

**Colloquium on Occupational Health Best Practices  
at Group Health Cooperative  
Today's Theme: Collaborative Care in Healing and Returning to Work**

June 18, 2014

<b>Time</b>	<b>Topic</b>	<b>Who</b>
<b>8:00 – 8:30</b>	<b>Gathering and Greeting</b>	<b>Colloquium Participants</b>
<b>8:30 – 9:00</b> (30 min) 5 min for Natalee 25 min for Dr. Gilmore	<b>1. Welcome and Orientation</b> <ul style="list-style-type: none"> <li>Description of Day: Collaborative Care in Healing and Returning to Work</li> <li>Welcome to Group Health Cooperative</li> </ul>	<b>Natalee Fillinger, JD,</b> L&I Self-Insurance Program <b>Tim Gilmore, MD,</b> Medical Director for Group Health Cooperative
<b>9:00 – 9:20</b> (20 min)	<b>2. WSIA Leadership Message</b>	<b>Kris Tefft,</b> Executive Director, Washington Self-Insurers Association
<b>9:20 – 9:50</b> (30 min)	<b>3. L&amp;I Updates:</b> <ul style="list-style-type: none"> <li>Leadership, Programs, and Projects</li> </ul>	<b>Leah Hole-Marshall, JD,</b> L&I Office of Medical Director
<b>9:50 – 10:50</b> (60 min)	<b>4. Barriers to Return to Work</b> <ul style="list-style-type: none"> <li>Overview: Risk Factors Impacting Return to Work</li> <li>Example: Adverse Childhood Events</li> </ul>	<b>Nicholas Reul, MD,</b> L&I Office of the Medical Director <b>Laura Porter,</b> Learning Institute for the Comprehensive Health Education Foundation
<b>10:50 – 11:00</b>	<b>Ten Minute Break</b>	
<b>11:00 – 12:30</b> (90 min)	<b>5. Best Practices for Effective Collaboration on Challenging Claims</b> <ul style="list-style-type: none"> <li>Multidisciplinary Round Table Discussion</li> <li>Hear experts in the field - including self-insured employers, health care providers, claims managers, vocational counselors, and nurse case managers discuss claim scenarios</li> </ul> <p style="text-align: center;"><b>Panelists:</b></p> <p><b>Glenn Hansen,</b> Workers' Compensation Manager MultiCare Health System</p> <p><b>Kevin Kincade,</b> Account Manager Eberle Vivian</p> <p><b>James K. Jackson,</b> Claim Manager, L&amp;I</p> <p><b>Cory Turner, M.Ed., CRC,</b> Vocational Connections, Inc.</p> <p><b>Jill C. Falk, M.Ed., CRC, CDMS</b> Advanced Vocational Solutions, Inc.</p> <p><b>Greg Carter, MD,</b> Medical Director, St. Lukes Rehabilitation and COHE Community of Eastern WA</p> <p><b>Stephen Thielke, MD,</b> MSPH Puget Sound VA Medical Center</p> <p><b>Jill Morrison, BSN,</b> Nurse Case Manager EIS Group</p>	<b>Moderators - David Overby, MPA,</b> Manager, Program Analysis & Development, Health Services Analysis, L&I <b>Richard Wilson, CRC,</b> Return-to- Work Services Program Manager, L&I
<b>12:30 – 1:10</b>	<b>Networking Lunch</b>	<b>Group Health Cooperative</b>

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<b>Time</b>	<b>Topic</b>	<b>Who</b>
<b>1:10 – 2:10</b> (60 min)	<b>6. Collaborative Care in the Workers' Compensation System</b> <ul style="list-style-type: none"> <li>• Integrated Practice Units in the Workers Comp Arena</li> <li>• Collaboration in Community and Institutionally Supported Settings</li> </ul>	<b>Dianna Chamblin, MD</b> , Medical Director for the COHE at the Everett Clinic <b>Gregory Carter, MD</b> , Medical Director COHE Community of Eastern Washington
<b>2:10 – 2:20</b>	<b>Ten Minute Break</b>	
<b>2:20 – 3:10</b> (50 min)	<b>7. Progressive Goal Attainment Program:</b> <ul style="list-style-type: none"> <li>• Success Stories and Relevance to Self-Insured Employers</li> </ul>	<b>Terri Smith-Weller</b> , Occupational Health Nurse, UW Department of Environmental & Occupational Health Sciences <b>Jill Goodrich</b> , Occupational Therapist and PGAP coach, Olympic Sports and Spine
<b>3:10 – 3:20</b> (10 min)	<b>8. Self-Insured Colloquium Goals:</b> Ensuring time well spent <ul style="list-style-type: none"> <li>• Goal of Colloquium and meeting participant needs</li> <li>• Theme Approach and Topics</li> </ul>	<b>Natalee Fillinger, JD</b>  <b>Facilitated Discussion</b>
<b>3:20 – 3:30</b> (10 min)	<b>9. Closing:</b> Insights from today's presentations and take-aways	<b>Natalee Fillinger, JD</b>

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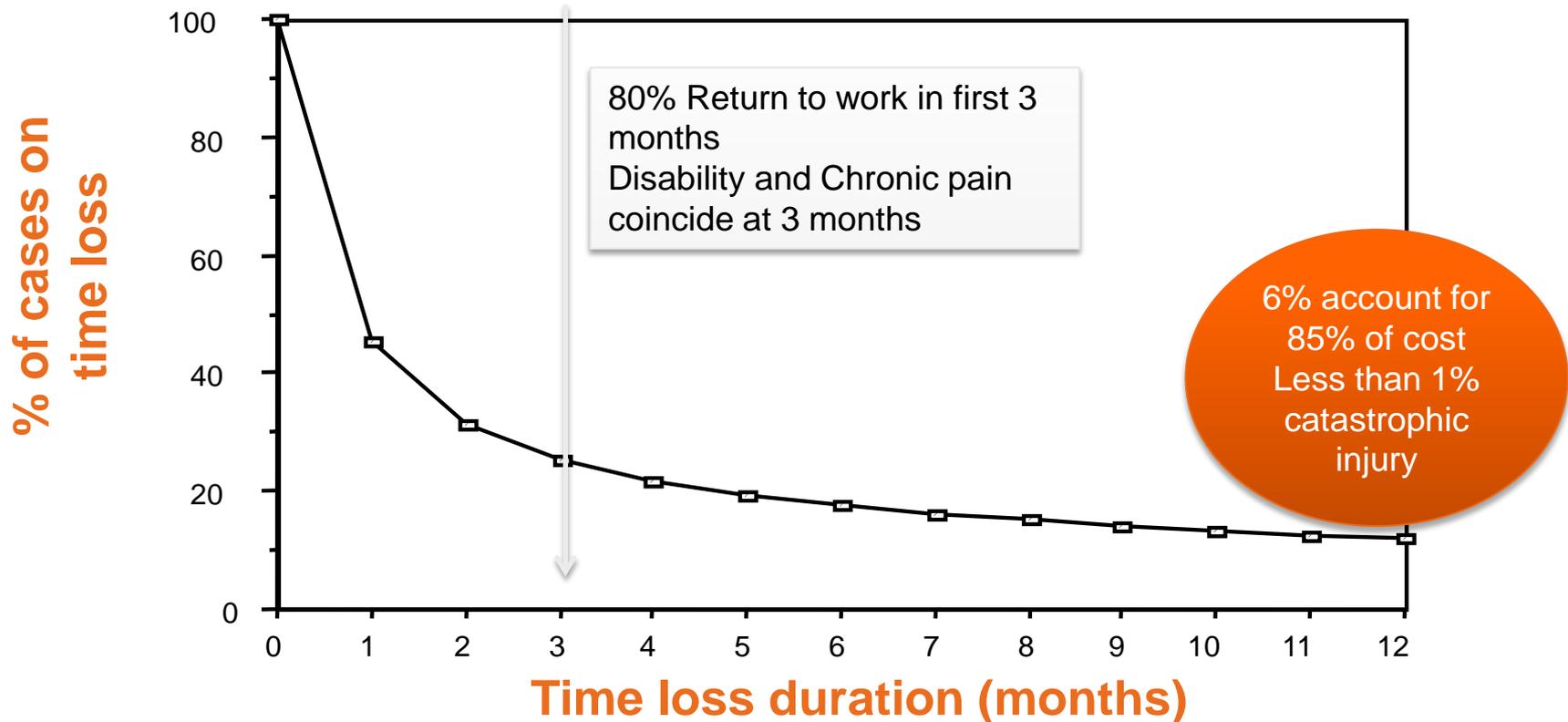
**3. L&I Updates:  
Leadership, Programs, and Projects  
Leah Hole-Marshall, JD**

# COLLOQUIUM ON OCCUPATIONAL HEALTH BEST PRACTICES

***L&I UPDATE ON HEALTH CARE  
LEADERSHIP, PROGRAMS, POLICY***

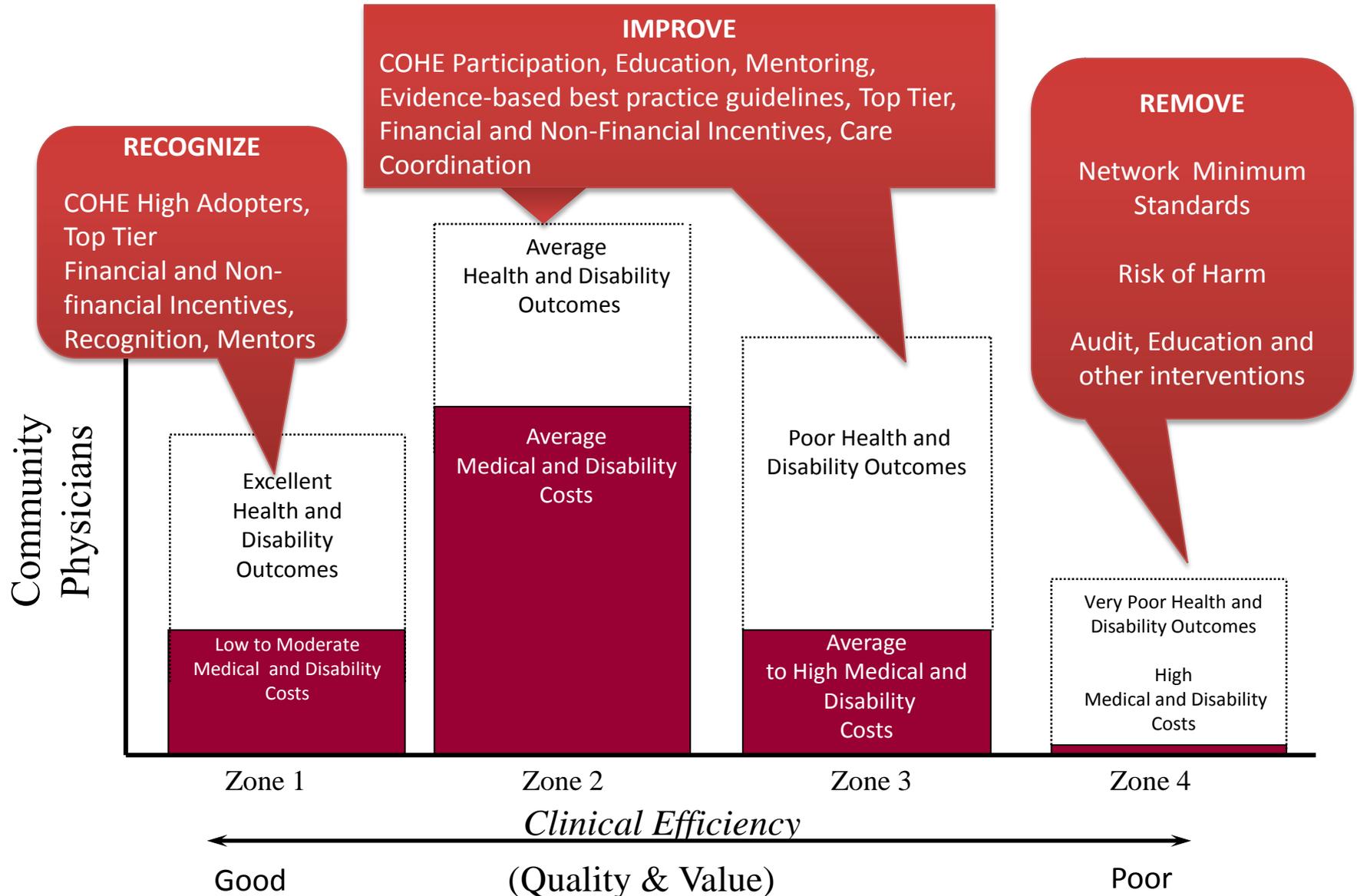
***Leah Hole-Marshall  
Medical Administrator***

# Disability Prevention is the Key Health Policy Issue



*Adapted from Cheadle et al. Am J Public Health 1994; 84:190-196.*

# Distribution of Quality of Care





# L&I Health Quality Expansion Vision

- **Set Minimum Standards**
  - Medical Provider Network and Risk of Harm
- **Incentivize Collaborative Model and Occupational Best Practices**
  - COHE Expansion
  - Top Tier
  - Evidence based treatment guidelines
- **Promote/Identify Evidence Based Policies and Practices**
  - Evidence Based Treatment Guidelines
  - Functional Recovery Questionnaire/Intervention
  - Activity Coaching
  - Surgical Best Practice
- **Identify areas of ongoing need for system innovation**
  - Behavioral health
  - Long term disability/Chronic pain



# HSA Core Contributions to High Quality Care

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**Welcome Karen Jost:** Health Services Analysis (HSA) Program Manager

- 1. Provider Access** – outreach, recruitment, directories, credentialing, accounts,
- 2. Provider Quality** – COHE/Best Practices, Top Tier, Audit/complaints
- 3. Provider Reimbursement** – Paying bills correctly and timely, authorizing services, audit
- 4. Provider Support** – Hotlines, Web Information, Directory, Surveys,
- 5. Medical Cost Oversight** – Medical cost analysis, Rates, reimbursement pilots



# OMD Core Contributions to High Quality Care

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**Welcome Simone Javaher:** ONC Supervisor, Health Policy

## 1. Clinical Expertise for Claims

- Right claims at the right time (Referral Standard work and turnaround – ONC, CTU, Med. Consult.)

## 2. Leadership in Evidence Based Health Policy

- Evaluate best practices, guideline development

## 3. Ensure Highest Quality Care

- Risk of Harm
- Opioid Policy
- Utilization Review

## 4. Resource for Providers

- Provide tools, resources, and education to providers



# L&I Agency Alignment - 2014

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## **L&I Agency Goal #2** - Help injured workers heal and return to work

*Key Focus Area:* Reduce the development of preventable permanent disability. Strategies:

- Adoption of COHE best practices
  - Progressive Goal Attainment Program (PGAP)
  - Functional Recovery Questionnaire
  - Chronic Opioid Use
- 
- For Discussion Today
    - L&I Goal #2 Measures
    - Update on Reform Efforts
    - Update on Quality Care Expansion Projects

# Helping Workers Heal and Return to Work Dashboard

Status	Focus Area	Key Indicator	Baseline 2012	1 <sup>st</sup> Qtr 2014	Target by June 2015
	Overall indicator	<b>Decrease number of long-term disability (LTD) claims</b>	436 claims (out of every 10,000 accepted claims)	<b>415 claims</b> (out of every 10,000 accepted claims)	377 claims (out of every 10,000 accepted claims)
	Culture of return to work	<b>Increase return to work in 6 months</b>	832 (out of every 1,000 new TL claims)	<b>833</b> (out of every 1,000 new TL claims)	850 (out of every 1,000 new TL claims)
	Reduce preventable disability	<b>Decrease time-loss persistence from three to six months</b>	70.9%	<b>70.1%</b>	62%
	Collaborate to Reduce system delays	<b>Decrease average days of time-loss paid at three months from the first time-loss payment.</b>	56.1 days	<b>57.4 days</b>	54 days

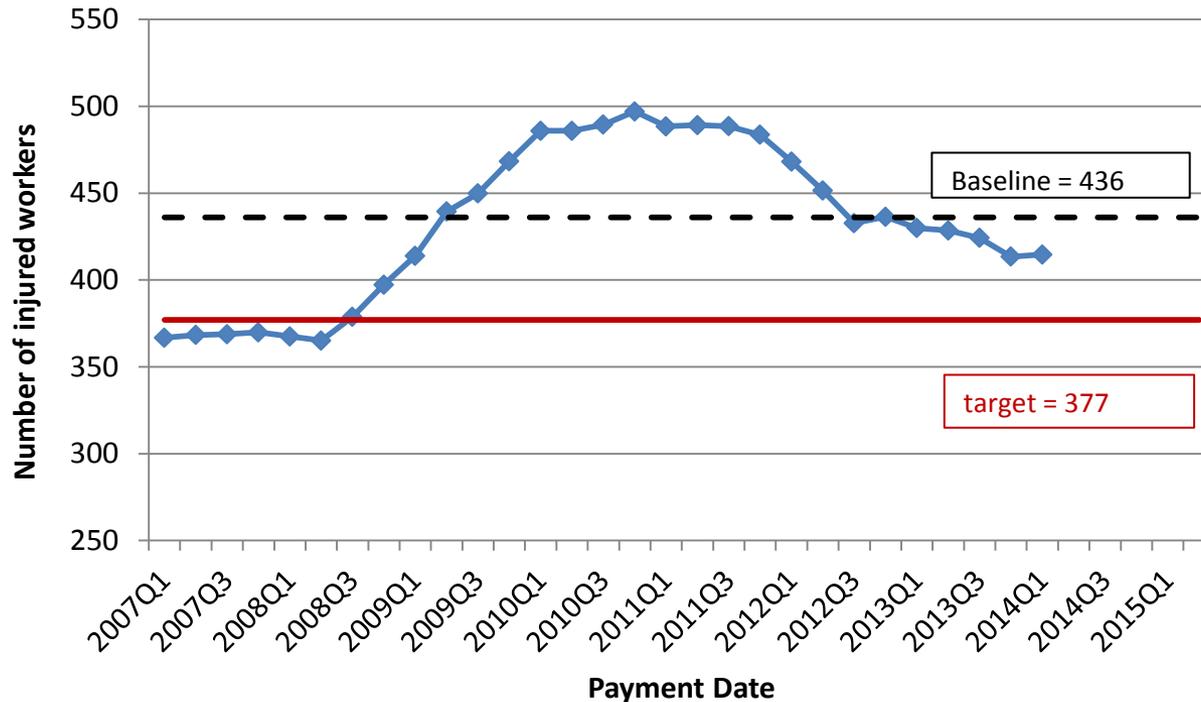
-  green making progress towards target
-  yellow not making consistent progress towards target
-  Red moving consistently in wrong direction

# Definitions

1. **Long-term disability claims** – For every 10,000 accepted claims, the number that are on time-loss 12 months from their injury month, smoothed.
2. **Return to work in 6 months** –For every 1,000 new time-loss claims, the number that are off time-loss for at least a 30 consecutive day period during their first six months.
3. **Time-loss persistence** – the number of claims that have time-loss payments at sixth months from their injury month divided by the number of claims that had a time-loss payment three months from their injury month, smoothed.
4. **Time-loss days paid at 3 months** – of claims receiving time-loss, the average number of time-loss paid per claim at 90 days from the 1<sup>st</sup> time-loss payment, smoothed.
5. **Injured Worker overall experience** – For a sample of injured workers who have at least 30 days of time-loss, what is their overall rating of their worker's comp experience.
6. **Employer overall experience** – for a sample of employers who have at least one claim that has had 30 days or more of time-loss in the last two years, what is their overall rating of their workers comp experience

# Overall Measures – Help injured workers heal and return to work

Number on time-loss 12 months from injury.



**Target: 377**

*Current Status is **GREEN.***

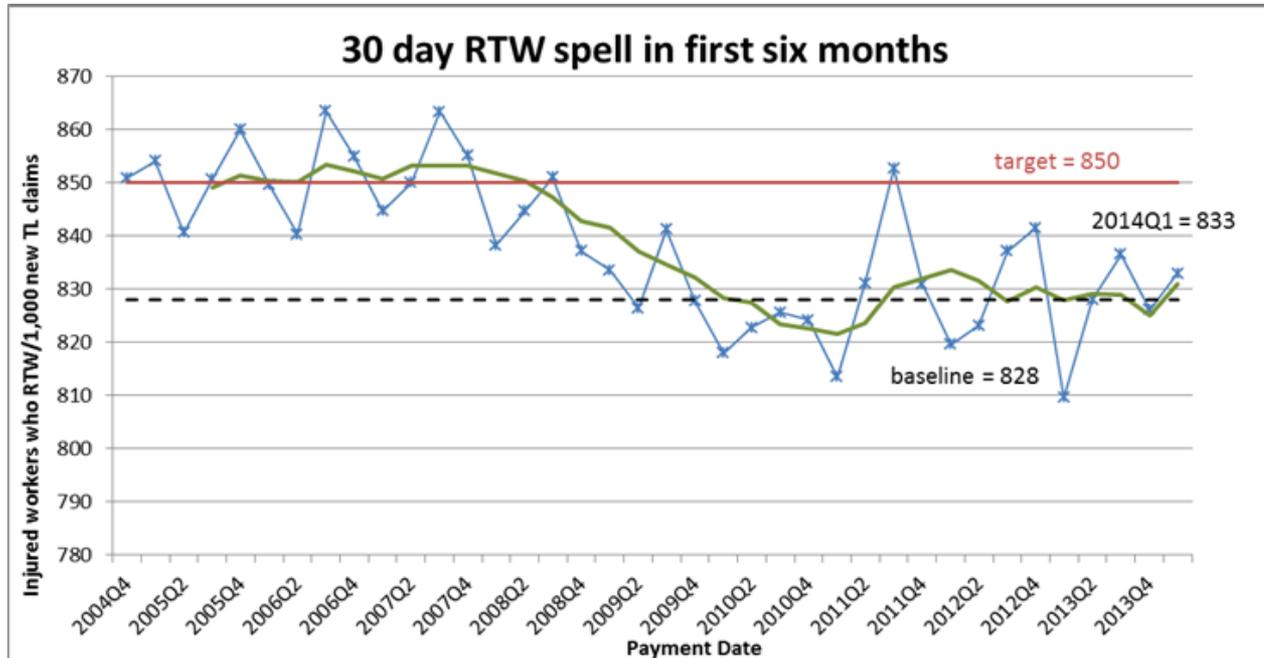
*Our goal is to be **BELOW** the target line.*

*We are on track to reduce the number of injured workers still on time-loss 12 months after their injury.*

**Definition of Long-term disability claims** – For every 10,000 accepted claims, the number that are on time-loss 12 months from their injury month, smoothed.

**Analysis & Detail:** We have instituted a number of strategies to reduce disability at 12 months. The decline after 2011 was largely due to the implementation of legislative reforms. Now we are using Lean to identify and implement internal policy changes to continue the positive change.

# Focus Area – Create a culture of return to work



**Target: 850**

 *Current Status is **YELLOW.***

*Our goal is to be **ABOVE** the target line.*

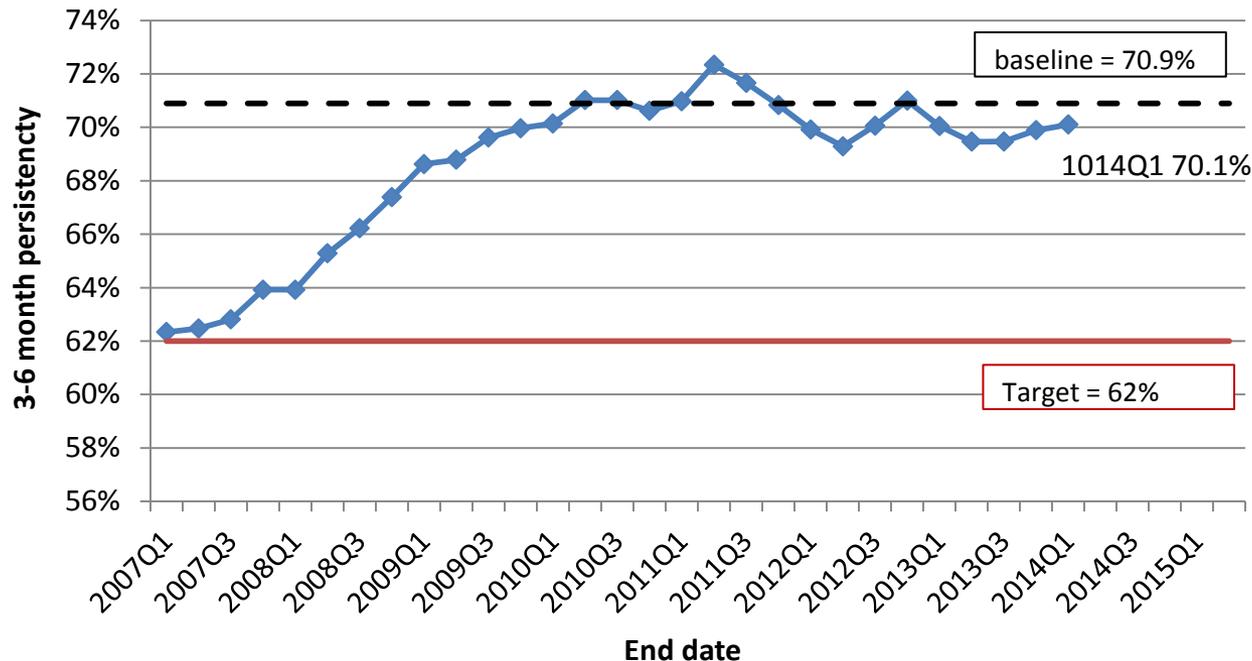
*We are struggling to increase our RTW measure during the first 6 months of the claim.*

**Definition of Return to work in 6 months** –For every 1,000 new time-loss claims, the number that are off time-loss for at least a 30 consecutive day period during their first six months.

**Analysis & Detail:** We are convinced that only by creating a pervasive culture of return to work will individual staff members be empowered to systematically eliminate barriers that prevent return to work. You will see that we are making real progress in our key strategies, but we need to understand better why we are not seeing the anticipated increase in this measure.

# Focus Area – Reduce preventable disability

Three to six month persistency rate has not yet turned.



**Target: 62%**

*Current Status is **YELLOW.***

*Our goal is to be **BELOW** the target line.*

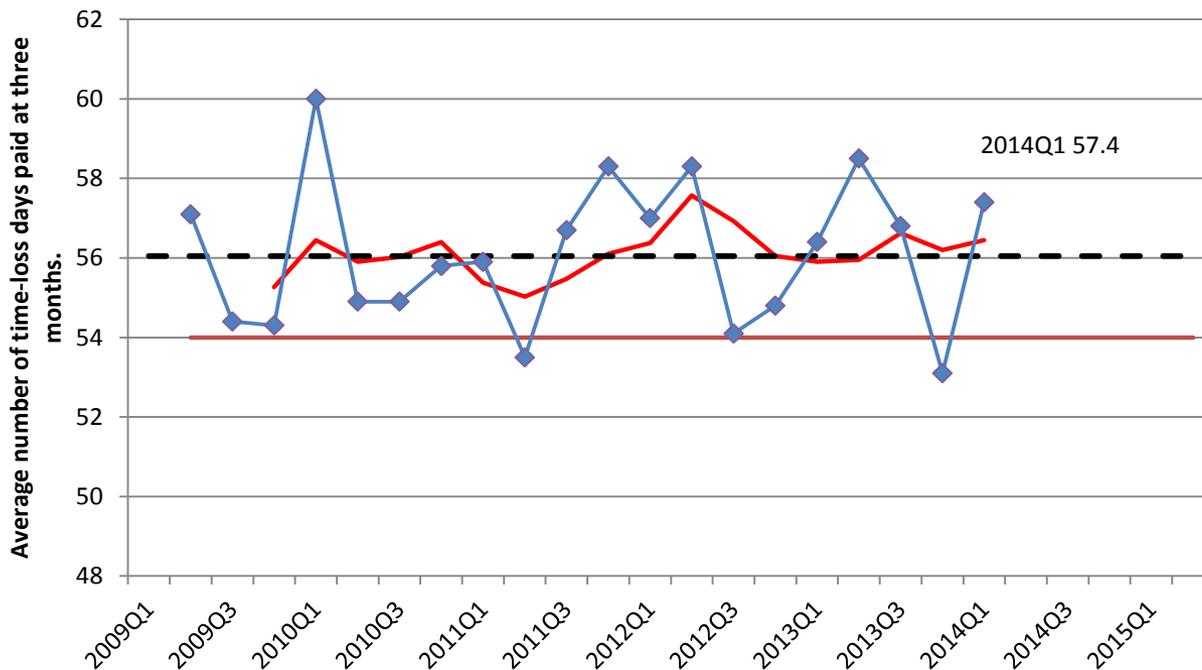
*While the persistency rate stopped increasing in 2010, it has not yet started to decline.*

**Time-loss persistence** – the number of claims that have time-loss payments at sixth months from their injury month divided by the number of claims that had a time-loss payment three months from their injury month, 12 month rolling average. Report value last smoothed month in quarter.

**Analysis & Detail:** We are implementing broad-based, proven strategies to prevent disability in injured workers. While these strategies have been shown to improve outcomes for injured workers, their main impact may not be on time-loss claims between three and six months. We continue to explore the connection between our strategies and this measure.

# Focus Area – Collaborate to reduce system delays

Average days paid 90 days shows a lot of variation.




**Current Status is YELLOW.**  
 Our goal is to be **BELOW** the target line.  
 The average number of time-loss days paid at three months bumps along near its baseline.

**Time-loss days paid at 3 months** – of claims receiving time-loss, the average number of time-loss paid per claim at 90 days from the 1<sup>st</sup> time-loss payment, smoothed.

**Analysis & Detail:** Lean processes and standard work give us tools to systematically integrate good ideas into our standard business processes. When these ideas are tested against a return to work objective, we maximize the potential of an injured worker to return to the job. Early in a claim, time-loss days paid indicates the extent of time away from the job.



# Medical Provider Network

Beginning **January 1, 2013**, the following Washington State providers can treat for the initial visit *only* unless they are in the network or submitted a complete application by December 31, 2012:

- Physicians (medical and osteopathic)
- Chiropractors
- Naturopathic Physicians
- Podiatric Physicians
- Advanced Registered Nurse Practitioners
- Physician Assistants
- Dentists
- Optometrists



# Medical Provider Network – Summary Status

Status	Comment
Network Size - Approved Providers ~20,500 providers in network Equivalent to baseline of 5 primary docs w/i 15 miles	Increased number of providers able to provide care and meeting minimum quality standards
Change Rate ~130 providers apply weekly; equivalent delegated provider changes	Volume higher and processing time is longer than planned
Patient Care Disruption – Transition and Access	Low volume needed transition coordination 98% of claims have network or exempt provider
Provider Disruption - Billing and scheduling	Limited disruption except dentists, anesthesiologist, radiologists; and out of state/new providers to system
Ongoing Access to Quality Care	Same as pre-network: generally good, but psychiatric services and complex, long term claims continue to have issues



# Network Enrollment and Application

## Network Enrollment (Comparing April 2013 to June 2014)

<u>Status</u>	<u>Providers 4-13</u>	<u>Providers 6-14</u>
Approved	13,143	20,311
Provisional/Other	1,813	240
Pending (Applicant)	3,932	1,287
<b>TOTAL</b>	<b>18,888</b>	<b>21,838</b>
Withdrawn	N/A	1520
Denied	59	115

### Appeals

Total appeals:	23
Complete (not in network):	18
Complete (in network):	2
In Process:	3

# Medical Provider Network Next Steps

- Identify and Implement approach to Network Management and Oversight
  - Complaint Management Process
  - New Information and Changes
  - Recredentialing
- Manage requests for reconsideration and appeals from denied providers
- Support transfer of care for injured workers as needed
- Design and implement data analysis to identify providers who present a “risk of harm”



# Incentivize Collaborative Care and Best Practices

## Expand COHE Enrollment

Current # of Enrolled Providers	Proposed # of Enrolled Providers	COHE Name
1,149	1,451	COHE Community of Eastern Washington
220	230	COHE at The Everett Clinic
36	70	COHE at Group Health Cooperative
181	233	COHE at Harborview Medical Center
265	300	COHE at UW Medicine/Valley Medical Center of the Puget Sound
109	1,208	COHE Alliance of Western Washington
<b>1,960</b>	<b>3,492</b>	<b>TOTAL</b>



# Incentivize Collaborative Care and Best Practices

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

- **Top Tier Goals**

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

- **Advisory Group (ACHIEVE) Items for Discussion**

- Top Tier Timing
- Top Tier Eligibility
- Top Tier Incentives
- Top Tier Administration



# Incentivize Collaborative Model and Best Practice Use

## **Occupational Health Management System (OHMS)**

- Technology to support COHE expansion and other provider-based programs
  - Care coordination & alerts (high risk claims or actions due)
  - Track occupational health best practices
  - Integrate with L&I systems and (in later phases) providers' Electronic Medical Record systems
- Project has multiple phases through 2015
- Phase 3 is on track to go “live” in June
  - Focus of this phase is on tools for COHE Health Services Coordinators



## Promote Evidence Based Policies

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### Evidence Based Treatment Guidelines

#### IIMAC

- Opioid Guideline
- Shoulder Surgery Guideline

#### IICAC

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

#### Bree Collaborative

- Accountable Payment Models - Warranty for total knee and total hip replacement surgery.
- Spine Care -participation in Spine SCOAP as best practice for surgeons
- Low Back Pain – Best practices recommendations to prevent Transition to Chronic pain.



# New Best Practices – Identify and Pilot

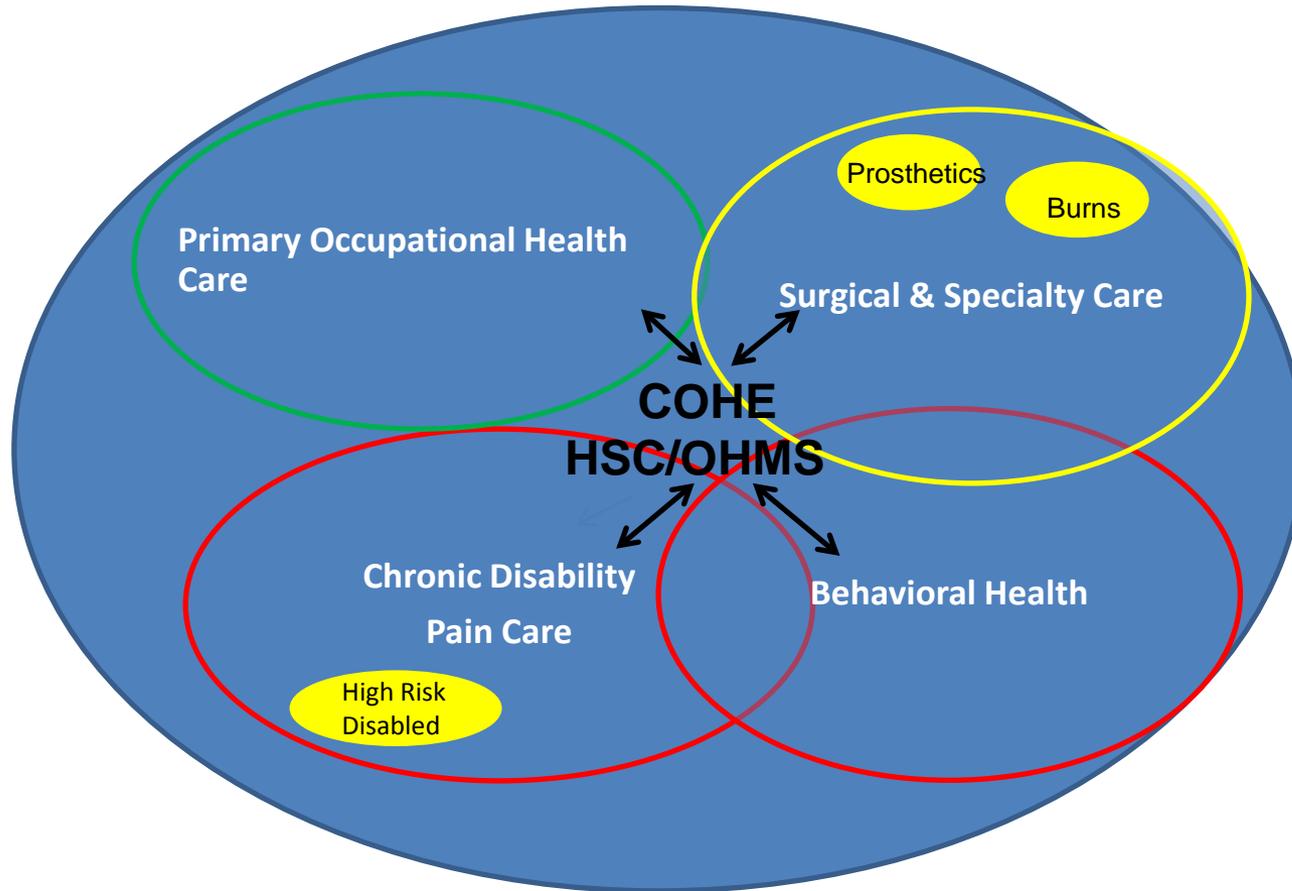
**Identification:** UW led process based on literature review and selection by a focus group of providers

## Pilots Underway

- **Functional Recovery Questionnaire/Intervention Pilot**
  - Early identification of potentially “at risk” workers
  - Providers incorporate interventions to enhance recovery
- **Activity Coaching Pilot**
  - Tested program: Progressive Goal Attainment Program (PGAP) where coaches encourage and track structured activities
- **Surgical Best Practice Pilot**
  - Four best practices covering (1) transition of care, (2) return to work planning, (3) care coordinator to coordinate care and track transition, and (4) assist with complex cases



# Collaborative Care Vision



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## **4A. Barriers to Return to Work**

Overview: Risk Factors Impacting Return  
To Work

Nicholas Reul, MD

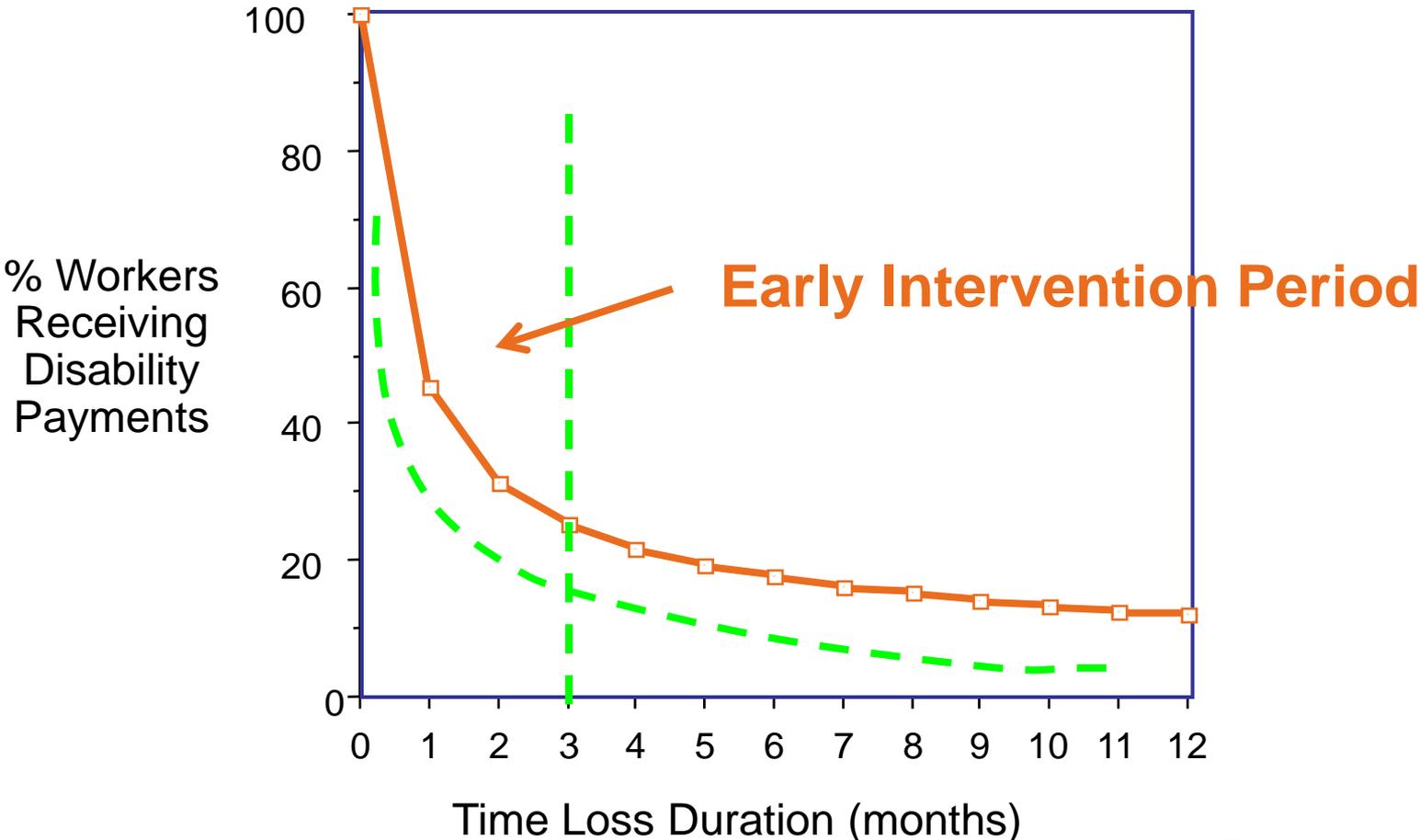
# Preventing Disability: Risk Factors for Return to Work

*Nicholas K. Reul, MD, MPH*

*June 18, 2014*



# Changes in Disability Status among Injured Workers in WA State



Adapted from Cheadle et al. *Am J Public Health* 1994; 84:190-196.

# What is the relationship between health care delivery and prevention?

## Disability Prevention: Changing the Paradigm



*Franklin et al. 2013. Disability Prevention. In: Encyclopedia of Pain. RF Schmidt and GF Gebhart, eds. Springer-Verlag: Berlin. DOI 10.1007/978-3-642-28753-4*

# Disability Prevention in Workers' Compensation

## Most important risk factor categories



# Some partnerships in disability prevention

- Worker
- Employer
- Vocational counselor
- Provider
- Claims and administrative support

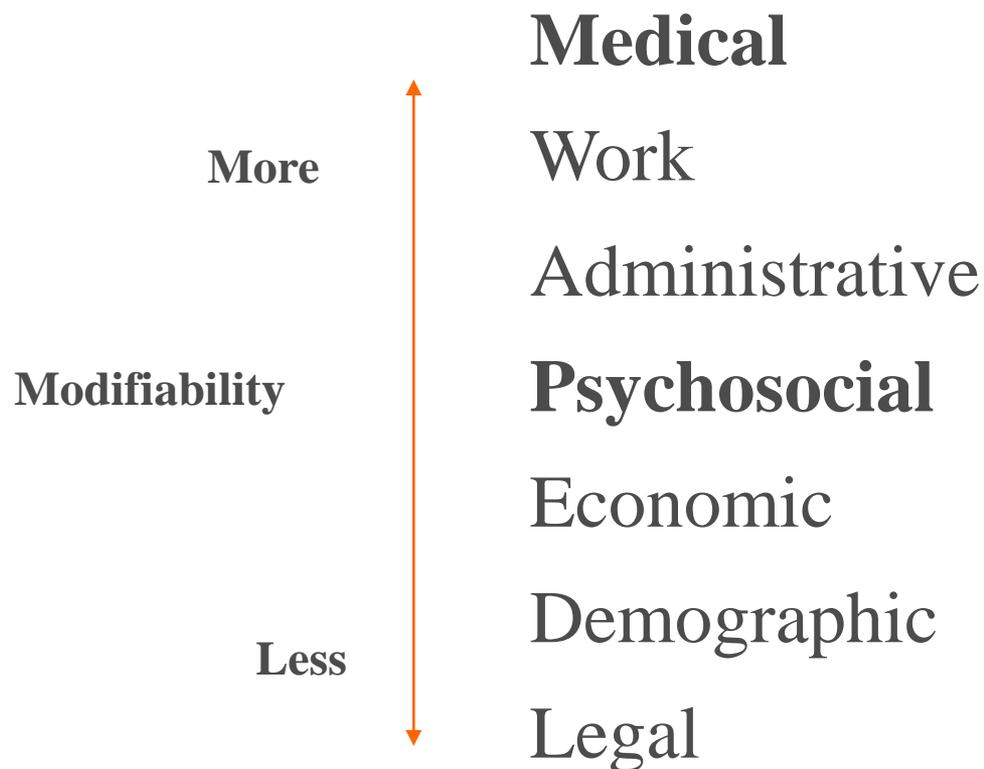
# Disability Prevention in Workers' Compensation

## Most important risk factor categories



# Disability Prevention in Workers' Compensation

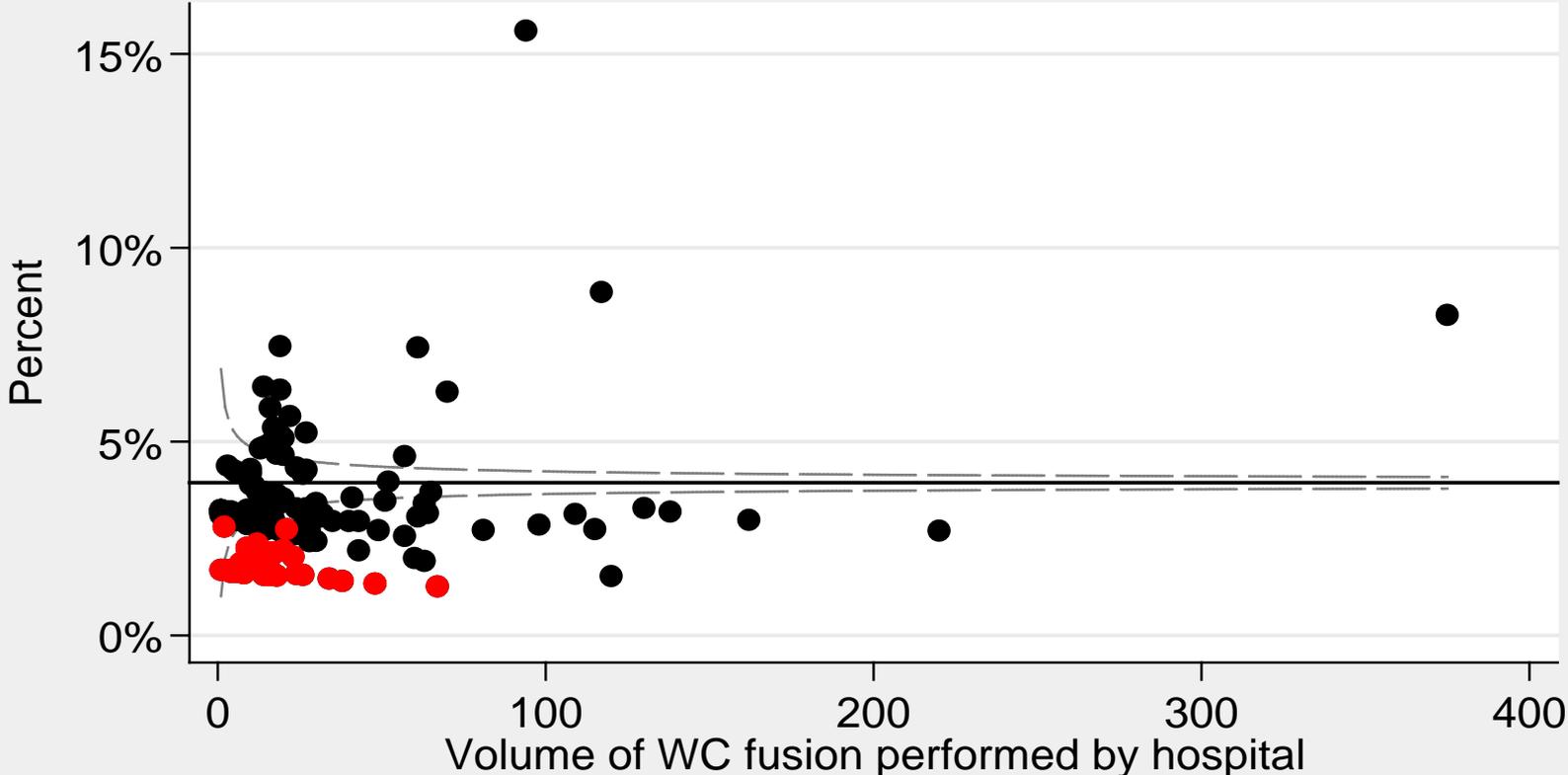
## Most important risk factor categories



# Strategic Focus in WA State

- **Use best evidence to pay for services that improve outcomes and reduce harms for injured workers**
- Identify efficient method for identification of workers at risk for long term disability
- Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability

# 3 month reoperation rates across hospitals in California (Black) and Washington (Red)



Source: SID CA & WA, 2008-2009  
Adjusted for age, sex, comorbidity, and diagnosis  
Horizontal black line represents overall mean

Martin, BI et al. 2013. How do coverage policies influence patterns, safety, and cost of initial lumbar fusion surgery? *Spine J.* 2013 Nov 7. pii: S1529-9430(13)01465-4. doi: 10.1016/j.spinee.2013.08.018

# Opiates and Disability

- 1/3 of all workers with compensable low back pain receive an opiate Rx in the first 6 weeks (Stover et al, J Pain 2006; 7: 718-25)
- Receipt of opiates for more than 7 days doubles the risk of one year disability (N-1843) in multivariate analysis (Franklin et al, Spine, 1/15/2008)

# Reduce the Development of Preventable Disability

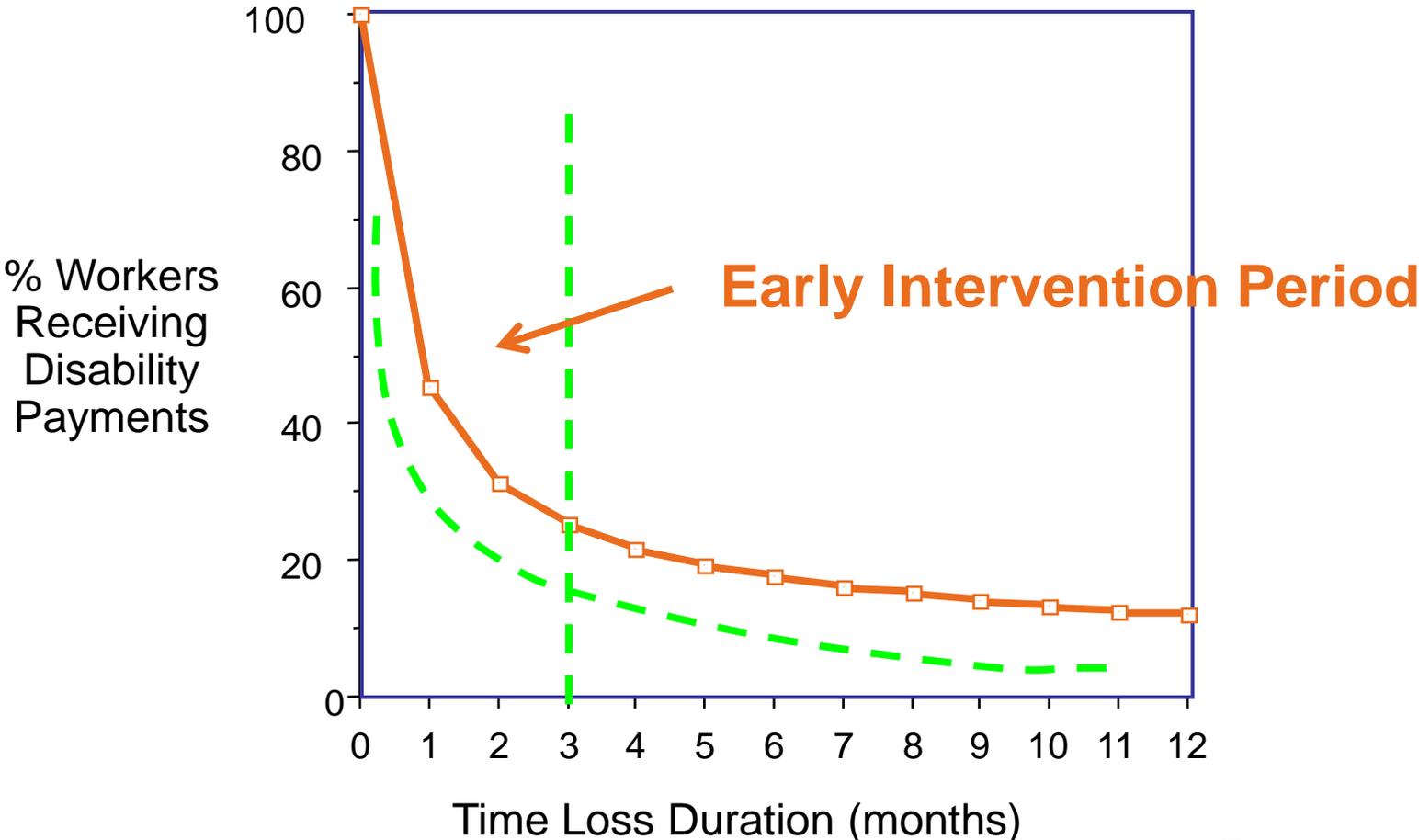
- Decrease the proportion of injured workers on Chronic opioids.

	Baseline: 2012	1Q 2013	2Q 2013	3Q 2013	4Q 2013	TARGET By 6/2015
Percent of claims received with opioids 6-12 wks from injury	4.9%	4.6%	3.3%	1.4%	1.1%	

# Strategic Focus in WA State

- Use best evidence to pay for services that improve outcomes and reduce harms for injured workers
- **Identify efficient method for identification of workers at risk for long term disability**
- Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability

# Changes in Disability Status among Injured Workers in WA State



Adapted from Cheadle et al. *Am J Public Health* 1994; 84:190–196.

# Washington Workers' Compensation Disability Risk Identification Study Cohort (D-RISC)\*

- Prospective, population based
- Low back injury and carpal tunnel syndrome
- For LBP, N=1885 workers enrolled and completed baseline interview (median 18d)
- Predictors of disability at 1 year

CDC/NIOSH RO1 OH04069-end 8/31/2007

*\*Turner, Franklin, Wickizer, Fulton-Kehoe et al. ISSLS Prize Winner: Early Predictors of Chronic Work Disability: A Prospective, Population-Based Study of Workers With Back Injuries. Spine 2008; 33: 2809-2818*

## Assessed >60 variables in 8 risk factor domains at baseline:

- **Sociodemographic**
- **Employment-related** (e.g., industry, job physical and psychosocial demands, offer of job accommodation, job duration)
- **Pain and function** (multiple measures, including Roland)
- **Clinical status** (e.g., injury severity, radiating pain, previous injuries, comorbidities)
- **Health care** (e.g., provider specialty)
- **Administrative/legal** (e.g., attorney)
- **Health behavior** (tobacco use, alcohol use, BMI)
- **Psychological** (catastrophizing, blame for injury, recovery expectations, work fear-avoidance, Mental Health)

## D-RISC–Primary Outcome

**At 1 year:** 261 of the 1,885 study participants (13.8%) were receiving work disability compensation (information obtained from workers' compensation administrative database).

## Baseline Predictors of 1 Yr Work Disability, Final Multi-domain Model (OR of worst category, adjusted for all other variables in model)

- Injury severity rating (from medical records) (3.7)
- Previous injury with > 1 month off work (1.6)
- Roland Disability Questionnaire score (7.0)
- Multiple pain sites (1.7)
- Job is hectic (2.2)
- No employer offer of job accommodation (1.9)
- First provider seen for injury (ref=Primary care; Occupational Medicine 1.8, Chiropractor 0.4, Other 1.9)

AUC=0.88 (excellent ability to predict 1 year disability)

# Job Accommodation Offer

	Disabled at 1 yr, %	Work disability days at 1 yr, median
Offer	7	10
No offer	19	35

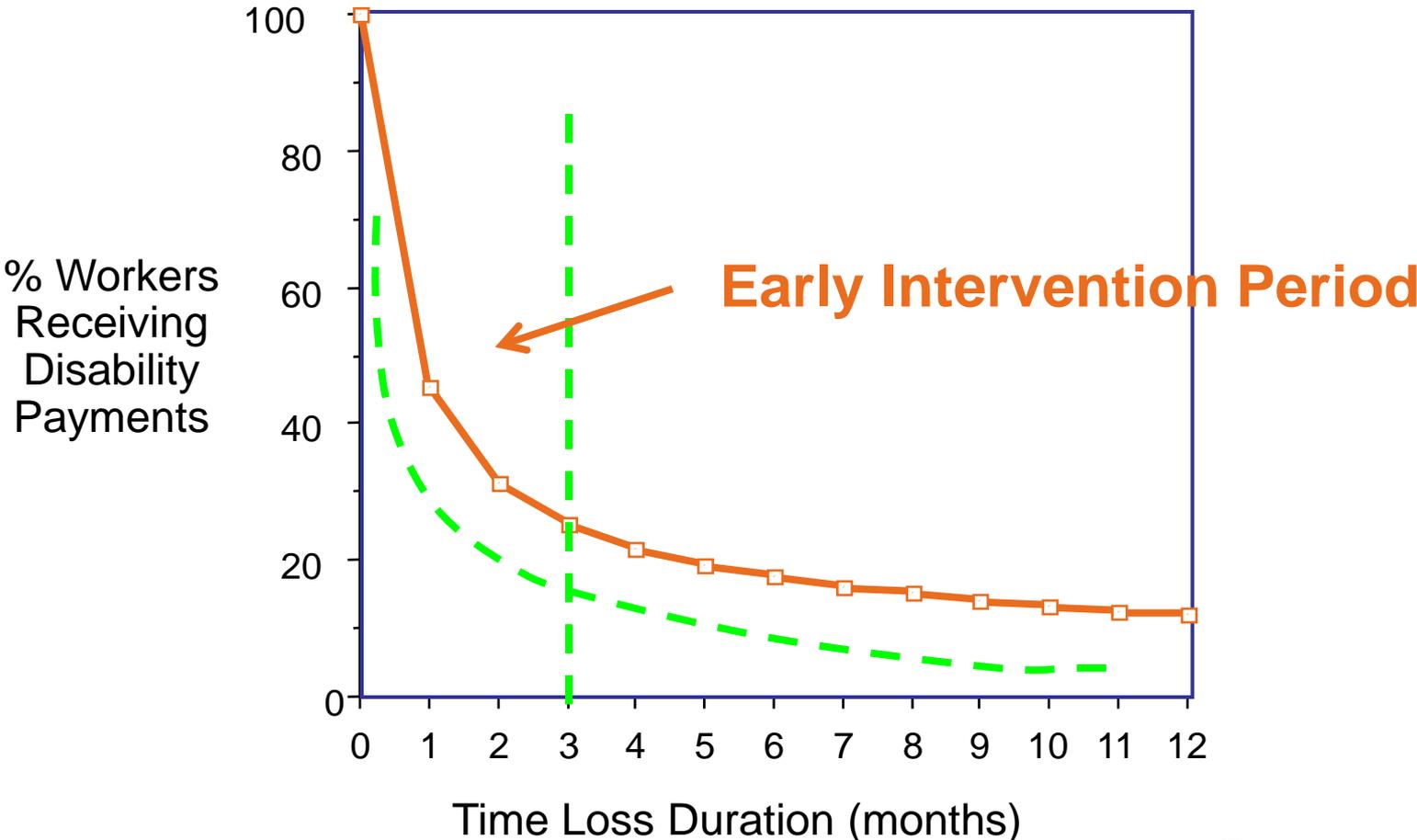
# Conclusions-D-RISC Study

- Factors in multiple domains, internal and external to worker, are important in the development of chronic back-related work disability
- Injury severity is an important risk factor, but even after adjusting for this and other factors, more widespread pain, greater physical disability, job factors, health care provider type, and prior work disability were significant predictors of chronic work disability
- Results support clinical impressions that patients with similar clinical findings vary in disability outcomes, likely due to factors other than biological ones

# Conclusions-D-RISC Study

- The biopsychosocial conceptualization of pain might benefit from greater emphasis on environmental factors (e.g., health care provider, employer, and family responses, and work and economic factors) that may interact with biological and psychological factors to affect disability
- Societal problem of chronic disabling back pain will likely require development of new, expanded approaches to prevention and treatment that consider environmental factors

# Changes in Disability Status among Injured Workers in WA State



Adapted from Cheadle et al. *Am J Public Health* 1994; 84:190-196.

# Disability Predictors—Next Steps

- Link risk identification with practical interventions
  - Targeted, graded exercise and incrementally graded activity
  - Education Re: fear avoidance/expectations
  - Workplace modifications
  - Pilot brief questionnaire and interventions in community-based occupational-health pilots (COHEs)

# Screening for Disability Risk Linked to Delivery of Occ Health Best Practices

## Positive Functional Recovery Questionnaire (FRQ)

- Not worked for pay in past two weeks
- Pain interference  $\geq 5$
- Back and leg pain **OR** pain in multiple body sites
- Available at <http://deohs.washington.edu/occepi/frq>

## Functional Recovery Interventions (FRI)

- Graded exercise/activity
- Address low recovery expectations
- Address any fear of usual activity reinjuring or worsening condition
- Flag additional HSC focus on RTW

# Strategic Focus in WA State

- Use best evidence to pay for services that improve outcomes and reduce harms for injured workers
- Identify efficient method for identification of workers at risk for long term disability
- **Incentivize collaborative delivery of occupational health best practice care sufficient to prevent disability**

# Important components of COHE Model

- This is a health care system, not an insurance company, intervention
- Health care institutional support
- Occupational health leadership
- Business/labor advisory committee

# Centers of Occupational Health and Education: Final Report on Outcomes from the Initial Cohort of Injured Workers, 2003-2005

*Thomas Wickizer et al. 2007.*

# Selected Findings

- **Pilot disability effects:**
  - **Time loss incidence: ORs  $\approx$  .75 - .80;  $p < .01$**
  - **Reduced disability days**
    - **All cases: 4.8 days to 6.0 days,  $p < .01$**
    - **Time loss cases only: 15.9 days to 18.0 days,  $p < .01$**
    - **Strongest effects: Back sprains, other sprains, CTS**
- **Pilot Cost savings:**
  - **Renton: \$381 per claim,  $p < .01$**
  - **Spokane: \$518 per claim,  $p < .01$**
  - **60% - 70% of cost savings from reduced disability costs**

# Do Cost Savings Increase Over Time?

- **Administrative data for Renton pilot site for outcome year 4 and for Spokane pilot site for outcome year 3 were obtained and analysis was repeated to assess longer-term cost savings effect.**
- **Small percentage of claims account for most of costs. If disability prevention can reduce long-term claims, substantial savings can result.**

# Changes in Cost Savings Associated with Longer Follow Up Period

---

	<b>1 Year Follow Up</b>	<b>Extended Follow Up</b>
<b>Renton</b>	<b>\$381</b>	<b>\$819</b>
<b>Spokane</b>	<b>\$591</b>	<b>\$1,279</b>

---

# Disability Prevention in Workers' Compensation

## Most important risk factor categories



Colloquium on Occupational Health Best Practices  
at Group Health Cooperative  
Today's Theme: Collaborative Care in Healing and Returning to Work  
June 18, 2014

## **4B. Barriers to Return to Work**

Example: Adverse Childhood Events

Laura Porter



COMPREHENSIVE  
HEALTH  
EDUCATION  
FOUNDATION

# ACEs & Work

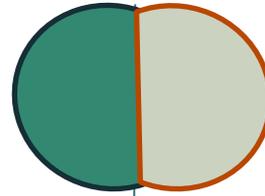


# Experience & Adaptation

Safe

Concepti on

Dangerous



Nurturing  
Challenge, Support

Episodic or Lasting  
Fear or Danger

Relational  
Process-Oriented  
Multi-Focused

Experi ence

Reactive  
Hyper- Vigilant  
or Numb

Social & Biological  
Expectations Align

Adaptati on

Isolation  
Dependency  
Crisis

Soci etal  
Response

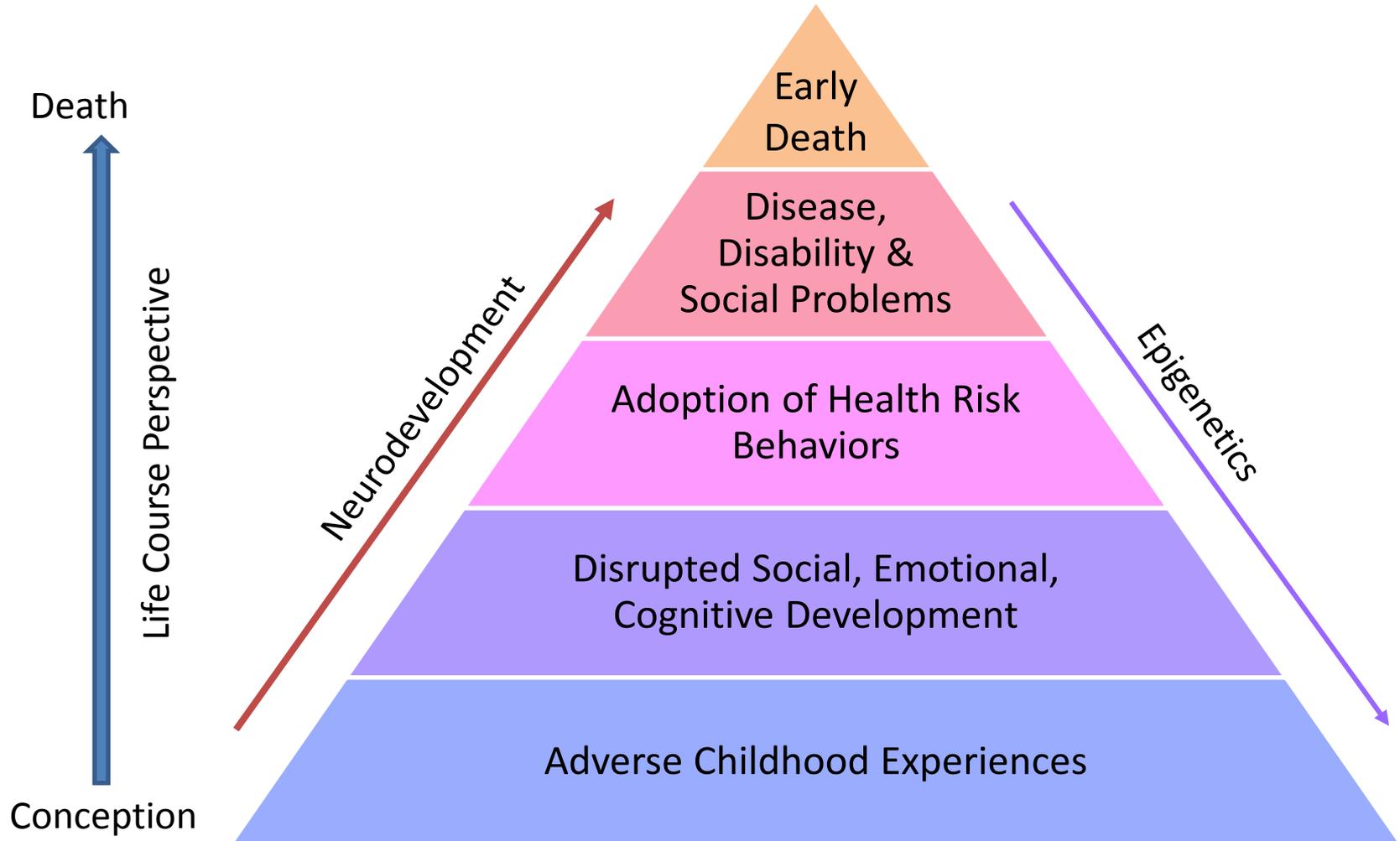
Long  
Productive Life

Early Death

Health Across Life Course



# Adverse Childhood Experience “The ACE Study”



# Experiences Considered

## Indicators of Family Dysfunction

1. Mentally ill, depressed or suicidal person in home
2. Drug addicted or alcoholic family member
3. Parental discord – indicated by divorce, separation, abandonment
4. Witnessing domestic violence against the mother
5. Incarceration of any family member

## Abuse

6. Child physical abuse
7. Child sexual abuse
8. Child emotional abuse

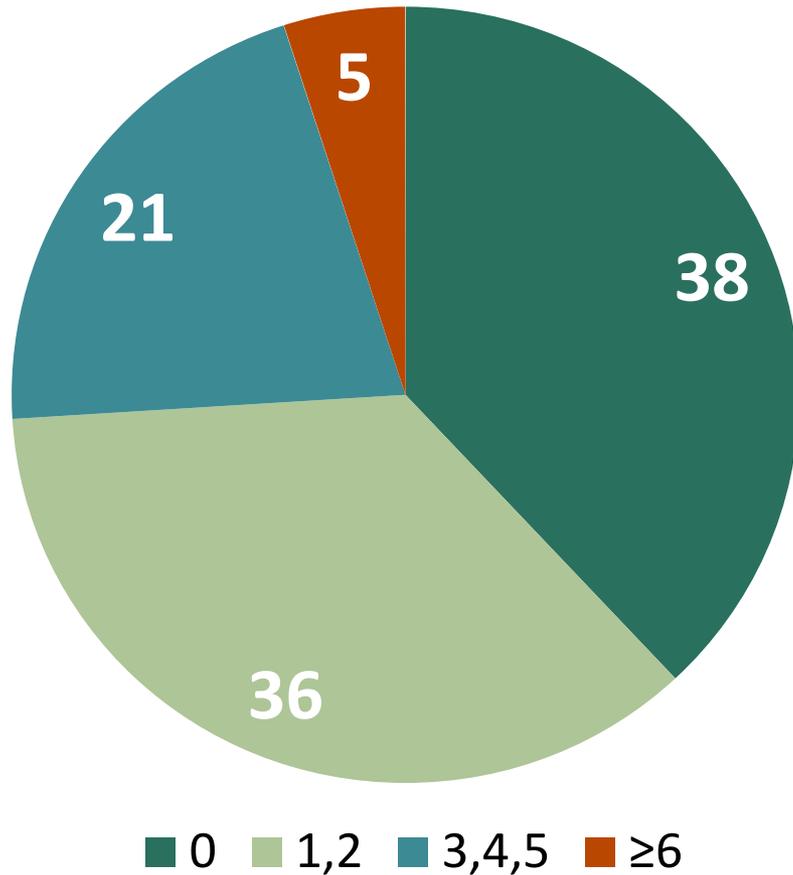
## Neglect

9. Physical Neglect
10. Emotional Neglect

ACE Score = Number of Categories (1-10)



# ACEs are Common



**62% of adults  
have  $\geq 1$  ACE**

**5% have  $\geq 6$**



# Major Findings

## ACE Categories (ACEs) are Interrelated

- 87% of people with 1 have >1

## ACEs are Common

- Nearly 2/3 of adults have  $\geq 1$ ; 27% have  $\geq 3$ ; 5% have  $\geq 6$

## Accumulation of ACEs Matters

- Higher # (ACE Score) = higher population risk

## Graded Relationship: Disease, Disability, Social, Productivity

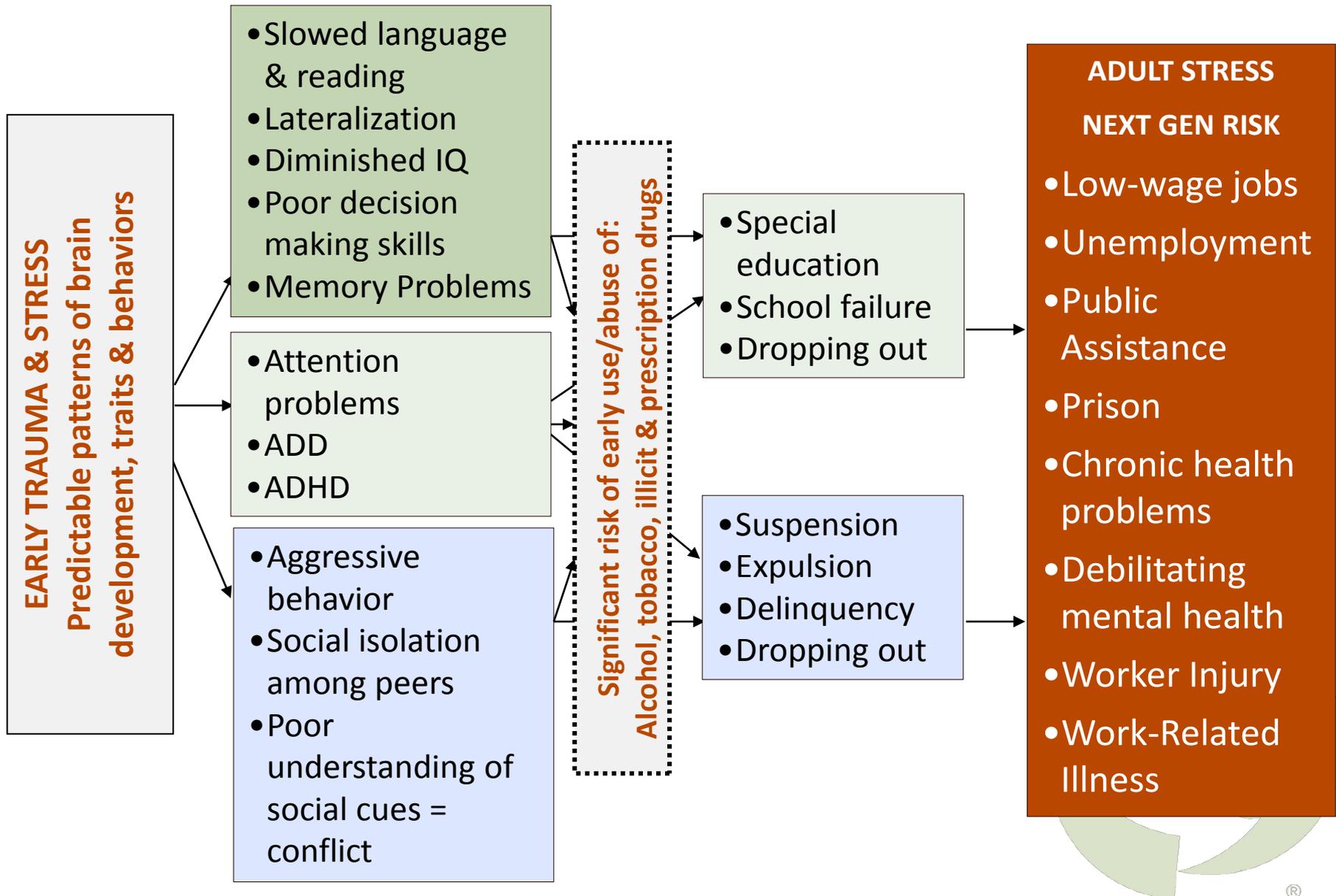
## Scores= Good Proxy Measure Childhood Toxic Stress Dose

## ACEs are the Most Powerful Known Determinant of Health

- Mental, Physical, Behavioral, Productivity, Disability, & Social Problems



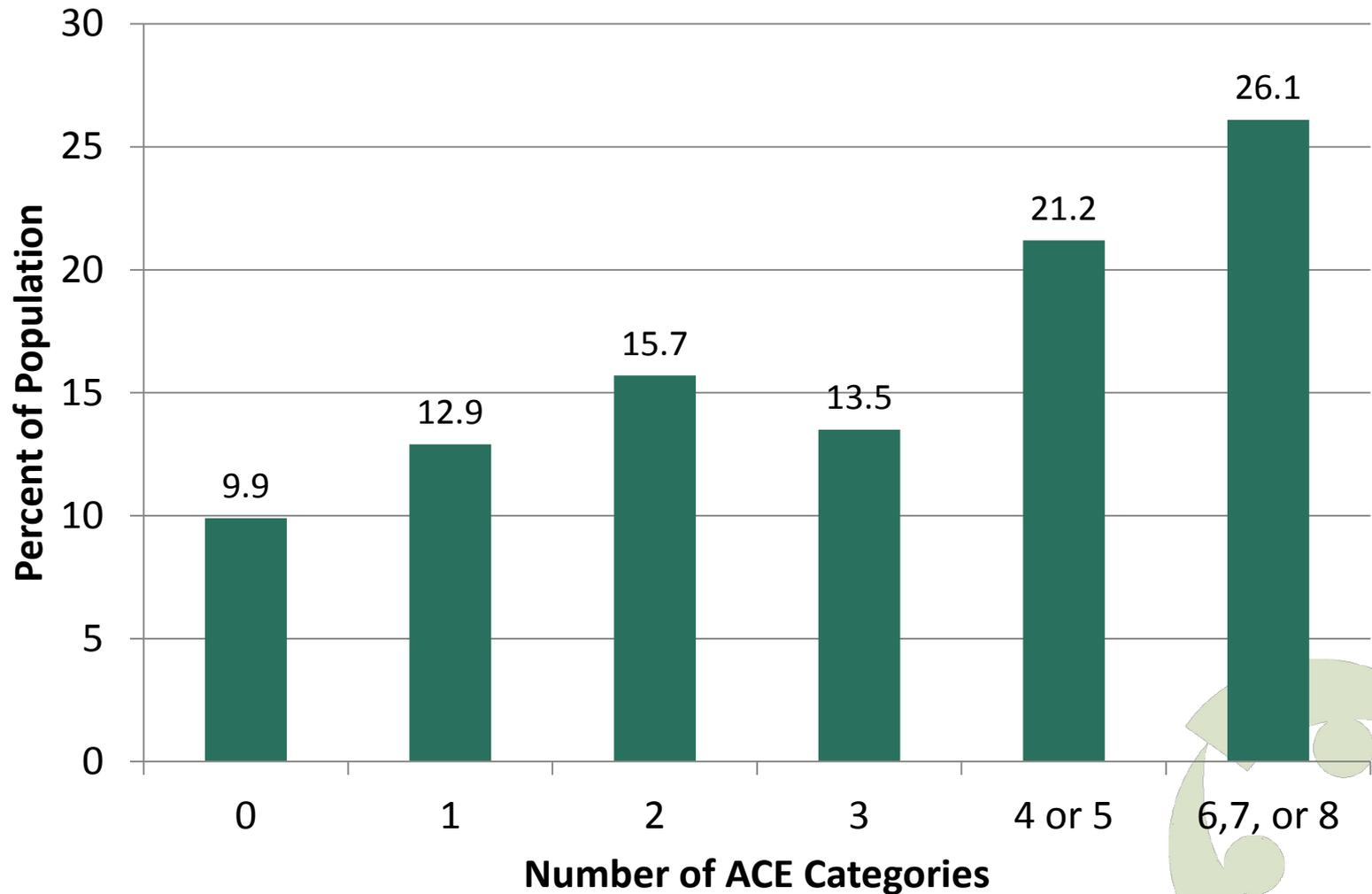
# The Fast Track to Poverty



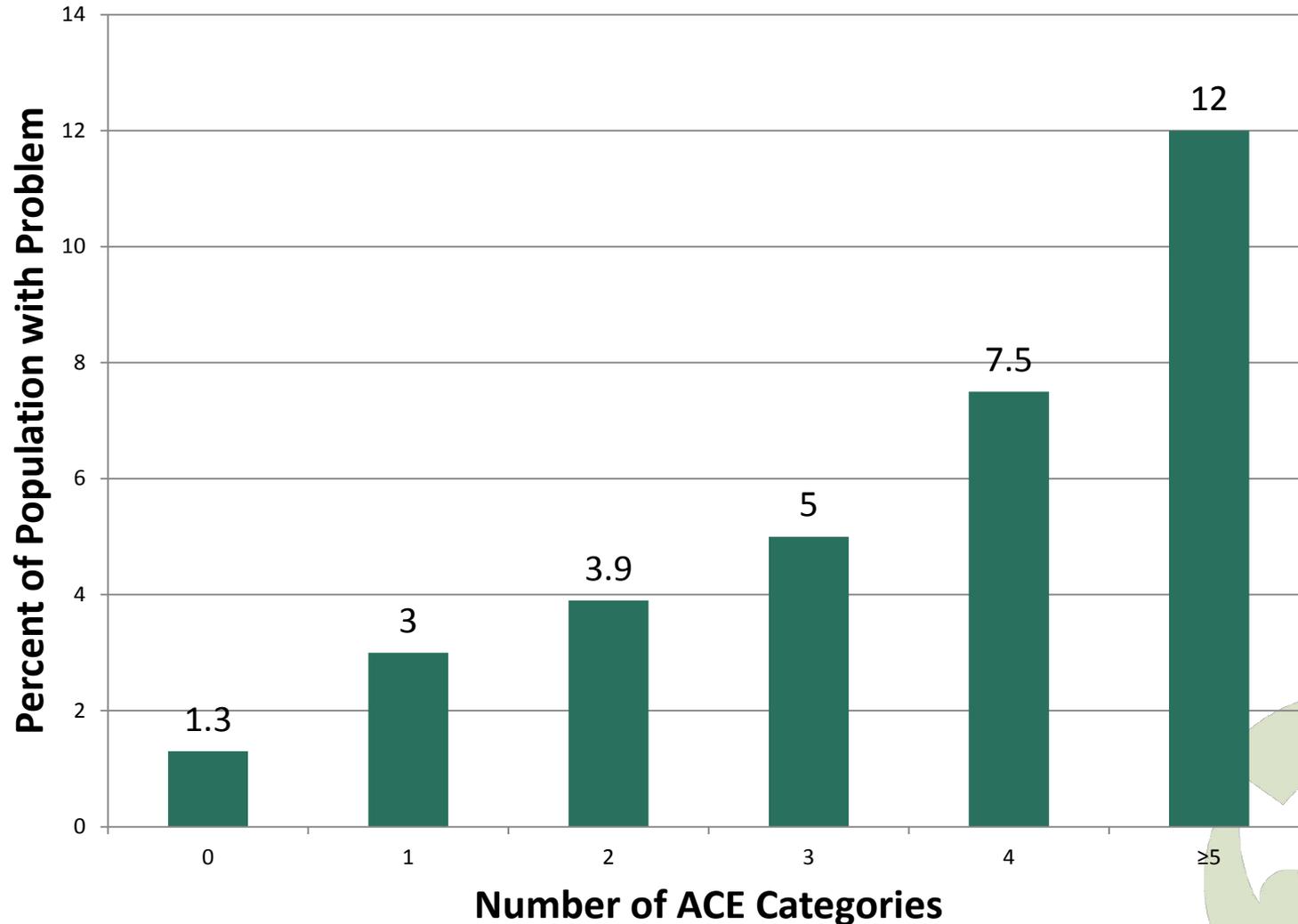
# Adverse Childhood Experience & Risks for Workplace Injury/Illness



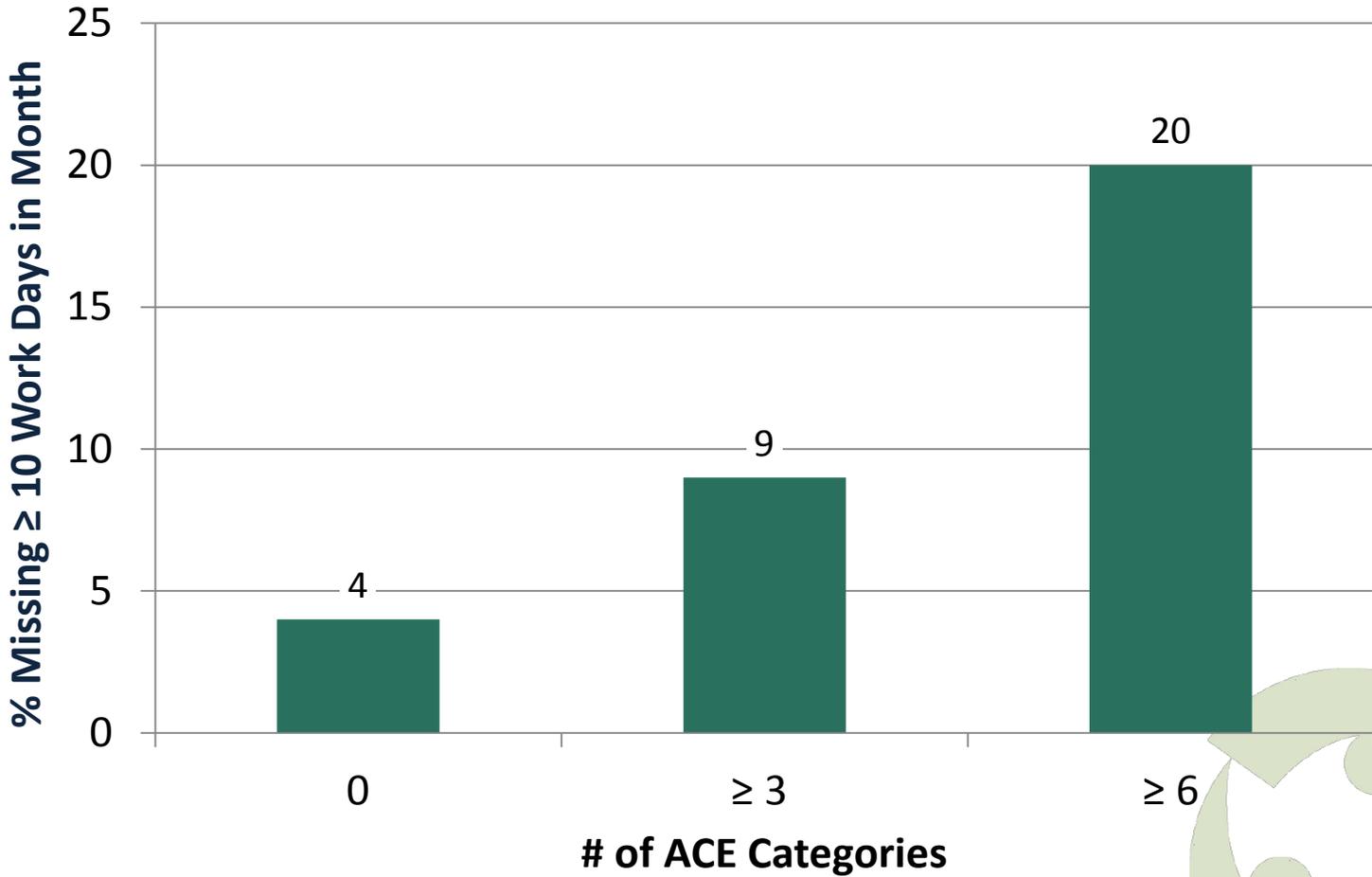
# Insufficient Sleep $\geq 21$ of 30 Days



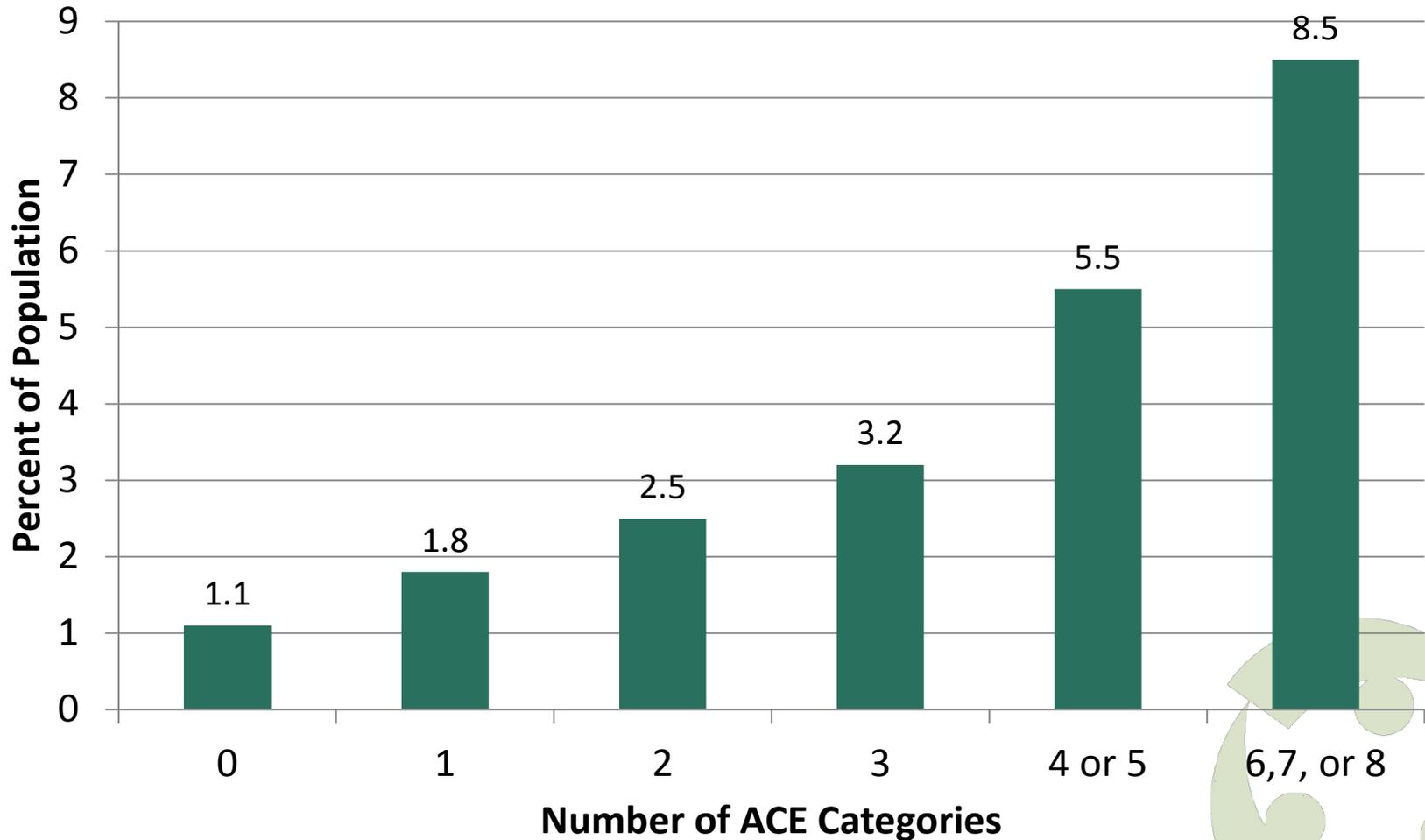
# Ever Had a Drug Problem



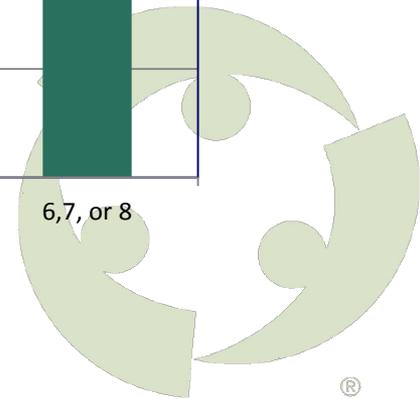
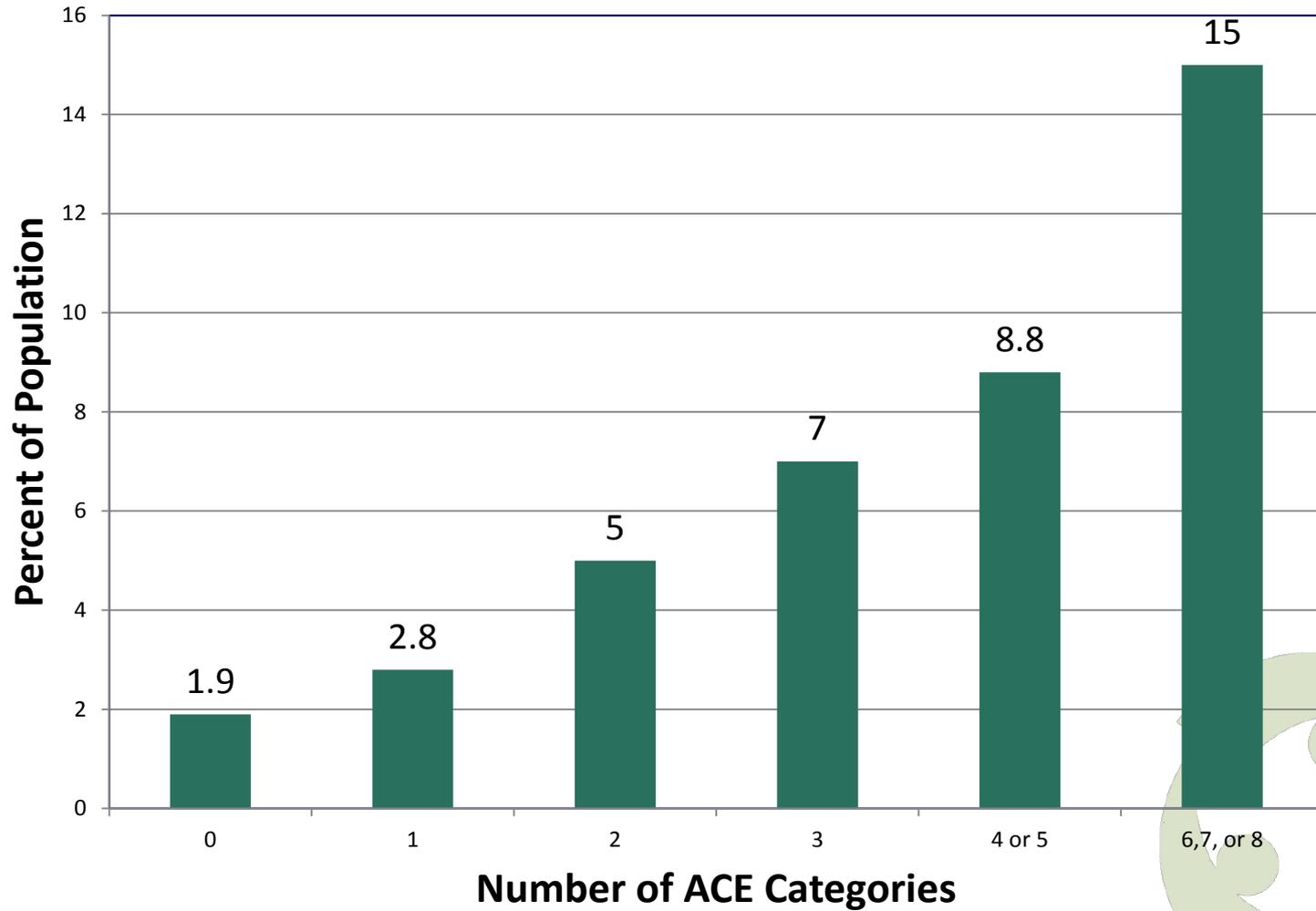
# Missed Work



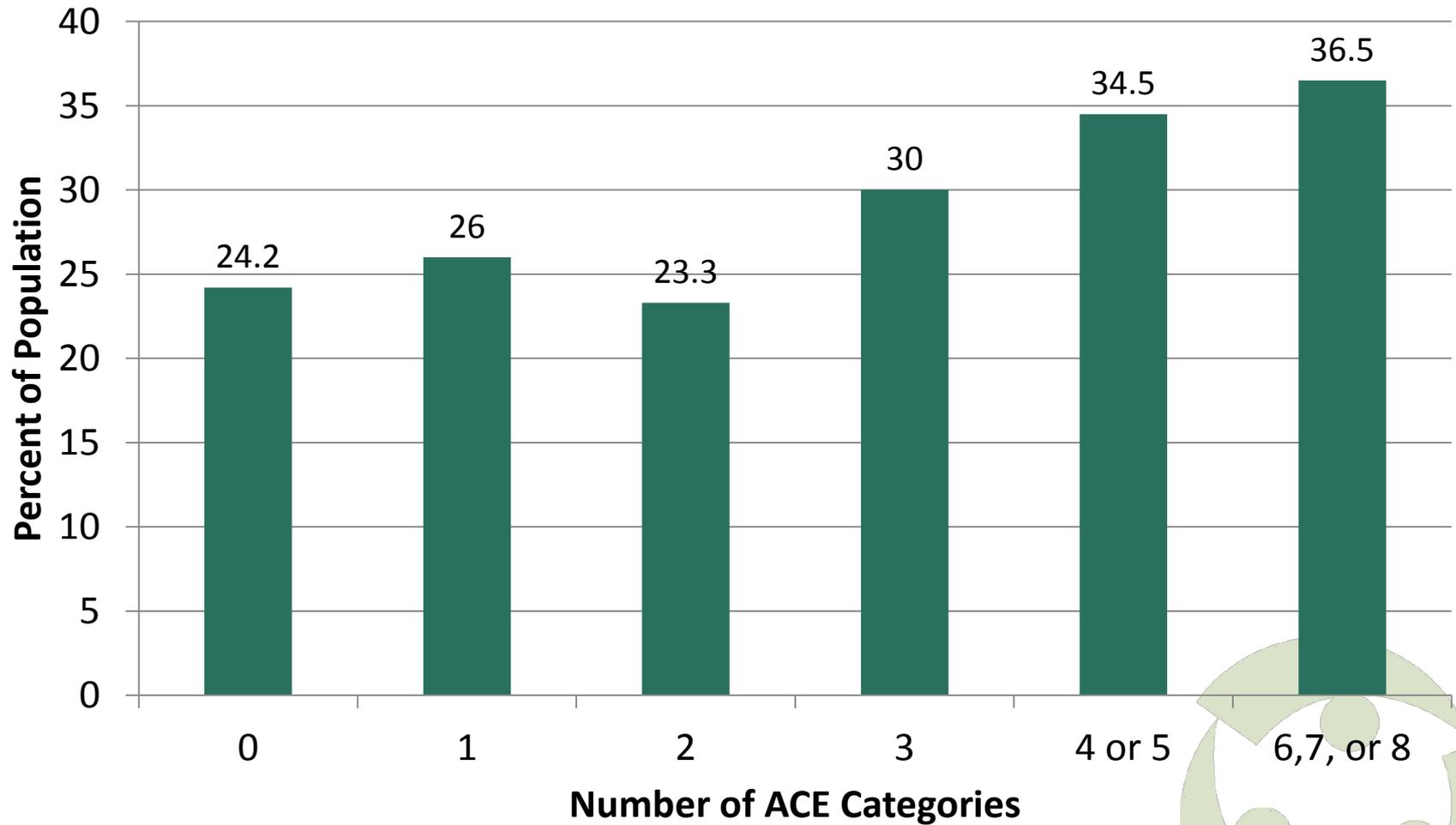
# Missed Work $\geq 30$ Days Due to Mental Health



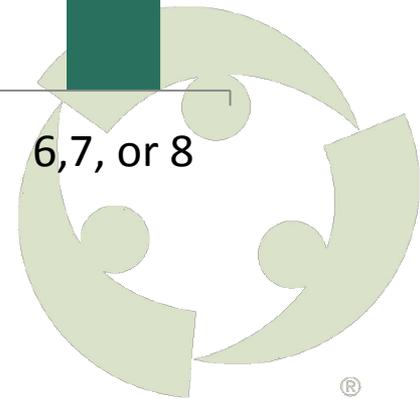
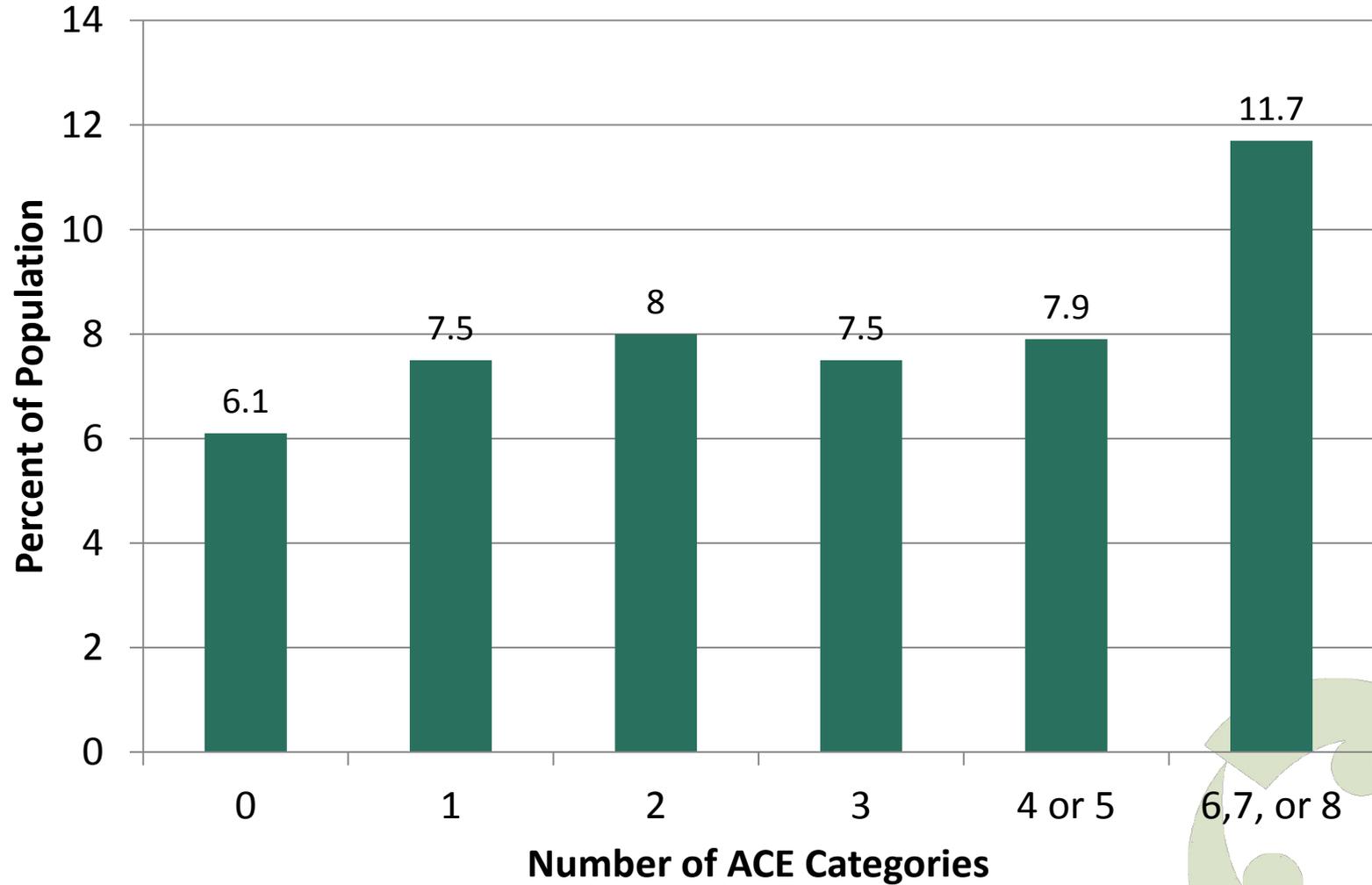
# Anxiety



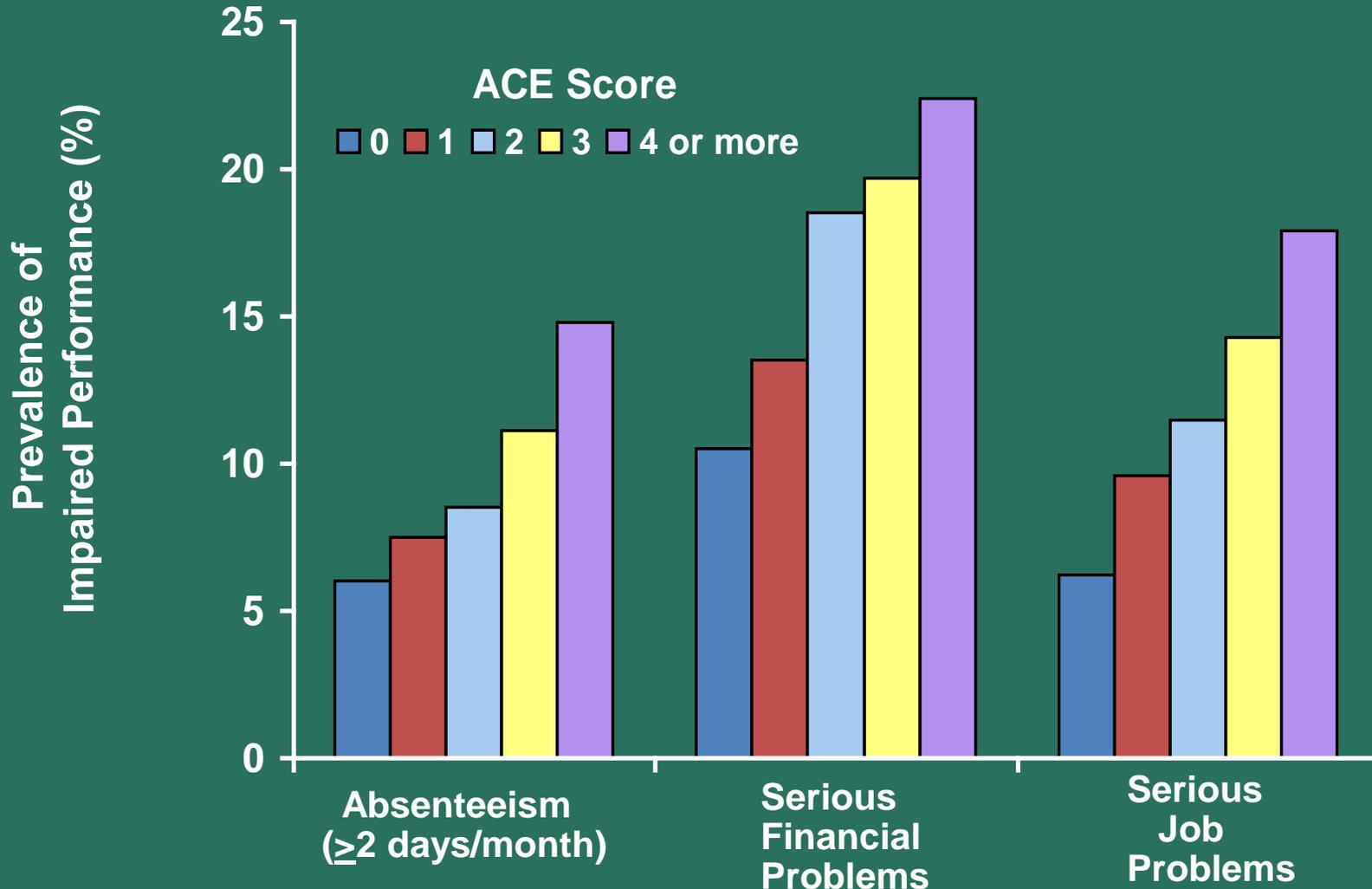
# Obesity



# Diabetes



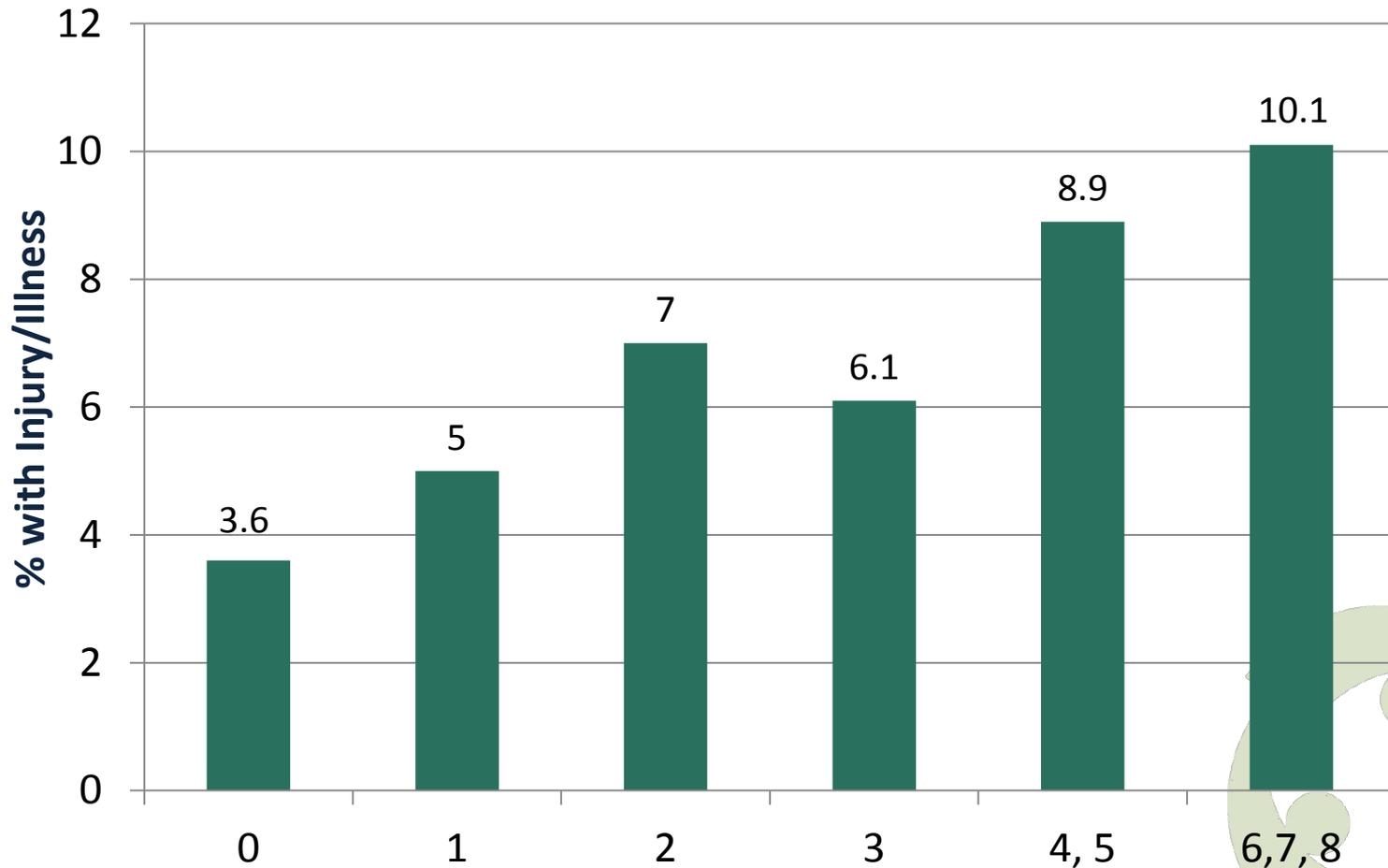
# ACE Score and Indicators of Impaired Worker Performance



# Adverse Childhood Experience & Worker Injury, Work-Related Illness



# Work-Related Injury or Illness in Past Year

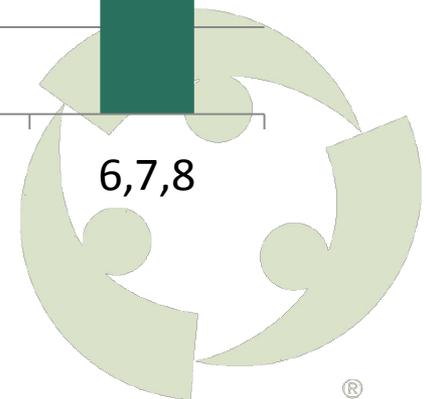
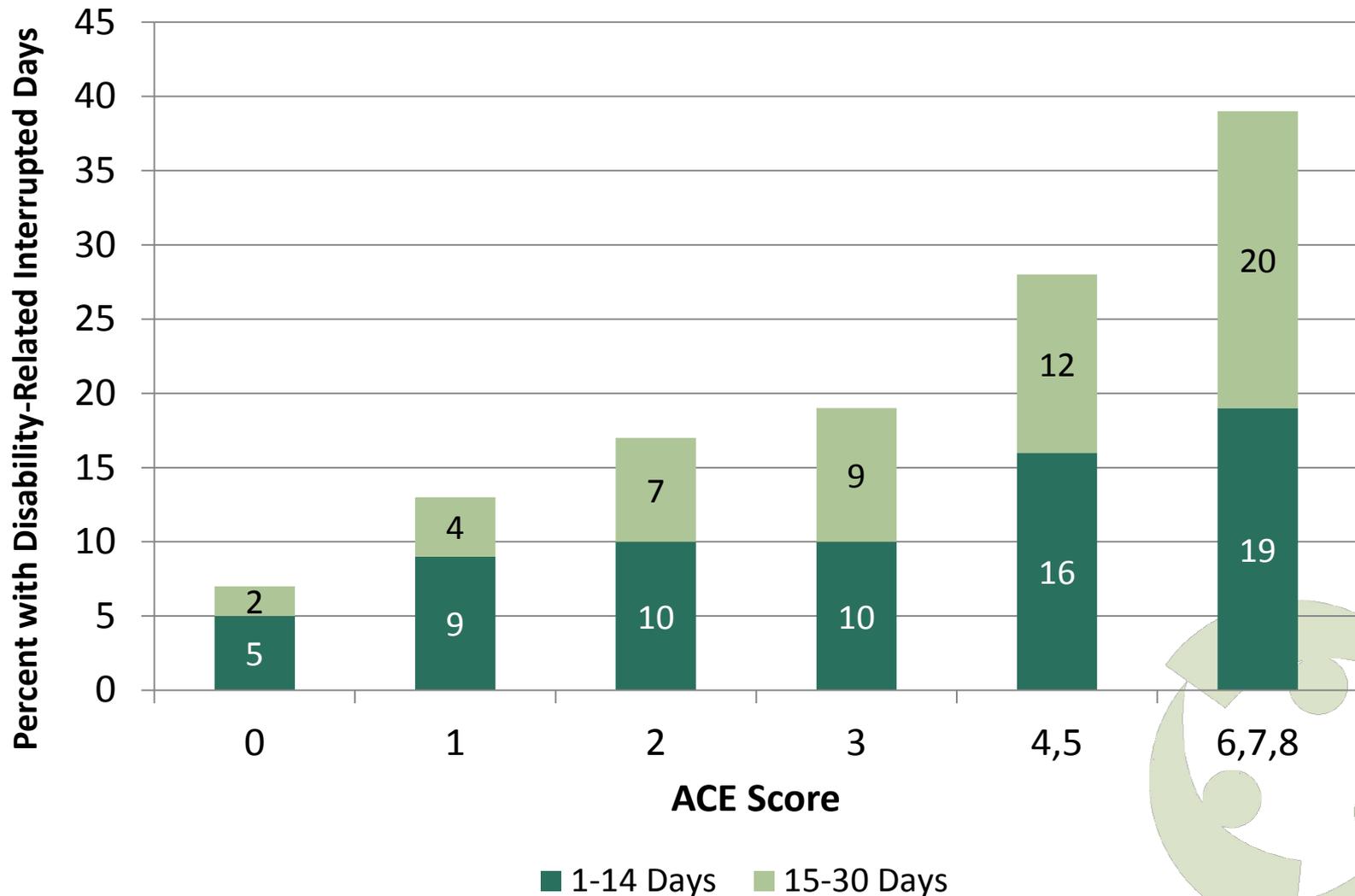


# Adverse Childhood Experience & Barriers to Returning to Work



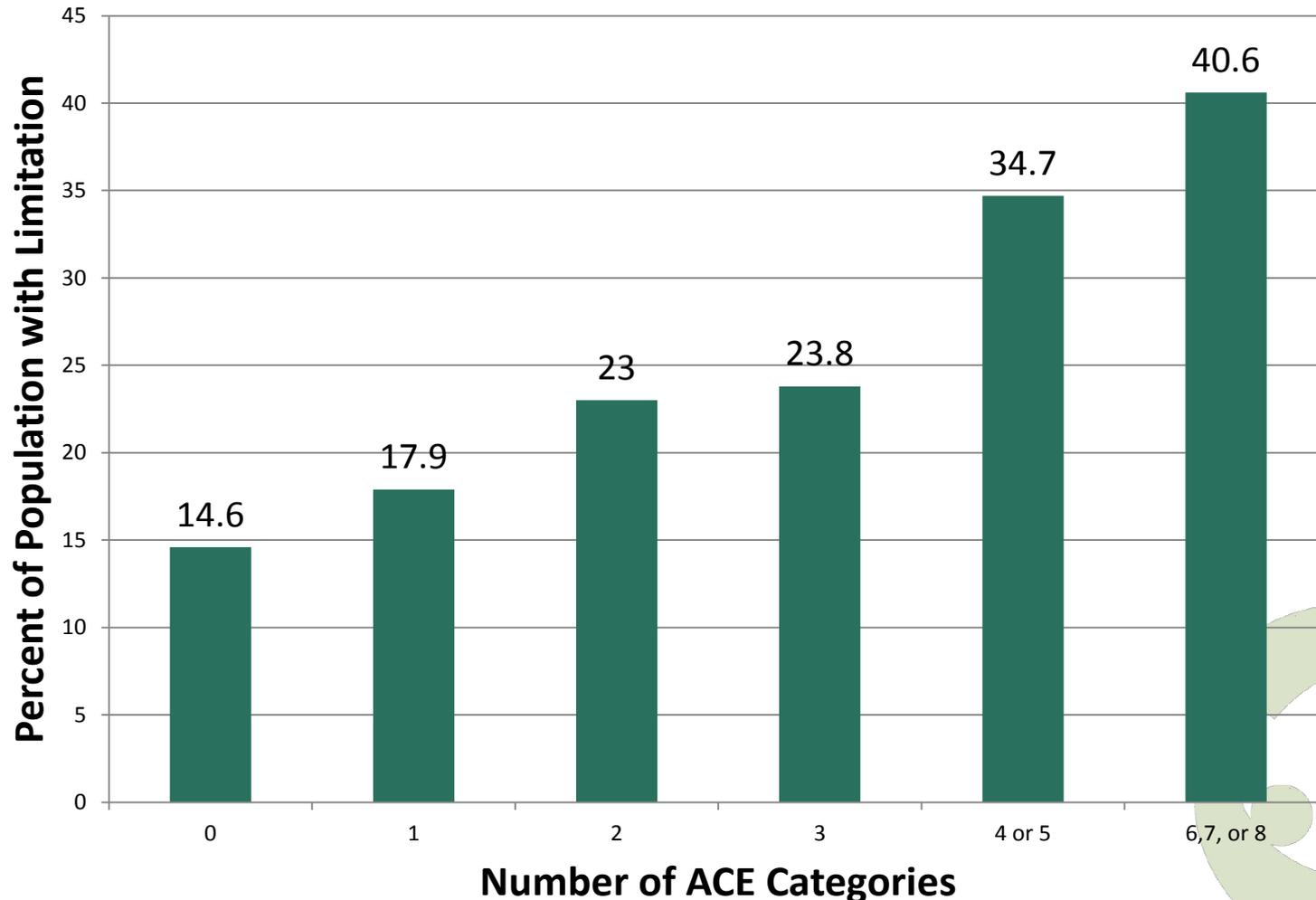
# Disability-Related Days

## When Can't Do Usual Activities

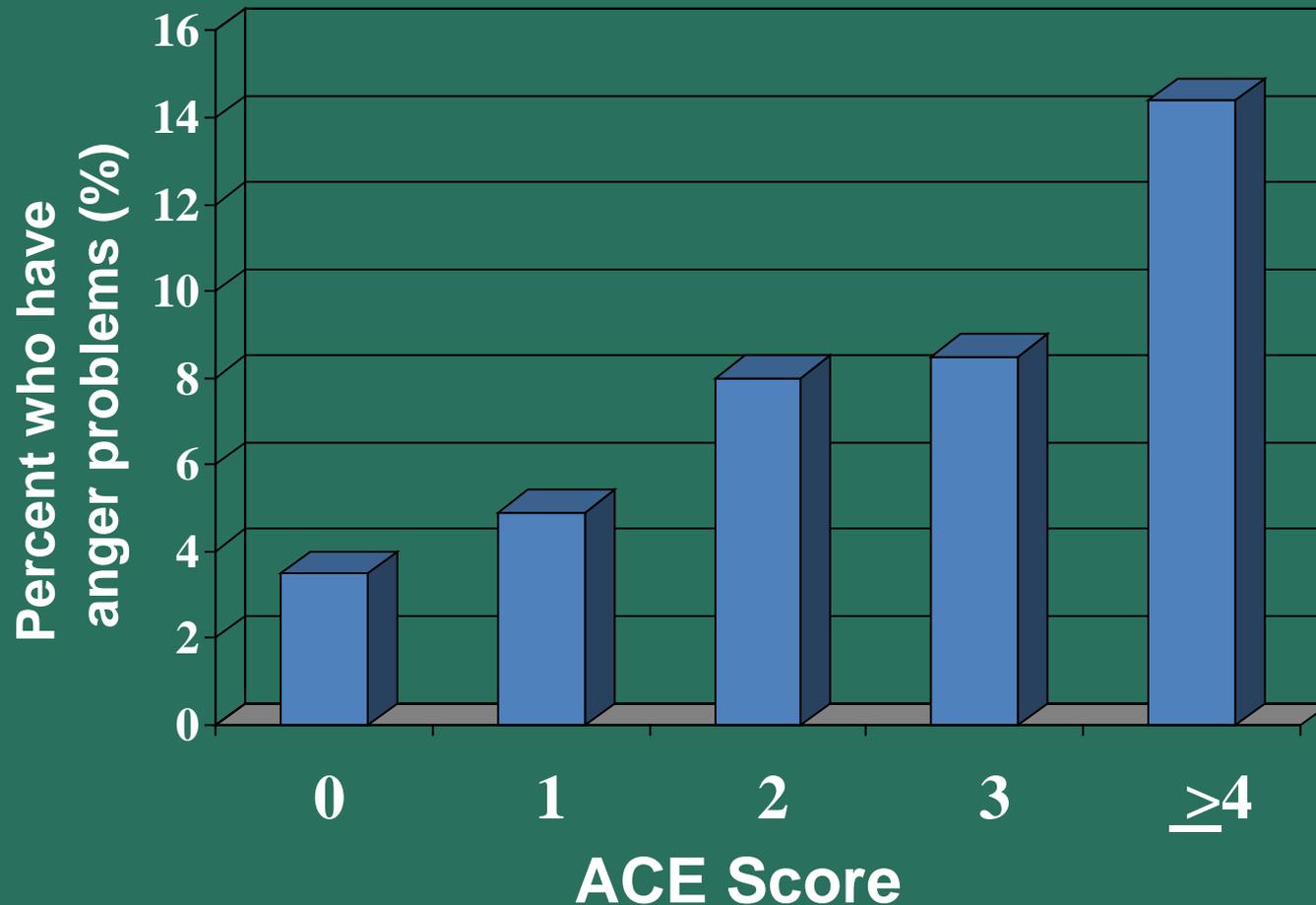


# Activity Limitation

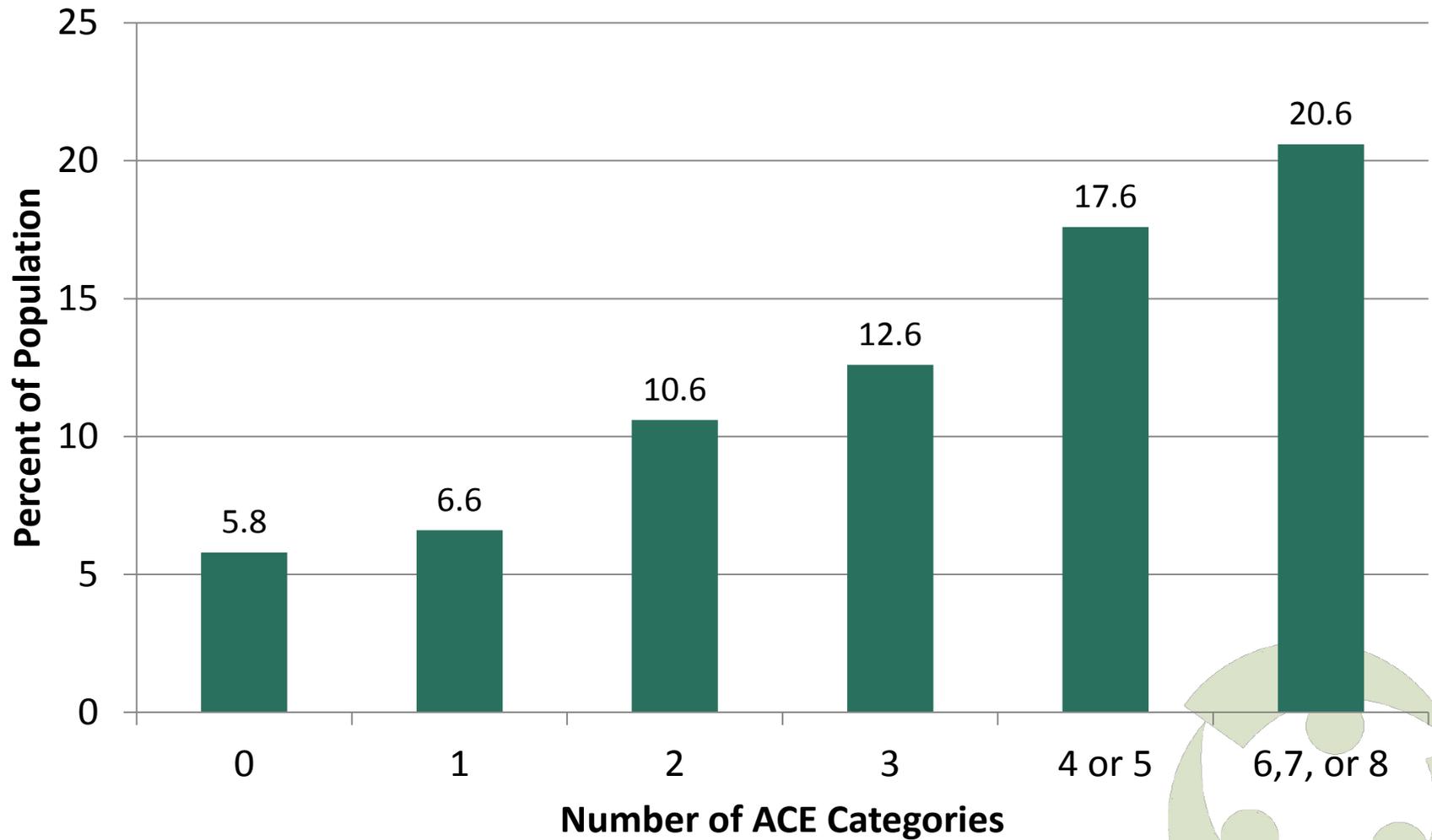
Due to Mental, Physical or Emotional Problems



# The ACE Score and Difficulty Controlling Anger

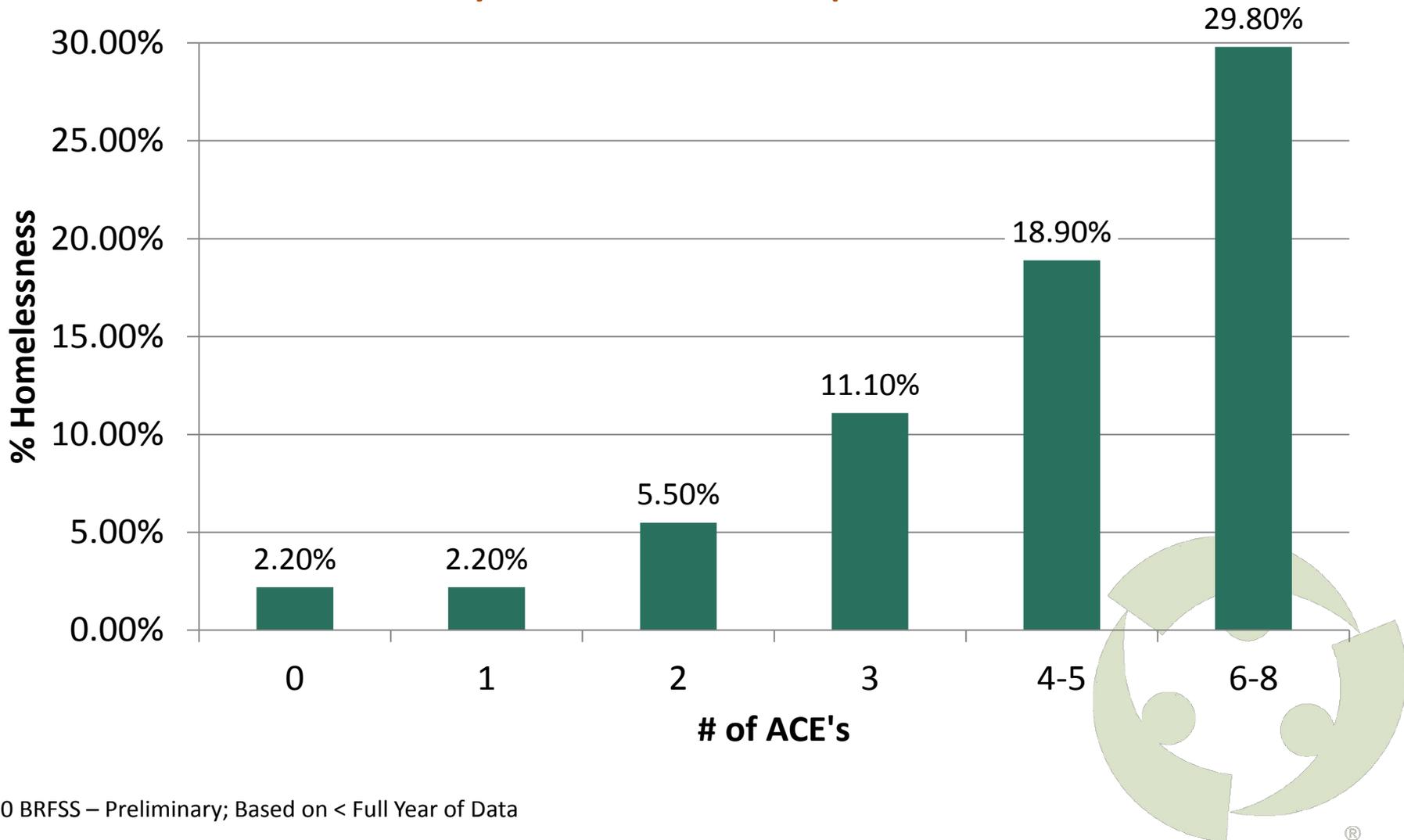


# ≥14 of 30 Unhealthy Mental Health Days

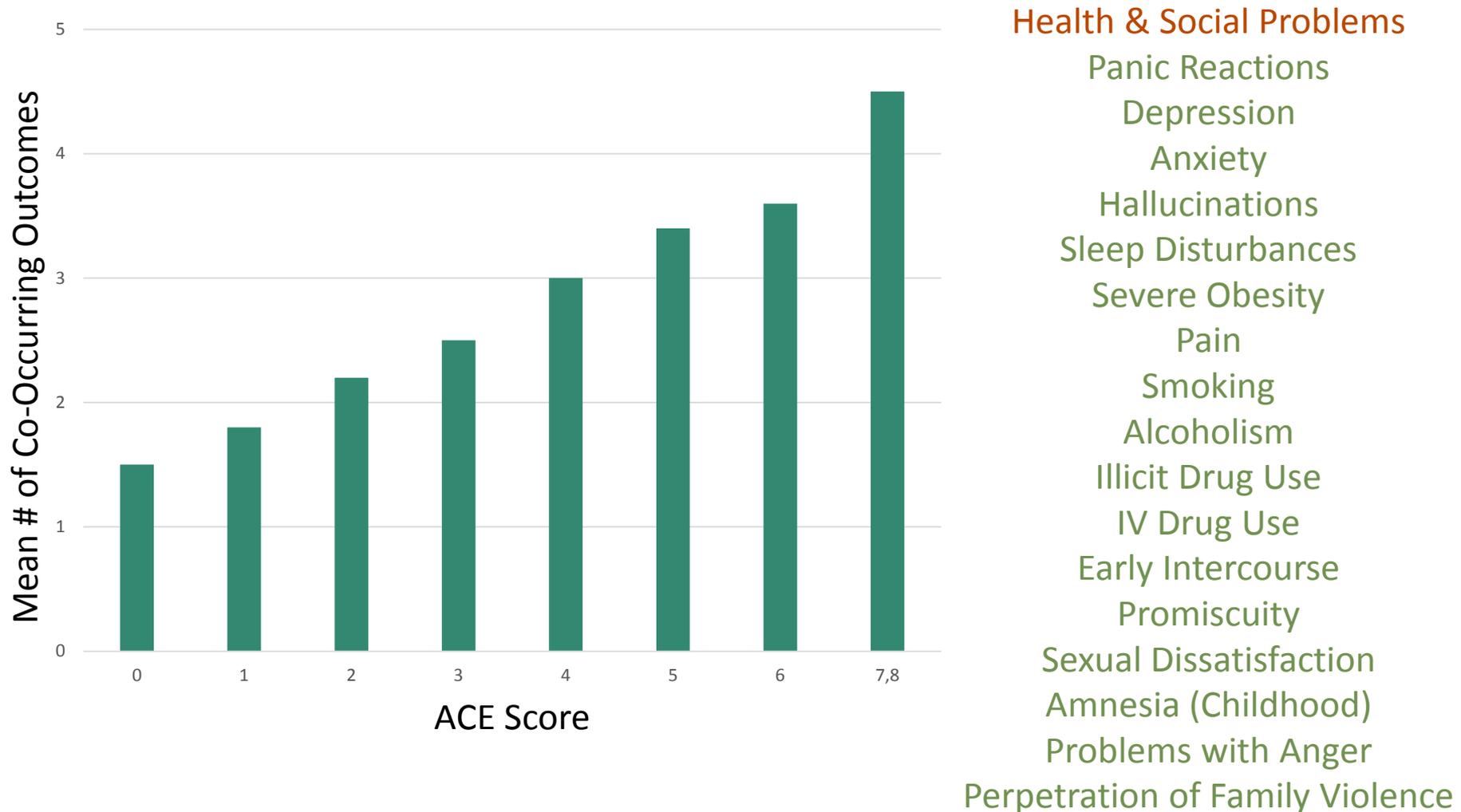


# ACEs & History of Homelessness

## 25-54 yr Old Adult Population



# ACEs and Co-Occurring Problems



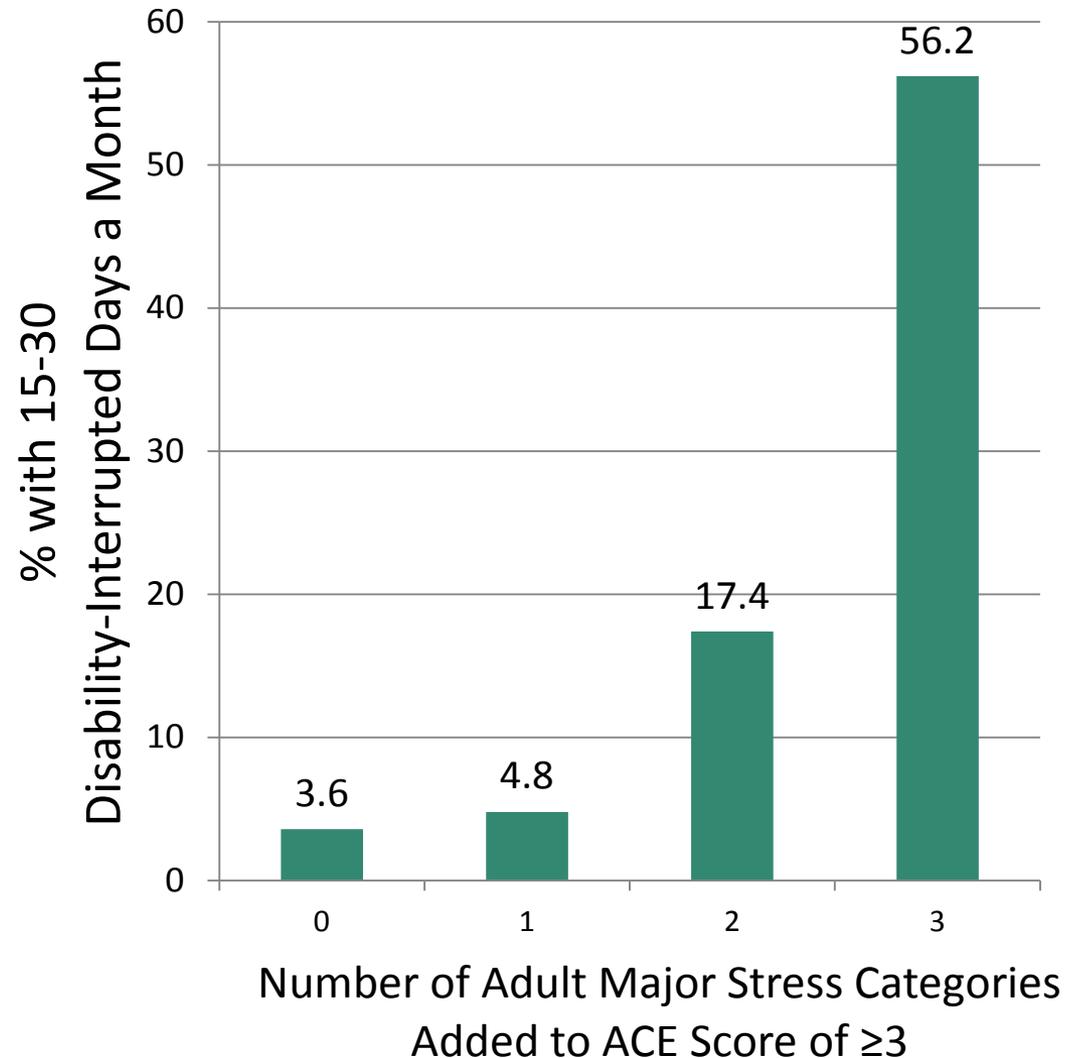
# Adult Adversity Compounds Effects

Adults with  $\geq 3$  ACEs

Plus

Major Stress Categories:

1. Homelessness
2. Incarceration
3. Chronic illness
4. Separation/Divorce
5. Severe Depression
6. Work-related Injury/  
Illness



# Outcomes Attributable to ACEs

## Risk

- Smoking
- Heavy drinking
- Obesity
- Risk of AIDS
- Taking painkillers to get high
- Obesity

## Prevalent Disease

- Cardiovascular
- Cancer
- Asthma
- Diabetes
- Auto immune
- COPD
- Ischemic heart disease
- Liver disease

## Poor Mental Health

- Frequent mental distress
- Sleep disturbances
- Nervousness
- MH problem requiring medication
- Emotional problems restrict activities
- Serious & persistent mental illness

## Intergenerational ACE Transmission

- Mental Illness
- Drugs or Alcohol Problem
- Multiple divorces, separations
- Victim of family violence
- Adult incarceration

## Health & Social Problems

- Fair or poor health
- Life dissatisfaction
- Health-related limits to quality of life
- Disability that impedes daily functioning
- Don't complete secondary education
- Unemployment
- History of adult homelessness



# Cascade of Experience- Societal Response Matters

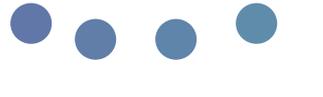
Historic Trauma



Adverse  
Childhood  
Experience



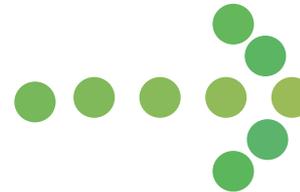
Adverse Peer  
&/or School  
Experience



Adverse Adult  
Experience



Multiple Mental,  
Physical,  
Relational, &/or  
Productivity  
Problems



ACE  
Transmission  
Risk



# The Help that Helps

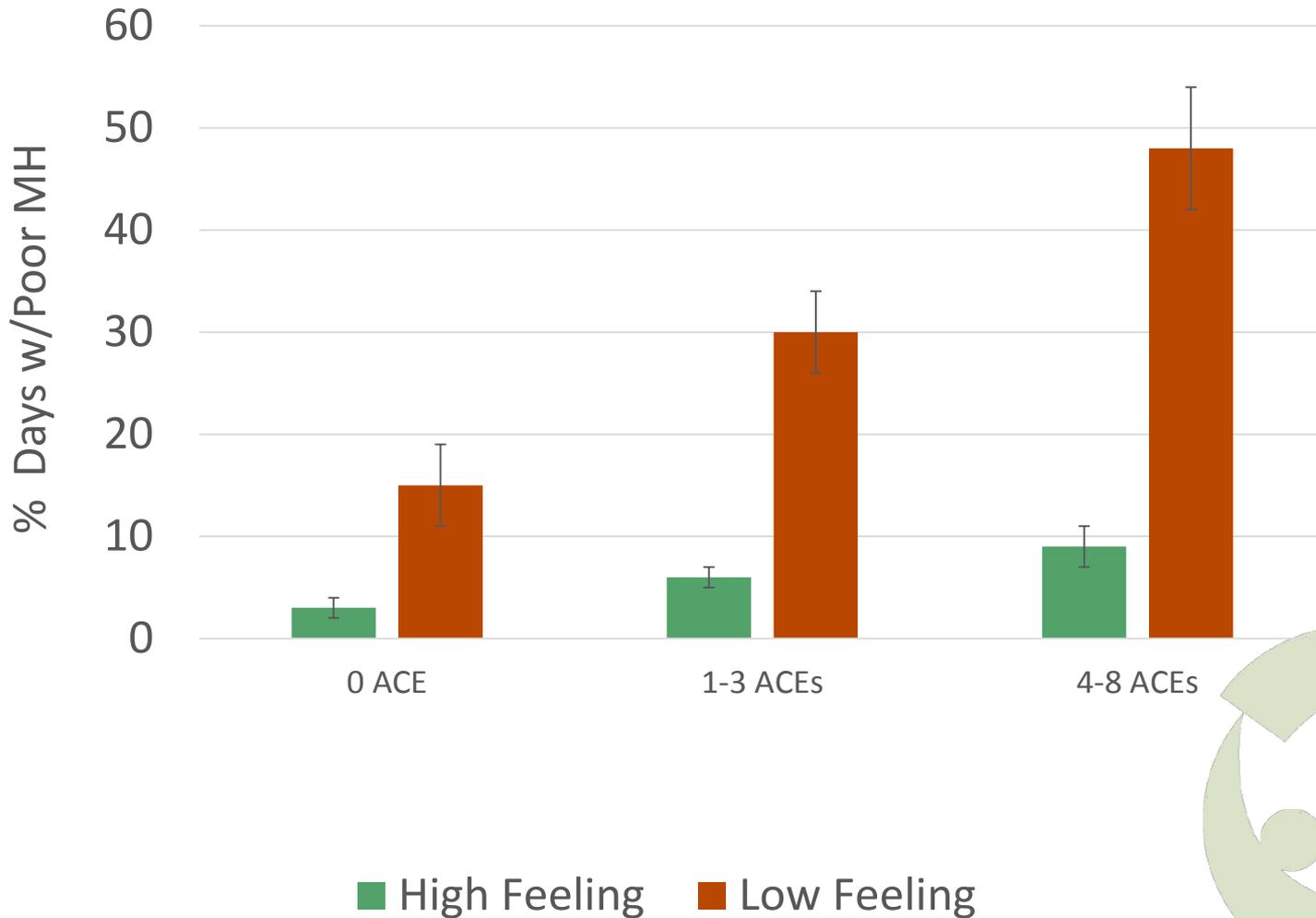
## Three Resilience Themes Each Make a Difference

They are even more powerful when we Layer Up...

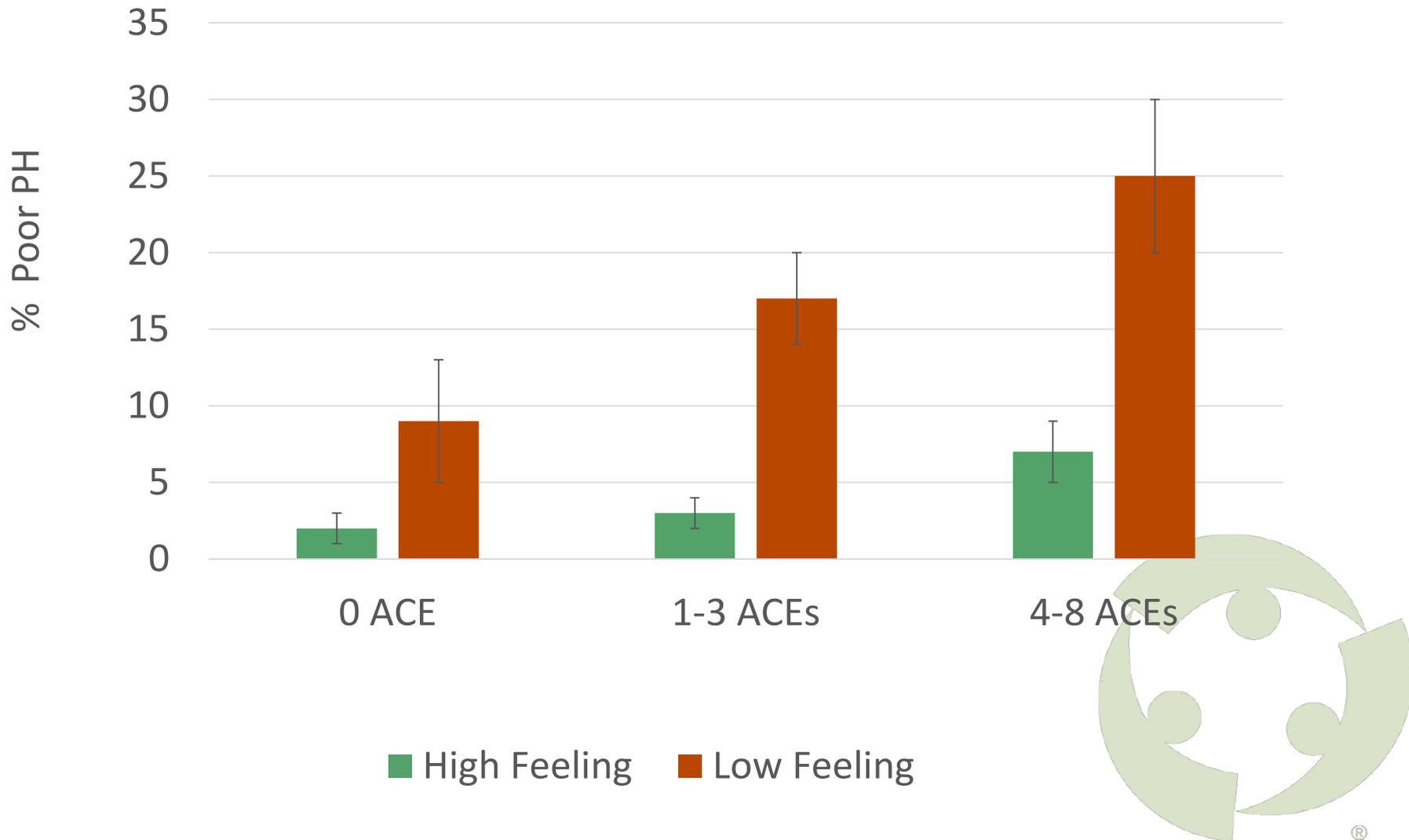
1. **Feeling** socially & emotionally supported, satisfied with life and hopeful
2. **Experiencing** hope plus two or more people who give concrete help when needed
3. **Community reciprocity** in watching out for children, intervening when they are in trouble, asking for help from friends and doing favors for one another (Community Reciprocity).



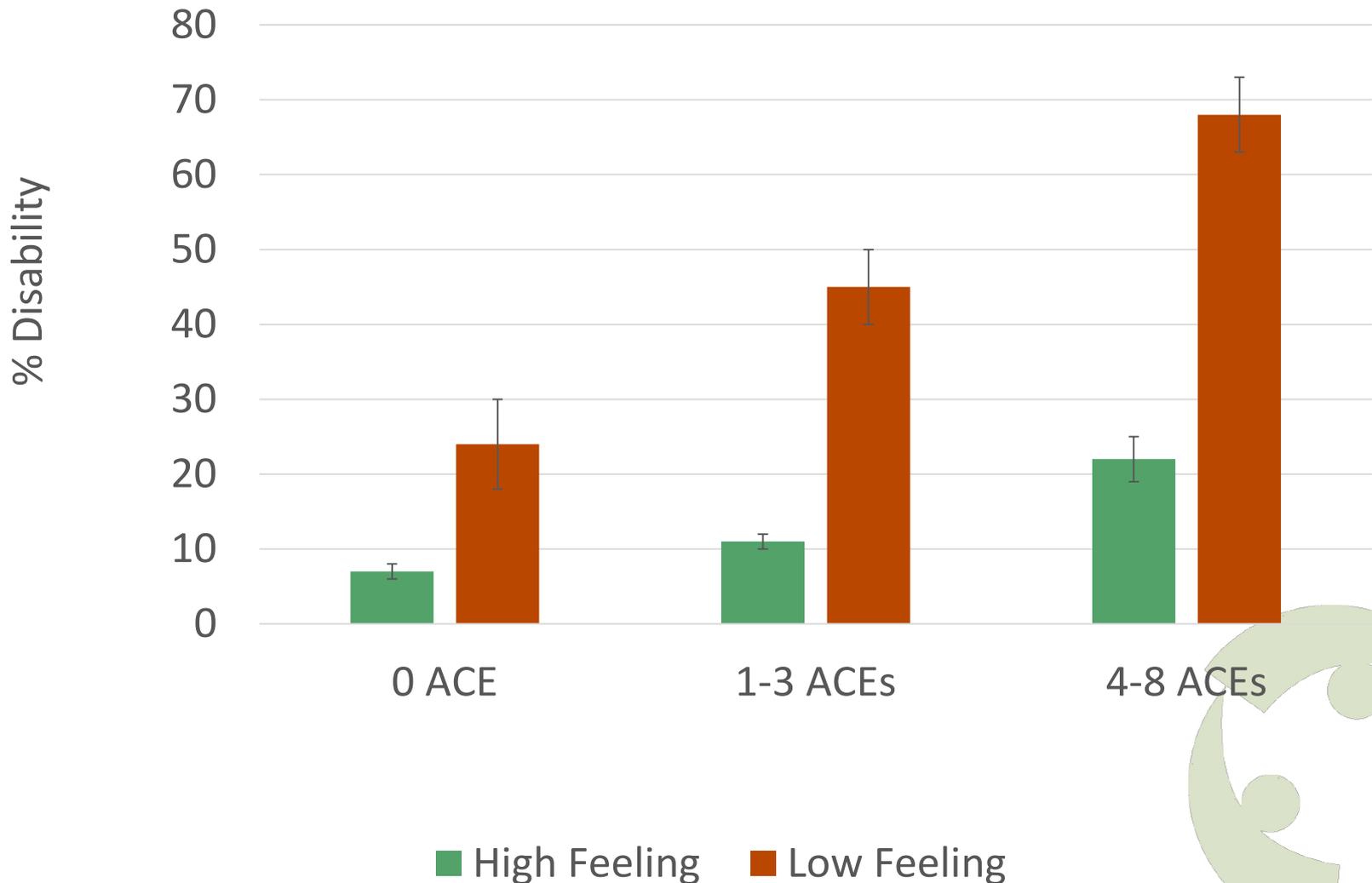
# Poor Mental Health Days & Feeling Supported, Satisfied, Hopeful



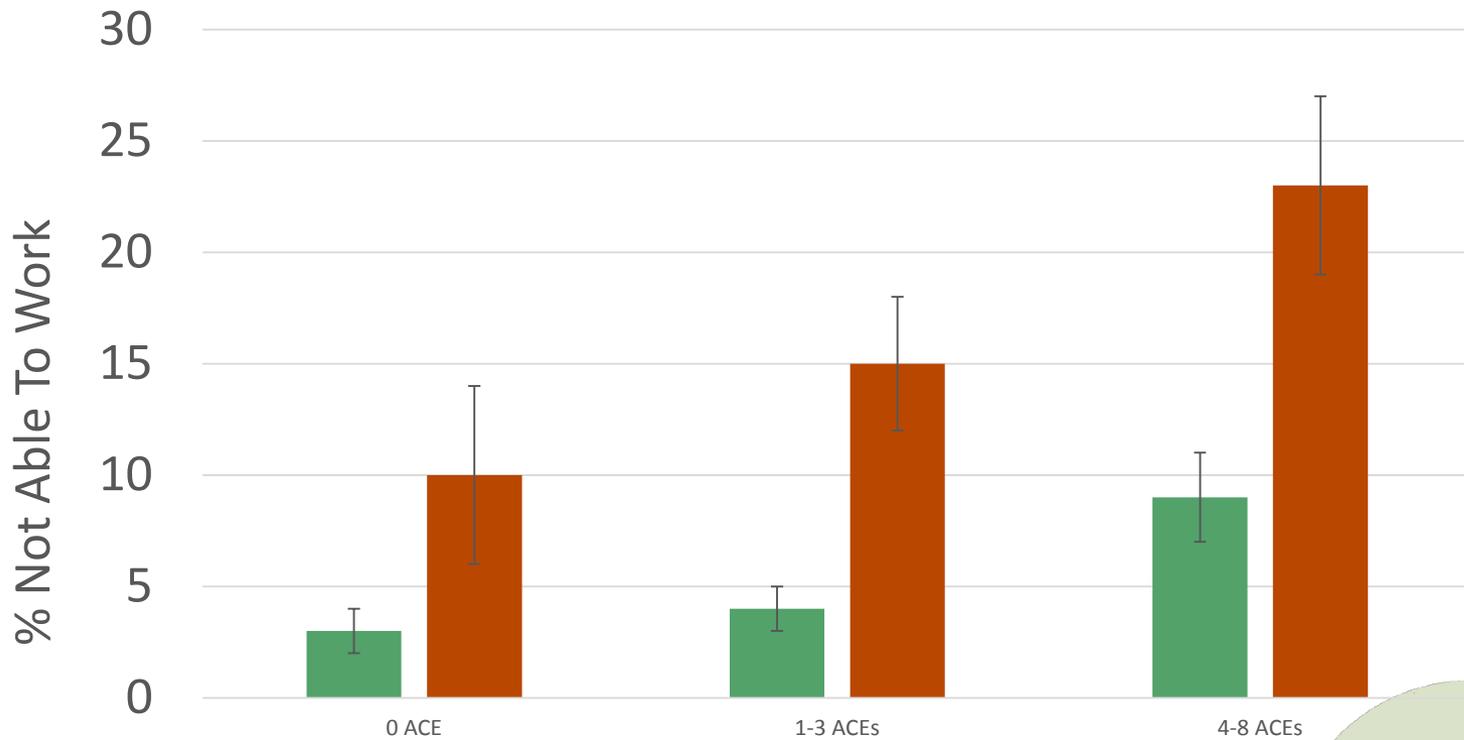
# Poor Physical Health & Feeling Supported, Satisfied, Hopeful



# Functional Disability & Feeling Supported, Satisfied, Hopeful



# Report Not Being Able to Work & Feeling Supported, Satisfied, Hopeful



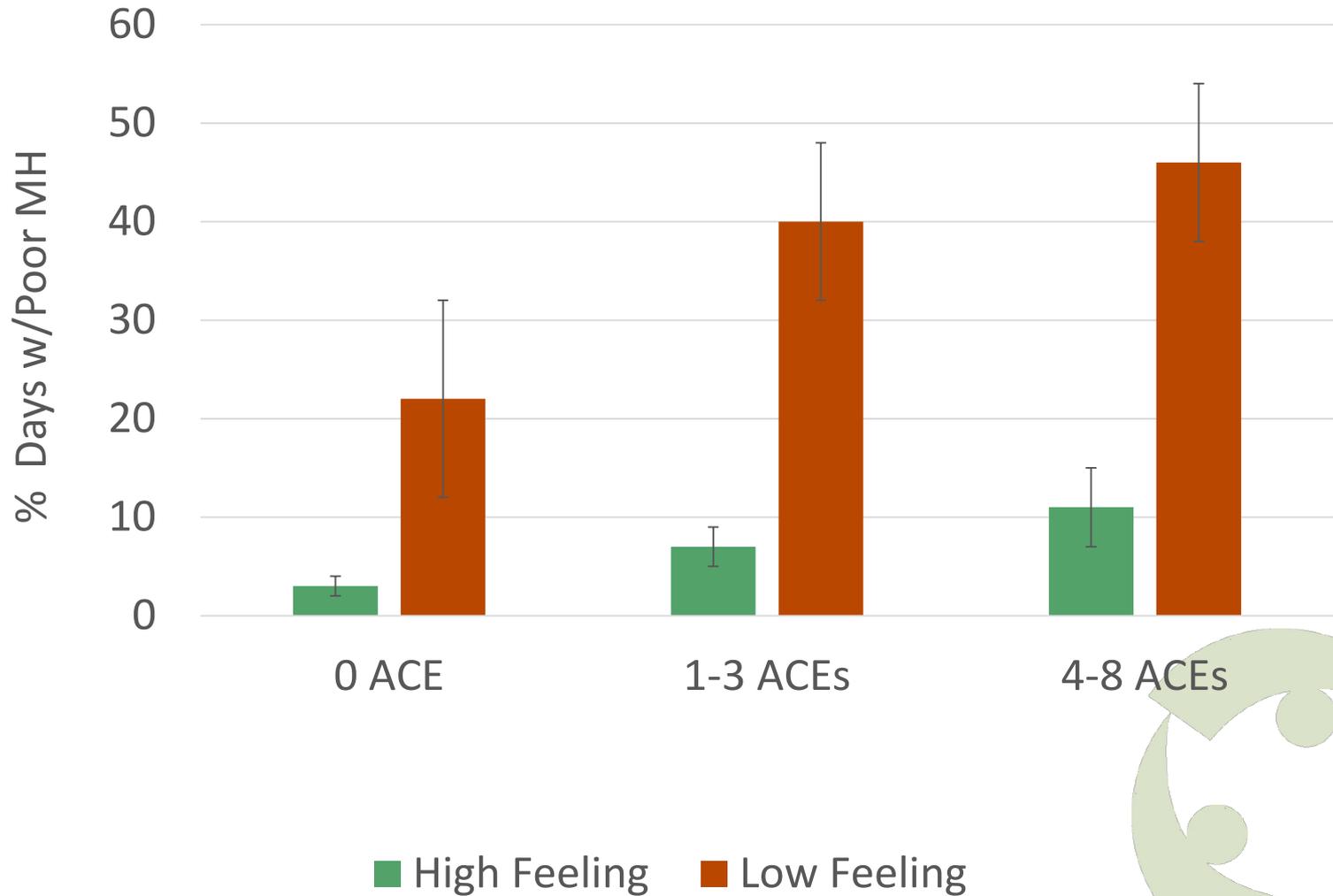
■ High Feeling ■ Low Feeling



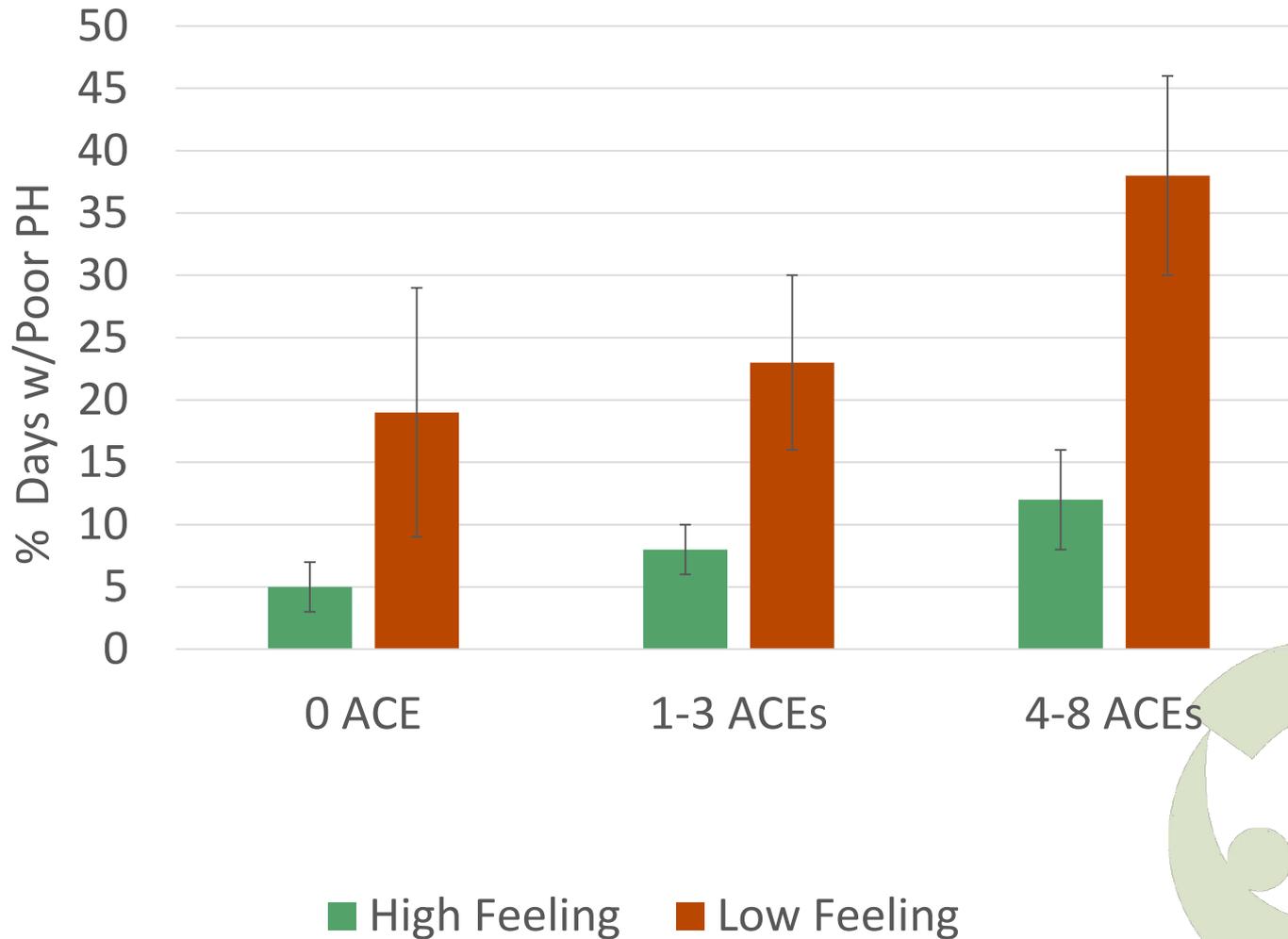
# Experiencing Hope + At Least Two People Who Help



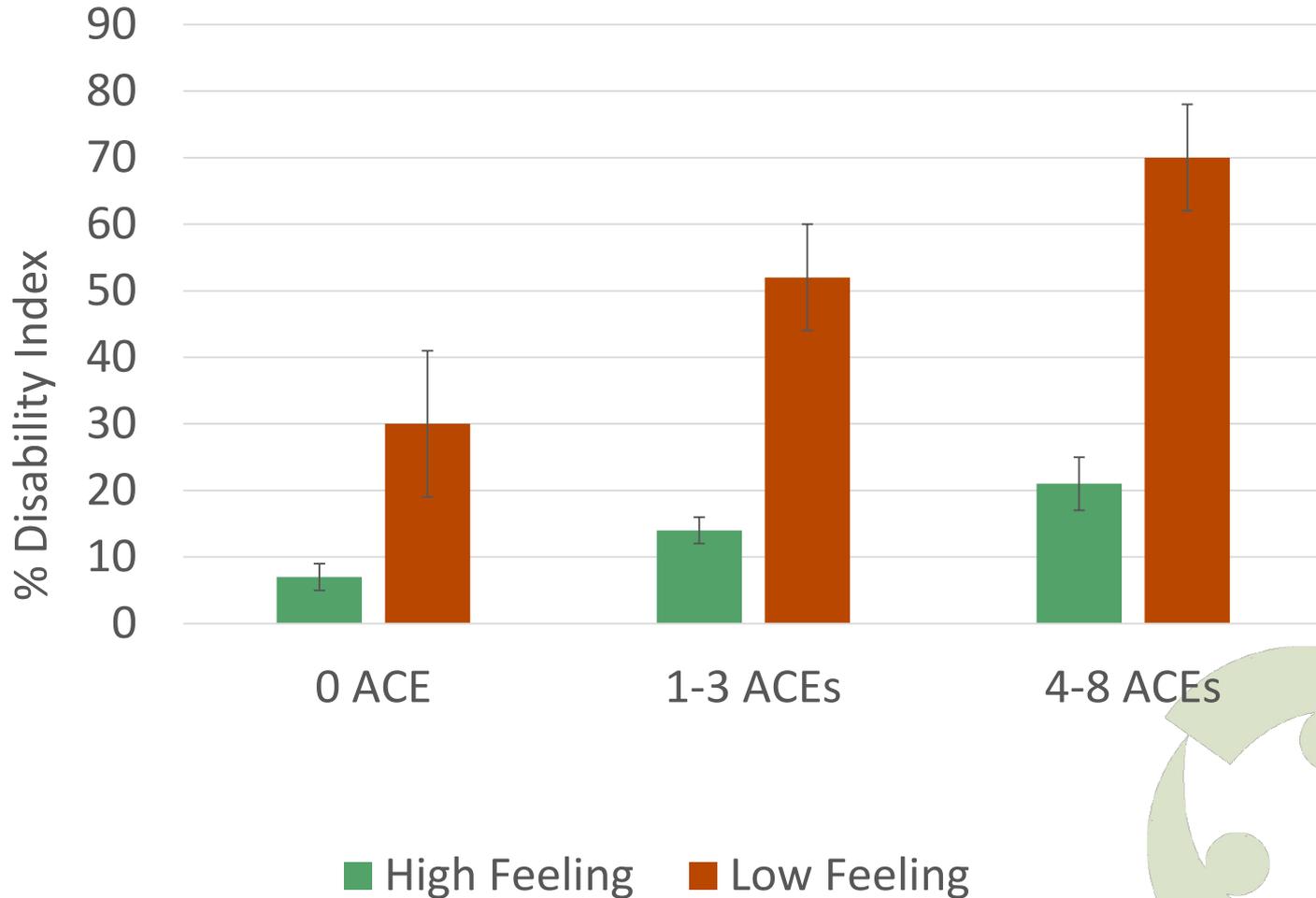
# Poor Mental Health Days & Experiencing Help & Hope



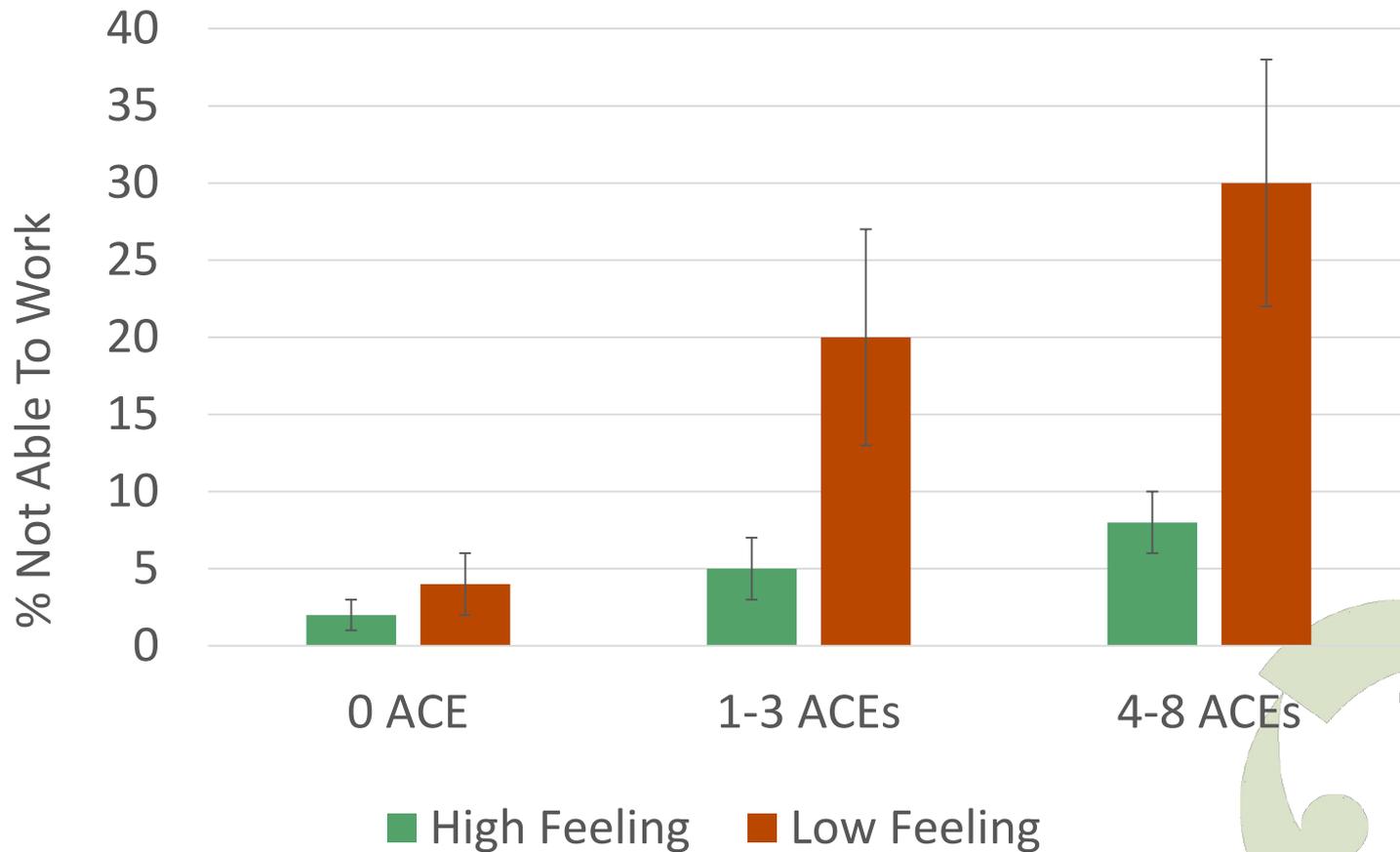
# Poor Physical Health Days & Experiencing Help & Hope



# Functional Disability & Experiencing Help & Hope



# Report Not Being Able to Work & Experiencing Help & Hope



# Community Reciprocity

- a. Watching out for children,
- b. Intervening when they are in trouble,
- c. Reaching outside friendship circle to seek help for friends
- d. Doing favors for one another (Community Reciprocity).

A Rising Tide Lifts All Boats

Mental Illness

Obesity

Alcohol consumption

Physical activity meeting recommended levels



# Layer Up

## Strengths in All 3 Resilience Factors: Population-Level Impacts

1. **Feeling** socially & emotionally supported, satisfied with life and hopeful
2. **Experiencing** hope plus two or more people who give concrete help when needed
3. **Community reciprocity** in watching out for children, intervening when they are in trouble, asking for help for friends and doing favors for one another (Community Reciprocity).



# Protocol: Ask, Listen, Educate, Affirm

*“We now know that childhood experience has a big impact on health throughout our lives. These ACE questions are important for us to work together to improve your health and the health of your family.”*

When you know the ACE score, ask:

*“How have these experiences affected you through your life?”*

Support the next steps in the conversation, e.g.:

*“People with high ACE scores often have to work harder in many aspects of their lives... how have you managed to do so well?”* (Build from their answer to affirm their strengths and resilience.)

*“I am sorry these things happened in your childhood. We didn’t know back then; this science is new. Now that we know about the power of ACEs, how would you like to use that information to improve the health of your family?”*

# Develop Learning Collaborative; Systematically Test Innovation

ACE-Informed Communication with Customers

Decision Aids Informed by ACE Impacts to Executive Function

Screen for Depression among High ACE Patients, Use  
Combination to Improve Predictive Value of Health Testing

Consider Two Generations in Patient Interaction – Education &  
Support Should Include Reducing the Odds of High ACE Scores in  
the Next Generation

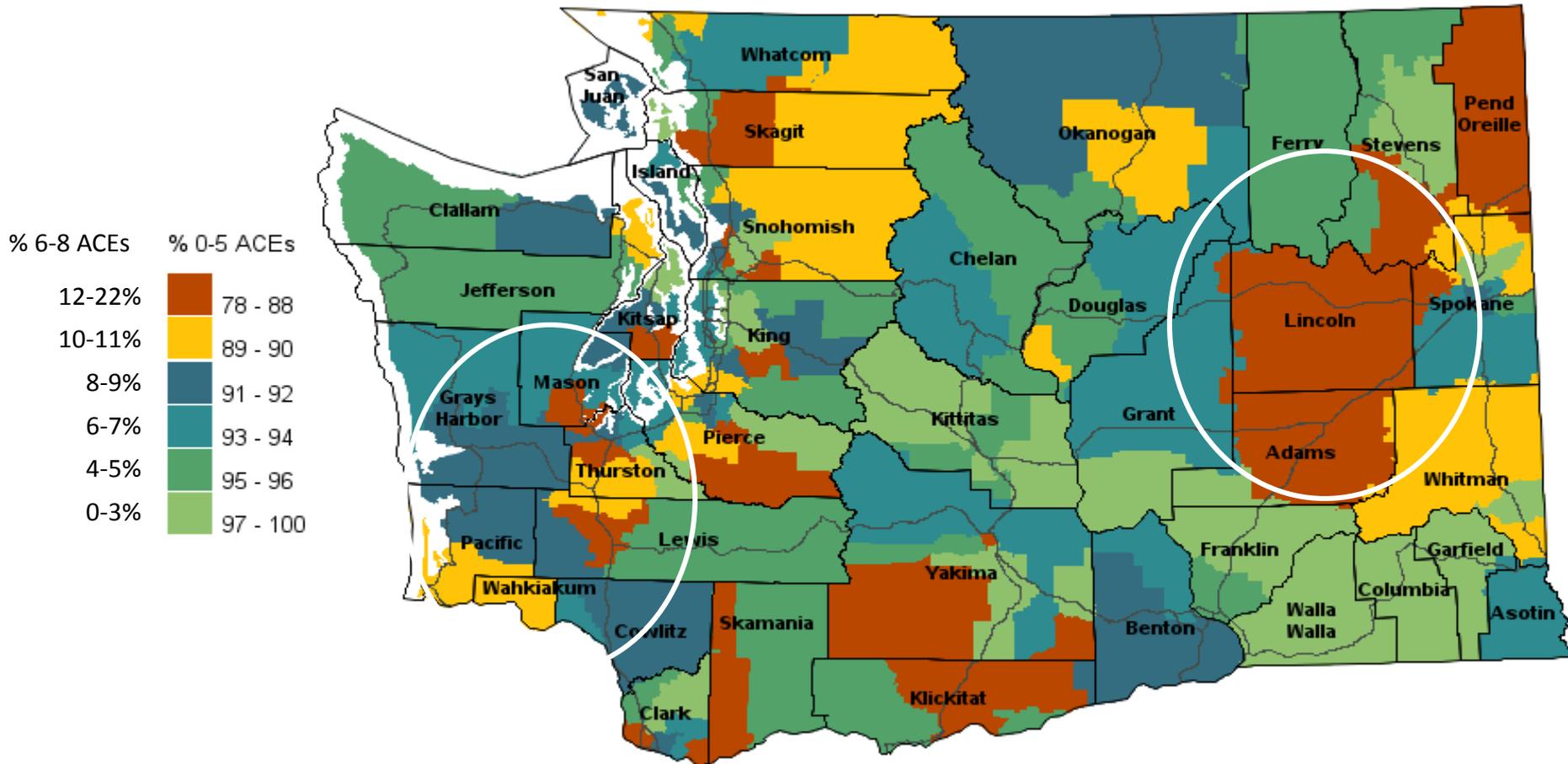


# Differential Help & Resource Distribution

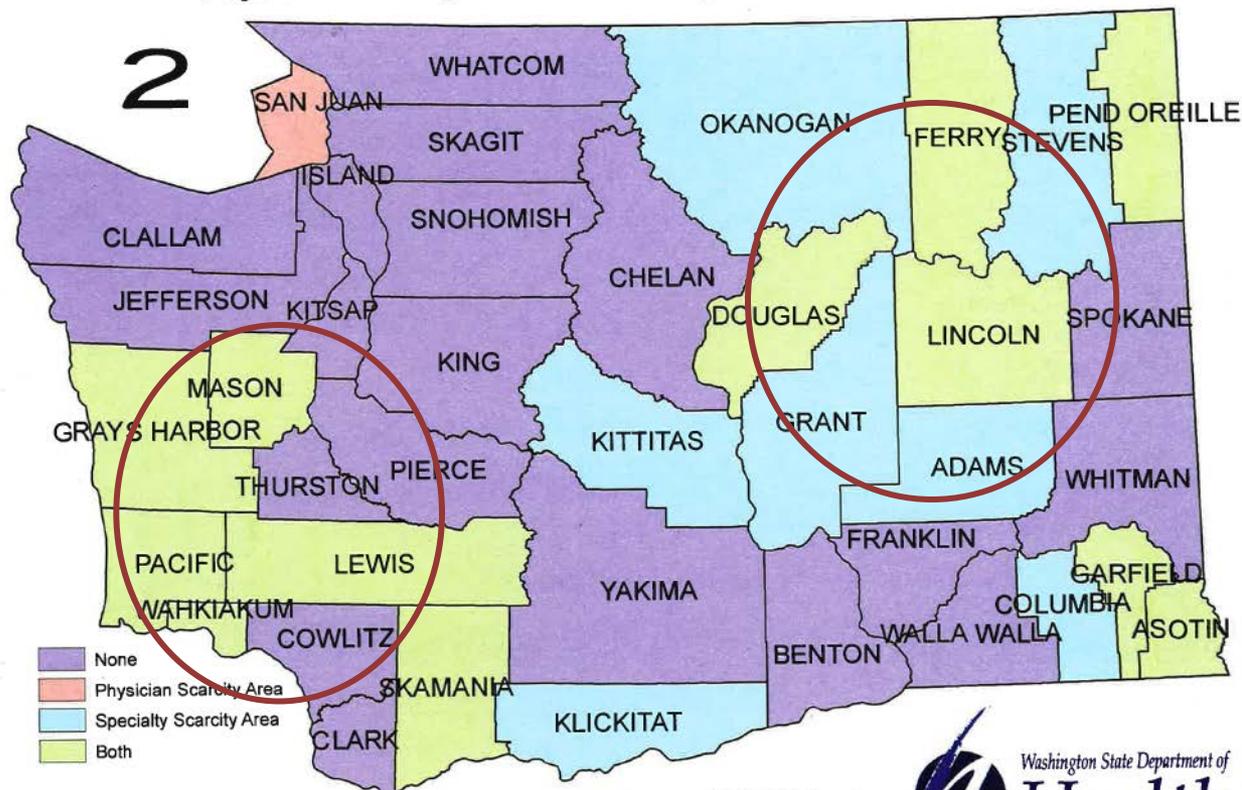


# Population with $\geq 6$ ACEs

## Ages 18-64



## Physician Scarcity Areas in Washington State, August 2007

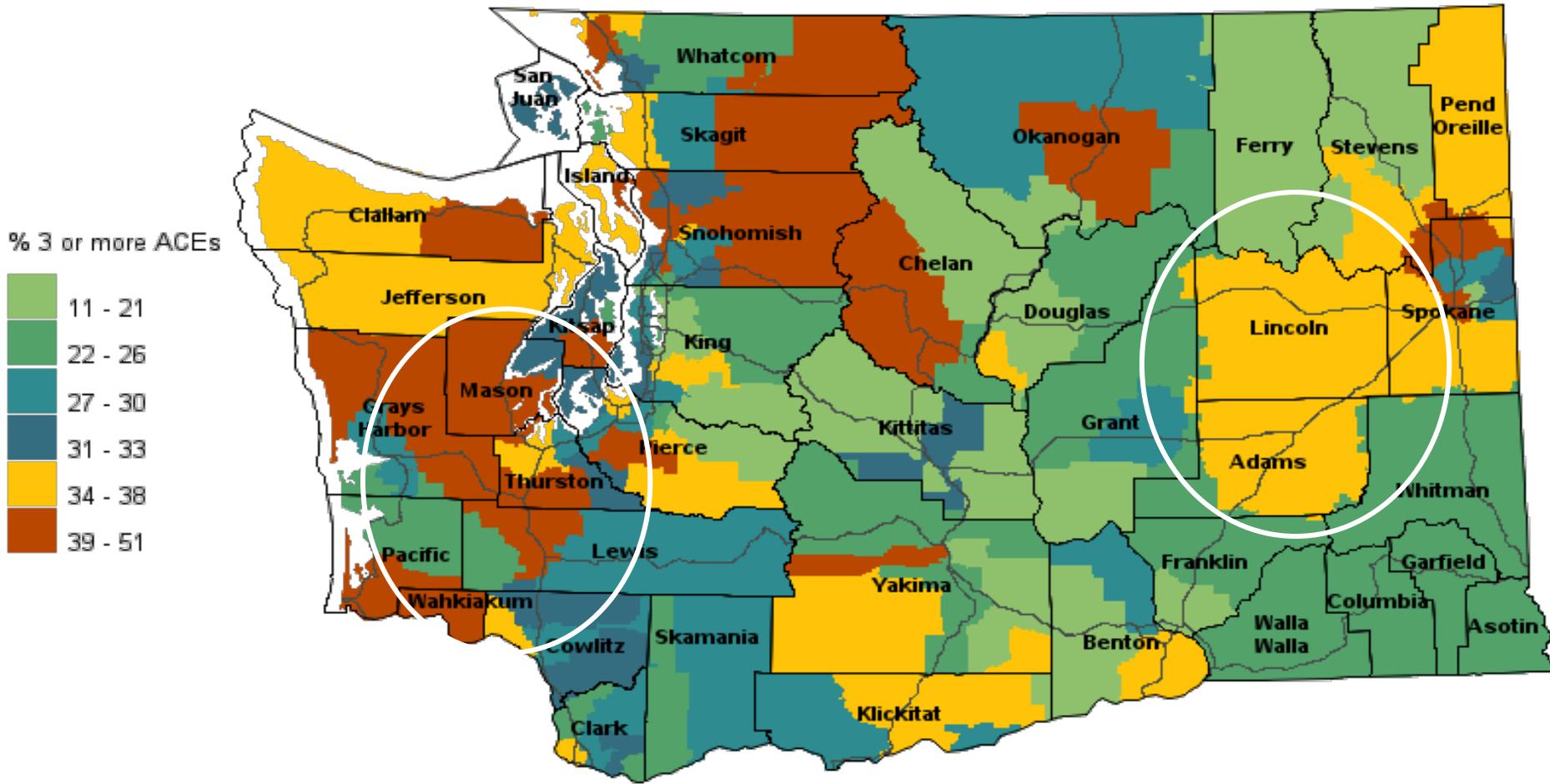


Created August 1, 2007 in ArcGIS 9.2  
 Kristina Keran, Research Analyst,  
 Office of Community & Rural Health  
 kristina.keran@doh.wa.gov  
 Geo-data updated by craig.erickson@doh.wa.gov

The Washington State Department of Health (DOH) does not warrant the accuracy, reliability, or timeliness of any information published in this map and assumes no responsibility for errors in the content of the information provided. Persons or entities that rely on any information obtained from this map do so at their own risk.



# Population with $\geq 3$ ACEs, Ages 18-64

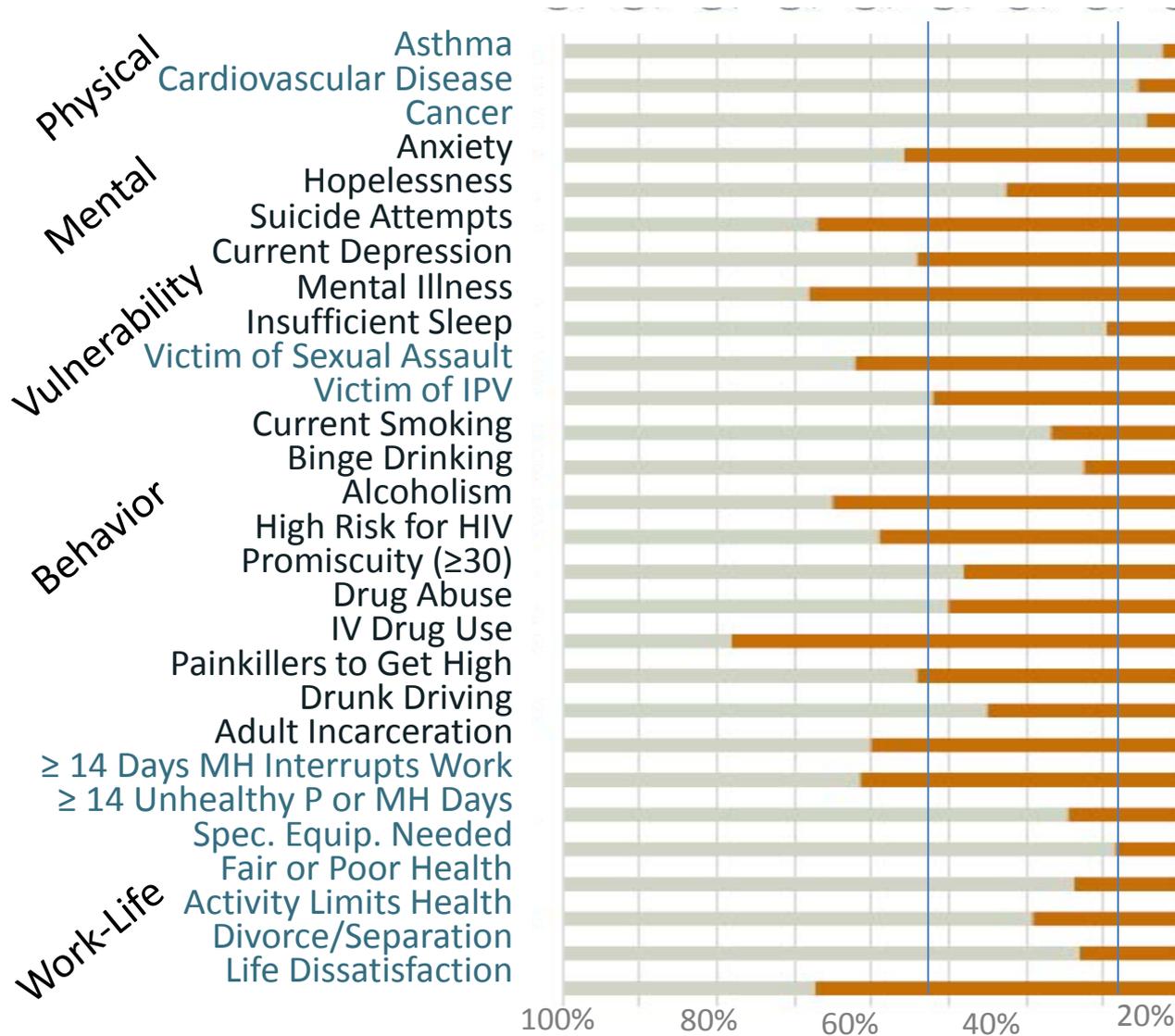


# New Era of Workforce Investment

- 1. Effects Whole Person and Context** of Family, Community & Society - Understands Behavior as Language of Adaptation
- 2. Considers Experience Over Time** - Prevents Escalation of Toxic Stress; Interrupts Accumulation and Transmission
- 3. Invests in Positive Adaptation** through Healthful Relationships, Cultural Integrity & Hope-filled Engagement
- 4. Employs Dual Generation Strategies** - Intentional Supports are Sensitive to Age/Stage and History of Adversity
- 5. Shifts the Status-Quo Interplay of Stress & Neurogenesis** throughout Peer & Universal Systems



# The Magnitude of the Solution



Population Risk of Disease  
Attributable to ACEs.

ACE  
Prevention  
Reliably  
Predicts  
Concurrent  
Rate  
Reductions  
for All ACE-  
Attributable  
Problems





COMPREHENSIVE  
HEALTH  
EDUCATION  
FOUNDATION

# Thank You



**5. Best Practices for Effective  
Collaboration on Challenging Claims**

Multidisciplinary Round Table Discussion

**Moderators:**

David Overby

Richard Wilson

**Panelists:**

Glenn Hansen

Kevin Kincade

James K. Jackson

Cory Turner

Jill C. Falk

Gregory Carter, MD

Stephen Thielke, MD

Jill Morrison

# Best Practices for Effective Collaboration on Challenging Claims

*Colloquium on Occupational Health Best  
Practices - June 18, 2014*

*Moderators:*

*David Overby, Health Services Analysis, L&I*

*Richard Wilson, Return to Work Services Program Manager, L&I*





## Goal for Today

Interactive, multidisciplinary discussion on challenging case scenarios to identify new ideas for effective collaboration of care



## Our Panelists

Glenn Hansen, Workers' Compensation Manager

MultiCare Health System

Kevin Kincade, Account Manager, Eberle Vivian, Inc.

James K. Jackson, Claim Manager, L&I

Cory Turner, M.Ed., CRC, Vocational Connections, Inc.

Jill C. Falk, M.Ed., CRC, CDMS Advanced Vocational Solutions, Inc.

Greg Carter, MD, Medical Director, St. Luke's Rehabilitation and

COHE Community of Eastern WA

Stephen Thielke, MD, MSPH Puget Sound VA Medical Center

Jill Morrison, BSN, Nurse Case Manager EIS Group



## Format

- Discussion among panelists about 2 case scenarios
- Looking for collaborative ways to overcome barriers within current system
- Panelists have previewed the scenarios
- Audience questions/comments at end of each scenario
- Overall wrap up at the end



## Scenario 1: Conflicting opinions

### Key points

- Complex claim
- Receiving psych treatment
- Healthcare provider disagreement about work-readiness
- Claims manager and VRC efforts stalled
- Worker is conflicted about returning to work

*How can we achieve better coordination of the care and assessment of the worker's ability to return to work?*



## Scenario 2: Motivation to train

### Key Points

- Apparently no light duty with employer of injury
- Worker fear that post-training wages will be significantly less than wages of injury and may not support current needs (e.g. house payments)
- Family stress
- New pain symptoms without objective findings
- Doctor and worker not seeing retraining as practical, given age of worker

*What actions can the claims manager, vrc, doctor, employer, NCM, worker and others take to move things along?*



## Let's hear from the audience

- Key learnings
- Additional suggestions
- Observations



## Scenario 3: Trouble at work

### Key points

- Unresolved issues between worker and supervisor
- Supervisor doesn't want worker to RTW
- Worker is worried about getting fired and suspicious of employer's motives
- AP is protective

*What can be done to achieve a successful return-to-work?*

Colloquium on Occupational Health Best Practices  
at Group Health Cooperative  
Today's Theme: Collaborative Care in Healing and Returning to Work  
June 18, 2014

## **6A. Collaborative Care in the Workers' Compensation System**

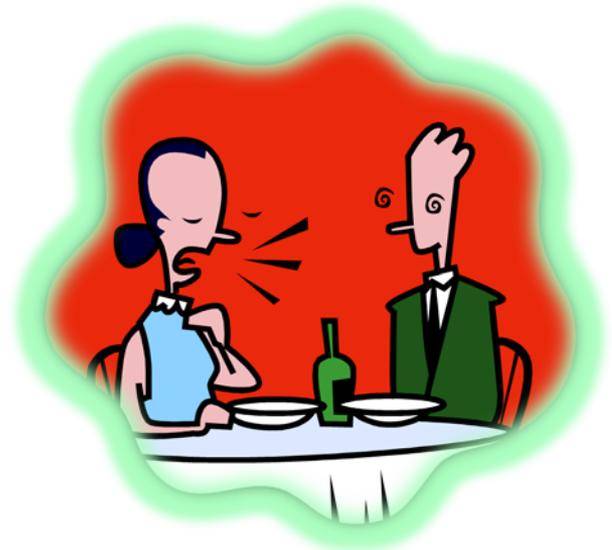
Integrated Practice Units in the Workers'  
Compensation Arena  
Dianna Chamblin, MD

# INTEGRATED PRACTICE UNITS IN WORKERS COMP?

Colloquium  
on Occupational Health Best Practices  
June 18 2014

Dianna Chamblin, MD

**The Everett Clinic**  
For the whole you.







## Stakeholders:

Patient

Employer

Insurer

Provider

Washington State

# Collaborative Care vs IPU

- \* Similar but different
- \* Not mutually exclusive
- \* Benefits of each





# Collaborative Care

- \* Broadly defined: a way of working together to ensure individuals receive the services they most need.
- \* Involves system communication and co-operation between systems and providers.

# Collaborative Care Examples

## Between providers

- \* Specialist provides consultation or care for patients referred by PCP.

## Between institutions

- \* Patient stabilized at outlying hospital then transferred to trauma center

## Between Insurers and providers

- \* IIMAC
- \* TPAs



# Industrial Insurance Medical Advisory Committee

“Advise the department on matters related to the provision of safe, effective, and cost-effective treatments for injured workers, including but not limited to the **development of practice guidelines and coverage criteria** ....”

# L&I Approved Surgeries before and after Guidelines Implemented

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

# Collaborative Care Model: TPA examples

- \* Close communication between TPA, Employer and Provider may:
  - identify breakdown in standard work or identify trends faster
  - provide team conferencing to facilitate claim management.
  - allow contrast and comparison of health care providers to promote process improvement suggestions



How are IPU's different?

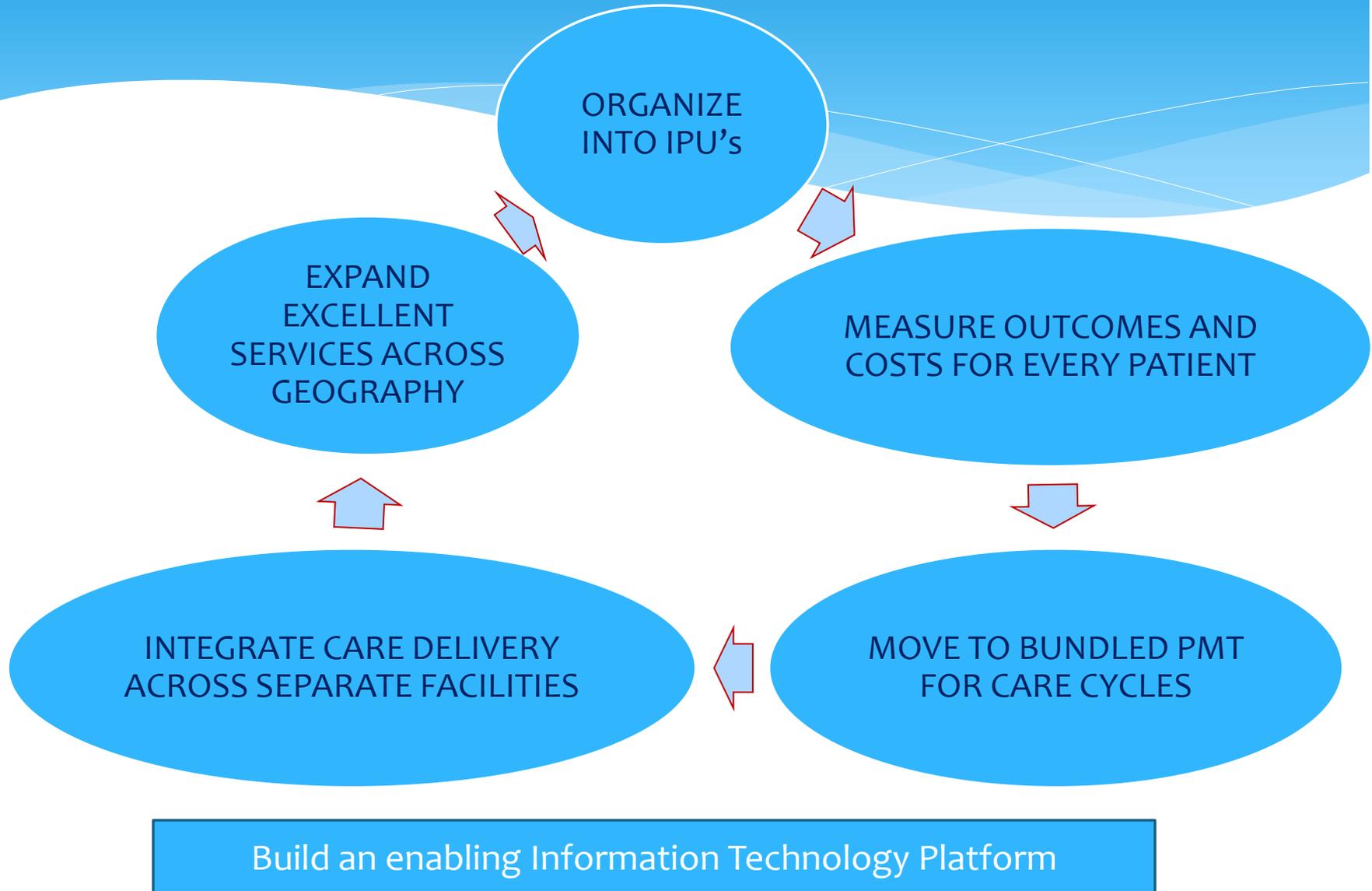
# INTEGRATED PRACTICE UNITS, IPUs

Michael E. Porter, Thomas H. Lee, Harvard Business Review October  
2013

- \* **GOAL:** Maximize the patient's overall outcomes as efficiently as possible.
- \* A dedicated team made up of both clinical and nonclinical personnel provides the full care cycle for the patient's condition.
- \* IPUs treat the disease and associated conditions and complications.
- \* IPUs engage the patients and their family (Employers/ Insurers?).
- \* Single point of entry.
- \* Team measure outcomes, costs and processes.

# The Value Agenda

Michael E. Porter, Thomas H. Lee, Harvard Business Review October 2013



ORGANIZE INTO IPU's  
**(Create COHEs)**

EXPAND EXCELLENT SERVICES ACROSS  
GEOGRAPHY  
**(Increase Community  
COHE base or create more  
COHEs)**

MEASURE OUTCOMES AND COSTS FOR EVERY  
PT  
**(Measure TIMELOSS for  
COHE vs nonCOHE patients  
and Provider metrics)**

**Generic COHE IPU**

INTEGRATE CARE DELIVERY ACROSS  
SEPARATE FACILITIES  
**(Integrate providers to  
adhere to COHE Best  
Practices)**

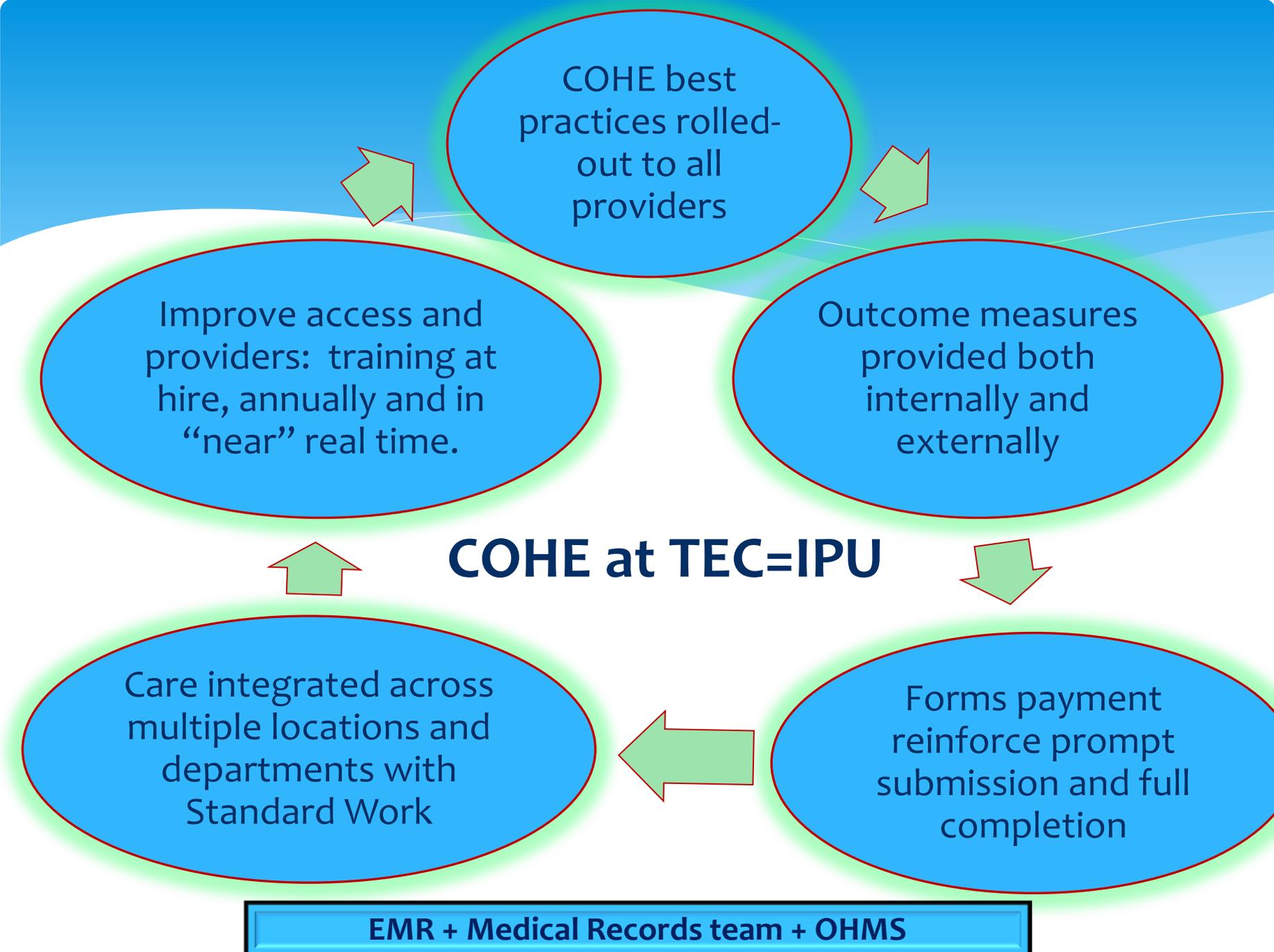
MOVE TO BUNDLED PMT FOR CARE CYCLES  
**(Enhanced fees for  
COHE providers)**

**OHMS Communication and Alerts**

# Generic COHE Outcome Metrics

## COHEs Reduce Disability & Costs

- Injured workers will return to work an average of 4 days faster
- About \$500 in savings in 1st year of claim
  - Helps employers reduce their workers' compensation premium costs.
- About \$1600 in savings over the life of the claim



COHE best practices rolled-out to all providers

Improve access and providers: training at hire, annually and in "near" real time.

Outcome measures provided both internally and externally

**COHE at TEC=IPU**

Care integrated across multiple locations and departments with Standard Work

Forms payment reinforce prompt submission and full completion

**EMR + Medical Records team + OHMS**

COHE at TEC (IPU) Outcome Measure

# Timeloss Comparison by Provider in Snohomish County

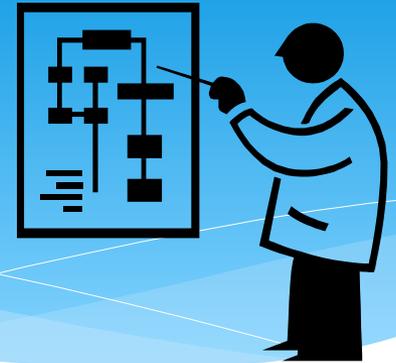
Providers	% Claims of Total		% of Timeloss claims	
	Qtr 3 2013	Qtr 4 2013	Qtr 3 2013	Qtr 4 2013
COHE at TEC	52%	51%	15%	15%
Non-COHE	48%	49%	19%	21%

IPU Foundation



Means changing the  
way clinicians are  
organized to deliver  
care.

# Disclaimer



In true system integration, organizations must provide four sets of choices:

1. definition of the scope of services (all care of injured workers, crosses potentially all specialties)
2. concentration of volume in fewer locations (employee choice factors: convenience, access...)
3. choosing the right location for each service line (employee choice factors: convenience, access...)
4. integrating care for patients across locations.

# Another TEC Occ Med IPU



**Occ Med - PT collaboration.**  
Acute low back pain pilot  
for injured workers.  
[Learn more.](#)

# Why LBP?

**#1 Cause of Disability  
Worldwide**

Time March 25, 2014

**\$50 Billion spent by  
Americans each year**

National institute of Neurological  
Disorders and Stroke (NINDS)

# Why LBP?

In WA L&I, low back pain has the highest number of time-loss days and some of the lowest claim resolution



The two most expensive diagnoses amongst patients with L&I coverage?

- \* A. Amputations
- \* B. Carpal tunnel syndrome
- \* C. Back injuries
- \* D. Knee injuries
- \* E. Rotator cuff Tears



# Low Back Conditions

and

# Carpal tunnel syndrome



## More LBP: [depressing] Stats

### Bree collaborative Report & Recommendations 11/21/13

- \* **<80%** of adults will have LBP at some point in their life, **20-30%** at any given time
- \* In 2010, **King County** self-insured health plan spent **>\$31 million for LBP**
- \* In 2011, **Costco Wholesale** spent **\$124 million** on musculoskeletal and connective tissue conditions.
- \* **80%** of total costs are incurred by **6-20%** who become disabled.

# True or False?

- \* Acute LBP, is most prevalent type of LBP
- \* **85%** of LBP diagnoses are for acute or non-specific LBP
- \* Only **15%** of all LBP has an identifiable anatomic or physiologic cause





## Caution: Narcotics and Acute LBP

Patients prescribed narcotics for acute back pain during the first week have a higher incidence of time loss and long term disability.

(Franklin GM, Stover BD, Turner JA, Fulton-Kehoe D, Wickizer TM. 2008. Early opioid prescription and subsequent disability among workers with back injuries. *Spine* 33:199–204.)

# Priority Health, Michigan

*Spine* 2013; 38(3):E178-E184

- \* Physiatry visit required prior to surgeon (non-urgent spine related pain or disability)
- \* Researchers compared utilization rates between 2006-2007 and 2008-2010
- \* Results:
  - \* 70% increase physiatry referrals
  - \* 48% decrease in surgical referrals
  - \* 29% decrease in spinal surgeries
  - \* 18% decrease in spinal imaging

**Total spine care costs dropped 12%**

# The Virginia Mason Spine Clinic Experience\*

- \* Created in 2005 as a “Marketplace Collaborative” with Starbucks and Aetna.
- \* Same day access triaged by schedulers: red flags vs yellow flags.
- \* Same day appointment first with PT, then physiatrist for 20 minutes followed by more PT.
  - PT total time = one hour
  - Physician total time = 20 minutes
- \* Hard stops on MRI orders and inclusion of Jarvik et al Spine 2001 findings in MRI reports.

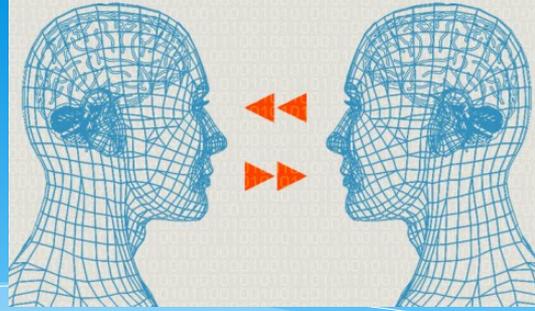
**\*Patients covered by L&I in minority**

# VM's results: saved and



- \* Reduced unnecessary MRI imaging by **23%**
- \* Reduced work loss days by **over 50%** (12 to 4.5)
- \* Reduces average # PT visits from 9 to 4
- \* High patient satisfaction (average 4.9/5)
- \* Ability to care for four times the volume of patients with fewer staff improved the margins for VM and offset the loss of revenue from unnecessary imaging

TEC



VM

- \* TEC and VM both have
  - \* MRI hard stops and TEC also reduced imaging by 23%
  - \* Jarvik et al MRI findings included in lumbar reports
  - \* Many great spine care physicians and therapists.

**TEC did have a collaborative care model but not an integrated practice unit dedicated to acute low back pain**

## TEC Lumbar MRI report inclusion since 2006

*Please note: the following findings are commonly seen in patients without low back pain:*

*Disc degeneration (91%)*

*Disc signal loss (83%)*

*Disc height loss (56%)*

*Disc bulge (64%)*

*Disc Protrusion (32%)*

*Annular high signal intensity zone (38%)*

*Jarvik et al, Spine 2001*

# TEC ACUTE LBP PILOT IPU

Indications: For WA state injured workers with  $\leq 4$  weeks of acute LBP

Question: Can a collaborative early intervention model of care for acute low back pain improve patient outcomes and reduce the cost of care in this workers comp population?

## Initial

- Patient presents to WIC or PCP
- Patient with  $\leq 4$  weeks of LBP, L&I coverage

## Assessment

- Rule out red flags
- No imaging unless meets criteria

## Treatment

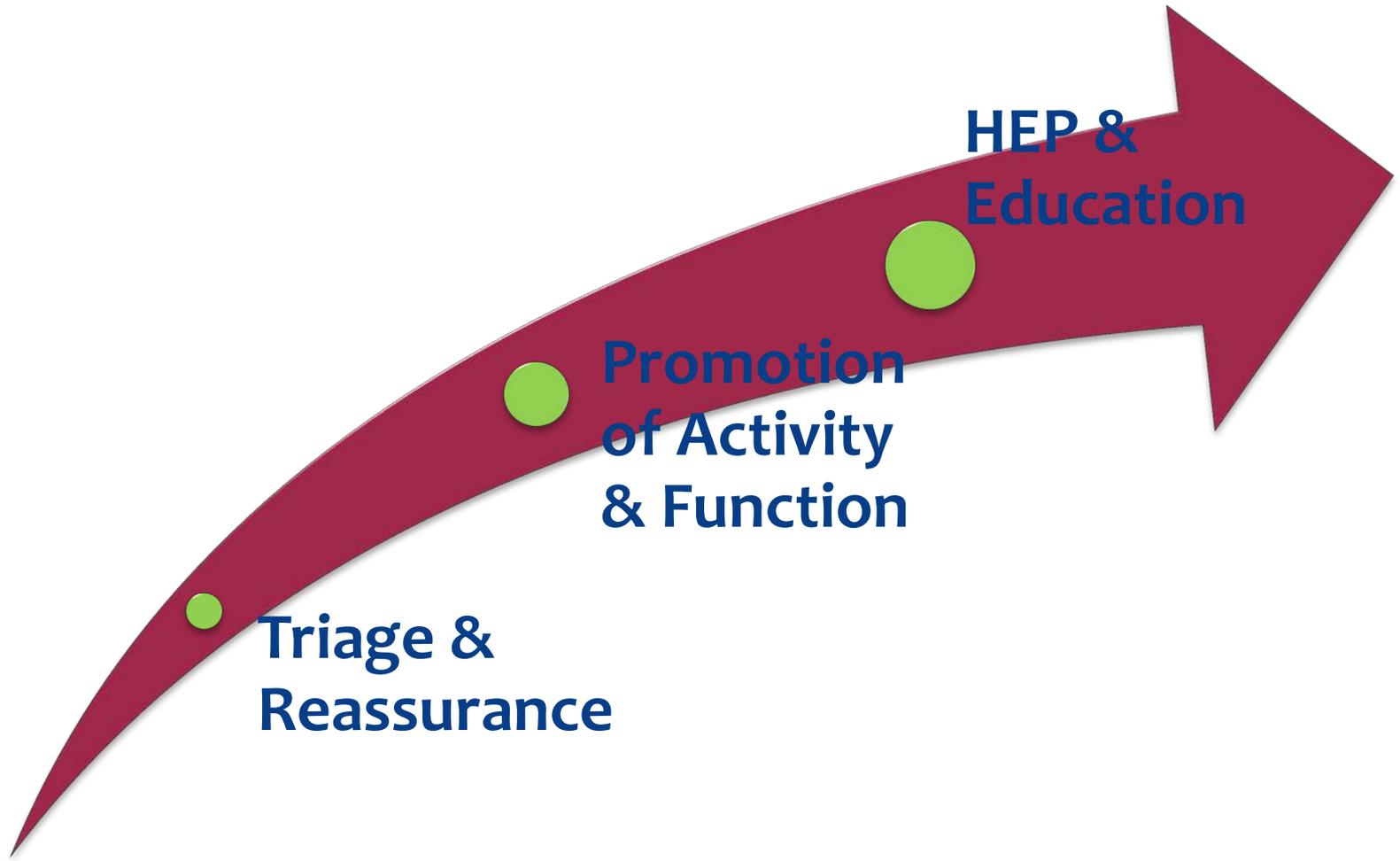
- No opioids unless meets criteria
- Refer to Occ Med Dept. after first visit for LBP

## Occ Med

- Encourage referral to Smokey Point pilot
- Appointment within a couple days to Smokey Point

## SP Occ Med & PT

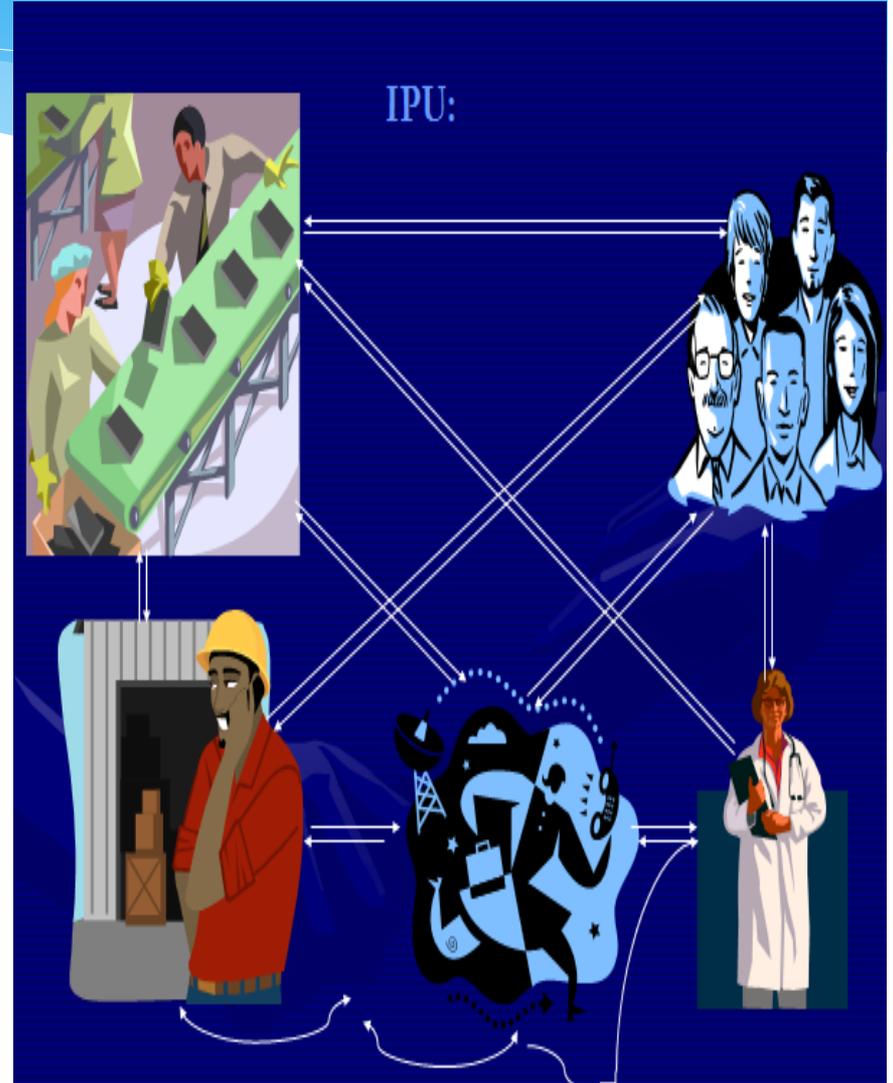
- Appointment with Doc and PT
- Ongoing PT care
- 2 week Team conference





\*Married → working together

# Consider Opportunities



Colloquium on Occupational Health Best Practices  
at Group Health Cooperative  
Today's Theme: Collaborative Care in Healing and Returning to Work  
June 18, 2014

## **6B. Collaborative Care in the Workers' Compensation System**

Collaboration in Community and  
Institutionally Supported Settings  
Gregory Carter, MD



## **L&I Self-insurance Colloquium RTW Roundtable Discussion June 18, 2014**

- ***Gregory T. Carter, MD, MS***
- **Medical Director**
- **COHE Community of Eastern Washington**
- **St Luke's Rehabilitation Institute**
- **Spokane, WA**



# **Case Vignette: A Pre-existing condition complicating RTW**

- **A 33-year-old man who works seasonally in a commercial fish processing plant in Alaska has insidious onset of difficulty extending his right wrist. He complains of a burning in his midforearm and right lateral elbow pain for about 4 months. He attributed this to the repetitive work he does in the plant.**
- **On physical examination he has pain on passive range of motion at the elbow and wrist. Weakness in wrist extension with dorsal wrist pain is noted. There is subtle radial deviation with active extension**



## Vignette

- On physical examination he has pain on passive range of motion at the elbow and wrist.
- Weakness in wrist extension with dorsal wrist pain is noted.
- There is subtle radial deviation with active extension



# Vignette





## Vignette

- **additional finding is include:**
- **Weakness in the hand and foot intrinsic muscles**
- **Pes cavus foot deformity**
- **hyperhydrosis and allodynia in the feet**
- **Generalized diminished reflexes**



## Vignette

- He reports that his pain is markedly increased when you apply resistance to supination of the forearm.



## Vignette

- Differential diagnosis
- extensor tendonitis/epicondylitis
- Cervical radiculopathy
- posterior interosseous nerve syndrome
- trigger finger with extensor tendon rupture
- Plus something else?



# Vignette



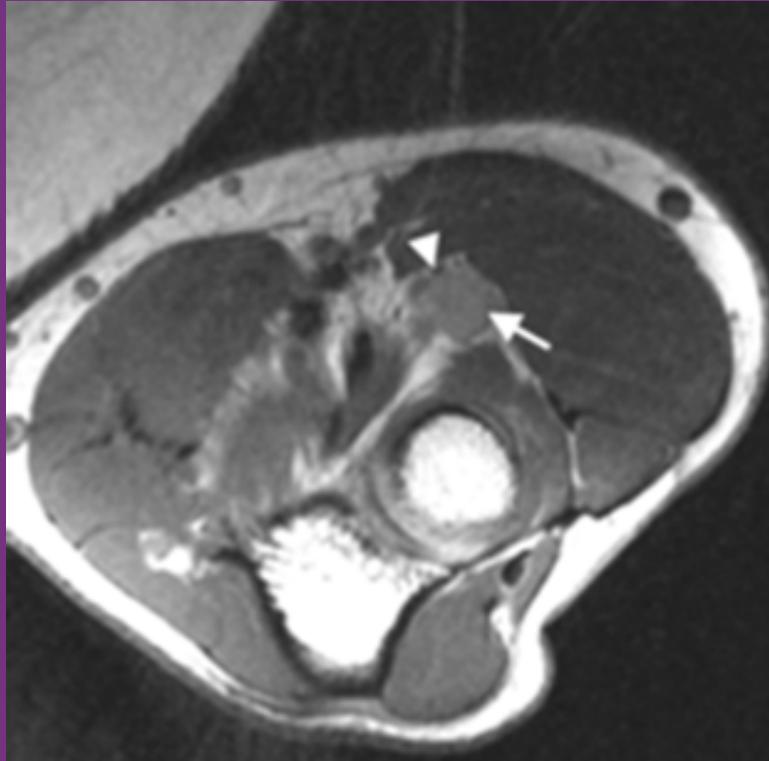


## Vignette

- **Magnetic resonance imaging of the forearm, revealing abnormal thickening in the arcade of Frohse and edema in the supinator along with partial extensor tendon rupture versus severe tendonosis**



# Vignette





## Vignette

- Important to note that the thickening in the arcade of Frohse occurs in 30–100% of people, most likely due to repetitive pronation–supination. This is not uncommon in folks who do repetitive work
- This is probably also true of extensor tendonosis



## Vignette

- Full pronation of his forearm cause much pain because full pronation of forearm produces pressure on the posterior interossues nerve by the sharp tendinous edge of the origin of extensor carpi radialis brevis muscle.
- Full pronation of forearm creates longitudinal tension on the posterior interosseus nerve



## Vignette

- You refer the man to an outpatient physical and occupational therapy program
- Soon you are receiving requests from the therapists regarding bracing.
- The therapist is reporting hyperlordotic positioning of the spine with heel cord tightness. **RED FLAG: Contractures of Achilles tendons and gastrocnemius muscle are common in patients with neuromuscular diseases and may deteriorate performance in daily living activities**



## Vignette

- The therapists request a prescription for ankle foot orthotics (AFOs)
- You agree that AFOs are appropriate but note that this is an L&I claim for upper extremity injury
- The therapists tell you that since the injury this patient has become very sedentary and they are concerned that poor positioning of his ankle joints (with lack of support for standing) will impair walking ability ultimately



# Vignette

- You obtain electrodiagnostic studies which show evidence of the following:
- Posterior Interosseus Nerve (PIN) entrapment
- Diffuse motor and sensory, demyelinating > axonal, peripheral neuropathy



## Vignette

- You refer the patient to an orthopedic hand surgeon for assessment of the arm
- The patient undergoes release of the Arcade of Frohes and supinator muscle
- Post op the patient is sent for proprioceptive neuromuscular stretching through a hand therapist and close clinical monitoring by physician



## Vignette

- After a few weeks in therapy, he starts complaining of a vague periscapular pain in both shoulders. He described this as a “burning”, nagging pain that is increased with exercise, but may persist for hours after he stops activities. More recently it is present at rest. The pain is increased by any overhead activity or carrying objects.
- He now also notes feeling weakness in grip, along with generalized arm pain and fatigue.



## **Pre-existing condition**

- You refer the patient to a neurologist who confirms the existence of a peripheral neuropathy
- DNA testing indicate type 1A Charcot Marie Tooth disease
- Patient now admits to a family history of this



# Issues

- The pre-existing condition now becomes the MAIN problem
- Pre-existing condition will substantially impair RTW
- This man should not have even been doing the type of work he was given his diagnosis of CMT 1A



## **Outcome**

- **In this case, the patient was never cleared for any RTW**
- **Issues of “were it not for the pre-existing condition, could he do JOI?” came up**
- **He ultimately applied for, and successfully gained SSDI/Medicare**
- **Months of time loss, very protracted case**

Colloquium on Occupational Health Best Practices  
at Group Health Cooperative  
Today's Theme: Collaborative Care in Healing and Returning to Work  
June 18, 2014

## **7. Progressive Goal Attainment**

### **Program:**

Success Stories and Relevance to Self-  
Insured Employers

Terri Smith-Weller

Jill Goodrich

# Activity Coaching (PGAP™) Pilot with Success Stories

18 June 2014

# What is Activity Coaching?

- Trained coach works with patients to promote healthy behavior change
  - exercise
  - activity participation
  - motivational and behavioral techniques
- Worker sets own goals

# Progressive Goal Attainment Program (PGAP™)

- One activity coaching intervention has been developed specifically for injured workers
- Progressive Goal Attainment Program (PGAP™)
- Developed by Dr. Michael Sullivan, McGill University

# New Best Practice Pilots

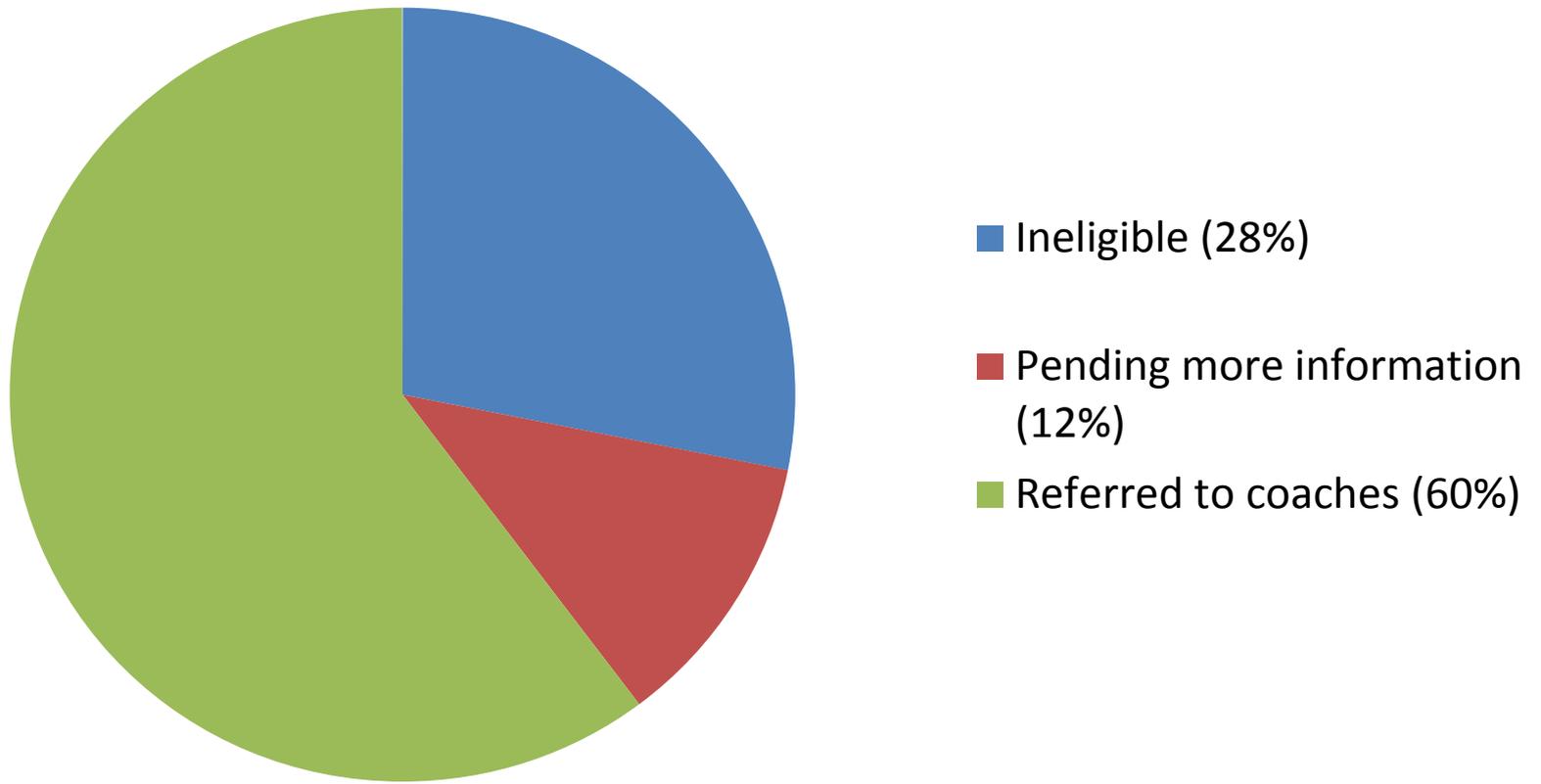
- Progressive Goal Attainment Program (PGAP™)
  - Pilot to test use of Progressive Goal Attainment Program model with Washington injured workers.

# PGAP™ Goals

- Reduce psychosocial barriers to rehabilitation progress
- Promote re-integration into life-role activities
- Increase quality of life
- Facilitate return to work

# Referrals to Screeners

January 2012 through May 2014 N=224



# Eligibility Criteria

- Off work greater than 5 weeks
- Less than 6 months since Claim Filing
- Able to speak, read, AND write in English
- No evidence of a drug or alcohol problem
- Work hardening is not in process or scheduled for the same time
- Symptoms are stable (e.g., surgery ruled out)
- Not post-surgery

# Referral Form

Eligibility Criteria	TRUE	NOT TRUE
The Attending Provider has talked to the IW about this referral?		Not Yet Eligible
The injured worker (IW) is currently not working.		Not Eligible
The IW has missed work because of this injury for at least 5 weeks PGAP™ is not needed before 5 weeks of work are missed. When the provider is using Best Practices, most IW will return to work before 5 weeks.		Not Eligible
Surgery is not likely The IW needs to not be expecting a “fix”		Not Eligible
Work hardening is not in process or scheduled for the same time If the IW isn't off work or is busy 40 hours per week in work hardening there is no time for the PGAP™ process.		Not Eligible
There is no evidence of a drug or alcohol problem		Not Eligible
The diagnostic work-up is completed. The IW can focus on recovery		

# Reasons ineligible

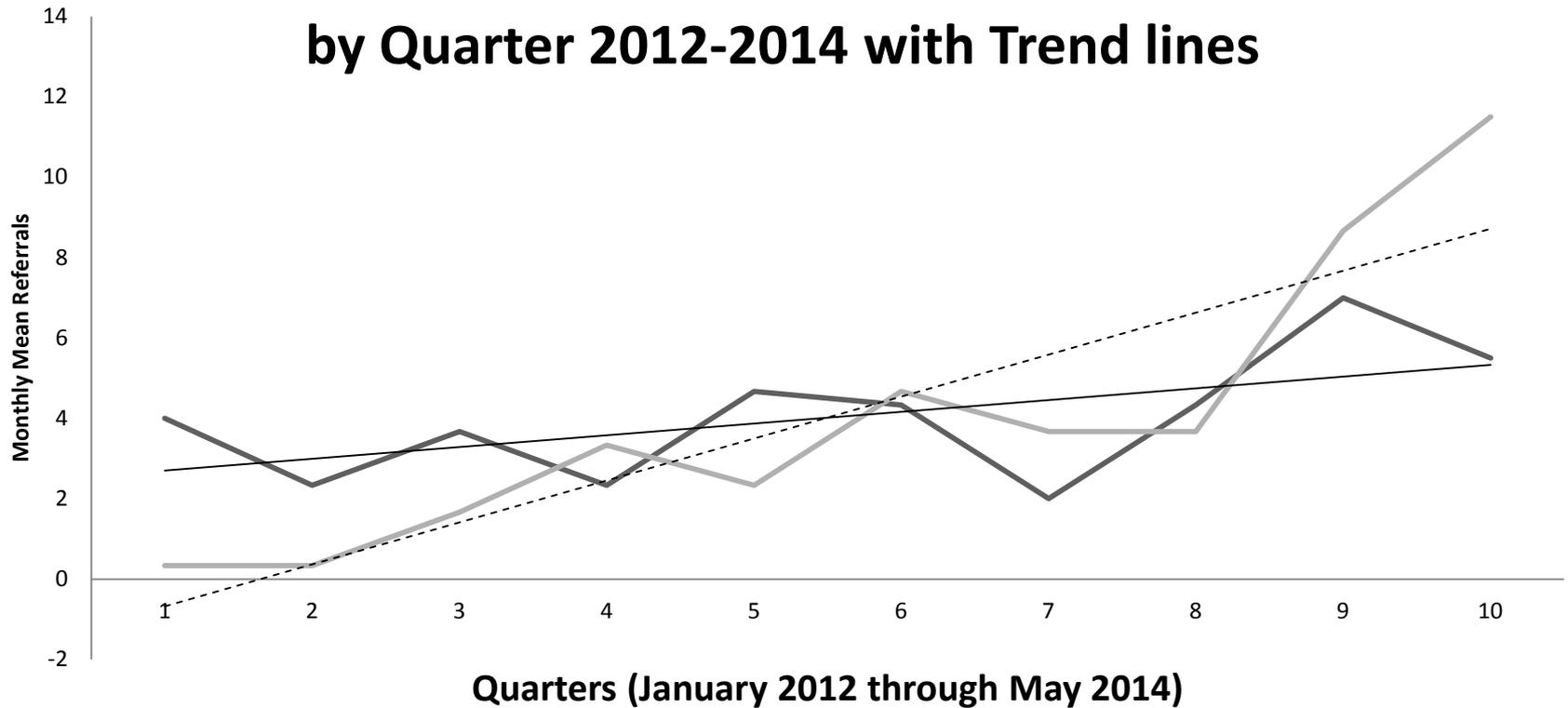
Reason	Number N=61
Worker has returned to or is working	13
AP withdrew or never agreed with referral	13
Not fluent in English	9
Less than 5 weeks off work	7
Going to or from surgery	5
Too late in claim	5
Work hardening	3
IW had already declined AC to HCP	3
Other	5

# Language fluency

Language	Number of referrals
Spanish	24
Arabic	2
Albanian	1
Punjabi	1
Swahili	1
Vietnamese	1

# Monthly Mean Activity Coaching Referrals

## by Quarter 2012-2014 with Trend lines



— < 6 months off work      — > 6 months off work  
— Linear (< 6 months off work)      - - - - Linear (> 6 months off work)

# Health Care Providers that Referred

IWs referred to screeners (N)	Providers with referrals (N)	Providers that initiated referrals (%)	% providers with IW with at least 1 visit
1	102	21	26
2	17	59	76
3	5	40	100
4	5	80	80
5	2	100	100
6	1	100	100
7	2	100	100
9	2	100	100
10	1	100	100

# Time from Injury to Screener

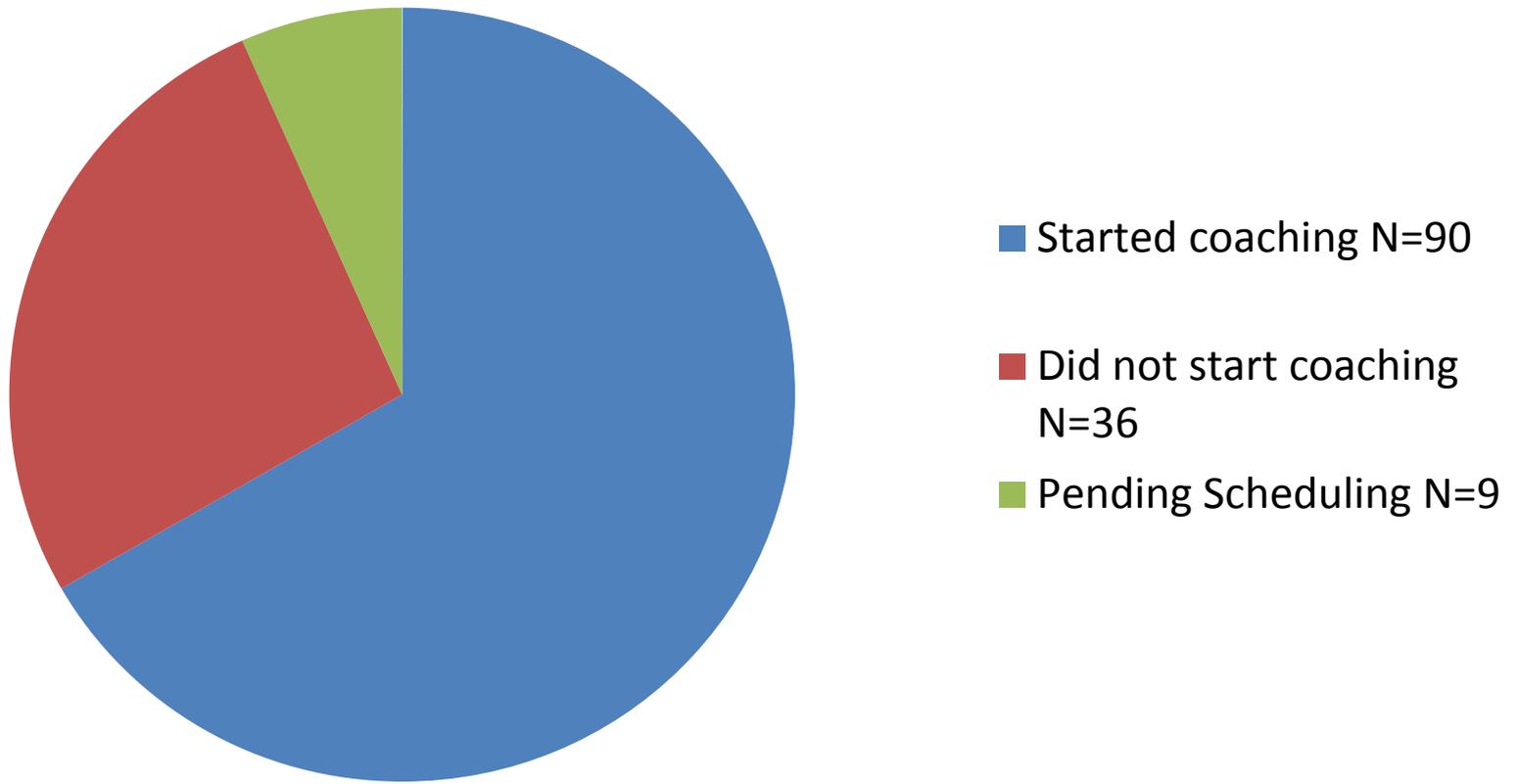
	Number referred
< 3 months	42
3- 6 months	46
6-12 months	51
12-24 months	30
2-5 years	27
5-10 years	14
> 10 years	11
Missing information	3

# Days from Screener to Coach

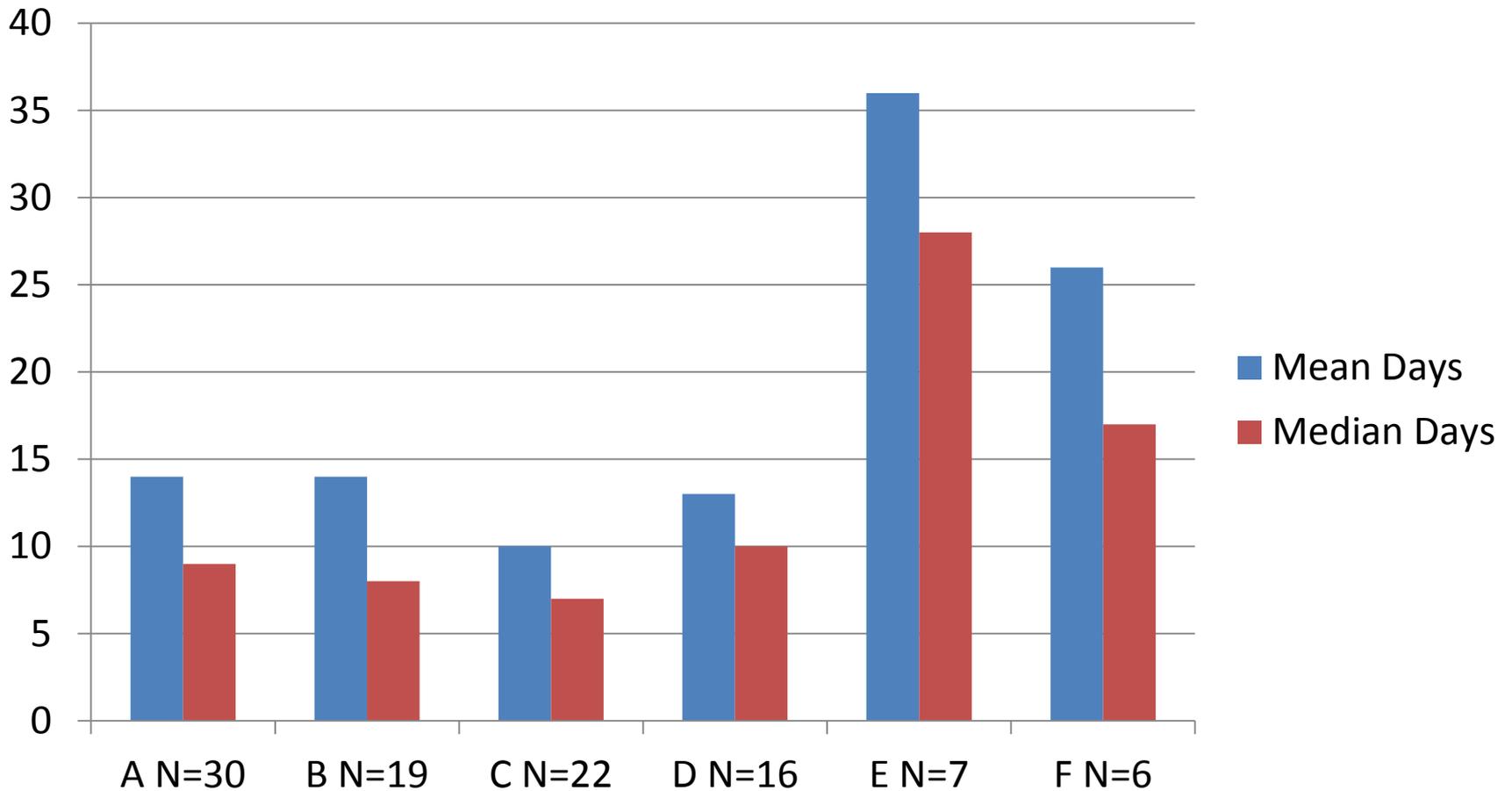
Source	# IW	Mean Days	Median Days
Activity Coach	16	15	3
Health Care Provider	34	7	1
Claim Manager	7	25	26
HSC	52	11	5
ONC	4	40	11

# Those referred to coaches

**N=135**



# Days from Coach to 1<sup>st</sup> Appt.

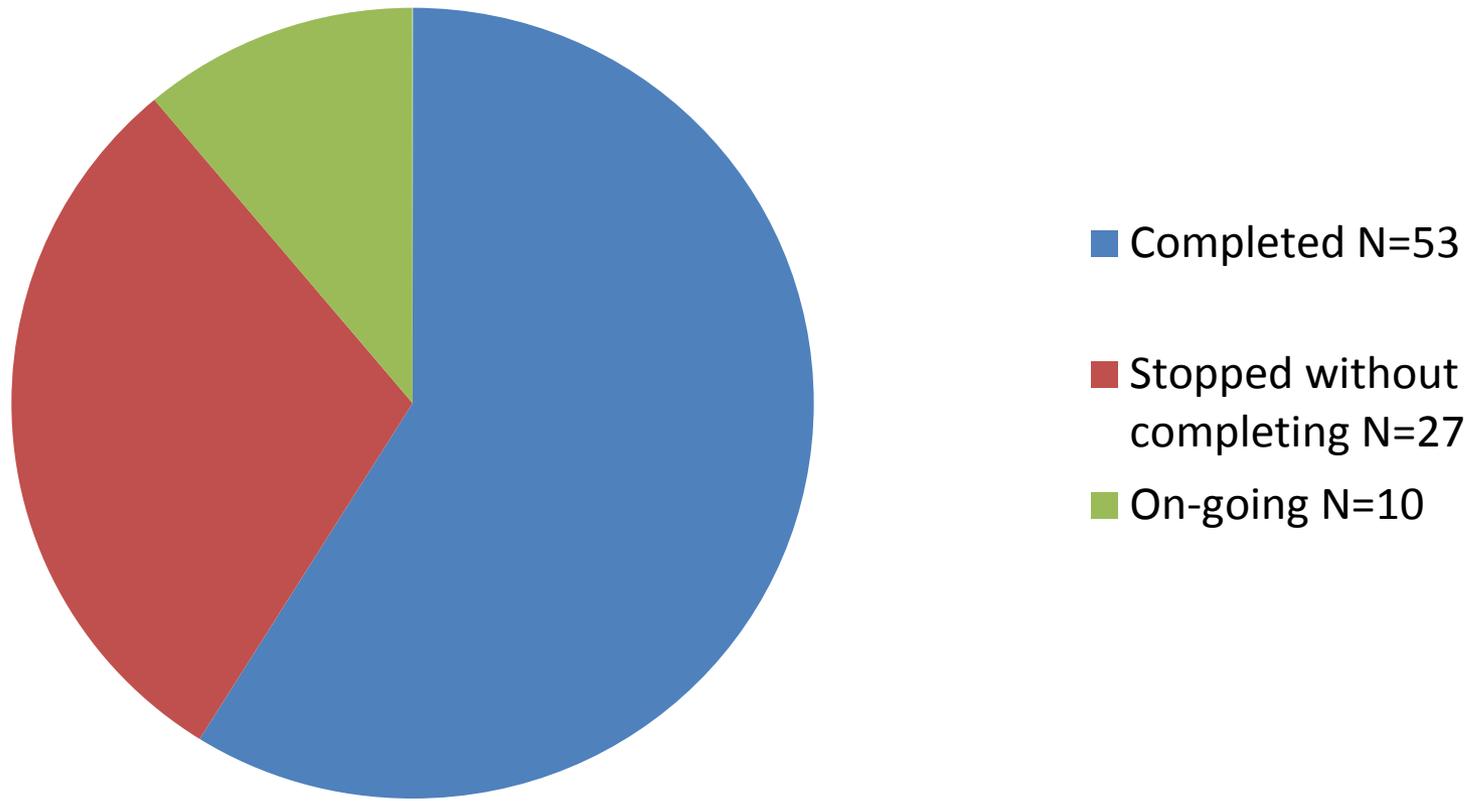


# Reasons for no Initial Assessment

Reason	Number N=17
Released to full duty or started working	5
Declined	4
Language barriers	2
No show for appointments	2
Other	4

# Those who started coaching

N=90



# Reasons for not Completing Coaching

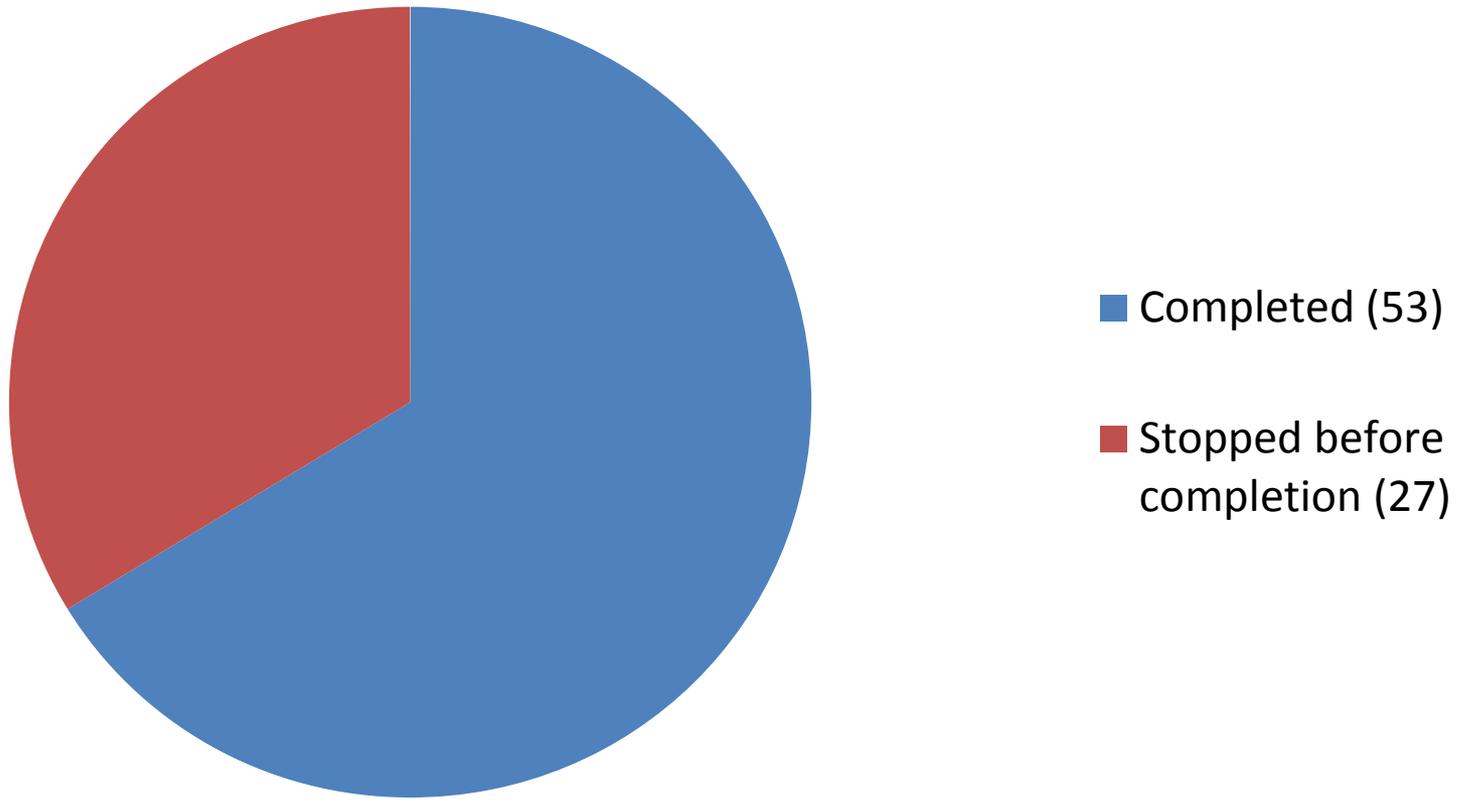
Reason	Number N=27
Repeated “no-shows” or non-compliance	6
Mental health issues limiting participation	5
IW chose to stop	5
Surgery	4
Lack of improvement	4
Other	3

# Average Number of Visits

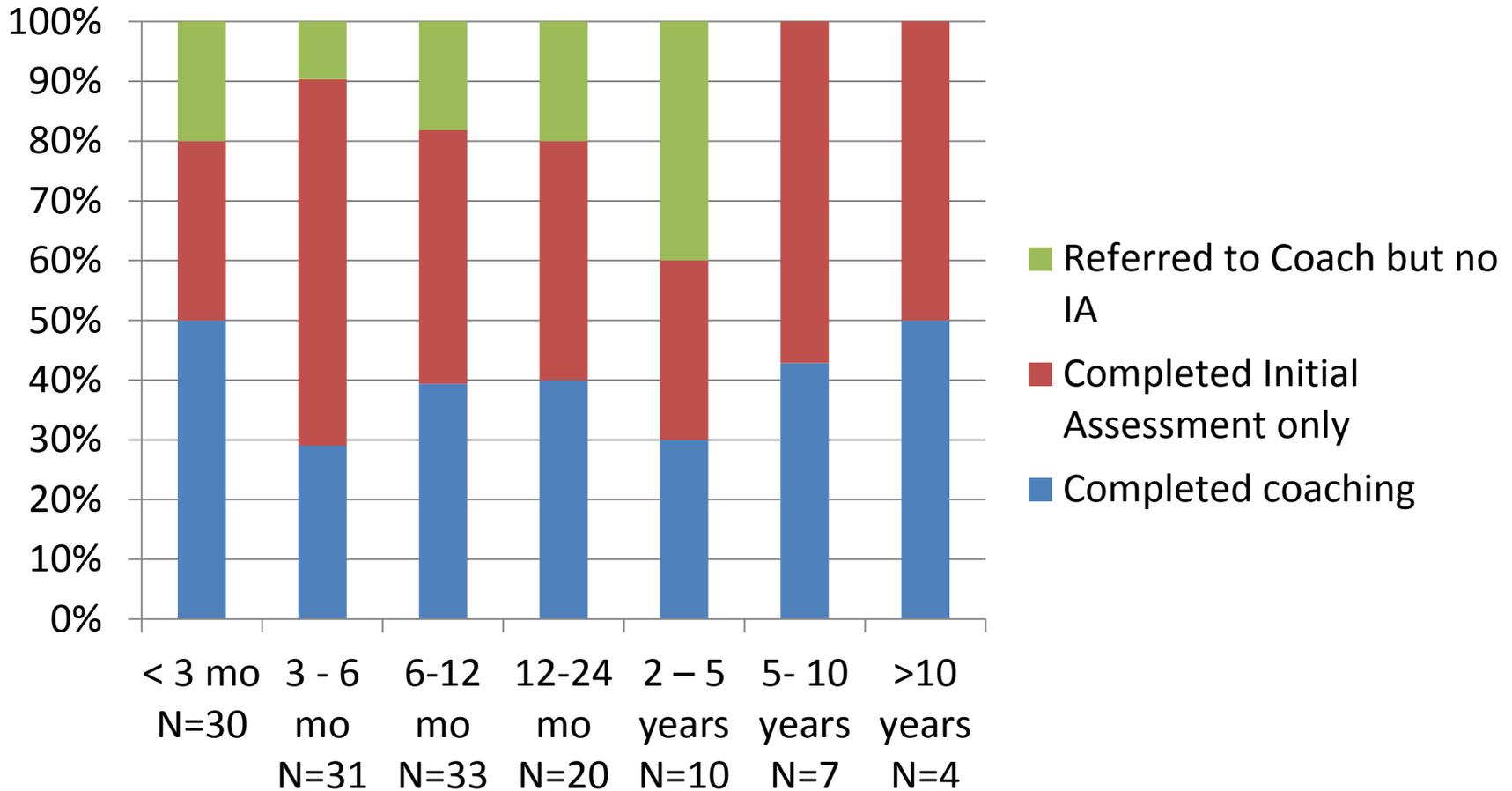
- 8 visits for those who completed coaching
- 4 visits for those who stopped coaching without completing
- These averages don't vary with the age of the claim

# Finished coaching

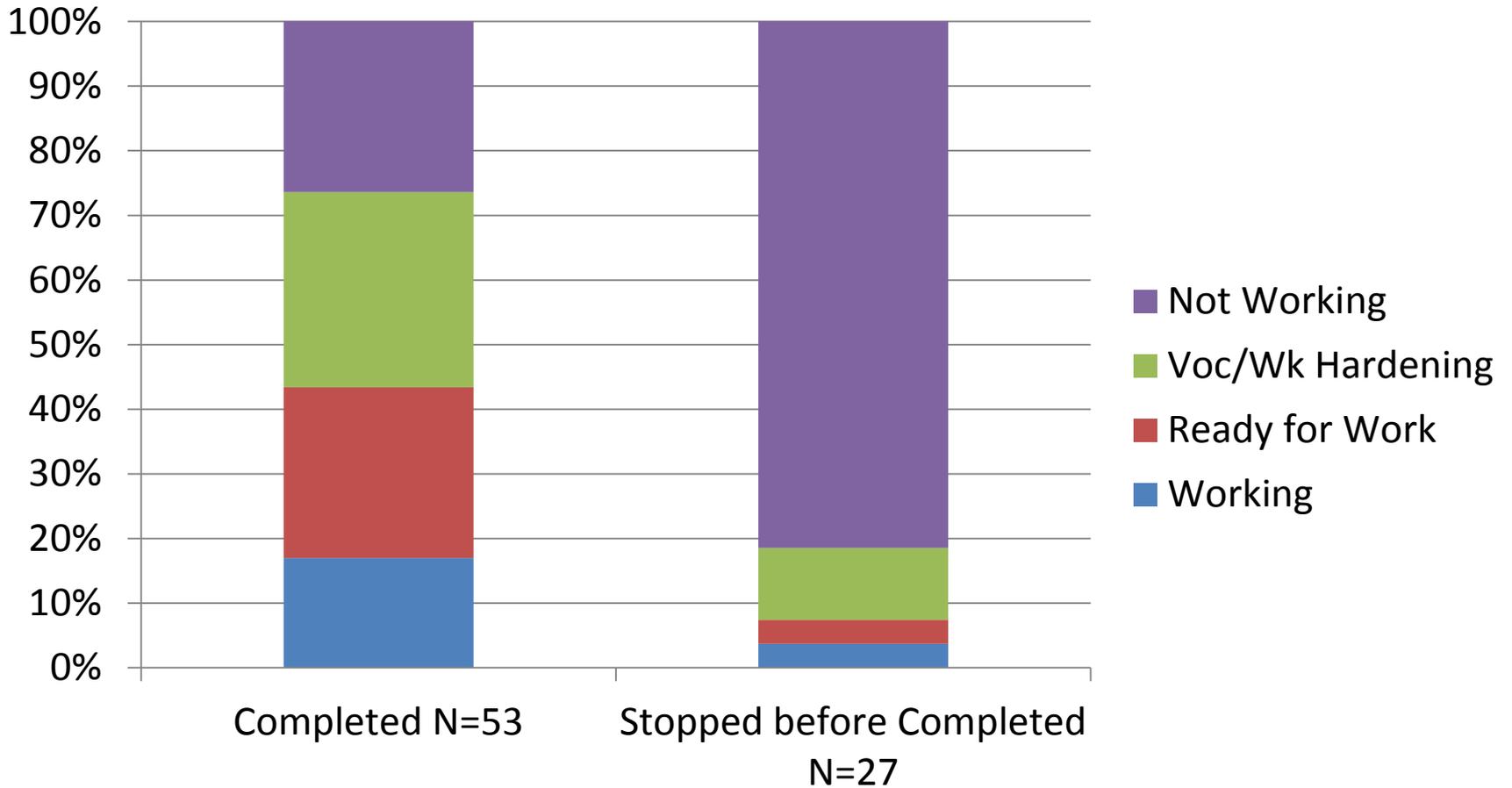
N=80



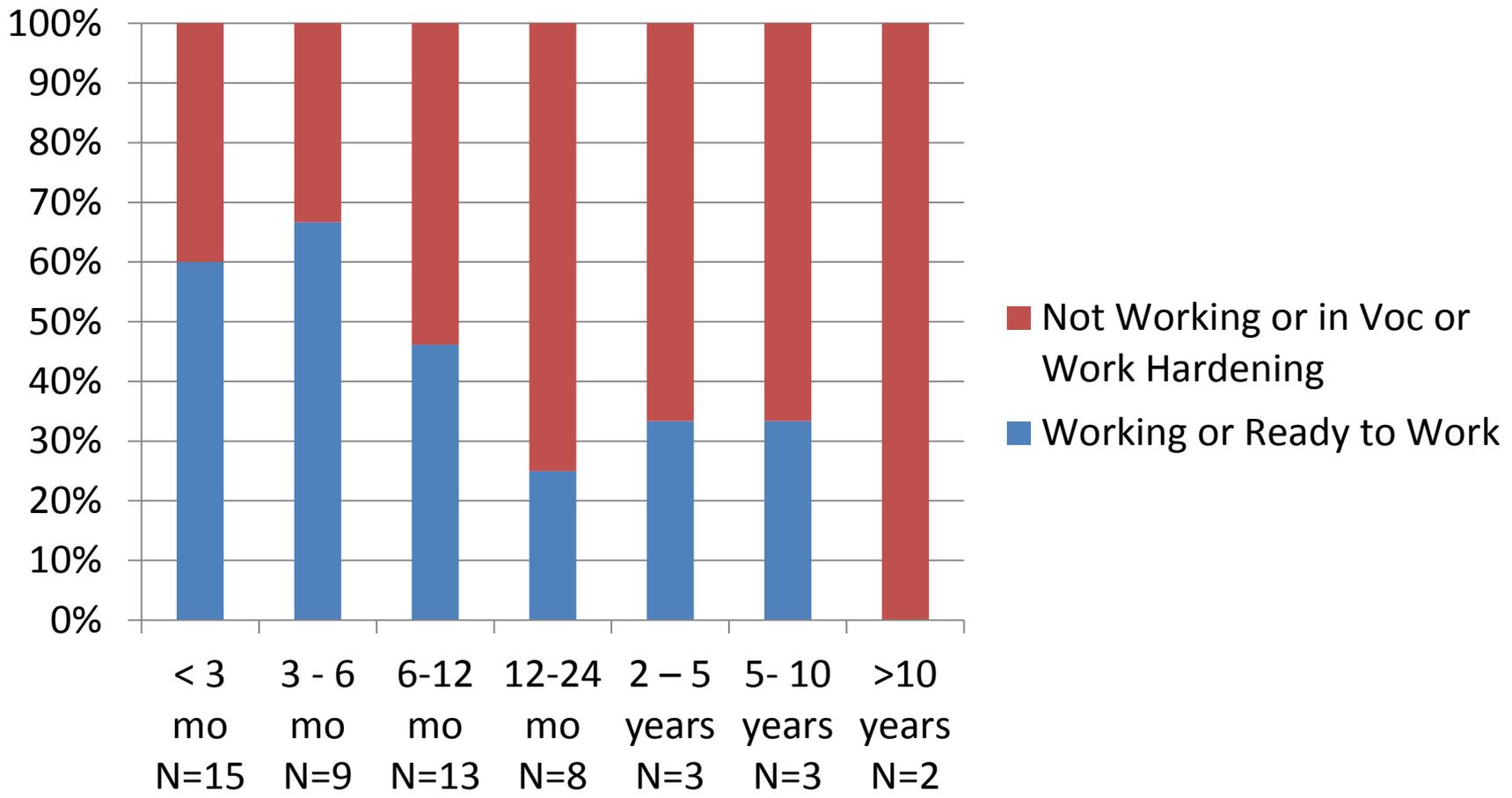
# Completion by Age of Claim



# Work status at End of Coaching



# Work Status at Completion by Age of Claim at Referral



# Psychosocial Assessment Scales

- Pain (McGill Pain Scale)
- Depression (PHQ-9)
- Multidimensional Fatigue Scale (FFQ-F)
  
- Pain Catastrophizing Scale (CIEQ-C)
- Injustice Experience Scale (CIEQ-I)
- Disability Index (GPDI) – perceived disability
- Tampa Scale of Kinesiophobia (FFQ-K) - fear of movement

# Psychosocial scales

Measured 3 times

	Visit number	# Completed
Baseline	1	76
Mid-treatment	5	59
Final	11	32

# PGAP™ psychosocial assessment scales - baseline

Scale	Range (possible)	Mean
Pain (McGill)	0-45	20.2
Depression (PHQ-8)	0-24	13.3
Fatigue (FFQ-F)	0-10	6.1
Fear of movement (FFQ-K)	0-10	5.3
Catastrophizing (CIEG-C)	0-14	8.8
Injustice (CIEQ-I)	0-10	6.1
Disability Index (GDPI)	0-50	35.3

# Changes in Pain (McGill)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	20.3	17.1	-15	61
Baseline to final	19.6	15.0	-23	63

# Changes in Depression (PHQ-9)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	14.1	10.4	-26	71
Baseline to final	12.6	8.0	-37	81

# Fatigue

- Example Questions

- I feel tired all the time.

- As soon as I start something, I feel weak all over.

- 0 – never

- 1 – sometimes

- 2 - often

# Changes in Fatigue (FFQ-F)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	6.3	4.9	-22	58
Baseline to final	5.8	4.3	-26	66

# Fear of Movement

- Example Questions
  - My body is telling me I have something dangerously wrong.
  - It's not really safe for a person with my condition to be physically active.
    - 0 – never
    - 1 – sometimes
    - 2 - often

# Changes in Fear of Movement (FFQ-K)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	5.4	4.5	-17	59
Baseline to final	5.2	3.7	-29	63

# Catastrophizing

- Example Questions
  - My symptoms are awful and I feel that they overwhelm me.
  - I worry all the time about whether my symptoms will end.
    - 0 – never
    - 1 – sometimes
    - 2 - often

# Changes in Catastrophizing (CIEQ-C)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	9.0	7.2	-20	63
Baseline to final	8.7	6.2	-29	78

# Injustice

- Example Questions
  - Most people don't understand how severe my condition is.
  - Nothing will ever make up for all that I have gone through.
    - 0 – never
    - 1 – sometimes
    - 2 - often

# Changes in Injustice (CIEQ-I)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	6.4	5.8	-9	49
Baseline to final	6.1	5.2	-15	56

# Disability Index

- Example Question:
- For each of the 5 categories of life activity listed, please choose a number between 0 and 10 to indicate how disabled you are due to your health condition. A score of 0 means no disability at all and a score of 10 signifies total disability.

– (4) Occupation

0 1 2 3 4 5 6 7 8 9 10  
no disability total disability

# Changes in Disability Index (GPDI)

Timing	Baseline	Follow-up	% change	Percent Improved
Baseline to mid-treatment	34.6	27.0	-22	75
Baseline to final	36	25.3	-30	81

# Summary

- Statistically significant decreases in all scales
- Scores improved for 50% – 80% of workers

# Strengths and limitations

- Strengths
  - Multiple psychosocial scales
  - Measured at multiple times
  - Seeing positive changes in all scores
- Limitations
  - No psychosocial measurements in an untreated comparison group
  - Intermediate outcome

# Intermediate outcomes

Example:

- HBP and risk of stroke
  - HBP is associated with an increased risk of stroke
  - Does using a particular medication decrease the risk of stroke?
  - Smaller, shorter studies
    - does BP decrease with use of BP medications?
  - Larger, longer studies
    - is the risk of stroke lower in patients randomized to BP treatment than in patients randomized to placebo?

# Intermediate outcomes

- Psychosocial measures and risk of time away from work (long-term disability, LTD)
  - Psychosocial measures are associated with an increased risk of time away from work
  - Does addressing psychosocial risk factors decrease the risk of time away from work?
  - Smaller, shorter studies
    - does PGAP™ improve psychosocial measures?
  - Larger, longer studies
    - is the risk of LTD lower in patients treated with PGAP™?

# Contacts and Web Link

- Susan Campbell – (360) 902-5053  
[susan.campbell@lni.wa.gov](mailto:susan.campbell@lni.wa.gov)
- Terri Smith-Weller (206) 543-3666 [smithwel@uw.edu](mailto:smithwel@uw.edu)
- PGAP™ [www.pdp-pgap.com/pgap/en/index.html](http://www.pdp-pgap.com/pgap/en/index.html)

# **PRESENTER BIOS**

## **Natalee Fillinger**

Natalee is the Self-Insurance Program Manager. She has held that position since March 2012. Prior to joining LNI, Natalee worked for the Attorney General's Office as an Assistant Attorney General beginning in 2002. During her time at the AGO, Natalee was a managing attorney and also held a case load, which included third party subrogation claims and DOSH cases. However, Natalee's last 6 years with the AGO focused on advising and litigating significant cases on behalf of the Self Insured Program. Natalee attended Gonzaga University, graduating cum laude with a BA in Political Science and earning a secondary education teaching certificate. She went on to attend and graduate from Seattle University Law School cum laude.

## **Tim Gilmore, MD**

Dr. Gilmore is a medical co-director for the occupational health department at Group Health Permanente, a staff-model HMO serving about 600,000 patients in Washington State. He supervises 7 occupational medicine specialty clinics and provides oversight and consultation for about 150 primary care physicians who care for injured workers in 19 other clinics throughout the Puget Sound Area.

Dr. Gilmore is an associate clinical professor in Occupational Medicine and in Family Practice at the University of Washington. He serves on advisory boards to the State Medical Association, the University of Washington Department of Environmental Health, and the University Occupational Medicine Residency.

Dr. Gilmore has practiced both primary care medicine and specialty occupational medicine for 28 years after graduating from medical school at the University of Washington. He is board certified in both Occupational Medicine and Family Practice after completing post-graduate studies at Swedish Hospital (R-1 internship) and Group Health (Family Practice Residency). He is also a licensed professional engineer (chemical engineering), and he worked for 7 years as an environmental engineer for the State of Alaska prior to medical school. He has an S. B. in aeronautical engineering from M. I. T. and an M. S. E. from the University of Washington in Environmental Engineering.

Dr. Gilmore has published multiple articles on several subjects ranging from carbon monoxide measurements, lead poisoning in children, and factors contributing to occupational injuries, to cross country skiing.

Avocationally, Dr. Gilmore is an avid outdoor sportsman and master's swimmer, and a retired rugby player, finisher of IronMan Canada 2009. He and his wife Susan are "empty nesters" with three children living in the Northwest.

## **Kris Tefft**

### **Washington Self-Insurers Association**

Kris Tefft is the eighth Executive Director of the Washington Self-Insurers, joining WSIA in March of this year. Prior to that, he was the General Counsel and Government Affairs Director for over ten years at the Association of Washington Business, where he was a lead voice for the business community before the Legislature, the Department of Labor & Industries, and the courts on labor and employment issues, including workers' comp and workplace safety. Kris will guide WSIA's governmental advocacy and public relations efforts, direct their events and educational programming, and represent WSIA in the courts as our general counsel. Kris is a graduate of Seattle University and the Notre Dame Law School, and lives in Olympia with his family.

360.754.6416

[Kris.tefft@wsiassn.org](mailto:Kris.tefft@wsiassn.org)

## **LEAH HOLE-MARSHALL, JD**

### **MEDICAL ADMINISTRATOR-L&I**

Leah Hole-Marshall, JD, is committed to improving the quality and safety of health care through ensuring high quality public health policy. Ms. Hole-Marshall is currently the medical administrator for the Washington State Department of Labor and Industries. In this role, she oversees the office responsible for creating, stakeholdering, implementing, updating, disseminating, and enforcing medical policy to ensure high quality health care for injured workers in Washington State. She also serves as the state health policy representative on the Board of Governors for Patient Centered Outcomes Research Institute ([www.PCORI.org](http://www.PCORI.org)); a national, non-profit research entity created by federal health reform legislation in 2010.

Previously, she directed Washington State's Health Technology Assessment program, created in 2006. The HTA program is a nationally recognized effort to purchase high-quality health care that is proven safe, effective, and cost-effective. The program relies on independent evidence reports and a committee of current practitioners to guide state purchasing decisions of medical technologies. From 2001 to 2006, Ms. Hole-Marshall provided regulatory consulting and project management to state Medicaid agencies and the federal Department of Health and Human Services (Medicaid, Office of HIPAA Standards, Office for Civil Rights) as a consultant with Fox Systems, Inc. She focused on HIPAA (Health Insurance Portability and Accountability Act) and information technology projects. She was consulted as an authority on HIPAA implementation by local, state, and federal entities; spoke nationally and regionally on HIPAA impacts, especially for public agencies; participated in workgroups and chaired a national workgroup. Ms. Hole-Marshall began her commitment to improving quality and safety of public health systems working for the Departments of Social and Health Services and Labor and Industries in Washington, providing contract management and regulatory compliance guidance. Prior to working in the public health care field, she practiced land use, real property, and business law in Olympia, WA for several years. She received her JD, Magna Cum Laude, at Seattle University School of Law in 1997 and a B.A. from Evergreen State College.

## **Nicholas K. Reul, MD, MPH**

Dr. Reul received his Master of Public Health degree from the University of Washington after completing the Occupational and Environmental Fellowship program in 2012. He received a Bachelor of Science degree in Geology-Biology from Brown University, went to medical school at the State University of New York at Stony Brook, and completed an intern year in Internal Medicine at the University of Minnesota. Board certified in Occupational and Environmental Medicine, he is the Associate Medical Director for Occupational Disease at the Washington State Department of Labor and Industries.

### ***Multidisciplinary Round Table Discussion: Best Practices for Effective Collaboration on Challenging Claims***

**Moderators:**     **David Overby**; MPA, Manager, Program Analysis & Development, Health Services Analysis, L&I  
                          **Richard Wilson**; CRC, Return-to-Work Services Program Manager, L&I

**Panelists:**       **Glenn Hansen - Multicare**  
Glenn is the Workers' Compensation Program Manager for Multicare and has been there 12 years. He started out in the industry in 1983 supporting and handling Boeing WC claims. Glenn is an active member of the WSIA.

**Kevin Kincade – Account Manager**  
Kevin Kincade has been involved in Washington workers' compensation for over twenty years. He first worked for Johnston & Culberson Inc. as a Claim Adjuster and later as a Supervisor. Between 1999 and 2012 he was the Branch Manager of Gallagher Bassett Services and Berkley Risk Administrators. Since January of 2013 Kevin has worked at Eberle Vivian as a Supervisor and an Account Manager. Kevin has extensive experience in handling claims, overseeing proper claims-handling of others, and in working with self-insured employers to arrive at win-win solutions to their workers' compensation issues.

**James K Jackson - WCA3**  
James began his career in workers' compensation for the Bureau of Workmen's Compensation, with the Industrial Commission of the State of Ohio in 1981-1992. As a mail clerk, he worked his way up to Claims Examiner II and became Compensation Consultant for injury claims.

James enlisted in the U S Army Reserves in 1985- 1998, as a legal specialist in claims. He also maintained the Legal Library for the

Judge Advocate General. He became a Staff Sergeant (E6p) patient administration supervisor, while managing and establishing electronic records management of personnel admitted to the Combat Support Hospital. James attended Bliss College in 1987, receiving an associate degree in Business Administration.

He worked in multiple Hospital and urgent care clinics as a Registration and Admissions Representative.

James joined the Department of Labor & Industries in 2010 and completed the Workers' Compensation Adjudicator (WCA2) Apprenticeship program in December 2011. He then completed the WCA3 level training and certification program.

## **Cory Turner, M.Ed, CRC**

Cory Turner is a Certified Rehabilitation Counselor (CRC) with 18 years of experience in the vocational rehabilitation field in Washington State, both in State Fund and Self Insured. She has owned her own business for the past 11 years, taking pride in providing high quality service to injured workers, third parties, and employers. She is active in her professional association, WSIA, the Vocational Technical Stakeholders Group, and often volunteers to participate in groups to improve the quality of vocational rehabilitation in the State of Washington. She does her best to help identify win/win solutions to difficult situations with honesty and integrity.

## **Jill C. Falk | M.Ed., CRC, CDMS**

[jillfalk@advancedvocational.com](mailto:jillfalk@advancedvocational.com)

Ms. Falk has been practicing as a Vocational Rehabilitation Counselor for over 20 years in Central Washington and is the principal owner of Advanced Vocational Solutions, Inc. Ms. Falk holds a Masters of Education in Counseling and Guidance. She is a Certified Rehabilitation Counselor and a Certified Disability Management Specialist. Ms. Falk provides vocational assessment services for State Fund and Self-Insured Employers. In addition, she provides expert witness services.

Ms. Falk served on the state and national board of the International Association of Rehabilitation Professionals (IARP). She has served on the Foundation for Rehabilitation Education and Research. Jill is a Past Vice-Chair of the Commission on Rehabilitation Counselor Certification and Past Chair of the Ethics Committee.

Ms. Falk has presented on the topic of ethics and standards in rehabilitation counseling on numerous occasions at both state and national professional conferences and to the Washington State Department of Labor and Industries State Fund and Self-Insured Sections. In addition, she has presented to large employers including Boeing and Union Pacific Railroad.

## **Gregory T. Carter, MD, MS - Medical Director**

Dr. Greg Carter's interest in medicine came from his father, a general surgeon. After losing a close friend to Amyotrophic Lateral Sclerosis (ALS), he began researching better ways to ease symptoms of neuromuscular disease. Dr. Carter co-founded the Muscular Dystrophy Association (MDA) / ALS Center at the University of Washington and the MDA Regional Neuromuscular Disease Center at Providence St. Peter Hospital in Olympia, WA. He later received the Excellence in Clinical Care award from the MDA.

In 2012 Dr. Carter received the Distinguished Researcher Award from the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) and appointed to the AANEM board in 2014. He is also the past recipient of the Best Research Paper Published by a Psychiatrist Award from the American Academy of Physical Medicine and Rehabilitation as well as the Excellence in Research Writing Award from the Association of Academic Psychiatrists.

Dr. Carter graduated from Loyola University of Chicago, Stritch School of Medicine. He is Board Certified by the American Board of Physical Medicine and Rehabilitation, American Board of Electrodiagnostic Medicine and the American Board of Psychiatry and Neurology with a subspecialty in neuromuscular medicine. He completed a Physical Medicine and Rehabilitation residency and neuromuscular disease research fellowship at the University of California, Davis, where he also earned a Master's degree in physiology. Following that he completed a MayDay Pain Fellowship at the University of Washington.

Dr. Carter is editor of the *Physical Medicine and Rehabilitation Clinics of North America* publication and senior editor for the medical journal *Muscle and Nerve*.

Dr. Carter enjoys spending time with his wife Carolyn and their four children, and playing guitar.

## **Stephen Thielke, MD, MSPH, MA**

Stephen Thielke is a psychiatrist and health services researcher at the Geriatric Research, Education, and Clinical Center (GRECC) of the Seattle VA Medical Center. He completed medical school, psychiatry residency, fellowship in geriatric psychiatry, and an NIMH fellowship in geriatric mental health services research at the University of Washington. He conducts research about pain and mental health, and about methods for longitudinal data analysis. He was the President of the Washington State Psychiatric Association in 2010-11. Stephen has been a Physician Consultant to Washington State Department of Labor & Industries since June 2013. He

currently serves as a member of Industrial Insurance Medical Advisory Committee (IIMAC) and the Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV).

### **Jill Morrison; BSRN, NCM**

Jill was born and raised in Eastern Washington and graduated from Pacific Lutheran University with a Bachelor's Degree in Nursing in 1985. After working in the hospital setting in departments ranging from Med/Surg, Oncology to Labor and Delivery, she initiated her Nurse Case Management career in Wenatchee, Washington in 1991. Jill worked as both a Vocational Counselor and a Nurse Case Manager until 2000, when she focused her efforts on providing the most comprehensive, efficient and effective medical case management for injured workers and their Self-Insured employers throughout Washington State. Jill has proudly worked for EIS Group based out of Cashmere, WA, since 2000 and continues to take pride in her ongoing professional efforts to quickly resolve difficult medical issues to facilitate a claimant's successful return-to-work. After 23 years in this business, Jill continues to be a firm believer in honest, positive collaboration throughout the claim process for a common goal of achieving the best possible outcome for all involved parties.

### **Dr. Dianna Chamblin**

Dr. Dianna Chamblin is board certified in Physical Medicine and Rehabilitation. She wears several hats in her role at The Everett Clinic. In addition to her active clinical practice, she serves as The Everett Clinic's Occupational Medicine Department director and as medical director for The Everett Clinic Center for Occupational Health and Education. She is an employer representative in their retrospective rating program and provides oversight of their return to work program for their employees' work related injuries/illnesses.

Currently, Dr. Chamblin is chair of the Industrial Insurance Medical Advisory Committee and the Provider Network Advisory Group. She has chaired and participated in several IIMAC guidelines subcommittees and participated in the Agency Medical Directors' Group opioid guideline development of 2010 and prior 2007 opioid guideline. She is an associate member of the Washington Self Insured Association and is moderator of a quarterly self-insured roundtable at The Everett Clinic.

She is committed to disability prevention and the promotion of a collaborative team approach to care of the injured worker.

### **Terri Smith-Weller**

Terri is an Occupational Health Nurse in the Environmental and Occupational Health Sciences Department at the University of Washington for more than 20 years. Before beginning work at the UW she was an Occupational Health Specialist for the Tacoma-Pierce County Health Department. At the UW she managed a research study of retired painters and carpenters and a long-term study of Parkinson's disease risk factors. Since joining Gary Franklin's research group at the UW as the occupational health nurse on the multi-

disciplinary team, she has managed workers' compensation –related studies and the COHE evaluation team. She has a Bachelor of Science in Nursing degree from Walla Walla College and Masters of Nursing (Occupational Health Nursing) from the University of Washington.

## **Jill Goodrich**

Jill Goodrich arrived in Washington from the East Coast in 2011. Since, her arrival she has managed Occupational Therapy Services at Olympic Sports and Spine Rehabilitation (OSSR). Current and Prior education has provided her with a wealth of knowledge in Industrial Rehabilitation, Work Hardening/Work Conditioning, Hand Therapy and Ergonomics. She became a PGAP provider in 2012.

### **Education**

- [Bachelor of Science](#) in Occupational Therapy, [Utica College](#) of Syracuse University, 1999
- [Masters in Business](#) Administration, [Norwich University](#), 2006

### **Affiliations**

- NBCOT, 1999
- Professional in Workers' Compensation Member, 2011

### **Interests**

Jill enjoys spending time with family, traveling, and [quilting](#).