



Washington State Department of
Labor & Industries

Healthy Worker 2020

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Vision: To be the quality leader in workers' compensation healthcare, achieving the best outcomes and quality of life for workers at the minimum cost and using the simplest means.

Objectives

1. Improve outcomes for injured workers and the overall system.
2. Align system objectives and incentives so that no injured worker falls through the cracks.
3. Expand capacity for and improve quality of occupational health best practices for both primary and specialty care for secondary and tertiary prevention of disability.
4. Increase satisfaction of providers, employers, and injured workers with the workers compensation system.

Strategies

1. Increase partnerships with accountable providers for delivery of collaborative, coordinated, systematic, and effective care to injured workers.
2. As a health care purchaser, invest in programs that provide support to providers so they can deliver coordinated, systematic, best practice care.
3. Develop best practices for services or activities that attending providers provide or direct.
4. Develop incentives to increase the use of evidence based, occupational health best practices by attending providers, and other providers who deliver best practices.
5. Provide systematic feedback to providers and ongoing program evaluation to continuously improve medical care, coordination of services, and the incentive programs.
6. Retain worker's ability to select provider from L&I's Medical Provider Network.
7. Integrate programs for incentives, best practices, and quality improvement so that they are seamless to providers, workers, employers, and integrated across L&I programs.

	Where we are in 2014		Where we want to be in 2020
The community / Access (1)*	<ul style="list-style-type: none"> ■ A culture that promotes safe, high quality care, including Business and Labor involved regionally ■ Workers choose their attending provider from the MPN ■ Y providers participating in various best practices programs ■ Best practices programs and pilots are available in some geographic areas 	➔	<ul style="list-style-type: none"> ■ HW 2020 is part of a regional culture of providers, business, and labor to promote safe, high quality care ■ Workers choose a Best Practice provider for ongoing care ■ Every provider participating in HW 2020 ■ HW 2020 services available statewide
Health System (Integration) (2)	<ul style="list-style-type: none"> ■ Multiple pilots, projects, and programs separately incorporating and testing best practices ■ COHE not widely recognized or known in L&I ■ Clinical and administrative leadership engaged and see L&I as partner, key to success of COHE ■ COHE promotes identification of barriers and continuous system improvement 	➔	<ul style="list-style-type: none"> ■ All best practice incentive programs integrated seamlessly and integrated within L&I ■ HW 2020 has broad visibility and seen as high value ■ Clinical and administrative leadership engaged and see L&I and HW 2020 as partners ■ HW 2020 promotes identification of barriers and continuous improvement
Clinical Info. System (3)	<ul style="list-style-type: none"> ■ Electronic system to share information, launched early stages to identify workers and track activities 	➔	<ul style="list-style-type: none"> ■ Shared electronic system(s) used to seamlessly identify at risk workers, plan, track care progress, monitor performance of team and system, provide feedback
Delivery System Design (define roles, coordinate, planned action) (4)	<ul style="list-style-type: none"> ■ Defined Health Services Coordination available for providers in COHE for first 12 weeks and Surgical Best Practices Pilot ■ Care coordinators are not always known to all participants and interaction not fully planned ■ Care coordination services vary by COHE ■ Providers do not consistently identify and intervene to help a worker who is at risk for long-term disability 	➔	<ul style="list-style-type: none"> ■ Sponsoring organization assures injured worker receives seamless care coordination and planned services over entire episode of care ■ Providers, workers, employers, claim managers can easily identify the care coordinator and next step/action in plan ■ Care coordination services are defined and delivered according plan/need ■ Providers consistently identify and intervene to help a worker who is at risk for long-term disability
Decision Support (EBM, Occ Med Best Practices) (5)	<ul style="list-style-type: none"> ■ Services are focused on non-occupational conditions with limited RTW planning ■ Best practices identified for first 12 weeks and surgical care ■ Evidence-based best practices are available for specific provider types or claim statuses ■ Best Practices tracked, goals established, and feedback provided 	➔	<ul style="list-style-type: none"> ■ Services are focused on meaningful clinical and return to work outcomes ■ Best practices in place for care provided in first year of claim ■ Planning complete to identify best practices for entire episode of care ■ Best practices are embedded and tracked in individual and system practice, goals met or adoption rate improving
Self Mgmt Support (6)	<ul style="list-style-type: none"> ■ Coordination and care does not regularly include effective support for patient engagement. 	➔	<ul style="list-style-type: none"> ■ Coordination and care includes effective patient empowerment: assessment, goal setting, action planning, problem solving, and follow up.

*Title and (#) Refer to the Six Elements of the [MacColl Institute Chronic Care Model](#).

Reference: RCW 51.36.010 Findings — Minimum standards for providers — Health care provider network — Advisory group — Best practices treatment guidelines — Extent and duration of treatment — Centers for occupational health and education — Rules — Reports

(1) The legislature finds that high quality medical treatment and adherence to occupational health best practices can prevent disability and reduce loss of family income for workers, and lower labor and insurance costs for employers. Injured workers deserve high quality medical care in accordance with current health care best practices. To this end, the department shall establish minimum standards for providers who treat workers from both state fund and self-insured employers. The department shall establish a health care provider network to treat injured workers, and shall accept providers into the network who meet those minimum standards. The department shall convene an advisory group made up of representatives from or designees of the workers' compensation advisory committee and the industrial insurance medical and chiropractic advisory committees to consider and advise the department related to implementation of this section, including development of best practices treatment guidelines for providers in the network. The department shall also seek the input of various health care provider groups and associations concerning the network's implementation. Network providers must be required to follow the department's evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient. The department, in collaboration with the advisory group, shall also establish additional best practice standards for providers to qualify for a second tier within the network, based on demonstrated use of occupational health best practices. This second tier is separate from and in addition to the centers for occupational health and education established under subsection (5) of this section.

(2)(a) Upon the occurrence of any injury to a worker entitled to compensation under the provisions of this title, he or she shall receive proper and necessary medical and surgical services at the hands of a physician or licensed advanced registered nurse practitioner of his or her own choice, if conveniently located, except as provided in (b) of this subsection, and proper and necessary hospital care and services during the period of his or her disability from such injury.

(b) Once the provider network is established in the worker's geographic area, an injured worker may receive care from a nonnetwork provider only for an initial office or emergency room visit. However, the department or self-insurer may limit reimbursement to the department's standard fee for the services. The provider must comply with all applicable billing policies and must accept the department's fee schedule as payment in full.

(c) The department, in collaboration with the advisory group, shall adopt policies for the development, credentialing, accreditation, and continued oversight of a network of health care providers approved to treat injured workers. Health care providers shall apply to the network by completing the department's provider application which shall have the force of a contract with the department to treat injured workers. The advisory group shall recommend minimum network standards for the department to approve a provider's application, to remove a provider from the network, or to require peer review such as, but not limited to:

(i) Current malpractice insurance coverage exceeding a dollar amount threshold, number, or seriousness of malpractice suits over a specific time frame;

(ii) Previous malpractice judgments or settlements that do not exceed a dollar amount threshold recommended by the advisory group, or a specific number or seriousness of malpractice suits over a specific time frame;

(iii) No licensing or disciplinary action in any jurisdiction or loss of treating or admitting privileges by any board, commission, agency, public or private health care payer, or hospital;

(iv) For some specialties such as surgeons, privileges in at least one hospital;

(v) Whether the provider has been credentialed by another health plan that follows national quality assurance guidelines; and

(vi) Alternative criteria for providers that are not credentialed by another health plan.

The department shall develop alternative criteria for providers that are not credentialed by another health plan or as needed to address access to care concerns in certain regions.

(d) Network provider contracts will automatically renew at the end of the contract period unless the department provides written notice of changes in contract provisions or the department or provider provides written notice of contract termination. The industrial insurance medical advisory committee shall develop criteria for removal of a provider from the network to be presented to the department and advisory group for consideration in the development of contract terms.

(e) In order to monitor quality of care and assure efficient management of the provider network, the department shall establish additional criteria and terms for network participation including, but not limited to, requiring compliance with administrative and billing policies.

(f) The advisory group shall recommend best practices standards to the department to use in determining second tier network providers. The department shall develop and implement financial and nonfinancial incentives for network providers who qualify for the second tier. The department is authorized to certify and decertify second tier providers.

(3) The department shall work with self-insurers and the department utilization review provider to implement utilization review for the self-insured community to ensure consistent quality, cost-effective care for all injured workers and employers, and to reduce administrative burden for providers.

(4) The department for state fund claims shall pay, in accordance with the department's fee schedule, for any alleged injury for which a worker files a claim, any initial prescription drugs provided in relation to that initial visit, without regard to whether the worker's claim for benefits is allowed. In all accepted claims, treatment shall be limited in point of duration as follows...:

(5)(a) The legislature finds that the department and its business and labor partners have collaborated in establishing centers for occupational health and education to promote best practices and prevent preventable disability by focusing additional provider-based resources during the first twelve weeks following an injury. The centers for occupational health and education represent innovative accountable care systems in an early stage of development consistent with national health care reform efforts. Many Washington workers do not yet have access to these innovative health care delivery models.

(b) To expand evidence-based occupational health best practices, the department shall establish additional centers for occupational health and education, with the goal of extending access to at least fifty percent of injured and ill workers by December 2013 and to all injured workers by December 2015. The department shall also develop additional best practices and incentives that span the entire period of recovery, not only the first twelve weeks.

(c) The department shall certify and decertify centers for occupational health and education based on criteria including institutional leadership and geographic areas covered by the center for occupational health and education, occupational health leadership and education, mix of participating health care providers necessary to address the anticipated needs of injured workers, health services coordination to deliver occupational health best practices, indicators to measure the success of the center for occupational health and education, and agreement that the center's providers shall, if feasible, treat certain injured workers if referred by the department or a self-insurer.

(d) Health care delivery organizations may apply to the department for certification as a center for occupational health and education. These may include, but are not limited to, hospitals and affiliated clinics and providers, multispecialty clinics, health maintenance organizations, and organized systems of network physicians.

(e) The centers for occupational health and education shall implement benchmark quality indicators of occupational health best practices for individual providers, developed in collaboration with the department. A center for occupational health and education shall remove individual providers who do not consistently meet these quality benchmarks.

(f) The department shall develop and implement financial and nonfinancial incentives for center for occupational health and education providers that are based on progressive and measurable gains in occupational health best practices, and that are applicable throughout the duration of an injured or ill worker's episode of care.

(g) The department shall develop electronic methods of tracking evidence-based quality measures to identify and improve outcomes for injured workers at risk of developing prolonged disability. In addition, these methods must be used to provide systematic feedback to physicians regarding quality of care, to conduct appropriate objective evaluation of progress in the centers for occupational health and education, and to allow efficient coordination of services.

(6) If a provider fails to meet the minimum network standards established in subsection (2) of this section, the department is authorized to remove the provider from the network or take other appropriate action regarding a provider's participation. The department may also require remedial steps as a condition for a provider to participate in the network. The department, with input from the advisory group, shall establish waiting periods that may be imposed before a provider who has been denied or removed from the network may reapply.

(7) The department may permanently remove a provider from the network or take other appropriate action when

the provider exhibits a pattern of conduct of low quality care that exposes patients to risk of physical or psychiatric harm or death. Patterns that qualify as risk of harm include, but are not limited to, poor health care outcomes evidenced by increased, chronic, or prolonged pain or decreased function due to treatments that have not been shown to be curative, safe, or effective or for which it has been shown that the risks of harm exceed the benefits that can be reasonably expected based on peer-reviewed opinion.

(8) The department may not remove a health care provider from the network for an isolated instance of poor health and recovery outcomes due to treatment by the provider.

(9) When the department terminates a provider from the network, the department or self-insurer shall assist an injured worker currently under the provider's care in identifying a new network provider or providers from whom the worker can select an attending or treating provider. In such a case, the department or self-insurer shall notify the injured worker that he or she must choose a new attending or treating provider.

(10) The department may adopt rules related to this section.

(11) The department shall report to the workers' compensation advisory committee and to the appropriate committees of the legislature on each December 1st, beginning in 2012 and ending in 2016, on the implementation of the provider network and expansion of the centers for occupational health and education. The reports must include a summary of actions taken, progress toward long-term goals, outcomes of key initiatives, access to care issues, results of disputes or controversies related to new provisions, and whether any changes are needed to further improve the occupational health best practices care of injured workers.