

Implementation of the Medical Provider Network & Expansion of the Centers for Occupational Health and Education (SSB 5801)

2014 Report to the Legislature

December 2014

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Executive Summary

Introduction

This report is required by Substitute Senate Bill (SSB) 5801, an important piece of the historic workers' compensation reform legislation passed in 2011. SSB 5801 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 third of five annual reports from L&I to the legislature on implementation of SSB 5801.

SSB 5801 aims to reduce disability among injured workers by improving the quality of medical care they receive. To accomplish this, it requires the Department of Labor & Industries (L&I) to provide increased access to high quality health care for injured workers by establishing a medical provider network (MPN) and expanding the centers of occupational health and education (COHEs).

During 2014, L&I made significant progress toward achieving the legislation's goal. The department's actuaries compared claims costs for injured workers treated by providers who were either denied admission to or withdrew their applications from the medical provider network. Though not yet complete, the preliminary analysis shows the program has been successful in improving patient outcomes, preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

L&I's comparison of claim costs and time loss shows reduced disability. The legislation projected that removing low-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. L&I also compared effects on time loss. Patients of providers in the medical provider network averaged 36 percent lower time loss than patients of providers who are no longer in the network.

L&I included planned actions for 2014 in its 2013 report. Figure 1 in the Executive Summary summarizes the general status of these actions.

2014 Progress

RCW 51.36.010 directs L&I to:

- Establish standards for medical providers who treat injured workers and manage a statewide network of providers who meet these standards; and expand COHEs to support providers' use of best practices.
- Create a top tier within the network 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.
- Convene an advisory group of clinical, business and labor representatives to help develop policies and give input related to these activities.

In its 2013 report, L&I included planned actions in support of the above objectives for 2014. Table 1 summarizes the overall status of these planned actions and is followed by more detailed information for each objective.

Figure 1: Status of planned 2014 actions

Planned action	Status
Stabilize the MPN and expand the COHEs: Continue reviewing applications to the medical provider network (MPN) and ensure that all participating providers meet network standards	Complete and ongoing
Stabilize the MPN and expand the COHEs: Continue to improve MPN application processing and turnaround	Backlog resolved; still working on balancing changes and incoming applications for network, non-network, and delegated providers
Stabilize the MPN and expand the COHEs: Develop a plan to integrate information from self-insured employers into MPN oversight, and increase collaboration on best practices programs	Not complete, working with Advisory Committee on Health Innovation and Evaluation (ACHIEV)
Stabilize the MPN and expand the COHEs: Establish processes to re-review MPN providers' qualifications at least every three years	Underway
Stabilize the MPN and expand the COHEs: Monitor quality-of-care issues and remove from the MPN those providers who present a risk of harm to injured workers, based on the definition of risk of harm in WAC 296-20-01100	Underway
Stabilize the MPN and expand the COHEs: Continue to monitor injured workers' access to care, and recruit MPN providers in needed specialties and underserved areas	Complete and ongoing
Stabilize the MPN and expand the COHEs: Analyze impacts of the MPN on outcomes for injured workers and workers' compensation benefit costs	Initial analysis complete
Stabilize the MPN and expand the COHEs: Support centers of occupational health and education (COHE) expansion into new areas that they have contracted to serve, and develop a plan to address any gaps in statewide access to COHE services	Underway
Build a new occupational health management system: Enhance web-based tools available in the occupational health management system to support best practices, including tools that help new users such as health-care providers	Underway; phases 2 and 3 delivered on time; remaining two phases on schedule for completion by June 2015
Create a top tier: Continue development of top tier provider criteria, incentives, and system needs; and create an implementation plan	Underway
Test emerging best practices: Launch the surgical best practices pilot project	Complete and ongoing

Stabilize the MPN and expand the COHEs

Progress has been made on both the MPN and the COHEs. L&I launched a robust medical provider network for injured workers covered by both L&I and self-insured employers. Since the last reporting period, L&I has enrolled another approximately 3,500 providers, for a total of about 21,500 providers in the state's medical provider 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.

Access to COHEs was also a focus. L&I was required to provide at least 50 percent of injured workers access to COHEs by December 2013, and must provide all injured workers access by December 2015. As of October 2014, L&I has agreements with six health-care organizations that sponsor COHEs, which will provide services in 38 out of 39 counties. The current number of providers in these centers of occupational health and education is nearly 2,500.

L&I is ahead of the legislatively set schedule to expand evidence-based purchasing through COHEs. Currently, about 80 percent of injured workers have access to five or more COHE providers within 15 miles of their home. L&I also continues to lead on evidence-based purchasing, which uses objective research about medical treatment to make better purchasing decisions.

Create a top tier

RCW 51.36.010 directs L&I to establish a separate tier within the MPN (top tier) 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. 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. Postponement was due to 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, staff resumed work with ACHIEV on top tier. A work plan and work groups have been established and the work groups hold regular discussions with ACHIEV.

L&I is also procuring a contract for a gap analysis (a comparison of current state with future state) to assist in developing an implementation plan. The implementation plan will include ways to document and measure providers' knowledge and use of occupational best practices in the most efficient manner.

Build a new automated occupational health management system

L&I has completed three of five phases (two releases of new computer applications in 2014) 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 will be expanded to other users (for example, health-care providers) and support additional L&I programs to promote occupational-health best practices. L&I is on target to complete all five phases by June 2015.

Test emerging best practices in occupational health

In 2014, L&I continued two pilot projects that began in 2013. The projects test emerging best practices in occupational health: activity coaching and functional recovery. As anticipated, L&I launched a third pilot on surgical best practices in 2014, aimed at improving care coordination for patients who may need surgery. The department provides more information about these pilot projects in the “Progress and Achievements in 2014” section of this report.

Adopt and implement risk of harm rules

L&I has adopted the nation’s first “risk of harm” rules. Risk of harm rules define a pattern of low-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 removing them from the MPN), the department needs proven data methods such as standards and measures the medical community agrees on. With the assistance of external advisory groups, L&I is establishing processes to use data to monitor quality of care issues and identify providers who present a risk of harm to injured workers.

Convene an advisory group

L&I established an advisory group, the Advisory Committee on Health Care Innovation and Evaluation (ACHIEV). The group, which includes representatives of business, labor, and health care providers, has met at least quarterly since July 2011 to give policy input on MPN status and implementation issues.

Conclusion

Starting in 2013, only network providers meeting standards were allowed to provide ongoing medical care, and COHE providers were expanded. A key question in measuring the success of this effort is whether disability and related costs are being reduced.

In 2014, L&I actuaries compared claims costs for injured workers treated by providers who were either denied admission to or withdrew their applications from the medical provider network. Though not yet complete, the preliminary analysis shows the program has been successful in improving patient outcomes, preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

L&I’s comparison of claim costs and time loss shows reduced disability. The legislation projected that removing low-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. L&I also compared effects on time loss. Patients of providers in the medical provider network averaged 36 percent lower time loss than patients of providers who are no longer in the network.

Plans for 2015

L&I’s plans for 2015 include:

- Review applications to the MPN and ensure that all participating providers meet network standards; and develop and implement a plan for re-review of currently approved network providers.
- Continue to develop criteria and processes to monitor quality-of-care issues and remove providers who present a risk of harm to injured workers.

- Support COHE expansion into new areas with contracts and develop a plan to address any gaps in statewide access to COHE services.
- Continue developing top tier criteria, incentives and system needs, and create an implementation plan.

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, and 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 was to reduce disability among injured workers by improving the quality of medical care they receive. SSB 5801 directed L&I to:

- Establish standards for medical providers who treat injured workers and manage a statewide network of providers who meet these standards.
- Expand COHEs to support providers' use of best practices.
- Create a top tier within the network 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.
- Convene an advisory group of clinical, business and labor representatives to help develop policies and give input related to these activities.

As required by the legislation, this report includes information about:

- Actions taken during 2014 on the above requirements of SSB 5801.
- Progress toward long-term goals.
- Outcomes of key initiatives.
- Access to care issues.
- Results of disputes or controversies related to new provisions.
- Whether changes are needed to further improve the occupational-health best practices care of injured workers.

2014 Progress

In 2014, L&I actuaries compared claims costs for injured workers treated by providers who were either denied admission to or withdrew their applications from the medical provider network. Though not yet complete, the preliminary analysis shows the program has been successful in improving patient outcomes, preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

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This section of the report describes actions L&I took during 2014 to achieve key objectives of SSB 5801 and explains outcomes of key initiatives.

Progress toward long-term goals

In 2014, L&I stabilized the medical provider network (MPN), expanded the centers of occupational health and education (COHEs), and made significant progress on other key objectives. These actions align with the department's long-term goals for every injured worker to receive high-quality care. L&I's goals for high quality care include:

- Using best evidence to pay for services that improve outcomes and reduce harm for injured workers.
- Efficiently identifying workers at risk for long term disability.
- Providing incentives for collaborative delivery of occupational health best practice care.
- Setting minimum standards for provider participation.

The MPN and the COHE expansion are key implementation strategies for reducing disability among injured workers in Washington – including workers covered both by self-insured employers and by L&I. L&I has made excellent progress toward achieving the goals for high-quality health care established in RCW 51.36.010 .

STABILIZE THE MPN AND EXPAND THE COHES

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 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 network 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 will consult with the Advisory Committee on Health Innovation and Evaluation (ACHIEV) on whether additional out-of-state providers and provider types not listed above (such as physical therapists and occupational therapists) should be required to submit their credentials to continue treating injured workers.

MANAGE THE MPN

L&I manages the MPN, which is now part of the department's ongoing operations. 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.

Initial surge of provider applications

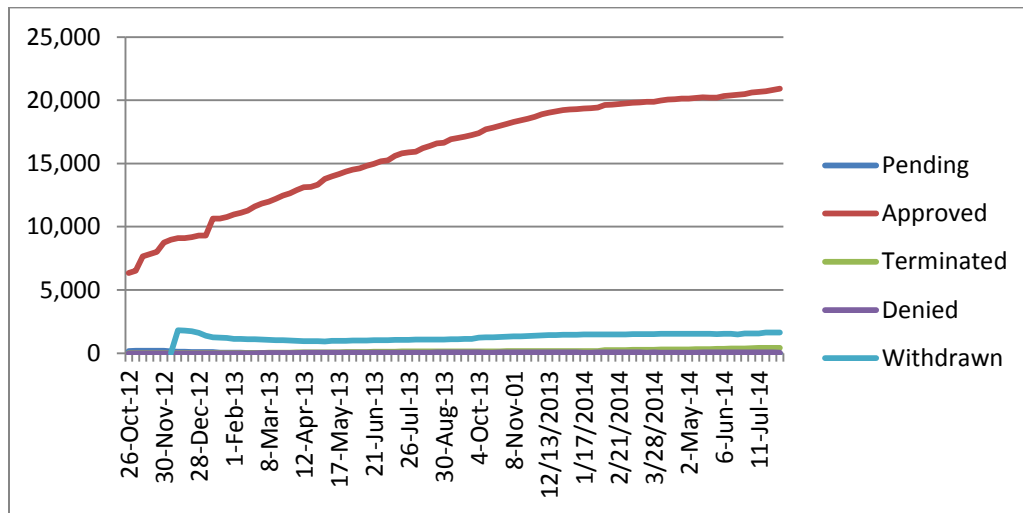
Initially, over 20,000 providers applied to the MPN. This exceeded expectations and resulted in a very robust network with good access to care and to a wide range of medical specialties. However, the volume of applications strained L&I resources for processing applications.

L&I took a number of actions to improve the efficiency of processing and acting on applications and to avoid having the department's workload issues disrupt care for injured workers. L&I:

- Screened applications to see if they met criteria for *provisional* status, allowing providers to treat and be paid while L&I finished verifying and reviewing their credentials.
- Adopted emergency rules so that any provider who applied prior to January 1, 2013 could 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).
- All providers who submitted a complete application before January 1, 2013 have been processed. L&I processed over 7,000 of these applications. In addition, a portion of these applications (about 1,400) were administratively withdrawn because L&I received the applications from a third party, but the provider did not respond to requests to finalize.

Figure 2: Status of provider applications, Oct. 2012 – July 2014



Source: L&I Provider Credentialing and Compliance

Current provider applications processing

Applications

The initial and ongoing volume of applications has exceeded expectations. This is positive in terms of access, but creates processing challenges. The high initial volume (now over 21,000) of providers means there is more work than expected to maintain and process changes on accounts. Each month, L&I receives about 1,000 new applications for MPN providers and 950 new applications for non-MPN providers.

L&I's application processing time is currently about five months per application. Change requests wait up to ten months. L&I continues to monitor and oversee MPN providers for compliance, but resource constraints and the focus on reducing application processing time prevent those efforts from being as robust as they could be. Providers also must be periodically recertified, which also requires resources.

Calls

In addition to application volumes, calls to L&I's dedicated provider lines (Provider Hotline and Preferred Drug Line) have swelled beyond expectations. This is largely due to the increased number of MPN providers and the roll-out of evidence-based treatment guidelines. Both a robust provider network and compliance with guidelines that prevent harm are contributing to higher-quality care. This is a positive development, but has unplanned impacts on workload. For example:

- Calls to the Preferred Drug Line spiked by 58 percent in 2013.
- Abandoned calls (calls in which the provider hangs up before being helped) now average more than 2,000 per month.
- Wait times average 7.5 minutes, but can be over 30 minutes.

L&I's response to challenges

L&I shifted priorities, hired additional temporary staff and is conducting Lean process improvement events to streamline processes. The department's goal is to process applications within 90 days (the credentialing industry standard) by early 2015. However, the onset of recertifying providers will further strain existing resources.

L&I continues to re-prioritize resources and initiate Lean projects to reduce waste in processes. The department also continues to monitor its ability to attract and retain high-quality providers to ensure resource constraints do not result in lower-quality care for injured workers. In addition, L&I has documented its "new normal" operations based on actual workload, and has requested additional resources through a decision package.

MPN approval and denial

L&I has issued over 21,000 approvals and 115 final denials of providers' MPN applications overall. The overall approval rate is over 99.7 percent. The denial rate based on final denials/approvals is about 0.3 percent.

Screening applications

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

Staff checks all information related to an application and reviews an applicant's L&I file for potential quality issues. Based on standards or criteria in L&I's rules¹, staff may flag applications for further review and discussion at a meeting of L&I's credentialing committee (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

¹ WAC 296-20-01030 and WAC 296-20-01050

Medical Director decides to deny an application, L&I sends the provider a letter summarizing the issues and quality concerns that led to denial.

Denied applications

A provider may request reconsideration of a denied application. Each reconsideration request, and any supporting information submitted by the provider, goes back to the credentialing committee for a determination about whether to uphold or change their original recommendation. Final decisions are made by L&I's Medical Director. A denial takes effect 60 days after the provider receives notification of the final decision.

L&I must report final actions to the National Practitioner Data Bank. If a provider appeals L&I's decision to the Board of Industrial Insurance Appeals, the provider cannot provide ongoing care for injured workers while the appeal is pending. 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.

In 2014, L&I successfully defended actions (provider network denials) at the Board of Industrial Insurance Appeals using the standards adopted in its rules. A total of 23 providers appealed the department's decisions to the BIIA. Of those appeals:

- Eighteen are completed and the provider is not in the network.
- Two were settled and the provider is in the network.
- Three appeals are still in process.

Of the cases with a ruling, L&I (through its Assistant Attorney Generals) has successfully defended its rules, process and decisions and received favorable decisions by the BIAA and lower courts in the vast majority of cases.

Quality of care issues addressed

Provider review

Initial denial letters sent through October 11, 2013 provided an average of more than four review criteria as the basis for credentialing committee recommendations. L&I has grouped the review criteria into six categories, shown in Figure 3 on the next page. Many providers are counted in more than one category. (For more information, including related rules, see Appendix A.)

Figure 3: Issues that caused providers to be denied network admission
(through Oct. 2014)

Categories of denials	Number of providers
Problems with clinical care (liability insurance and malpractice)	52
Lack of compliance with clinical guidelines	56
Criminal misconduct, substance abuse, sexual misconduct	24
License issues	96
Misrepresentations and omissions	31
Payer action or loss of hospital privileges	31

Source: L&I Provider Credentialing and Compliance

MPN monitoring

L&I initially planned to re-review all MPN providers' qualifications at least every three years. In 2014, L&I conducted an analysis of benefits, risks, resources and costs to determine a review process for the over 21,000 providers. The department considered many factors in its analysis, including:

- Risk to injured workers
- Purpose of MPN
- Potential for error
- Impact on access
- Provider ease
- Ratio of work involved to actionable findings
- Technology / capacity
- Staff impact / resource needs / cost
- Industry standards
- Defensible review process and criteria

At this time, L&I recommends a continuous monitoring approach rather than a three-year review cycle for provider qualifications. Over 99 percent of providers met network standards at initial review, and L&I expects that even fewer 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 use a cycle that would review all providers. This is consistent with Lean methodology and will reduce provider and staff rework. The department has just completed its analysis and will consult with ACHIEV to finalize a continuous monitoring process.

CREATE A PROVIDER TOP TIER

The law directs L&I to establish a separate 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 and direction from the Provider Network Advisory Group (PNAG) which consists of business, labor and clinical representatives, L&I began to develop preliminary eligibility criteria for top tier providers. Preliminary eligibility criteria for providers 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.

Decision to postpone launch

In the fall of 2012, L&I and ACHIEV agreed to postpone top tier implementation. Postponement was due to 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 with ACHIEV on eligibility criteria for top tier providers. A work plan and work groups have been established and the work groups hold regular discussions with ACHIEV.

L&I is procuring a contract for a gap analysis (a comparison of actual results with desired results) to assist in developing an implementation plan. The implementation plan will include ways to document and measure providers' knowledge and use of occupational best practices in the most efficient manner.

In 2015, L&I will complete the work plan, complete the gap analysis with assistance from a vendor and continue program development.

COHE expansion

The bill directed L&I to extend access to health-care providers participating in COHEs.

The first milestone was to expand access to COHE services to 50 percent of injured workers by December 2013. The second was to expand access to 100 percent of injured workers by December 2015. Expansion is well ahead of this schedule, with about 80 percent of injured workers having access to five or more COHE providers within 15 miles of their home.

How COHEs help injured workers return to work sooner

COHEs began as a pilot project in 2002. A 2011 University of Washington study found that workers treated by COHE-affiliated providers have 20 percent fewer time-loss days. COHE care also reduces disability and medical costs by about \$510 in the first year of the claim².

COHEs are run by health-care delivery organizations such as clinics or hospitals (referred to as sponsors). Sponsors help health-care providers coordinate care and use occupational-health best practices to treat injured workers. COHE participation is voluntary. Network providers are not required to join COHEs and injured workers are not required to use COHE providers.

With funding from L&I, 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).

COHE sponsors enroll health-care providers who are asked to use best practices with all their injured workers, and give these providers feedback on how well they are following the practices.

The initial COHE best practices focus on the first twelve weeks post-injury, a critical period for preventing disability. 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.
- For patients that are still off work, developing a plan to address barriers to returning to their jobs.

² Wickizer, "Improving Quality, Preventing Disability," 1105 (see n.1).

COHE sponsors

Six health-care organizations began participating in COHE 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.

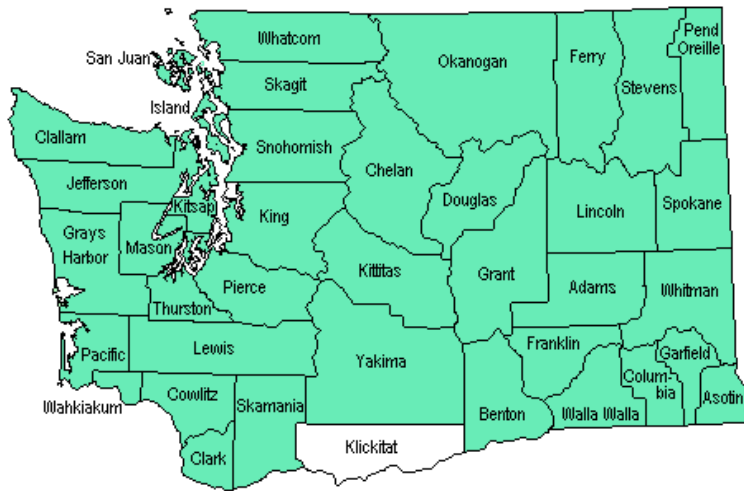
Figure 4: COHE sponsors

Sponsoring organization	Coverage	Year sponsorship began
Valley Medical Center (the <i>Renton COHE</i>)	Enrolled community providers in parts of King and Pierce counties.	2002
St. Luke's Rehabilitation Institute/Inland Northwest Health Services (the <i>Eastern Washington COHE</i>)	Expanding from 16 to 19 counties in 2013.	2002
Harborview Medical Center	Includes providers in Harborview's trauma center and several outpatient clinics.	2007
The Everett Clinic	Includes providers in nine Snohomish County clinics operated by the Everett Clinic	2007
Franciscan Health System , lead for a coalition of 12 health care organizations	Will enroll COHE providers in all western Washington counties. Health Services Coordinators will be located in Tacoma and an office in southwest Washington.	2013
Group Health Cooperative Patients do not need to be Group Health members to see providers in these clinics for work-related injuries or illnesses.	Will provide services to injured workers at 11 Group Health clinics in western Washington and one in Spokane.	2013

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. The new COHE service areas cover 38 out of 39 counties. The map in Figure 5 shows the coverage of COHE organizations and providers identified in the contracts (sign-up is not yet complete). Areas in green are those served by COHEs.

Figure 5: COHEs after expansion: areas served under new contracts



Next steps in COHE expansion

The next steps for COHE expansion will be for two business and labor advisory boards, one in western Washington and one in eastern Washington, to gather community input on COHE expansion and operations. L&I is procuring a contract for a gap analysis (a comparison of actual results with desired results). Following that analysis, L&I will develop a plan to address any remaining gaps and ensure ongoing access to COHE services in all parts of the state.

Number of COHE providers will nearly double

L&I expects the number of COHE-participating providers to more than double over the contract term, as shown in Figure 6 below.

Figure 6: Projected increase in COHE providers

	Number of COHEs	Number of providers
September 2012	4	1,774
September 2013	6	1,884
September 2014	6	2,468
September 2015 (projected)	6	2,980
September 2016 (projected)	6	3,492

Source: L&I's Occupational Health Services Unit

L&I expects about 52,000 new claims to be under the care of COHE providers in Fiscal Year (FY) 2015, which is consistent with fiscal note estimates. In FY 2016, the department expects about 62,000 new claims to be under the care of COHE providers. These estimates are based on claim volume (using trends of claim volume since 2008) and a projection of COHE providers initiating or treating 55 percent of claims.

BUILD THE OCCUPATIONAL HEALTH MANAGEMENT SYSTEM (OHMS)

RCW 51.36.010 requires L&I to implement a system to track use of best practices, support care coordination and give feedback to providers. In the fall of 2012, L&I hired a contractor to develop a new computer system supporting use of occupational-health best practices. The resulting occupational health management system (OHMS) provides a web-based case management tool. L&I is building and releasing the system in multiple phases. In the initial releases, existing care coordination processes are being centralized and streamlined across COHEs.

First release

The key users for the first release to centralize and streamline coordination processes are COHE health services coordinators. The first release went live as planned in June 2013, in time to begin training for new COHE sponsors and support COHE expansion. Response from health services coordinators was very positive. Because OHMS integrates with L&I systems, the coordinators receive updated work lists and claims information several times a day. They can send notes to L&I through a secure electronic interface using the system.

Upcoming releases

Upcoming OHMS releases will add new users such as COHE providers and will increase the tools available to identify and coordinate care for high-risk patients. OHMS will also be developed to support top tier and pilot projects for emerging best practices. In the summer of 2015, OHMS will integrate with providers' electronic medical records, which will enable better coordination of care for high-risk patients and easier monitoring of best practices use by providers.

For more information about OHMS users and the release schedule, see Appendix B.

TEST EMERGING BEST PRACTICES IN OCCUPATIONAL HEALTH

Best practices are methods that have consistently been shown to improve health care outcomes for patients. COHE providers receive financial incentives to deliver four best practices that currently focus on the first 12 weeks of treatment for injured workers. The law directs L&I to develop additional best practices that span the full period of recovery for longer-term cases. In collaboration with the University of Washington (UW), L&I has three pilot projects underway to test and develop emerging best practices in the following areas:

- Functional recovery.
- Activity coaching.
- Surgical best practices.

Functional recovery

L&I launched the functional recovery pilot project with providers in the eastern Washington COHE in 2013. It includes a questionnaire and an intervention.

The functional recovery questionnaire (FRQ) is 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.

Activity coaching

Activity coaching is a standardized intervention 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.

Initial participation in the activity coaching program is low. In 2014, L&I worked with the UW to find ways to identify and review claims of more potential participants. Injured workers continue to have access to the program while the UW finishes this evaluation. It is scheduled to be complete by April 2015.

Surgical best practices

The surgical best practices pilot, launched in 2014, will add four new best practices to the orthopedic and neurological surgeons' quality pilot requirements. These four best practices were selected to improve transition of care 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 support the pilot participants by ensuring 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.

ADOPT AND IMPLEMENT RISK OF HARM RULES

L&I adopted the nation's first risk of harm rules, which define a pattern of low-quality care that leads to harm or risk of harm to injured workers. L&I is establishing processes for using data to monitor quality of care issues and identify providers who present a risk of harm to injured workers.³ This will help the department ensure high quality care for injured workers.

In 2014, 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. L&I is now consulting with experts to establish appropriate ways to measure and monitor these focus areas. Currently, the department relies on ad-hoc time from clinical staff in L&I's medical policy, audit and complaint departments to do this work.

L&I expects to complete data analysis and develop benchmarks for measurement in 2015.

OTHER REQUIREMENTS

Convene an advisory board

The bill 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 committee 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 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.

³ Risk of harm is defined in WAC 296-20-01100.

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.

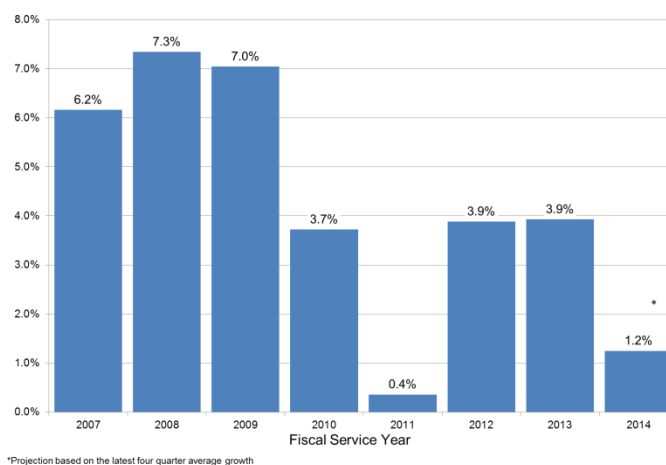
OUTCOMES OF KEY INITIATIVES

The MPN lowers health care cost trends

L&I's implementation of the medical provider network and innovative purchasing strategies are keeping health care costs low while improving quality of care.

Evidence-based purchasing uses objective research on and assessments of medical devices and health care solutions to make better purchasing decisions. By focusing on achieving high-quality health outcomes through evidence-based policy, L&I not only improves injured workers' ability to heal, but is a national leader in innovative purchasing and cost constraints. For example: L&I has kept health-care cost increases lower than the national health care cost trend by one percent. Since 2010, annual medical-cost growth in the workers' compensation system has been under four percent, and the projected growth for 2014 is under two percent.

Figure 7: Washington's medical cost growth for the state fund



L&I's innovations are being replicated nationally (e.g., opioid guidelines), and 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

In 2014, L&I actuaries analyzed claims costs for injured workers treated by providers who were either denied admission to or withdrew their applications from the MPN. While not yet complete, the preliminary analysis shows the program was successful in preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

The primary network outcome is reduced disability; however that outcome is difficult for a health-care payer to measure. L&I analyzes 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, improve worker outcomes and stabilize or reduce costs. The fiscal note for medical provider network reforms projected that removing low-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 providers no longer in the network (but in the network prior to network launch) who were treating four or more claims (135 providers). The providers no longer in the network had 10 percent higher costs and were involved in 18.6 percent of claims. 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. This amounts to an annual savings of 1.9 percent of the Medical and Accident Fund (\$34.7 million for 2013).

Time loss

In addition to analyzing claim costs, L&I actuaries also analyzed the impact on duration of time loss (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). Patients of MPN providers averaged 36 percent less time loss than patients of providers who are no longer in the network.

L&I's analysis compared average time loss days of claimants that were seen by providers not in the network with the average time loss of claimants 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 used a time period stable enough for comparisons (2003-2008). See Figure 8.

Figure 8: Days of time loss paid

Fiscal Year (FY)	Days paid: Non-MPN providers	Days paid: All attending providers
2003	420	267
2004	322	261
2005	295	259
2006	327	259
2007	382	269
2008	367	280

Source: L&I Actuarial Services

Access to care issues

Primary care

Throughout implementation of the provider network, L&I monitored 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. Figure 9 shows the percentage of workers statewide during 2014 who reside within 15 miles of at least five primary-care providers continues to be 99 percent. This number has remained stable throughout 2014.

Figure 9: Access to primary care

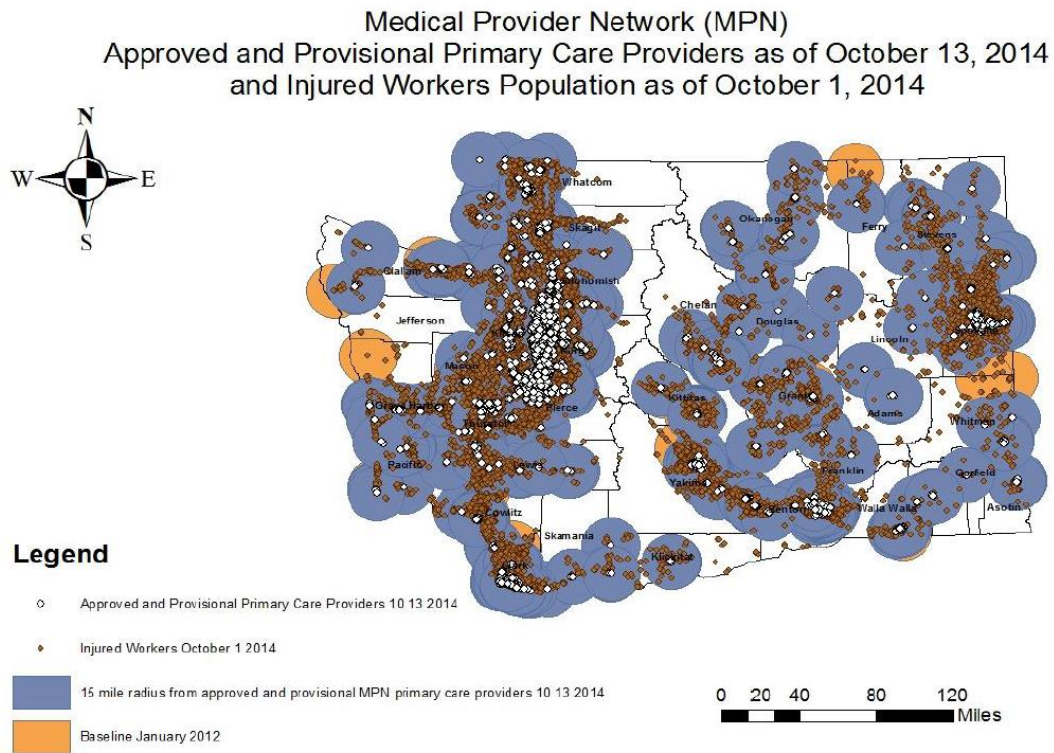
Percentage of injured workers with access to at least five primary-care providers within 15 miles

Payment source	2012 Baseline	Workers (as of Oct 2013)	Workers (as of Sept 2014)
State Fund	99%	99%	99%
Self-Insured	99%	99%	99%

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

Figure 10 shows a graphic representation of injured workers (represented by brown dots) and providers within a 15-mile radius.

Figure 10: Injured workers and providers within a 15-mile radius



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

In order to increase knowledge 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 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 restoring provider participation.

Psychiatric care

Due to ongoing concerns about access to psychiatric care, L&I reviewed the network's effect on access issues. The department's review found that the number of participating psychiatrists, psychiatric advanced registered nurse practitioners (ARNPs) and psychologists has not declined, and in fact has continued to grow at a steady rate.

L&I first reviewed data on the number of providers that provide psychiatric care and are approved within the L&I system in 2010, then updated the data in 2013 and 2014. The data shows the number of psychiatric providers has increased by nearly 400 providers (over 40 percent) from 2010 through mid-2014. In 2014, between 10 and 20 psychiatric providers applied each month to be approved L&I providers.

Data for 2010 and 2013 did not distinguish between provider types; however, the 2014 data separates providers by type and gives an updated total. See Figure 11.

Figure 11: Psychiatric providers in the L&I network

Year	Psychiatrists	Psychiatric ARNPs	Psychologists	Total
2010				887
2013				999
6/2014	574	129	576	1,279

Source: L&I Research and Data Services

Data Notes: "Active provider" for psychiatrists and psychiatric ARNPs means enrolled in the medical provider network. For psychologists, it means their account is active (e.g., there has been billing activity on their account in the previous 18 months). The count contains duplicate individual providers because the numbers represent the location of the provider's practice, and some providers practice at more than one location. This more accurately represents access at different service areas and does not significantly change the overall quantity.

RESULTS OF DISPUTES RELATED TO NEW PROVISIONS

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. The department hired care transition coordinators for each region; however, their services were not highly used overall. In 2014, L&I did not need to continue the special care transition service.

Some issues regarding providers' network eligibility were initially controversial, and some individual providers have challenged L&I's decisions to deny their application to the network. The number of appeals increased from 10 at the last report to 24 in 2014. L&I successfully defended cases before the Board of Industrial Insurance Appeals, and only two cases remain open. There have been very few new appeals filed in recent months.

Conclusion

SSB5801 in 2011, codified at 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 2014, L&I made significant progress toward these goals. The department's 2014 achievements are the foundation for additional work in 2015 and beyond to reduce disability by improving medical care for injured workers.

ARE ADDITIONAL CHANGES NEEDED?

By launching the MPN and establishing new COHE contracts, L&I has completed the first phase of implementing the law. Full implementation will be a multi-year process.

L&I is not currently requesting additional statutory changes to assist in implementing these reforms.

PLANS FOR 2015

L&I will continue to improve outcomes for injured workers through the MPN and COHEs in 2015 by focusing on the following:

- Review applications to the MPN and ensure that all participating providers meet network standards.
- Develop and implement a plan for re-review of currently approved network providers.
- Continue to improve application processing and turnaround times.
- Continue to develop criteria and processes to monitor quality-of-care issues and remove providers who present a risk of harm to injured workers.
- Continue to monitor injured workers' access to care and recruit providers in needed specialties and underserved areas.
- Monitor impacts on outcomes for injured workers and workers' compensation costs.
- Support COHE expansion into new areas with contracts and develop a plan to address any gaps in statewide access to COHE services.
- Enhance web-based tools available in OHMS to support best practices, including tools that help new users such as health-care providers.
- Continue developing top tier criteria, incentives and system needs, and create an implementation plan.
- Convene a focus group with in coordination with the UW to develop criteria, measures and outcomes for the next set of COHE best practices.

NEXT REPORT

L&I's next legislative report on the MPN and COHE expansion will provide an update on these planned activities, and will be published by December 1, 2015.

Appendix A

L&I may deny health-care providers admission into the medical provider network based on numerous issues or quality concerns that may be found in a provider's file. The department has summarized the reasons for denials into six categories:

Denial 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

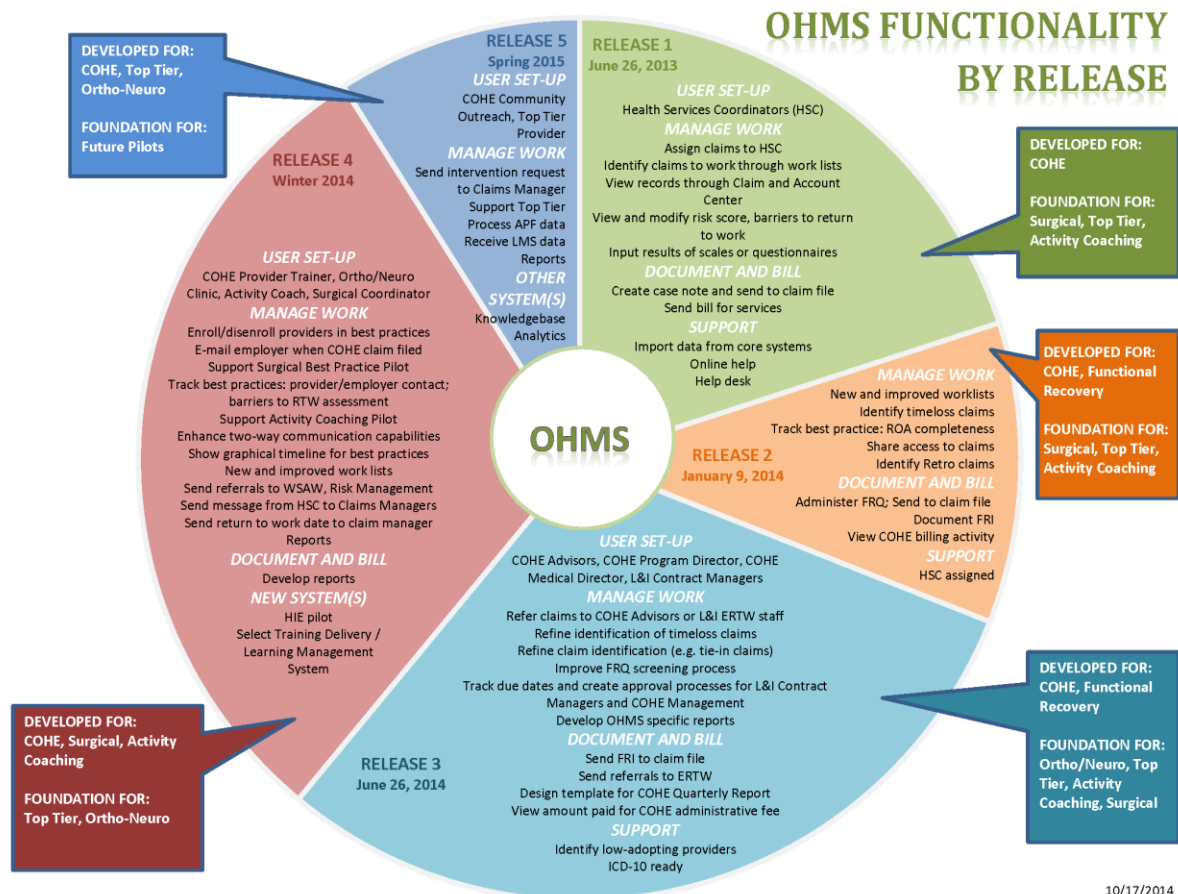
- Admitting privileges terminated, public payer termination (WAC 296-20-01030(3) and (4))
- Payer termination/exclusion, withdraw privileges (WAC 296-20-01050(e), (f), and (g))

Appendix B

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 centers of occupational health and education (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.

OHMS has five planned releases. The first release in June 2013 was well received. The second and third releases have been completed. Phase four and five are underway and on schedule and budget for June 2015 completion. The services delivered in each release have been changed to better address complementary processes and tasks. Figure 12 shows the release schedule and the services within each release.

Figure 12: OHMS users and release schedule



Source: L&I Information Services, Project Management Office