qualifications that are in good standing
- Use of occupational health best practices
- Some combination of
  - Participation in a quality improvement project
  - Board certification or other higher certification
  - Use of electronic medical records
  - Number of complex or at-risk patients
- Core competencies related to workers’ compensation and pain management
In the fall of 2012, L&I and ACHIEV agreed to postpone top tier implementation due to several factors: the high number of L&I program changes underway; other reforms affecting health care providers; and the additional time needed to further develop data, systems support and provider education programs.

In 2014, L&I resumed work on top tier, developing a work plan and establishing work groups that held regular discussions with ACHIEV.

In 2015, L&I continued to make progress on the work plan and with the work groups. The department hired consultants and completed a study documenting L&I’s current state, health care market innovations to encourage quality and recommendations for rapid implementation. L&I and ACHIEV were on track to finalize the program design for both eligibility criteria and incentives by spring of 2016. Several potential program elements for top tier require technology or staff resources not budgeted at the time. L&I requested and received supplemental budget funding.

In 2016, L&I focused on developing the detailed process for accepting and processing a top tier application, creating the framework for provider on-line testing, and determining the appropriate provider and health care organization incentives.

BUILD THE OCCUPATIONAL HEALTH MANAGEMENT SYSTEM (OHMS)

The law requires L&I to track use of best practices, support care coordination and give feedback to providers. Since 2012, L&I has worked with a software vendor and internal IT staff to build a new computer system that will make it easier for the COHEs to do business with the department. This occupational health management system (OHMS) provides a web-based case management tool that will centralize and streamline existing care coordination processes across COHEs. It will also be used to support top tier and pilot projects for emerging best practices.

The OHMS project has successfully delivered an application to support care coordination and tracking of occupational health best practices. A second application was also delivered, which supports provider training and collaboration. The OHMS project developed a data storage and analysis system (data mart) to deliver complex reports requiring multiple source system data.

The OHMS project also developed an enterprise-wide infrastructure that supports health information exchange (HIE) system interface with the statewide HIE, OneHealthPort. This allows L&I to collect/send) data from/to provider Electronic Medical Record Systems (EMRS). The HIE was recognized in a 2015 performance audit issued by the Joint Legislative Audit and Review Committee (JLARC) as a substantial improvement in claims processing. Two additional large health care organizations plan to start using the HIE by early 2017. L&I continues to add new document types to the HIE (for example, the Report of Accident) so that health care organizations can transmit more of their L&I data online. The L&I HIE project is one of six finalists for the 2016 National Association of State Chief Information Officers (NASCIO) Best Digital Government to Business Technology award.
In 2015, L&I completed, on time and on budget, the initial rollout of OHMS. Figure 7 shows the applications and services that make up OHMS.

**Figure 7: OHMS systems graphic**

![OHMS systems graphic](image)

Source: L&I Information Services, Project Management Office

**What OHMS accomplishes**

- Enables L&I to automatically send alerts and communications to health care provider staff coordinators about new and existing claims.

- Enables health care provider staff to maintain a worklist of L&I claims, prioritize their work, document their coordination and automatically generate a bill.

- Enables L&I to track and monitor best practices.

- Enables COHE leadership to view overall, clinic and individual performance.

- Enables providers to communicate with their coordinators, see claim information, get feedback reports and access L&I information and education.
OHMS release schedule

OHMS planned five releases between June 2013 and June 2015. All releases have been completed within budget. The services delivered in each release have been changed to better address complementary processes and tasks. Figure 8 shows the release schedule and the services within each release.

Figure 8: OHMS users and release schedule

Source: L&I Information Services, Project Management Office

Key success and next steps for OHMS

OHMS is web-based and integrates with L&I systems, which enables health care provider staff to receive updated information several times a day to help coordinate care. They can now send automated referrals for services and document case notes to L&I through a secure electronic interface.

L&I is the first in Washington to automate the exchange of clinical data directly from a health care provider’s electronic medical record (EMR) to a payer system – reducing paper, faxing and keying of
information for providers as well as for L&I. The first two participating providers are now exchanging data electronically without the need for data entry. The JLARC Report also noted this best practice, and confirmed that it speeds up claim resolution.

L&I’s goal is to transition as many providers and transactions to electronic filing as possible. The department offers an existing electronic exchange for Reports of Accident (ROAs) through a web-based application called FileFast. L&I currently transacts Activity Prescription Forms (APFs) with four provider organizations, with the goal of having 45 percent of these transactions done through HIE by June 2017. The department expects to reach 26 percent with these four partners, and will continue to add provider organizations as those organizations develop capacity.

L&I continues to coordinate with OneHealthPort, major electronic medical records software companies, and large health care organizations to assess ways to transition more provider transactions to the HIE. In addition, the department continues to add new document types to the HIE so that health care organizations can transmit more of their L&I claim-related data online. The following HIE transactions are expected to be added over the next year:

- Claim information: Automating information that is currently available to providers through L&I’s interactive voice response system allows providers to quickly see the claim’s status and the accepted diagnosis codes. This avoids confusion and keeps treatment focused on the workers’ compensation illness or injury. Requests for this type of claim information are some of the most frequent call types received by the Provider Hotline.

- Report of Accident (ROA): Automating information that currently initiates the filing of a claim helps ensure ROAs are submitted in a timely manner, which is an occupational health best practice. This automation will reduce delays and ensure critical information is received by L&I, speeding the delivery of benefits to injured workers.

- Care coordination case notes: Streamlining processes for COHE and other care coordinators who work with electronic medical records helps them identify and facilitate appropriate steps to ensure injured workers get the care they need. With HIE, care coordinator case notes are automatically uploaded to L&I directly from the health care organization’s medical records system twice per day. Streamlining documentation frees the coordinators up to assist more injured workers and allows L&I claim managers more timely access to critical information needed to manage the claim. Less time waiting for information means faster decisions for injured workers.

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13 In Washington, a health care provider and injured worker initiate a workers’ compensation claim by filing a Report of Accident (ROA).
IDENTIFY AND PILOT BEST PRACTICES IN OCCUPATIONAL HEALTH

Best practices are methods that have consistently been shown to improve health care outcomes for patients, which helps L&I achieve its goal of helping injured workers heal and return to work. COHE providers receive financial incentives to deliver four best practices that currently focus on the first 12 weeks of treatment for injured workers:

- Activity coaching
- Functional recovery
- Surgical best practices
- Chronic pain

The law directs L&I to also develop best practices that span the full period of recovery for longer-term cases. In collaboration with the University of Washington (UW), L&I developed three pilot projects to test and develop emerging best practices for functional recovery, activity coaching and surgical best practices. In 2015, L&I worked with consultants, staff, UW and its advisory committee ACHIEV to finish a comprehensive plan for best practice occupational medicine that prevents and adequately treats chronic pain. While the activity coaching pilot is complete, the other three are still underway. Each is described in detail below.

Activity coaching

Activity coaching is a standardized, cognitive behavioral therapy provided by specially trained, professional “coaches.” By focusing on structured activity, activity coaching helps injured workers overcome fears and other psychosocial barriers to recovery and regain normal daily function. The program’s final stages center on activities that help re-integrate injured workers into the workplace.

An activity coaching pilot project began in 2012. Coaches for the pilot were available in most parts of the state in 2013, though initial participation was low. In 2014, L&I worked with the UW to find ways to identify and review claims of more potential participants.

The UW evaluation concluded in spring 2015 that injured workers experienced clinically meaningful improvement in five measured areas: pain, catastrophizing/feelings of injustice, fear avoidance and fatigue, depression, and perceived disability. Findings were presented to L&I and ACHIEV, with a recommendation for approval of the program. The program is now approved and L&I is working to promote widespread use of and education of clinicians about the service.

Functional recovery

In 2013, L&I launched a multi-year functional recovery pilot project with providers in the eastern Washington COHE to study the most successful approaches to integrating functional recovery into
everyday practice. The study includes a questionnaire to identify high risk patients, and interventions to reduce risk. While the survey and interventions are available now, L&I and health care partners are testing for the best time and approach to deploy them. The pilot met its 2015 goals.

The pilot is also testing the use of functional recovery interventions for injured workers that have positive scores on the functional recovery questionnaire (FRQ) – a three-question survey given to workers who have missed two weeks of work. The FRQ is based on a UW study that identified predictors of disability such as recovery habits, fear of pain or re-injury, physical activity level and barriers to returning to work quickly. It is highly predictive of long-term disability; nearly 40 percent of workers identified as having a positive FRQ (meaning that the injured worker’s answers indicate a higher likelihood of long-term disability) are disabled one year after their injury, compared to fewer than three percent of workers with a negative FRQ.

For workers identified with a higher likelihood of long-term disability, providers participating in the pilot are given interventions they can use to improve patient outcomes. The functional recovery interventions (FRI) are focused on functional improvement, incremental activity, and documenting interventions and improvements to help injured workers. Interventions are selected based on the FRQ results as well as the individual’s clinical condition.

The number of providers using the FRI is increasing in the eastern Washington COHE. The Health Services Coordinators work closely with providers, using the FRI electronic form in OHMS. The electronic form matches the FRI paper form that providers use during clinic visits with injured workers.

**Surgical best practices**

The surgical best practices pilot, launched in 2014, adds four new best practices to the orthopedic and neurological surgeons’ quality pilot requirements. These best practices were selected to improve transition of care from one phase to the next and return to work planning. They are:

- Timely and appropriate transition to surgical care
- Pre-operative documentation of plans and goals for returning to work
- Post-operative intervention on goals for returning to work, if needed
- Timely transfer after surgical care ends

A surgical health services coordinator will ensure that referring providers know when and how to request assistance from surgeons. The coordinator will take the lead on planning and communicating about workers’ return to work. After surgery, the coordinator will track progress on return-to-work plans and coordinate needed interventions. When a patient is ready to move on to the next step of care, the coordinator will assist with the transition to the next provider.
In 2015, L&I worked with the health care provider organizations to implement the pilot, which is now underway at three sites. The initial start-up phase concluded in January 2016. Start-up accomplishments include:

- Developed and implemented an automated surgical care coordination system within the Occupational Health Management System
- Established Surgical Health Services Coordinator (SHSCs) standard work processes
- Developed potential pilot process quality indicators
- SHSCs reviewed over 4,000 cases resulting in opportunities to assist over 1,500 injured workers

The pilot is currently expected to run through June 30, 2019. That’s how long it will take to gather data from enough workers to make up a significant sample size, which is required to measure effectiveness. Ultimately, L&I plans to use data from the Surgical Best Practices Pilot and the Orthopedic and Neurological Surgeon Quality Program to establish a top tier for surgical providers.

**Best practices for chronic pain and behavioral health**

Despite best efforts to prevent long-term disability in injured workers with mild to moderate injuries, some workers will become disabled – mostly due to chronic pain. Current medical and behavioral-health approaches are inadequate and too uncoordinated to effectively address chronic pain and prevent these disabilities.

With best practices in place for acute care and pilots for sub-acute interventions underway and working well, L&I is ready to identify best practices for the chronic phase of pain (about three months to one year following injury). In 2015, L&I assessed literature and worked with its advisory committee, staff and consultants to define a vision and interventions. The interventions are based on a validated collaborative-care model, sometimes called a “medical home.” The interventions in this model test coordinated treatment across areas of care that are not currently integrated at all, including:

- Primary occupational care
- Coordinating treatments for psychosocial and behavioral health barriers to recovery
- Coordinating services for chronically disabled workers to prevent further harm and more effectively manage their conditions

This effort to prevent the transition from acute pain to chronic pain, and to effectively manage chronic pain, is consistent with a recent Robert Bree Collaborative recommendation to state agencies regarding best practice guidelines for management of low back pain. In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative so that public and private health care
stakeholders would have the opportunity to identify specific ways to improve health care quality, outcomes and affordability in Washington.

In late 2015 and 2016, L&I contracted with UW to develop a proposed workers’ compensation collaborative care model focusing on chronic pain and behavioral health, based on evidence-based collaborative care models that have demonstrated success. L&I and UW staff meet regularly and have shared preliminary information with ACHIEV for early feedback. L&I also requested and received resources for best practice development; hiring for this was completed in October 2016.

ADOPT AND IMPLEMENT RISK OF HARM RULES

In 2012, L&I adopted the nation’s first risk of harm rules, which define a pattern of lower quality care that leads to harm or risk of harm to injured workers. L&I is establishing processes for monitoring quality of care issues and identifying providers who present a risk of harm. 14 This will help the department ensure high quality care for injured workers.

L&I and an external medical advisory group, the Industrial Insurance Medical Advisory Committee (IIMAC), chose two initial areas of focus for risk of harm: opioid deaths/overdoses and rates of repeat surgery.

In 2015, L&I consulted with experts to establish appropriate ways to measure and monitor these two areas. L&I completed a data analysis and tested benchmarks and review processes for providers who prescribe dangerous amounts of opioids that lead to deaths/overdoses. Several providers have had multiple instances (a pattern) of deaths and/or overdoses and have been referred to the credentialing committee. L&I has nearly completed another data analysis that will enable benchmarks to be established, as well as review processes for providers with high reoperation rates in back surgeries.

L&I prepared a decision package for a permanent resource which was funded beginning in July 2016. L&I is hiring for this position and hopes to fill it by November 2016. In addition, L&I continued working with a researcher to establish benchmarks for providers who have very high rates of reoperation for back surgery, and presented the findings to the IIMAC. The IIMAC requested additional data in the analysis, and an updated report is scheduled to be completed by December 2016.

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14 Risk of harm is defined in WAC 296-20-01100.
CONVENE AN ADVISORY GROUP

The law directed L&I to establish an advisory group made up of:

- Business and labor representatives chosen by L&I’s Worker’s Compensation Advisory Committee (WCAC)
- Clinical members from the Industrial Insurance Medical Advisory Group and the Industrial Insurance Chiropractic Advisory Group

This advisory group is called the Advisory Committee on Health Care Innovation and Evaluation (ACHIEV). Its predecessor was the Provider Network Advisory Group. The committee has met at least quarterly since July 2011, and continues to meet to give policy input on:

- Standards and processes for enrolling providers in the network
- Risk of harm criteria for removing network providers
- Eligibility and incentives for top tier
- Other subjects related to implementation

The committee also receives regular updates on network enrollment status and implementation issues. Advisory committee meetings are open to the public. All meeting materials, including minutes, are posted online at http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/PNAG/default.asp.

L&I has worked closely with health care provider associations and other organizations to get input on implementing these reforms.
Conclusion

Legislation passed in 2011 and codified as RCW 51.36.010 gave L&I the ability to establish standards for medical providers who treat injured workers, and to expand programs that develop and provide incentives for occupational health best practices. In 2015, L&I continued to make significant progress toward these goals. The department’s achievements are the foundation for additional work in 2016 and beyond to reduce disability for injured workers by improving their medical care.

By launching the MPN, stabilizing operations to support the expanded number of providers, establishing new COHE contracts, launching the OHMS system and completing the first two risk of harm data analytics, L&I has completed the majority of the law’s implementation. Full implementation is a multi-year process, but the state is well on its way toward implementing these changes.

L&I requested and received additional resources from the legislature to fully implement and stabilize top tier; to identify, pilot and incentivize best practices in the chronic phase; to increase provider participation in the HIE; and to expand risk of harm analysis to other areas of lower quality care. A separate legislative report, L&I’s report on Reducing Long-Term Disability, provides information about the key activities underway based on this funding.

FUTURE PLANS

L&I is committed to continuous quality improvement of the foundational elements of the MPN, COHE expansion, top tier, and risk of harm rules resulting from the 2011 reforms. These reforms have resulted in high quality providers delivering evidence based, quality care that has improved outcomes for injured workers.

- The MPN is operational. L&I’s focus is on improving process and turnaround times, as well as enhancing risk of harm and other analytics to monitor quality of care issues.
- COHE expansion is complete. L&I’s focus is on targeting specific areas where COHE claim initiation remains low and expanding the number of best practices, especially to address chronic pain and behavioral health.
- Top tier is not yet operational. L&I’s focus, with the assistance of the new resources, is to complete development of and implement top tier in 2018.

This is the final legislative report on the MPN implementation and COHE expansion. As noted above, L&I requested additional resources to support the department’s efforts to reduce long-term disability for injured workers. Additional information regarding these requests is documented in a separate report, “Reducing Long-Term Disability.”
Appendix A

L&I may deny admission or terminate participation in the medical provider network based on quality concerns that were agreed to by an advisory group of business, labor, and providers, and are detailed in rule. A provider’s complete file is reviewed at initial admission, which includes the application, verification reports from data sources, and any L&I specific complaints or data. Once admitted, a provider is reviewed through a continuous monitoring process: L&I receives data feeds that alert L&I to provider license and other status changes; L&I conducts formal risk of harm analysis using data reports (currently Opioid death and overdose); and L&I monitors provider related complaints for patterns of patient harm concerns.

The department has summarized the reasons for denials or terminations after admission to the MPN into six primary categories, any of which could result in denial or termination:

**Denial/termination categories for L&I’s medical provider network**

1. **Clinical care**
   - Liability insurance (WAC 296-20-01030(2))
   - Admitting privileges, malpractice claims, inappropriate treatment, unlicensed staff, risk of harm (WAC 296-20-01050(3)(h),(i),(l),(m) and (t))

2. **Compliance with clinical guidelines**
   - Department rules, policies, guidelines or national guidelines, inappropriate prescribing (WAC 296-20-01050(3)(j) and (r))

3. **Criminal misconduct, substance abuse, sexual misconduct**
   - Felony, sexual misconduct (WAC 296-20-01030(6))
   - Substance abuse, criminal history (WAC 296-20-01050(3)(b),(n) and (s))

4. **License**
   - Active, unrestricted license and DEA registration (WAC 296-20-01030(7) and (8))
   - Pending charges, non-compliance with STID, informal actions, history of license actions (WAC 296-20-01050(3)(c),(d),(o) and (p))

5. **Misrepresentation and omissions**
   - Application misstatement/omission (WAC 296-20-01030(5))
   - Fraud, misrepresentation, billing fraud (WAC 296-20-01050(3)(k) and (q))

6. **Payer or institutional privileges**
   - Admitting privileges terminated, public payer termination (WAC 296-20-01030(3) and (4))
   - Payer termination/exclusion, withdraw privileges (WAC 296-20-01050(3)(e), (f), and (g))