HEALTH CARE QUALITY & L&I PURCHASING

Karen Jost
Program Manager
Health Services Analysis
Disability Prevention is the Key Health Policy Issue

Percentage of time-loss claims with duration beyond given month

Average of fiscal accident years 2009 to 2011

Queried: May 28, 2014
Actuarial Services
includes time-loss and LEP claims

70% Return to work in first 3 months
Disability and Chronic pain coincide at 3 months

8% account for 85% of cost
Less than 1% catastrophic injury

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Less than 1% catastrophic injury

Time loss duration (months)

2014 L&I Actuarial Services Analysis (for fiscal accident yrs 2009-2011)
Distribution of Quality of Care

**Clinical Efficiency**

- **Zone 1:** Excellent Health and Disability Outcomes
  - Low to Moderate Medical and Disability Costs

- **Zone 2:** Average Health and Disability Outcomes
  - Average Medical and Disability Costs

- **Zone 3:** Poor Health and Disability Outcomes
  - Average to High Medical and Disability Costs

- **Zone 4:** Very Poor Health and Disability Outcomes
  - High Medical and Disability Costs

**RECOGNIZE**
- COHE High Adopters, Top Tier
  - Financial and Non-Financial Incentives, Recognition, Mentors

**IMPROVE**
- COHE Participation, Education, Mentoring, Evidence-based best practice guidelines, Top Tier, Financial and Non-Financial Incentives, Care Coordination

**REMOVE**
- Network Minimum Standards
  - Risk of Harm
  - Audit, Education and other interventions

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**Community Physicians**

- Good
  - (Quality & Value)

- Poor
L&I Medical Care Purchases

Benefits Paid for Accident Year Ending 3/31/14

- Medical: $819.6 M (55%)
- Pension/Time Loss: $666.2 M (45%)

L&I Annualized Medical Cost Growth excluding Hearing Loss

Bars: Evaluation as of 6/30/2014

Percent Change:
- 2011Q3: 2.2%
- 2011Q4: 4.0%
- 2012Q1: 4.8%
- 2012Q2: 4.5%
- 2012Q3: 4.4%
- 2012Q4: 4.3%
- 2013Q1: 3.7%
- 2013Q2: 3.3%
- 2013Q3: 2.2%
- 2013Q4: 1.0%
- 2014Q1: 0.9%
- 2014Q2: 0.8%
L&I Health Quality Expansion Vision

1. **Set Minimum Standards**
   - Medical Provider Network and Risk of Harm

2. **Incentivize Collaborative Model and Occupational Best Practices**
   - COHE Expansion
   - Top Tier

3. **Promote/Identify Evidence Based Policies and Practices**
   - Evidence Based Treatment Guidelines
   - Functional Recovery Questionnaire/Intervention
   - Activity Coaching
   - Surgical Best Practice

4. **Identify areas of ongoing need for system innovation**
   - Behavioral health
   - Long term disability/Chronic pain
1. Medical Provider Network

- Claim costs are not a factor in the review of provider applications. However, data indicates low quality providers have worse outcomes and higher-than-average claims costs for injured workers.

- Projected impact of removing low quality providers using matching on injury type and body party
  - $16.5 million first year, and $33 million annually

- Actual impact
  - $34.7 Million Annual
1. Medical Provider Network Impact

- Historical comparison of Time loss associated with attending providers vs non-network providers
  - 30 highest cost groups matched by Injury Nature and Body Part
    - Time-loss claims only. Includes severe/complex claims: e.g. traumatic injuries to bones, nerves, spinal cord for back; Intercranial injuries for skull; musculoskeletal system and connective tissue disease and disorders for shoulder.
    - Values not developed to ultimate
  - Average of Non-MPN Group is 36% higher

<table>
<thead>
<tr>
<th>Fiscal-Accident Year</th>
<th>Days of Time loss Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>2003</td>
</tr>
<tr>
<td>Non-MPN</td>
<td>420</td>
</tr>
<tr>
<td>All Providers</td>
<td>267</td>
</tr>
</tbody>
</table>
2. Expand COHE and Best Practice

Why Centers for Occupational Health & Education?
– Study shows COHEs speed healing
  • Reduce time loss by 4.1 days
  • Save approx. $480 in first year and $1,600 overall

KEY COHE Elements
– Clinical Champion; Coordination; Evidence Based Best Practices

WHAT are Current Incentivized COHE Best Practices
1. Submit the Report of Accident to L&I within two business days
2. Complete an Activity Prescription Form at the first visit, and when the patient’s status changes
3. Two-way communication with the patient’s employer on return-to-work options
4. For patients that are still off work, developing a plan to address barriers for return to their job
## 2. Expand COHE Enrollment

<table>
<thead>
<tr>
<th>Current # of Enrolled Providers *</th>
<th>Proposed # of Enrolled Providers</th>
<th>COHE Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,208</td>
<td>1,451</td>
<td>COHE Community of Eastern Washington</td>
</tr>
<tr>
<td>207</td>
<td>230</td>
<td>COHE at The Everett Clinic</td>
</tr>
<tr>
<td>120</td>
<td>70</td>
<td>COHE at Group Health Cooperative</td>
</tr>
<tr>
<td>201</td>
<td>233</td>
<td>COHE at Harborview Medical Center</td>
</tr>
<tr>
<td>288</td>
<td>300</td>
<td>COHE at UW Medicine/Valley Medical Center of the Puget Sound</td>
</tr>
<tr>
<td>563</td>
<td>1,208</td>
<td>COHE Alliance of Western Washington</td>
</tr>
<tr>
<td>2,587</td>
<td>3,492</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

* As of December 4, 2014
2. Incentivize Collaborative Care and Best Practices

Top Tier Legislation: provide Financial and Non-financial incentives to providers for demonstrated use of best practices

- **Top Tier Goals**
  - Increase the use of best practices
  - Achieve positive outcomes for injured workers
  - Be simple for providers to understand and L&I to administer
  - Align with other incentive programs (such as COHE)

- **Advisory Group (ACHIEV) Items for Discussion**
  - Top Tier Timing
  - Top Tier Eligibility
  - Top Tier Incentives
  - Top Tier Administration
3. Promote Evidence Based Policies

Evidence Based Treatment Guidelines

IIMAC
- Opioid Guideline
- Shoulder Surgery Guideline

IICAC
- Evidence Based Practice Resources for Conservative Care - *Functional Improvement; Shoulder Care; Back Care, more*

Bree Collaborative
- Accountable Payment Models - Warranty for total knee and total hip replacement surgery.
- Spine Care - participation in Spine SCOAP as best practice for surgeons
- Low Back Pain – Best practices recommendations to prevent Transition to Chronic pain.
3. Promote Evidence Guidelines: L&I’s Opioid Guidelines

Decrease the proportion of injured workers on chronic opioids

- Baseline: 2012 - 4.93%
- Guideline: 7/2013
- Recent: 3/2014 - 1.17%

www.opioids.lni.wa.gov
3. L&I Approved Surgeries Before and After Guidelines Implemented

<table>
<thead>
<tr>
<th>IIMAC GUIDELINES</th>
<th>Year before Guideline</th>
<th>After Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpal Tunnel Syndrome (Effective 4/09)</td>
<td>2008 (2008)</td>
<td>1380 (2013 data) 31% reduction</td>
</tr>
<tr>
<td>Proximal Median Nerve Entrapment (Effective 8/09)</td>
<td>38 (58 total 2009)</td>
<td>10 (2012 data) 74% reduction</td>
</tr>
<tr>
<td>Ulnar Neuropathy at the Elbow (Effective 1/10)</td>
<td>302 (2009)</td>
<td>187 (2012 data) 38% reduction</td>
</tr>
<tr>
<td>Radial Tunnel Syndrome (Effective 4/10)</td>
<td>57 (2009)</td>
<td>19 (2012 data) 67% reduction</td>
</tr>
<tr>
<td>Thoracic Outlet Syndrome (Effective 10/10)</td>
<td>58 (2009)</td>
<td>30 (2013) 48% reduction</td>
</tr>
</tbody>
</table>
3. New Best Practices – Identify and Pilot

**Identification**: UW led process based on literature review and selection by a focus group of providers

**Pilots Underway**

- **Functional Recovery Questionnaire/Intervention Pilot**
  - Early identification of potentially “at risk” workers
  - Providers incorporate interventions to enhance recovery

- **Activity Coaching Pilot**
  - Tested program: Progressive Goal Attainment Program (PGAP) where coaches encourage and track structured activities

- **Surgical Best Practice Pilot**
  - Four best practices covering (1) transition of care, (2) return to work planning, (3) care coordinator to coordinate care and track transition, and (4) assist with complex cases
Contacts

- Leah Hole-Marshall: Medical Administrator
  leah.hole-marshall@lni.wa.gov  902-4996

- Karen Jost: Health Services Analysis Program Manager
  karen.jost@lni.wa.gov  902-6699

- Erik Landaas, Health Policy & Payment Methods
  erik.landaas@lni.wa.gov  902-4244