

Reducing Long-Term Disability Through Use of Medical Best Practices

2016 Report to the Legislature

December 2016

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Executive Summary

Introduction

This report responds to the legislature’s direction for the Department of Labor & Industries (L&I) to share its progress in expanding the use of evidence-based best practices to reduce the risk of long-term disabilities among injured workers. In a 2016 supplemental budget proviso,¹ the legislature provided contract funds to continue to add providers to the Occupational Health Management System (OHMS) and three staff to expand the use of best practices to reduce disability. L&I is required to report to the legislature by December 1, 2016 regarding the performance measures and metrics that will be used to evaluate whether the funded activities are improving care and outcomes for injured workers.

Eight percent of all injured workers account for about 85 percent of L&I’s workers’ compensation costs, due to long-term disability. The vast majority of these workers had mild to moderate injuries that should not necessarily result in long-term disability. Reducing preventable disability is a priority for L&I, and it remains the critical policy, clinical, and financial issue in workers’ compensation (and health care in general).

Workers’ compensation reforms passed in 2011 created a state mandate to expand best practices to reduce long-term disability for injured workers. Significant progress was made, and most of the related initiatives are fully implemented (see L&I’s December 2016 legislative report on Implementation of the Medical Provider Network & Expansion of the Centers for Occupational Health and Education (SSB 5801)). However, L&I used ad-hoc staff assignments to make that progress. After a performance audit issued in 2015 by the Joint Legislative Audit and Review Committee (JLARC) commended L&I’s evidence-based best practice programs and highlighted the need for more progress in identifying and implementing additional best practices, the department requested and received funds in the 2016 supplemental budget.

This report outlines the actions supported by L&I’s receipt of the supplemental budget funds. It includes information about:

- Actions taken by L&I in 2016 to expand the use of occupational health best practices to reduce disability
- Performance measures and metrics used to monitor reductions in disability, expansion of best practices and actions taken to address lower quality providers

¹ 2ESHB 2376 sec. 217(9) provides funding “solely to expand the use of evidence-based best practices to reduce the risk of long-term disabilities among injured workers” and requires a report by Dec. 1, 2016.

This report only addresses reducing disability through use of medical best practices, and does not include the reductions achieved through the multitude of non-medical interventions implemented by L&I.

Actions taken to expand use of occupational health best practices

Occupational Health Management System

The new web-based information system, Occupational Health Management System (OHMS), supports care coordination, tracks providers' use of occupational-health best practices and provides feedback to doctors. Currently, the health-services coordinators at the Centers of Occupational Health and Education (COHEs) use OHMS to coordinate claim activities and the system can automatically generate bills for those services. The system is capable of storing and tracking training for providers and other users. 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.

The OHMS project also developed an enterprise-wide infrastructure to support connection to Washington's portal (OneHealthPort) for statewide health information exchange (HIE). The HIE allows users to automatically send data to or receive it from providers' Electronic Medical Record Systems (EMRS). The ability to automatically exchange data has resulted in a huge reduction in processing times and delays associated with paper, fax or direct entry solutions. Providers use their EMR to enter information about patients when they are seen for care. That information has to be re-entered into L&I forms or websites to be sent to L&I. Using the HIE, data is transmitted from the electronic medical record and received by OHMS. The information is available to the L&I claim manager on the same day, as opposed to in seven to 21 days for paper forms. It can also be used to monitor health care provider best practice performance in an automated and real-time manner.

With supplemental funding, L&I continues to add new document types to the HIE, such as the Report of Accident form, so that health care organizations can automatically transmit more data from electronic medical records. This also enables L&I to expand the type of information collected through OHMS as new best practice metrics are established.

Staffing

L&I's initial best practices focused primarily on interventions in the first approximately 12 weeks of a claim, including timely and complete communication early in the claim, and early efforts to return an injured worker to work through employer communication and identification of barriers. In the 2016 supplemental budget, the legislature provided funding for three additional L&I staff to expand the use of evidence-based best practices. These staff have been deployed to reduce long-term disability by expanding the best practices using occupational health homes for both prevention and adequate treatment of chronic pain, which is the leading cause of disability in the workers' compensation system. These additional staff help provide L&I the necessary resources to ensure that workers get effective, quality, coordinated care.

Performance measures and metrics

Performance measures and metrics use data analysis to determine if an agency or activity is achieving its objectives based on identified standards.

L&I identifies appropriate performance measures and metrics when developing and implementing best practice programs. Measures and metrics for each program are based on desired outcomes and whether they are achieved. For example, key outcomes of the best practice programs are reduced disability and increased use of best practices by providers. To measure performance, L&I analyzes these outcomes (metrics) to determine if they indicate that increased delivery of quality health care services reduces the likelihood of long-term disability. This type of data analysis also enables L&I to identify, review and take appropriate action with providers who are not meeting specific quality standards (lower quality providers).

Measuring disability reduction

L&I has multiple initiatives focused on reducing long-term disability; therefore, it is challenging to attribute changes to any one effort. In addition to measuring overall long-term disability, L&I measures claim resolution rates for COHE providers, and the average cost per COHE claim compared to non-COHE claims. Data shows that long-term disability continues a downward trend, six- and 18-month claim resolution rates are higher for COHE claims than for non-COHE claims, and the average cost of a COHE claim is approximately 25 percent lower than the cost of a non-COHE claim.

Measuring best practices expansion

L&I measures expanded use of provider best practices using participation counts and the rate of adoption of best practices by COHE and surgical best practice program providers. L&I is developing measures for providers in the soon-to-be-established top tier of the medical provider network.

Addressing lower quality providers

L&I has established metrics to identify health care providers with dangerous opioid-prescribing patterns, and is finalizing measures related to harmful surgical practices.

Introduction

This report responds to the legislature’s direction for the Department of Labor & Industries (L&I) to share its progress in expanding the use of evidence-based best practices to reduce the risk of long-term disabilities among injured workers. A 2016 supplemental budget proviso² required L&I to report to the legislature by December 1, 2016 to identify the performance measures and metrics that will be used to evaluate whether funding to add three staff and expand the use of Occupational Health Management System (OHMS) are improving care and outcomes for injured workers.

This report only addresses reducing disability through use of medical best practices, and does not include the reductions achieved through the multitude of non-medical interventions implemented by L&I.

Background information

Eight percent of all injured workers account for about 85 percent of L&I’s workers’ compensation costs. This is due to the costs of long-term disability. The vast majority of these workers had mild to moderate injuries that should not necessarily result in long-term disability. Reducing preventable disability is a priority for L&I, and it remains the critical policy, clinical and financial issue in workers’ compensation (and health care in general).

Workers’ compensation reforms passed in 2011 created a state mandate to expand best practices to reduce long-term disability for injured workers. To date, L&I has used ad-hoc staff to:

- Expand the Centers for Occupational Health and Education (COHEs) to the entire state.
- Apply provider network standards, removing very poor quality providers from the medical provider network that treats injured workers in Washington. These lower quality providers accounted for less than one percent of providers that applied to the network. However, claims served by those providers had an average of 36 percent higher time loss.
- Substantially reduce unintentional opioid poisoning deaths and inappropriate, chronic opioid use.
- Develop the framework for a top tier of the medical provider network.
- Improve rates of best practices adoption by surgical providers through maintenance of the Orthopedic & Neurological Surgeons Quality Program and implementation of the Surgical Best Practices Pilot.

A performance audit issued in 2015 by the Joint Legislative Audit and Review Committee (JLARC) highlighted the need for additional progress in identifying and implementing best practices. While

² 2ESHB 2376 sec. 217(9) provides funding “solely to expand the use of evidence-based best practices to reduce the risk of long-term disabilities among injured workers” and requires a report by Dec. 1, 2016.

the 2015 JLARC audit team complimented L&I's leadership in evidence-based standards, it also concluded that L&I needs to rapidly expand and enforce its best practices:

“Clinicians that substantially and frequently deviate from standard practices place a tremendous burden on the system...L&I reports that the Medical Provider Network has been an effective tool for L&I to remove many of these clinicians with standards. Recently, L&I has begun using data on chronically poor performance. In addition, L&I reports that it is using a data-driven analysis to identify those clinicians who have a pattern of low-quality care that results in harm or risk of harm, as defined by rule, and currently is analyzing data on repeat surgical rates and overprescribing.

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 enhancement to COHEs. These all have great promise for improving outcomes and should be vigorously pursued.”*

In the 2016 supplemental budget, the legislature provided funding for additional staff to expand the use of best practices to reduce long-term disability, and funding to expand use of the Occupational Health Management System (OHMS). This enabled the department to hire staff to help provide L&I the necessary resources to ensure that workers get effective, quality, coordinated care.

In this report

This report includes information about:

- Actions taken by L&I in 2016 to expand the use of occupational health best practices through OHMS and the addition of three staff
- Performance measures and metrics used to monitor reductions in disability, expansion of best practices and actions taken to address lower quality providers

Progress and Achievements in 2016

Reducing preventable disability for injured workers is a priority for L&I, and it remains the critical policy, clinical and financial issue in workers' compensation (and health care in general).

Medical providers who use evidence-based, proven occupational health best practices reduce disability among their patients. This section describes L&I's progress on expanding the use of occupational health best practices. It also presents performance measures and metrics currently in use and those proposed for future use to monitor expansion of occupational health best practices.

ACTIONS TAKEN TO EXPAND USE OF OCCUPATIONAL HEALTH BEST PRACTICES

L&I is implementing additional evidence-based best practices and expanding use of provider incentives to use best practices by investing resources in the Occupational Health Management System and additional staffing.

Occupational Health Management System

This 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 Centers of Occupational Health and Education (COHEs) use the Occupational Health Management System to perform and bill for coordination activities. The Occupational Health Management System (OHMS) is capable of storing and tracking training for providers and other users. 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.

The integration of OHMS with other L&I systems enables health care provider staff to receive updated information several times a day to help coordinate care. They can now send L&I automated referrals for services and document case notes through a secure electronic interface.

The OHMS project also developed an enterprise-wide infrastructure to support connection to Washington's portal (OneHealthPort) for statewide health information exchange (HIE). The HIE allows users to automatically send data to or receive it from providers' Electronic Medical Record Systems (EMRS). The ability to automatically exchange data has resulted in a huge reduction in processing times and delays associated with paper, fax or direct entry solutions. Providers use their EMR to enter information about patients when they are seen for care. That information has to be re-entered into L&I forms or websites to be sent to L&I. Using the HIE, data is transmitted from the electronic medical record and received by OHMS. The information is available to the L&I claim manager on the same day, as opposed to in seven to 21 days for paper forms. It can also be used to monitor health care provider best practice performance in an automated and real-time manner.

L&I had planned to finalize provider feedback reports by December 2015. New resources were brought on board in late 2015; however, the transition from project to maintenance was delayed to

some extent by staffing changes. Provider feedback reports and other reporting requested from OHMS have been re-prioritized and are expected to become available by mid-2017.

Staffing

In the 2016 supplemental budget, the legislature provided funding for three additional staff to expand the use of evidence-based best practices to reduce the risk of long-term disabilities among injured workers. With this funding, L&I hired three new staff:

- A Medical Program Specialist plans, implements, and maintains new best practice programs targeting difficult clinical areas such as the Chronic Pain and Behavioral Health Care Improvement Project.
- A Management Analyst supports and coordinates implementation of strategic and long-range planning activities. These activities are related to ensuring that all best practices are coordinated and integrated -- an initiative called Healthy Worker 2020 Quality Purchasing Initiative (Healthy Worker 2020).
- An Occupational Nurse Consultant works to expand the use of evidence in establishing clinical quality of care benchmarks, and to use data analytics to identify health care providers who practice below the standard of care and thereby put injured workers at risk of harm.

L&I dedicated these staff to create program requirements and incentives to use occupational health homes³ for both prevention and adequate treatment of chronic pain, and to continue to expand use of evidence-based best practices through COHEs and a second phase of the COHEs, the Healthy Worker 2020 initiative. The decision was made to focus on prevention and treatment of chronic pain because it is the leading cause of disability.

These additional staff help provide L&I the necessary resources to ensure that workers get effective, quality, coordinated care. They will focus on expanding best practices beyond the first 12 weeks following injury.

³ Occupational health homes are facilities that provide comprehensive care management and coordination, transitional care and follow-up, patient and family support, and referral to community/social support services.

COHEs

The COHEs were initially established as early innovative efforts to increase access to high quality health care for injured workers. These efforts led to widespread adoption of community- and large institution-based COHEs in all counties in Washington, with a network of over 3,000 providers. COHEs are based on:

- Defining, measuring and providing incentives for use of evidence-based best practices in occupational health
- Defining and paying for health services coordination
- Developing and using technology that supports information exchange between providers, coordinators and L&I
- Continuing to give Washington workers the freedom to choose their own practitioners

Formal evaluation of the COHEs found a substantial reduction in long-term disability and related costs for injured workers. Several unique characteristics in Washington have allowed this type of statewide experimentation and evaluation -- most notably, a special research relationship between L&I and the University of Washington.

Healthy Worker 2020

A second phase of COHE implementation, Healthy Worker 2020, is underway. This phase is transforming the initial health care coordination and best practices that focused on the first twelve weeks of care into more complex collaborative care, including treatment for behavioral health and chronic pain. These additional best practices and brief behavioral health interventions will further reduce disability and allow most patients to stay in their primary care environments. This expansion work is based on high quality evidence of what works, including randomized trials conducted over the past decade by senior psychiatric academicians at the University of Washington. Through collaborations with the University of Washington, L&I is working directly with this team of academicians to develop Healthy Worker 2020.

PERFORMANCE MEASURES AND METRICS

Performance measures and metrics use data analysis to determine if an agency or activity is achieving its objectives based on identified standards.

L&I, with assistance from researchers and practicing clinicians, identifies appropriate performance measures and metrics when developing and implementing best practice programs. Measures and metrics for each program are based on desired outcomes and whether they are achieved. For example, key outcomes of the best practice programs are reduced disability and increased use of best practices by providers. To measure performance, L&I analyzes these outcomes to determine if they indicate that increased delivery of quality health care services reduces the likelihood of long-term disability. This type of data analysis also enables L&I to identify, review and take appropriate action with providers who are providing lower quality care.

Developing and tracking performance measures is a key step in the process of establishing occupational health best practices. This section describes measures that are currently in place and those that will be implemented as data becomes available.

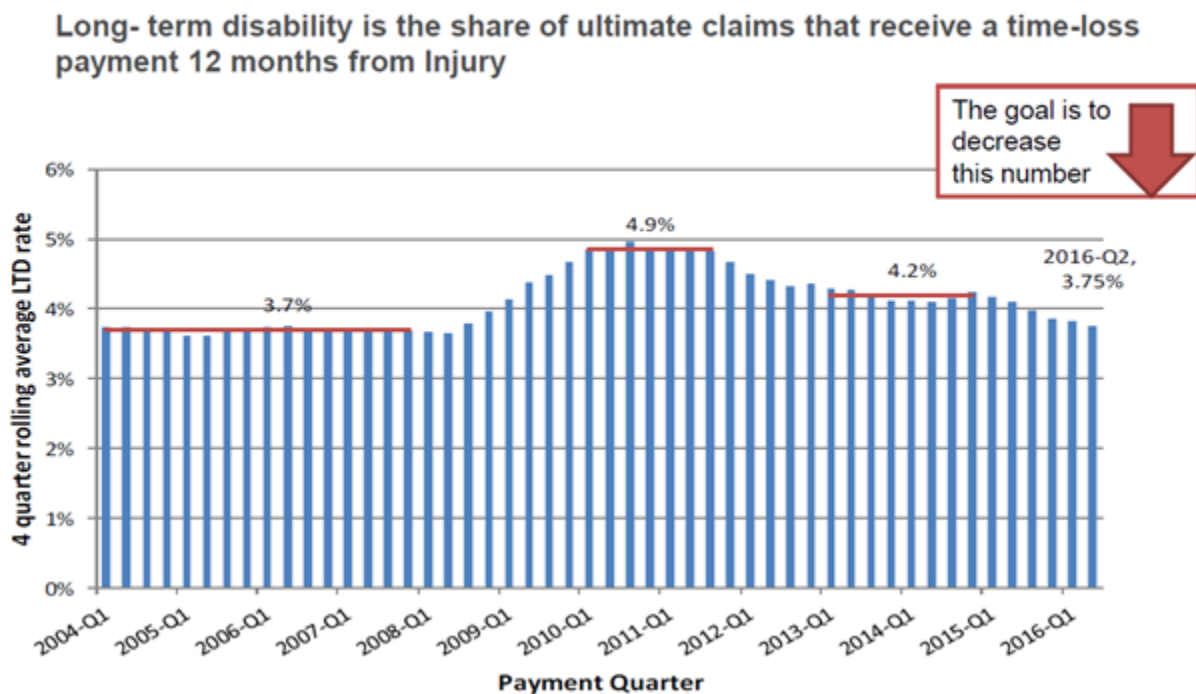
Measuring disability reduction

One of L&I's top goals is to reduce the number of injured workers who experience long-term disability. This is also a primary outcome measure for L&I.

Long-term disability is defined as the share of ultimate claims that receive a time-loss payment 12 months from injury. Many factors across employers, workers and health care providers influence the development of long-term disability, and L&I has multiple initiatives to address them.

The overall outcome measurement shown in Figure 1 is the percent of ultimate claims that receive a time-loss payment 12 months from injury. After an increase during 2008-2012, the number of these claims has been reduced to near-2004 levels, due in part to the implementation of workers' compensation reforms. Although reasons are difficult to pinpoint, the 2008-2012 increase could be due to a combination of economic recession and opioid use.

Figure 1: Share of ultimate claims that receive a time-loss payment 12 months from injury



Source: L&I Goal Team 2

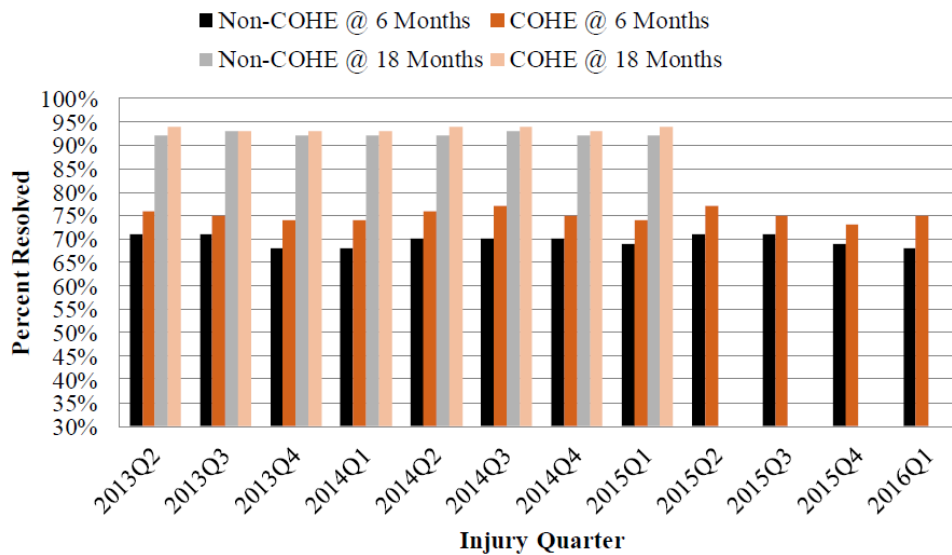
In addition to an overall outcome measure, L&I monitors the time it takes to resolve claims. Figure 2 demonstrates the higher resolution rates for claims treated by COHE providers compared to those treated by non-COHE providers. COHE providers resolved more claims than non-COHE providers at both six and 18 months, although the difference is greater at six months – likely because most current

best practices are targeted to early intervention. These results are achieved by using occupational health best practices in the first 12 weeks so that the injured worker has a treatment plan that is focused on recovery and return to work.

Figure 2: Claim resolution for COHE and non-COHE claims

Resolution: All Claims

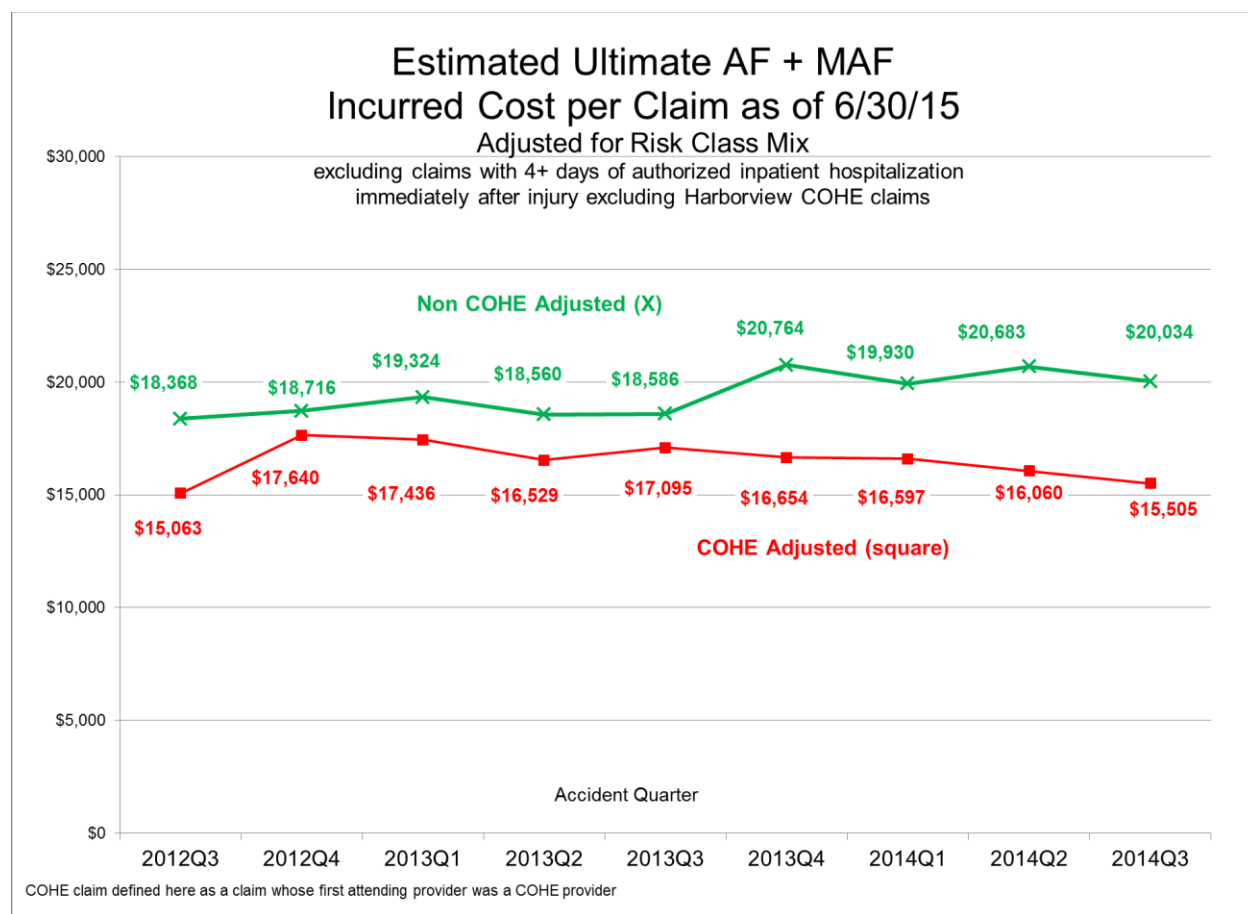
Percent Resolved at 6 and 18 Months



Source: July 2016 Centers of Occupational Health and Education Program Report

In addition to the impacts on injured workers and their families, long-term disability increases system costs. The best practices included in the COHE program focus on sending timely and accurate information to L&I to adjudicate claims. Earlier claim resolution results in lower long-term disability, and therefore lower costs per claim. Figure 3 demonstrates that the ultimate estimated cost is lower for COHE claims than for non-COHE claims. The costs analyzed include payments made from the Accident Fund (AF) and the Medical Aid Fund (MAF). The mix of cases analyzed is adjusted to enable comparison of similar risk classes.

Figure 3: Estimated incurred cost per claim for COHE versus non-COHE claims



Source: L&I Actuary

Measuring best practice expansion

The 2015 Joint Legislative Audit and Review Committee (JLARC) performance audit of the workers' compensation system concluded that L&I should rapidly expand and enforce best practices. Two of the three new staff L&I hired in 2016 – a Medical Program Specialist and a Management Analyst -- are dedicated to supporting this expansion.

L&I will evaluate best practice expansion in several areas, including:

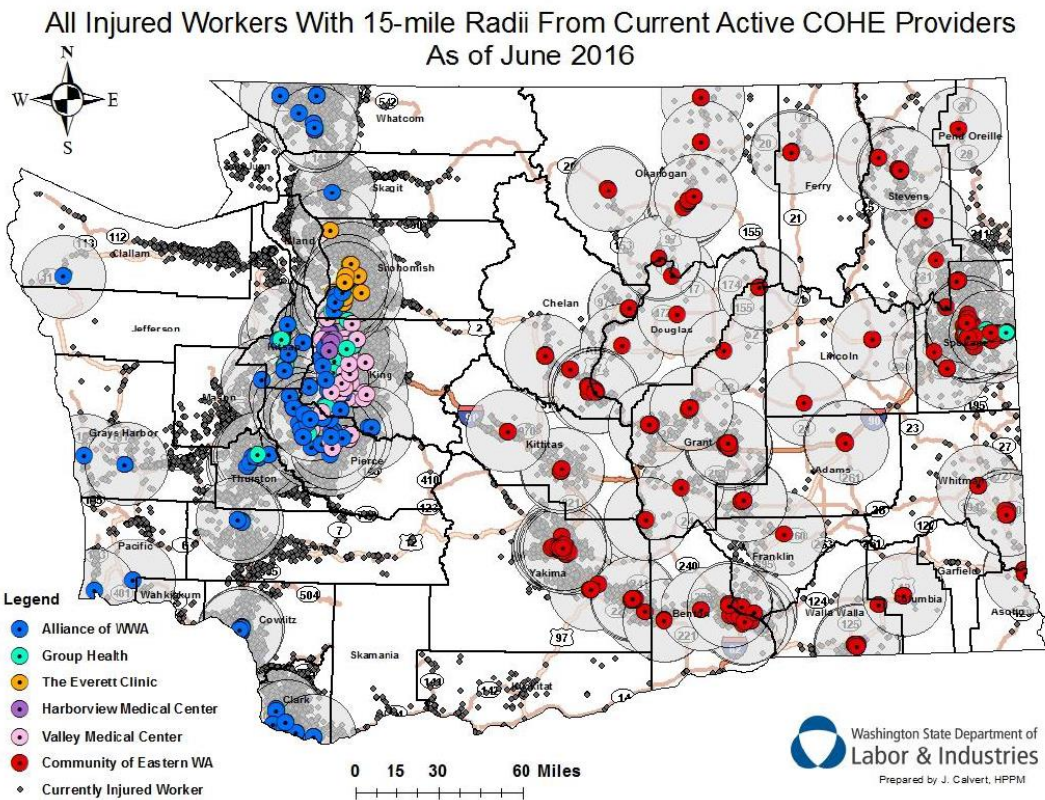
- access to COHE providers,
- the top tier of the Medical Provider Network, and
- Surgical Best Practices.

Access to COHE providers

SSB5801 required L&I to provide at least 50 percent of injured workers access to COHEs by December 2013, and to provide all injured workers access by December 2015. L&I has agreements with six health-care organizations that sponsor COHEs, which will provide services in all 39

counties. Ninety-six percent of injured workers have access to five or more COHE providers within 15 miles of their home, as shown in Figure 4. This level of access remains consistent.

Figure 4: Injured workers within 15-mile radius from current active COHE providers



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

L&I continues to work with COHE-sponsoring organizations to expand COHE participation so that more workers can benefit. As shown in Figure 5, 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 for the workers.

Figure 5: 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	6	3,218
September 2017	6	3,490

Source: L&I's Occupational Health Services Unit

In addition to increasing the number of COHE providers delivering best practices, L&I's strategy to expand best practice adoption includes developing a top tier of the Medical Provider Network, and identifying and developing additional occupational health best practices to improve care for injured workers.

Top tier of the medical provider network

L&I is establishing a top tier in Washington's medical provider network for providers who demonstrate occupational-health best practices in treating injured workers. Top tier providers will be eligible to receive financial and non-financial incentives, such as streamlined authorizations for treatment.

Top tier measurements will include the number of providers enrolled as top tier providers, with a goal to increase that figure. Individual providers will receive performance reports and peer group comparisons regarding their adoption of best practices. Providers will be monitored, and those not consistently meeting the established thresholds for the top tier may no longer receive top tier incentives. For example, the best practice of submitting a timely and complete Report of Accident might require that in order to remain eligible for top tier incentives, a provider must submit at least 80 percent of all Reports of Accident in a specified time frame with all required fields completed. A provider who does not meet that standard will no longer be eligible for the top tier.

Initially, in consultation with the statutory Advisory Committee on Healthcare 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. L&I presented a preliminary program model with best practice criteria and incentives to ACHIEV in October 2015. Additional work was completed in 2016 and L&I is on track to launch the top tier in 2018.

Surgical Best Practices

L&I has two surgical best practice initiatives underway: the Orthopedic and Neurological Surgeon Quality Program and the Surgical Best Practices Pilot. Ultimately, L&I plans to use data from both surgical quality initiatives to establish a top tier for surgical providers based on adoption of best practices.

Orthopedic and Neurological Surgeon Quality Program

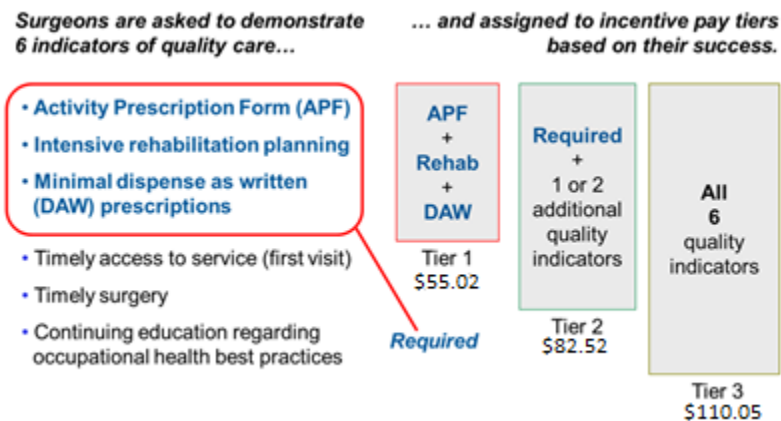
The Orthopedic and Neurological Surgeon Quality Program (ONSQP) began in 2006, and focuses on six best practices:

- Activity prescriptions for injured workers
- Provider-directed intensive rehabilitation geared toward return to work
- Minimal “dispense as written” (DAW)⁴ prescriptions
- Injured worker access to specialist care within seven days of referral
- Completion of non-emergency surgery within three weeks of surgical decision
- Provider participation in continuing education on occupational health best practices

Thresholds are established for each best practice, and surgeons are assigned to one of four tiers based on their performance on each best practice (referred to as quality indicators). In order to be eligible for incentive payments, surgeons must meet or exceed the threshold for three of the required quality indicators. Surgeons in tiers 1, 2 and 3 are eligible for incentive payments, which are payable each time an activity prescription form is completed. Tier 3 incentives are the highest. Figure 6 shows the six best practices for ONSQP and the incentives for providers to meet or exceed the thresholds.

⁴ In most states, when a doctor writes a prescription for a brand name drug, a pharmacist is allowed to substitute a generic version in its place. However, when a doctor indicates “DAW” or “dispense as written,” the pharmacist cannot substitute a generic and must provide the exact drug in the prescription.

Figure 6: Orthopedic and Neurological Surgeons Quality Program tier assignment



Source: Occupational Health Services Unit

As a performance measure, L&I tracks the number of providers participating in the ONSQP and the distribution of providers achieving each tier assignment. In addition, L&I provides individual performance reports to each participating surgeon. As shown in Figures 7 and 8, in 2016 just over 400 providers are participating in the ONSQP, with more than 80 percent receiving some incentive pay. While those figures have varied since inception, they have shown growth in the last three years.

While participation in ONSQP is voluntary, only eligible providers may participate. Eligible providers must meet one or more of these criteria:

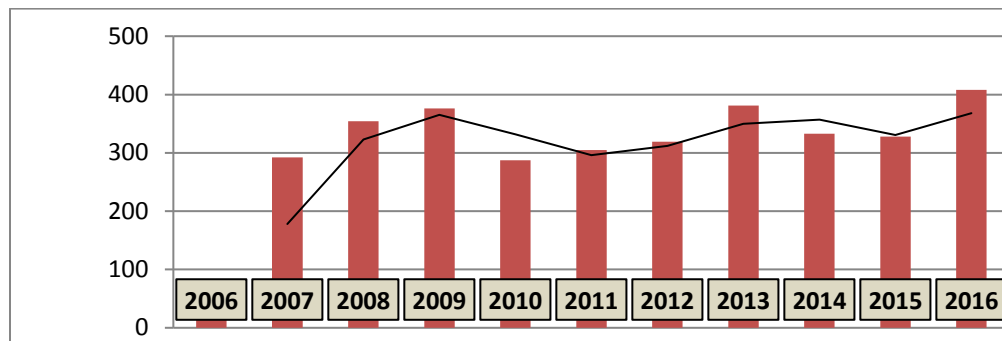
- Participation in initial project development
- Participation in the Centers of Occupational Health and Education
- Status as a Utilization Review Group A provider.⁵

Additional information about ONSQP is available at

<http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OrthoNeuro/default.asp>.

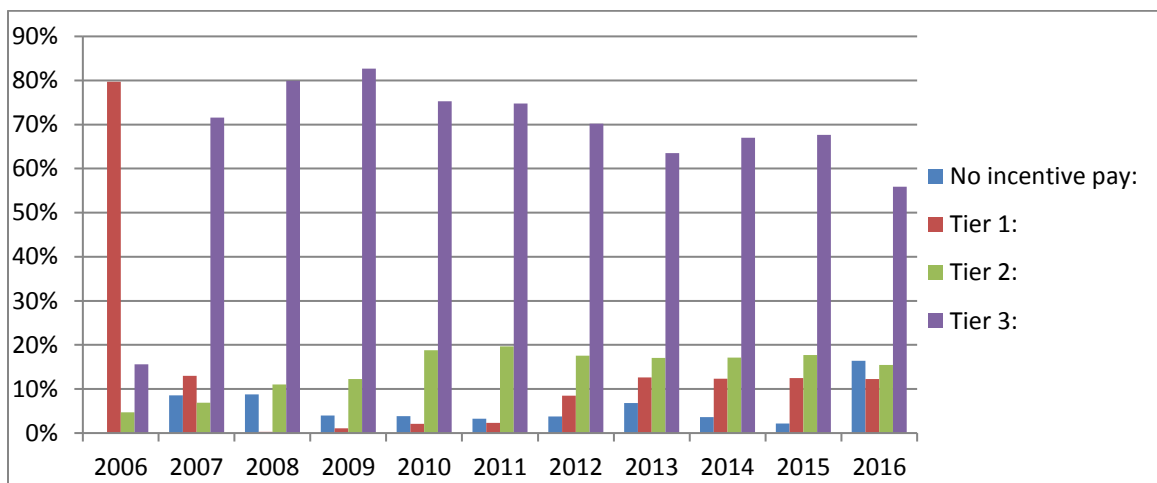
⁵ The utilization review (UR) process compares requests for medical services ("utilization") to published, evidence-based treatment guidelines. Providers with 10 or more requests that had 100 percent UR approval recommendations during the one-year review period are eligible to become a Group A provider where reviews are expedited.

Figure 7: Number of providers participating in ONSQP



Source: Occupational Health Services Unit

Figure 8: Distribution of provider tier assignments in ONSQP



Source: Occupational Health Services Unit

Surgical Best Practices Pilot

The Surgical Best Practices Pilot (SBPP) 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

The initial start-up phase for the SBPP was completed in January 2016. The pilot is expected to run through June 30, 2019. That’s how long it will take to gather data from enough workers to make up a significant sample size, which is required to measure effectiveness.

Data for the SBPP performance measurement relies largely on reporting capability in OHMS. Provider feedback reports and other reporting requested from OHMS have been prioritized and are expected to become available by mid-2017. Data to be included in these reports is:

- The number of days from referral of an injured worker to the surgeon, to the worker's transition back to the original attending provider or a new provider
- The number of days from referral of an injured worker to claim closure
- Outcomes on claims referred for surgical care

Addressing lower quality providers

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. The approach to risk of harm is to rely on evidence-based, clinically meaningful benchmarks that are established with practicing clinicians. These benchmarks are used in data queries to identify outlier providers, instead of using conventional complaint-based quality reviews.

L&I uses evidence- and data-driven processes for monitoring quality of care issues and identifying providers who present a risk of harm to help 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.

Opioid deaths and overdoses

L&I completed data analysis and tested benchmarks and review processes for providers who prescribe dangerous amounts of opioids that lead to deaths/overdoses. The review process and benchmarks are now in operation. L&I matches Department of Health data on deaths where opioid overdose is reported to L&I claims where an opioid prescription had been issued within the three months prior to death. About 20 cases per year are identified. Once they are identified, L&I performs a structured claim review to identify whether inappropriate prescribing contributed or possibly contributed to the death. The outcome of reviews is included in Figure 9. These review outcomes help L&I identify health care providers with dangerous opioid-prescribing patterns so that they can be removed from the provider network as appropriate.

Figure 9: Opioid-prescribing Risk of Harm outcomes

	2012	2013	2014
Opioid deaths with prescription within 3 months of death or pension referral	25	25	22
Confirmed prescription opioid-related deaths	21	7	8
Associated prescribers of confirmed deaths	25	12	10
Prescribers network status	14 – participating 11 – non-participating	9 – participating 3 – non-participating	7 – participating 3 – non-participating
Risk of Harm validation case review outcome	19 – no further action* 6 – further review by MPN	6 – no further action 6 – referred to MPN credentialing	1 – no further action 6 – referred to MPN credentialing 3 – pending staffing w/AMD

**No further action occurs when the case review does not meet the validation criteria (e.g., establish a possible link between prescriber care and harm) or when full records are unavailable.*

Source: Office of the Medical Director

Repeat surgery rates

The second area for focus to reduce risk of harm was repeat surgery rates. In 2016, L&I continued its work with a researcher to establish performance measure benchmarks for providers who have very high rates of reoperation for back surgery. After L&I presented the findings to the IIMAC, the IIMAC requested additional data. An updated report is scheduled to be completed by December 2016.

L&I requested and received funding in July 2016 for a permanent resource dedicated to risk of harm review, including repeat surgery reviews and future harm topics where benchmarks can be established using high quality evidence and advisory committee input. L&I hired an Occupational Nurse Consultant in October 2016. This dedicated clinician is working on completing the repeat surgery benchmarks and data queries as well as the file review standards. Data will be run at least annually to identify health care providers whose rates of reoperation exceed a benchmark. Those providers' claim files will then be subject to clinical review to ensure that factors not present in the data, such as two simultaneous patient conditions, are analyzed. When the benchmarks and data algorithms are complete, metrics will be established similar to those in the opioid risk of harm analysis.

Conclusion

Eight percent of all injured workers account for about 85 percent of L&I's workers' compensation costs, due to long-term disability. The vast majority of these workers had mild to moderate injuries that should not necessarily result in long-term disability. Reducing preventable disability is a priority for L&I, and remains the critical policy, clinical and financial issue in workers' compensation (and health care in general).

L&I is a recognized national leader in health policies and strategies to keep medical costs below national trends. With appropriate resources, L&I continues making improvements to reduce the length of disability for injured workers – a key measure of performance within the industry as well as one of L&I's main goals. L&I continues to expand the development and integration of occupational health best practices, has developed technology to electronically transmit information via the Health Information Exchange (HIE) and continues to support expanded use of HIE.

A performance audit issued in 2015 by the Joint Legislative Audit and Review Committee commended L&I's evidence-based best practice programs and highlighted the need for more progress in identifying and implementing additional best practices. In the 2016 supplemental budget, the legislature provided funding for additional staff to expand the use of best practices to reduce long-term disability, and funding to expand use of the Occupational Health Management System. This enabled the department to hire staff to identify and implement additional best practices.

In 2016, L&I added three additional staff and is expanding use of the Occupational Health Management System to further advance efforts to reduce long-term disability. L&I will measure the success of this expansion by monitoring:

- Reductions in disability
- Expansion of best practices
- Addressing lower quality providers

Developing and tracking performance measures is a key step in the process of establishing occupational health best practices. L&I will continue to measure performance using a variety of measurements as additional best practices are identified and integrated.