Washington State Department of Labor & Industries

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

2015 Report to the Legislature

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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 fourth of five annual reports 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).

During 2015, L&I continued to make significant progress toward achieving the legislation's goals. The department is reducing disability and related costs while improving outcomes for workers. Worker disability rates are lower when treated by MPN providers. This is demonstrated in an actuarial analysis finalized in 2015, which shows that patients of providers in the MPN averaged 36 percent less time-loss than patients of providers who are not in the network. A comparison of providers' practice patterns and claim costs shows that not allowing these providers in the network has saved $34.7 million a year. In addition, L&I's health care cost increases are one percent lower than the national cost trend, as of June 2015 projected to be 2.3 percent in 2015.

L&I has now implemented key provisions of the workers' compensation reform law, and has completed actuarial analysis demonstrating reductions in disability and related costs. With adequate resources, L&I can build on this success by expanding data analytics that identify low 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.[1] 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 45 percent now).

[1] Wickizer, Thomas M., PhD, MPH, "Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Healthcare: A Population-Based Intervention Study," *Medical Care* 94, no. 12 (2011): 1105–1111.

MPN savings
In 2015, L&I actuaries finalized a comparison of claims 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 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. Patients of providers in the medical provider network averaged 36 percent less time loss than patients of providers not in the network.

2015 Progress

To improve the quality of medical care for injured workers, the law requires 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
In 2011, 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 2014, L&I has enrolled another approximately 2,200 providers, for a total of about 23,300 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
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. L&I has agreements with six health-care organizations that sponsor COHEs, which will provide services in 38 out of 39 counties.

L&I expects the number of COHE-participating providers to more than double from about 1,800 to nearly 3,500 by September 2016. This will result in dramatically expanded access to COHE providers for injured workers. In 2016, COHEs are expected to initiate or treat about 55 percent of claims.

Figure 1: Actual and projected increase in COHE providers

	Number of COHEs	Number of providers
September 2012	4	1,770
September 2013	6	1,880
September 2014	6	2,470
September 2015	6	2,730
September 2016 (projected)	6	3,490

Source: L&I's Occupational Health Services Unit

L&I is on schedule to expand evidence-based purchasing through COHEs. Currently, about 90 percent of injured workers have access to five or more COHE providers within 15 miles of their home. The current number of COHE providers is over 2,700. 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

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.[2] The research, data analysis and stakeholder outreach to create a solid incentive program is a larger effort than initially expected. L&I is proceeding as quickly as possible within existing resources and has prepared a decision package for 2016 requesting additional resources. The department is on track to present a preliminary program model with best practice criteria and incentives to ACHIEV by December 2015.

Implement an automated occupational health management system
L&I has completed all five phases (including the final two releases of the new computer application in late 2014 and 2015) 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. OHMS is also able to track use of best practices, including those for COHEs.

L&I is currently finalizing the feedback reports and expects to complete them by December 2015. The department also 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. The HIE was recognized in the recent JLARC study as a best practice enhancement to speed claim resolution. L&I will continue to add providers to the HIE as resources allow.

Identify and pilot emerging best practices in occupational health
In 2015, L&I completed one pilot project and is continuing two others. The projects test emerging best practices in occupational health: activity coaching, functional recovery and surgical best practices. More information about these pilot projects is in the "Progress and Achievements in 2015" section of this report, beginning on page 8.

The pilot projects that are underway have addressed best practices within the acute and sub-acute phase of injury recovery (generally up to the first six months). L&I will work on chronic disability best practices, a key final step, as soon as resources are freed up from other projects.

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

[2] 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.

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 is establishing processes to use data to monitor quality of care issues and identify providers who present a risk of harm to injured workers. L&I has completed the data analysis, benchmarks and review process for monitoring providers who prescribe 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. The department is close to finalizing the data analysis, benchmarks and review process for providers who have very high rates of reoperation for back surgery. L&I is seeking a permanent resource to fully deploy these analytics and develop the next analysis and benchmarks on other types of low-quality care.

Convene an advisory group
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.

JLARC study
In addition to the department's analysis, a performance audit issued in 2015 by the Joint Legislative Audit and Review Committee (JLARC) highlighted the need for additional progress on best practices. While the 2015 JLARC audit team complimented L&I's leadership on evidence-based standards, it also concluded that L&I needs to rapidly expand and enforce its best practices.

To continue these successes, the department is committed to making more progress in 2016 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 UW to develop criteria, measures and outcomes for the next set of COHE best practices.

To support these activities, the department has requested additional resources from the Legislature.

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:

- 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 the above activities.

L&I is required to report annually on progress in implementing these changes. This report is the fourth of five annual reports required by the law. It includes information about:

- Actions taken during 2015 to support the requirements above.
- 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.

Progress and Achievements in 2015

This section of the report describes actions L&I took during 2015 to achieve key objectives of RCW 51.36.010, and explains outcomes of key initiatives.

CREATE THE MPN

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 Health 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 to ACHIEV on border-state providers. 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. Rather, the department will focus on stabilizing the existing MPN. 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 intends to pursue this recommendation as part of its overall quality purchasing initiatives.

MANAGE THE MPN

Ongoing operations to manage the MPN include processing new applications and change requests, and monitoring MPN providers for compliance. 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 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 23,000 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 23,000) 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 2015, L&I continued to receive about 1,100 applications per month – about 300 new applications from MPN providers and 800 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 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.

Response to challenges

Recognizing that resource constraints and the focus on reducing application processing time prevented those efforts from being as robust as they could be, L&I shifted priorities, hired additional temporary staff and conducted *Lean*[3] 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

[3] *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.

800 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 November, 2015, L&I has approved over 23,000 provider applications – 99.3 percent of all applicants. The remainder, 159 or 0.7 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 is a data bank that 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,[4] 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.

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

[4] WAC 296-20-01030 and WAC 296-20-01050

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 use a cycle that would review all 23,000 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 two provider matches with this exclusion list.
- Drug Enforcement Agency: L&I receives federal data on active prescribing licenses. L&I is working toward directly mapping[5] this data into its credentialing system to enable automatic updating (target date: December 2015).
- Washington State Department of Health: L&I receives Washington state license numbers, effective dates and status changes. The department is working toward mapping the data directly into the credentialing system (target: December 2015).
- National Practitioner DataBase (NPDB): L&I receives continuous updates on MPN provider applications processed in 2015 from the NPDB. This is a change from the previous process of individually requesting updates. Staff is now making individual changes to each provider file to include all providers credentialed in previous years (target: December 2015).

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 medical director. A denial or termination takes effect 60 days after the provider receives notification of the final decision.

[5] Data mapping is a process used to link different data models to each other.

L&I must report denials and terminations to the National Practitioner Data Bank. 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. 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 low quality providers have had a negative impact on injured workers' recovery.

Since network inception, about 450 providers have been referred by an L&I medical director to a panel of peer reviewers for a review and recommendation. Upon reviewing the recommendation of the panel, L&I's medical director has denied or terminated a total of 159 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 reason triggering a review (about 80 percent) is for a licensure action. In addition, most providers have more than one review issue.

Some issues regarding providers' network eligibility were initially controversial, 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 Board of Industrial Insurance Appeals, and only two cases remain 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.

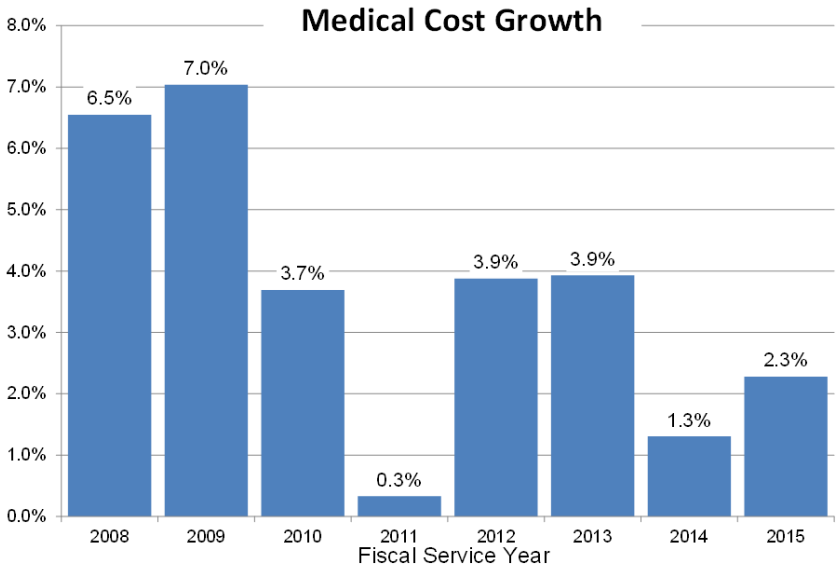
L&I anticipated that some workers may need special assistance in transitioning their care because their provider either did not apply to the MPN, or was not approved. As noted in 2014, care transition occurred smoothly and is now a normal course of operation.

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.

By focusing on achieving high-quality health outcomes through evidence-based purchasing[6] policy, L&I not only improves injured workers' ability to heal, but leads nationally in innovative purchasing and cost constraints. For example: L&I has kept health-care cost increases about one percent lower than the national health care cost trend. Since 2010, annual medical-cost growth in the workers' compensation system has been under four percent, and the projected growth for 2015 is about two percent. This low rate of growth includes small increases to the fee schedules in 2014 and 2015.

Figure 2: Cost trends in Washington's workers' compensation system



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 in preventing high-cost disabilities and generating savings that meet the fiscal note estimates.

[6] 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; 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 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 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 amounts to 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. [7] 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.

[7] 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

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 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.

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 COHES

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 percent of injured workers now have access to five or more COHE providers within 15 miles of their home, and 93 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.

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.[8]

In 2015, the Joint Legislative Audit and Review Committee (JLARC) audited the Workers' Compensation system. They made several observations about the system:

"Major Observations

- More timely medical management interventions and vocational rehabilitation services could improve overall claim outcomes for both workers and employers.
- 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**." [9]

"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

[8] Wickizer,"Improving Quality, Preventing Disability," 1105 (see n.1).
[9] 2015 JLARC Audit Team performance audit

> 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 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."[10]

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.

[10] 2015 JLARC Audit Team performance audit

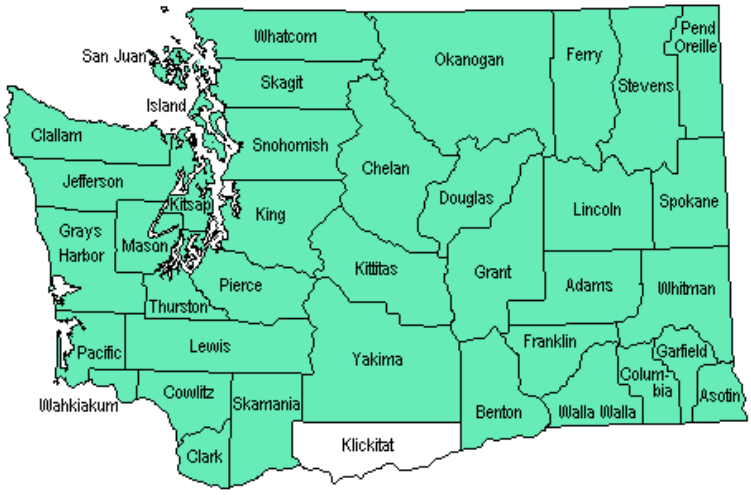
Figure 4: COHE sponsors

Sponsoring organization	Coverage	Year sponsorship began
Valley Medical Center (the *Renton COHE*)	Enrolled community providers in parts of King and Pierce counties.	2002
St. Luke's Rehabilitation Institute/Inland Northwest Health Services (the *Eastern Washington COHE*)	Expanded 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 with 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



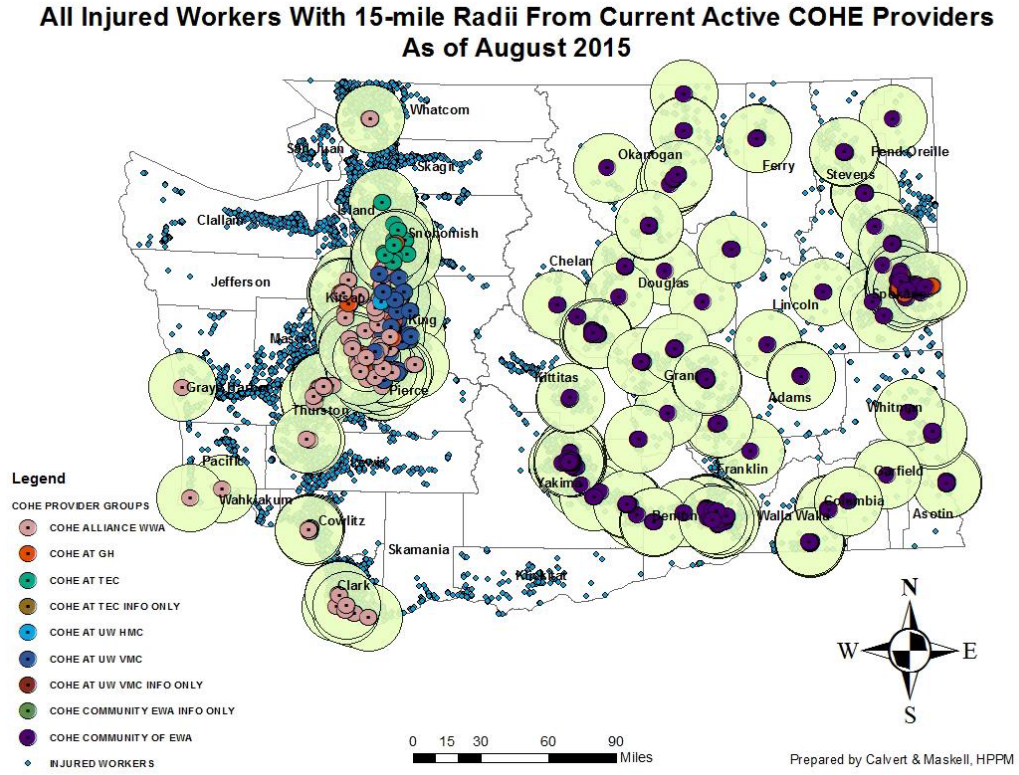
Source: L&I's Occupational Health Services Unit

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. L&I is working with two COHEs to potentially expand into Klickitat County, and expects coverage there in 2016.

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.

Figure 6: Injured workers within 15 miles of five or more COHE providers



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

COHE expansion status

L&I remains on target for projected COHE expansion. The department expected about 2,900 COHE providers to handle 52,000 new claims in FY 2015. Currently, there are over 2,700 COHE providers and slightly over 49,000 new claims initiated by COHE providers. This difference in expected and actual numbers is mainly due to a slowdown in COHE expansion, which was done to ensure that enough health services coordinators were available to sustain growth. The health services coordinators are now on board and the planned expansion is progressing.

Overall, L&I and its health care provider partner organizations are meeting projected enrollment and fiscal note estimates for the next year. 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.

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 are 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 currently budgeted. L&I has requested supplemental budget funding and also plans to initiate some program elements in 2016 within existing resources.

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

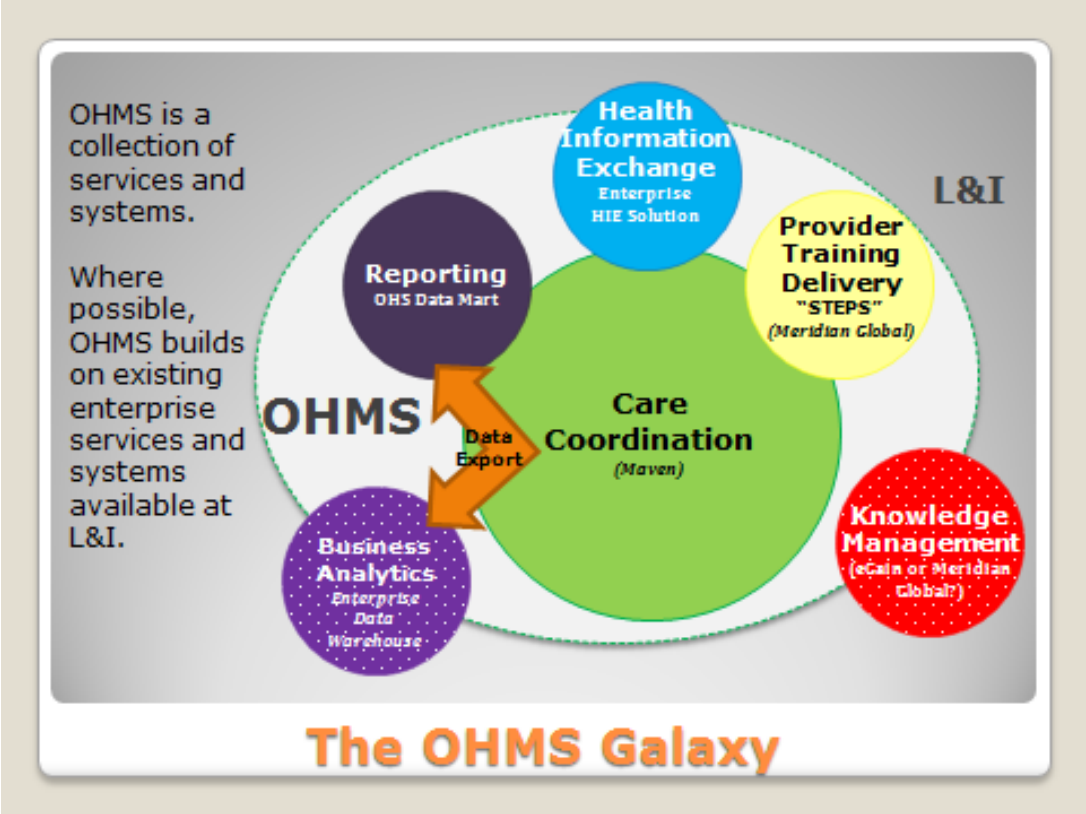
will centralize and streamline existing care coordination processes across COHEs. It will also be used to support top tier and pilot projects for emerging best practices.

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 (and send) data from (to) provider Electronic Medical Record Systems (EMRS).

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



Source: L&I Information Services, Project Management Office

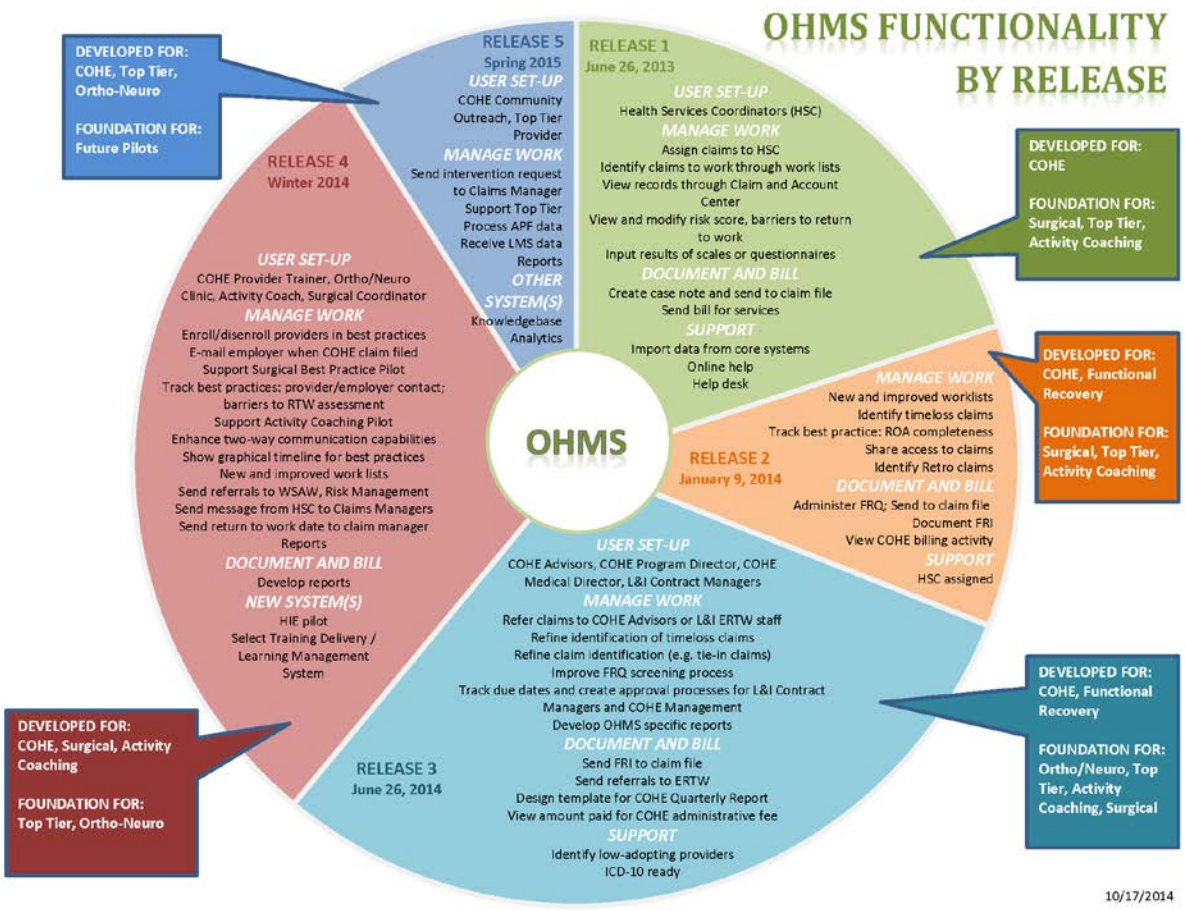
What OHMS accomplishes

- 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. L&I offers an existing electronic exchange for Reports of Accident (ROAs) through a web based application called FileFast.[11] In addition, L&I can now offer an automated exchange from the provider's electronic medical records in Washington's Health Information Exchange (HIE) into OHMS. If L&I is able to attract 30 to 50 high-volume providers to link their records through HIE, about 50 percent of the exchange of records would be automated. Outreach has identified providers who are requesting to participate in this efficient service – but L&I does not have the resources to help set up and connect them. L&I has requested temporary staff to support expansion of this effort.

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 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

[11] In Washington, a health care provider and injured worker initiate a workers' compensation claim by filing a Report of Accident (ROA).

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 is meeting its 2015 goals.

The functional recovery questionnaire (FRQ) is a three-question survey given to workers who have missed two weeks of work. It 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.

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 pilot evaluation phase is planned for 2016.

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 pilots for acute and sub-acute interventions underway and working well, L&I is ready to pilot and assess best practices for chronic pain. In 2015, L&I assessed literature and worked with its advisory committee, staff and consultants to define a vision and interventions to pilot. The interventions are based on a validated collaborative-care model called "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. 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. The pilot will require qualitative research to develop and then pilot the final set of best practices in collaboration with clinical leaders and the UW.

This final set of best practices will complement the best practices developed for the first six weeks of care and for the period of six weeks to three months. The pilot would require contract funds for the UW to develop and evaluate the best practices, as well as dedicated staff to design requirements and outcome measures, oversee implementation, collect and assess outcomes and permanently deploy if the pilot is successful. L&I is evaluating its resource options to determine how to accomplish this work.

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 low-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 to injured workers.[12] 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.

A constraint to completing this work is that L&I relies on ad-hoc time from clinical staff in the department's medical policy, audit and complaint departments. L&I prepared a decision package in 2015 for permanent resources, but ultimately it was not funded. The department will continue to make progress as resources allow.

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.

[12] Risk of harm is defined in WAC 296-20-01100.

- 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 medical care for injured workers.

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 has requested 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 HIE; and to expand risk of harm analysis to other areas of low quality care.

PLANS FOR 2016

L&I will continue to improve outcomes for injured workers through the MPN and COHEs in 2016 by:

- Reviewing 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 review 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 HIE 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 UW to develop criteria, measures and outcomes for the next set of COHE best practices.

NEXT REPORT

L&I's final legislative report on the MPN and COHE expansion will provide an update on these planned activities, and will be published by December 1, 2016.

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))