HEALTH CARE QUALITY & L&I PURCHASING

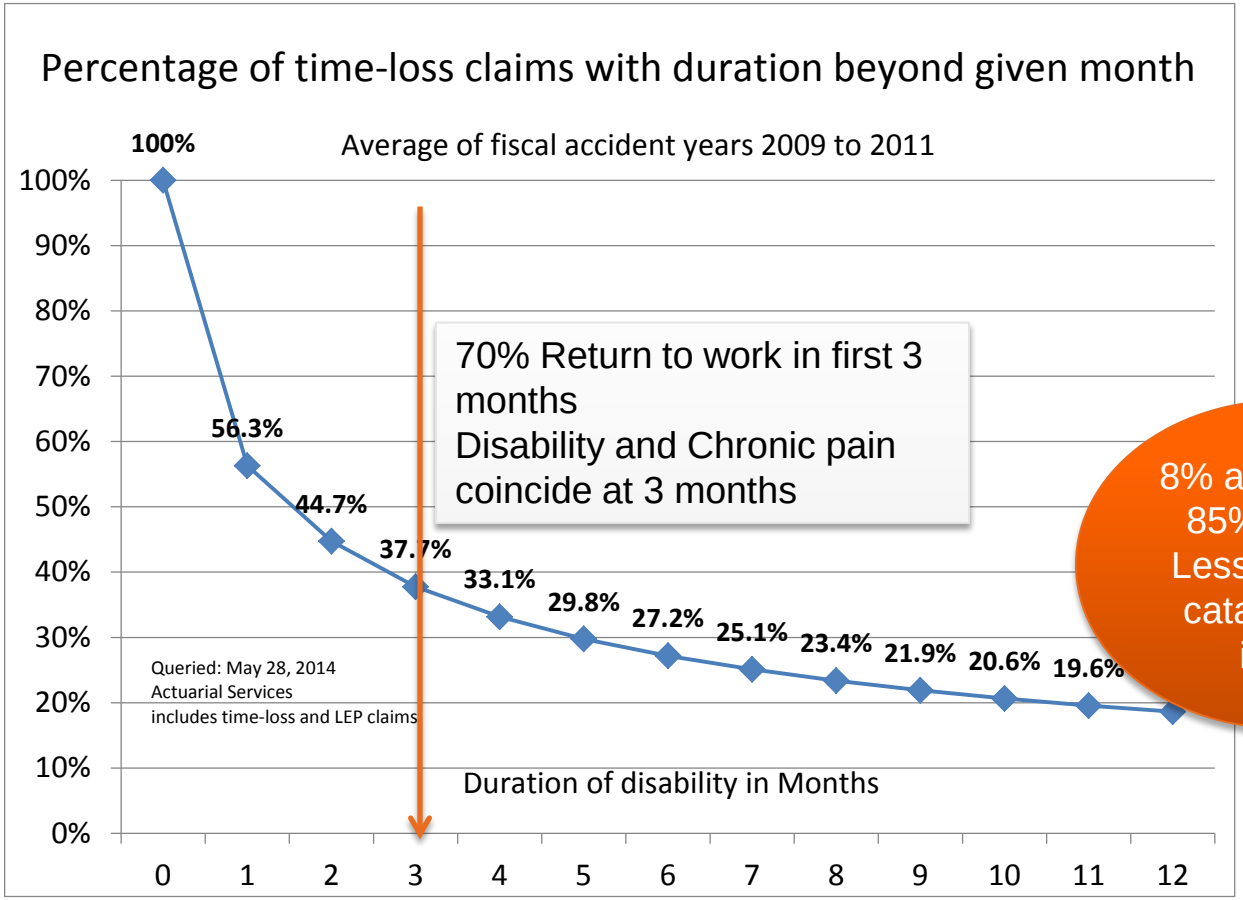
Karen Jost

Program Manager

Health Services Analysis

Washington State Department of Labor & Industries

Disability Prevention is the Key Health Policy Issue



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

2014 L&I Actuarial Services Analysis *(for fiscal accident yrs 2009-2011)*

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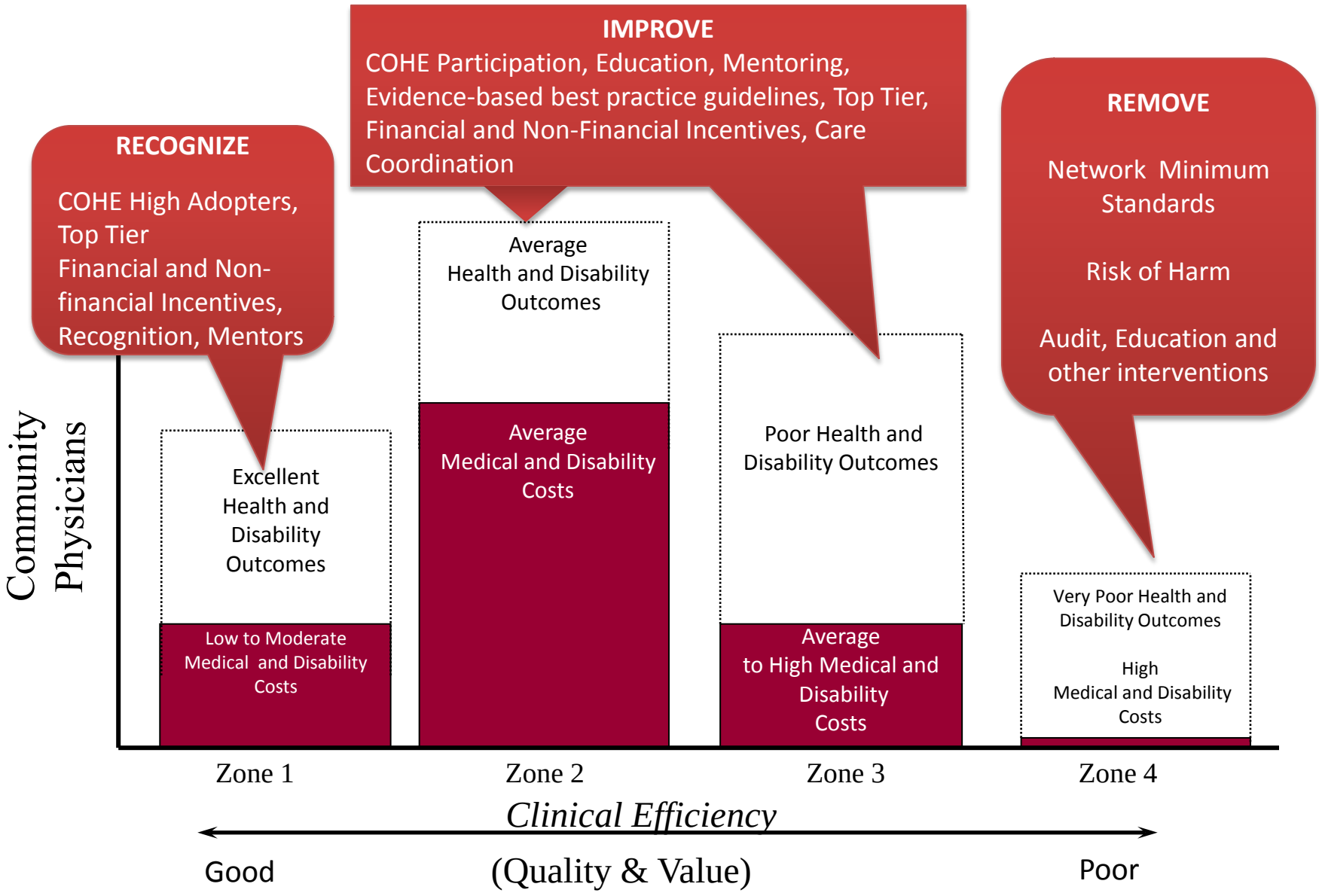
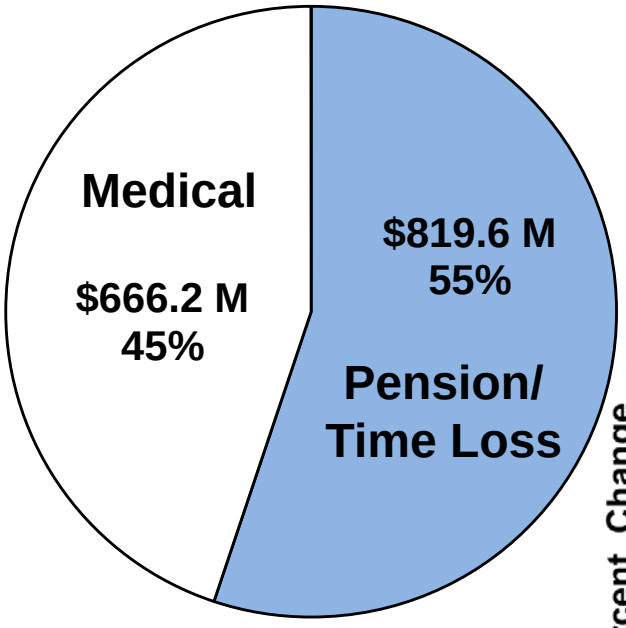
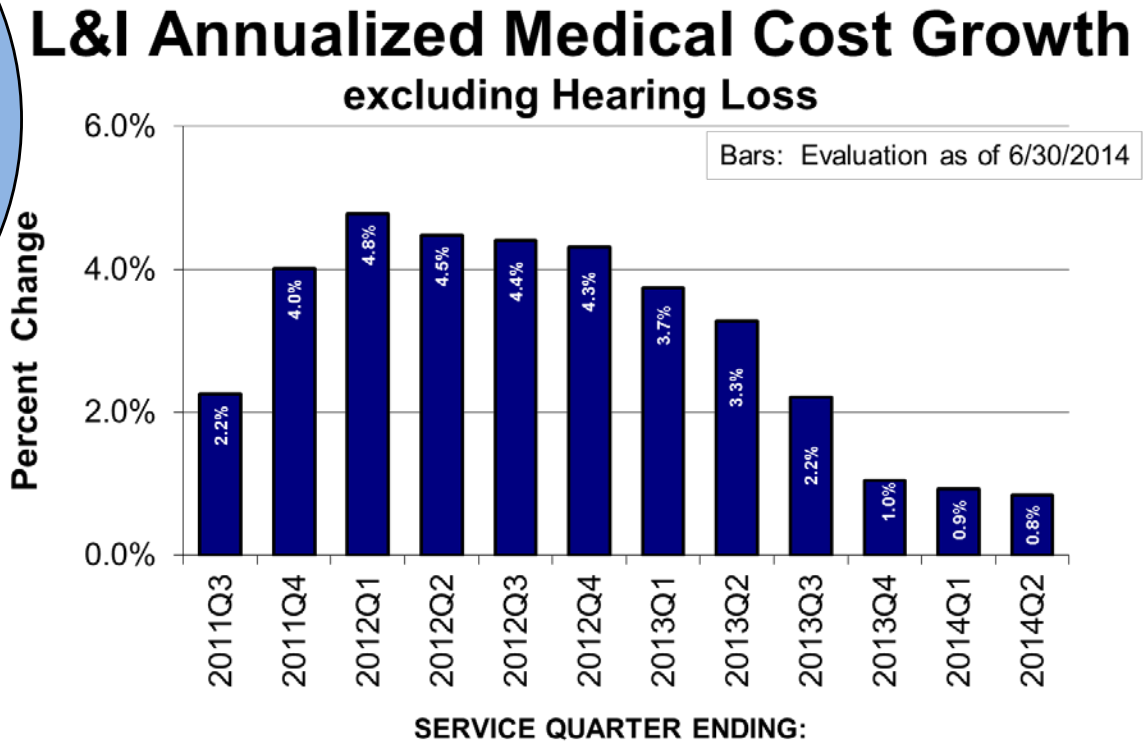
Distribution of Quality of Care



L&I Medical Care Purchases

Benefits Paid for Accident Year Ending 3/31/14





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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

	Fiscal-Accident Year Days of Time loss Paid					
Year	2003	2004	2005	2006	2007	2008
Non-MPN	420	322	295	327	382	367
All Providers	267	261	259	259	269	280

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

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2. Expand COHE Enrollment

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

* 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*

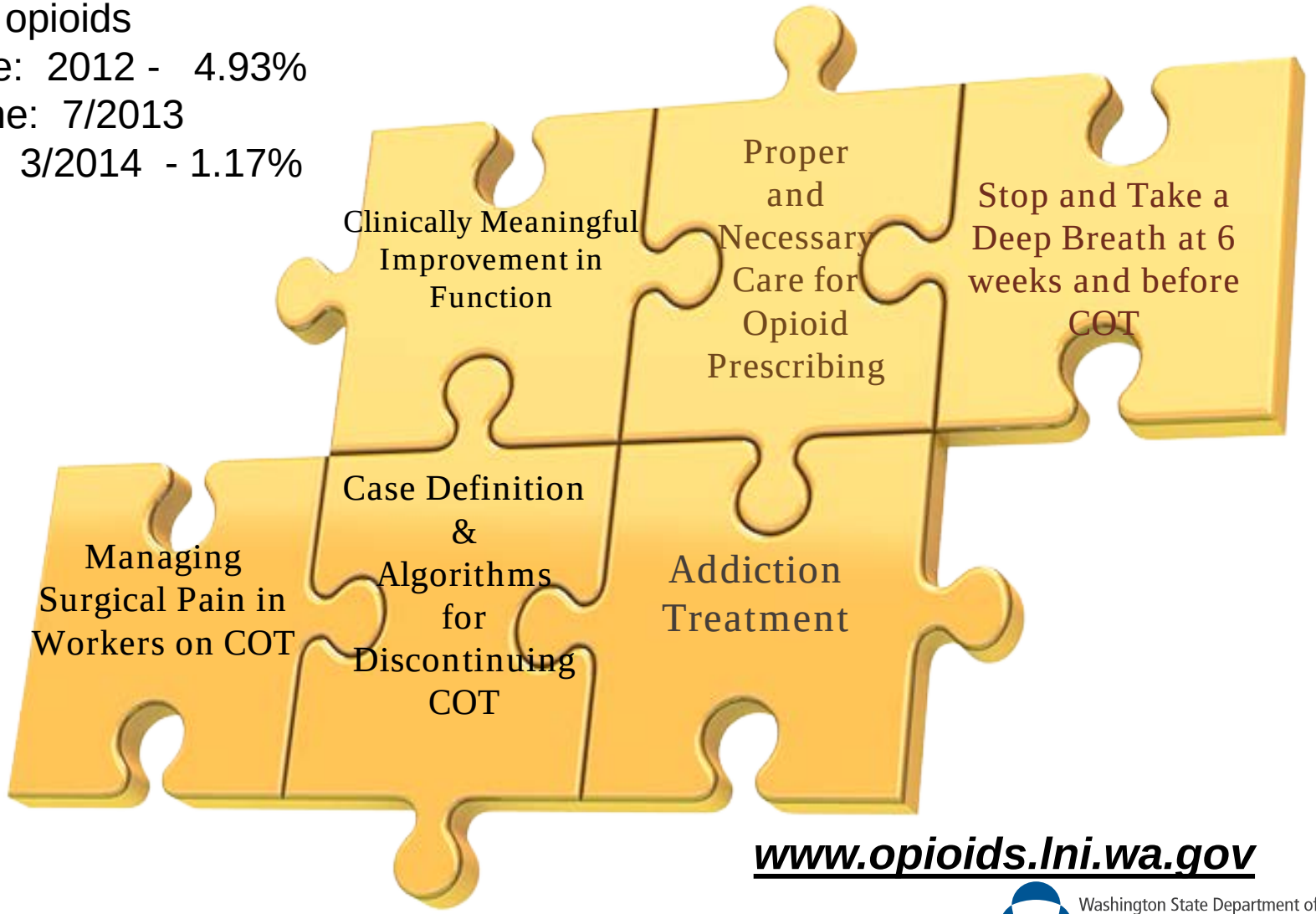
Bree Collaborative

- 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

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3. L&I Approved Surgeries Before and After Guidelines Implemented

IIMAC GUIDELINES	Year before Guideline	After Guideline
Carpal Tunnel Syndrome (Effective 4/09)	**2008** (2008)	**1380** (2013 data) **31% reduction**
Proximal Median Nerve Entrapment (Effective 8/09)	**38 (**58 total 2009)	**10** (2012 data) **74% reduction**
Ulnar Neuropathy at the Elbow (Effective 1/10)	**302** (2009)	**187** (2012 data) **38% reduction**
Radial Tunnel Syndrome (Effective 4/10)	**57** (2009)	**19** (2012 data) **67% reduction**
Thoracic Outlet Syndrome (Effective 10/10)	**58** (2009)	**30** (2013) **48% reduction**

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