DRAFT Colloquium on Occupational Health Best Practices DRAFT
at Swedish Medical Center
Today's Theme: The Washington Quality Advantage

June 29, 2016

Time	Topic	Who
8:00 – 8:45	**Gathering and Greeting** • Beverages and pastries	Colloquium Participants
8:45 – 9:00	**Welcome and Orientation** • Description of Day's Topics	**Jim Nylander**, Program Manager for Self-Insurance, Department of Labor and Industries **Steven P. Stanos, DO** Medical Director, Swedish Pain Center.
9:00 – 10:30	**Updates on Quality Initiatives – Treatment Guidelines and Practice Resources**	**Gary Franklin, MD**, Medical Director, Department of Labor and Industries **Dianna Chamblin, MD**, IIMAC Chair **Mike Dowling, DC**, IICAC Chair **Robert Mootz, DC**, Associate Medical Director, Department of Labor and Industries
10:30 – 10:45	**15 Minute Break**	
10:45 -11:15	**Our Quality Strategy and Current Implementation:** • Healthy Worker 2020 • Collaborative Care at Group Health	**Leah Hole-Marshall, JD**, Medical Administrator, Department of Labor and Industries **Tim Gilmore, MD** Group Health Cooperative
11:15– 12:15	**Key Note Presentation: Evidence-Based Medicine on Teatment of Chronic Pain**	**Steven P. Stanos, DO** Medical Director, Swedish Pain Center.
12:15 –1:00	**Networking Lunch**	
1:00 – 1:30	**Quality Updates from the Front Lines** • Reducing Harms from Inappropriate Opioid Prescriptions	**Gary Franklin, MD**, Medical Director, Department of Labor and Industries **Patrick C . Reiman, CPCU, CIC, AIC |** Director |Claims - WC - WA Sedgwick Claims Management Services, Inc.
1:30 – 2:15	**Quality Updates from the Front Lines** • Reducing Harm through evidence based Utilization Review	**Leah Hole-Marshall, JD** Department of Labor and Industries **Margaret Baker, MD** Qualis Health
2:15 – 2:25	**10 Minute Break**	

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2:25 – 3:20	**Quality Care - Evidence-Based Medicine before the Board and on Appeal**	**Jessica Creighton, JD** Assistant Attorney General WA State Attorney Generals Office
3:20 – 3:30	**Closing: Insights from today's presentations and take-aways**	**Kris Tefft**, Executive Director, Washington Self-Insurers Association

Treatment Guidelines and Practice Resources
-WSIA Colloquium-

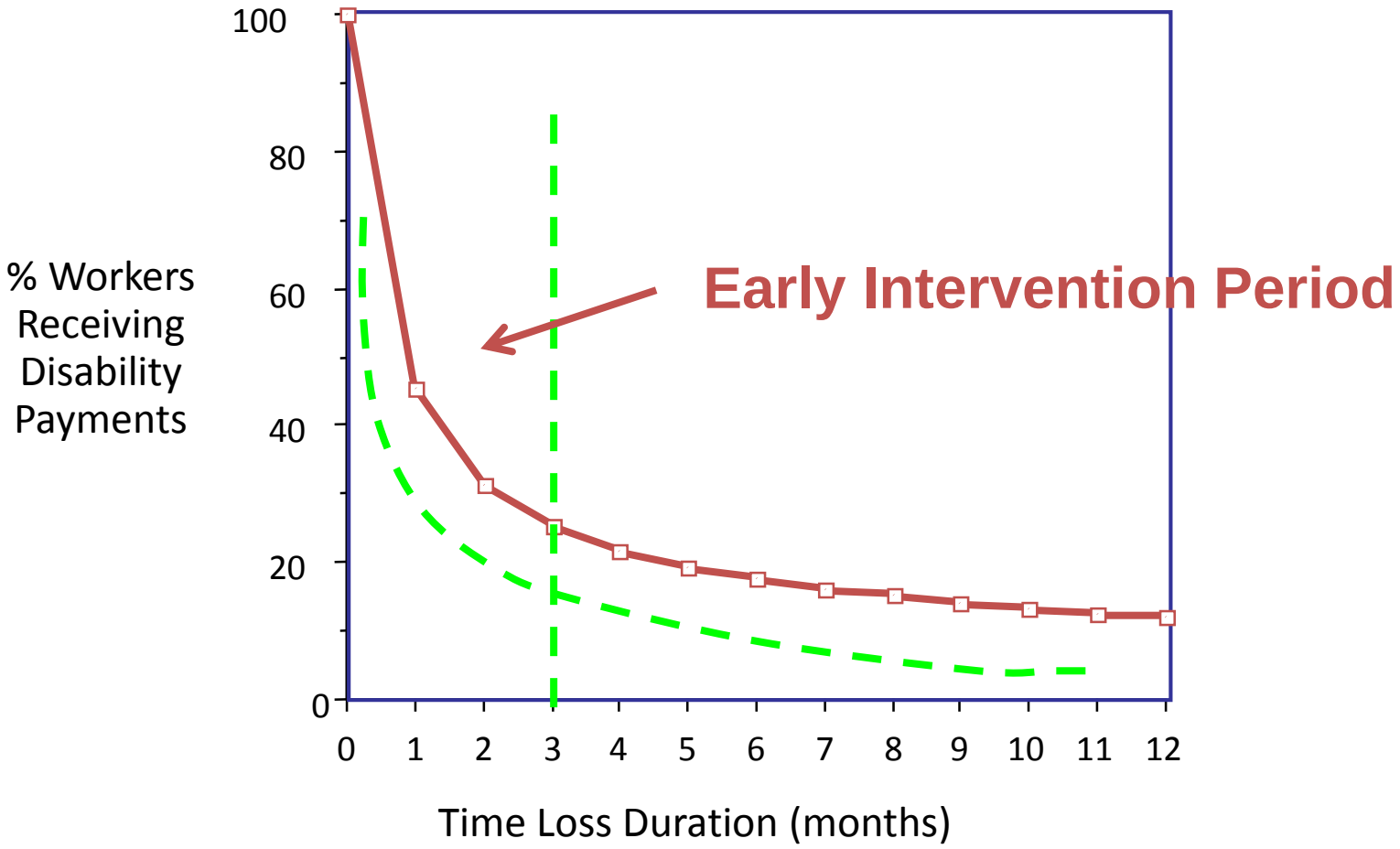
Gary Franklin, MD, MPH, Medical Director

Dianna Chamblin, MD, IIMAC Chair

Mike Dowling, DC, IICAC Chair

Robert Mootz,DC, Ass Med Director Chiropractic

Changes in Disability Status among Injured Workers in WA State



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

Disability Prevention in Workers' Compensation

Most important risk factor categories

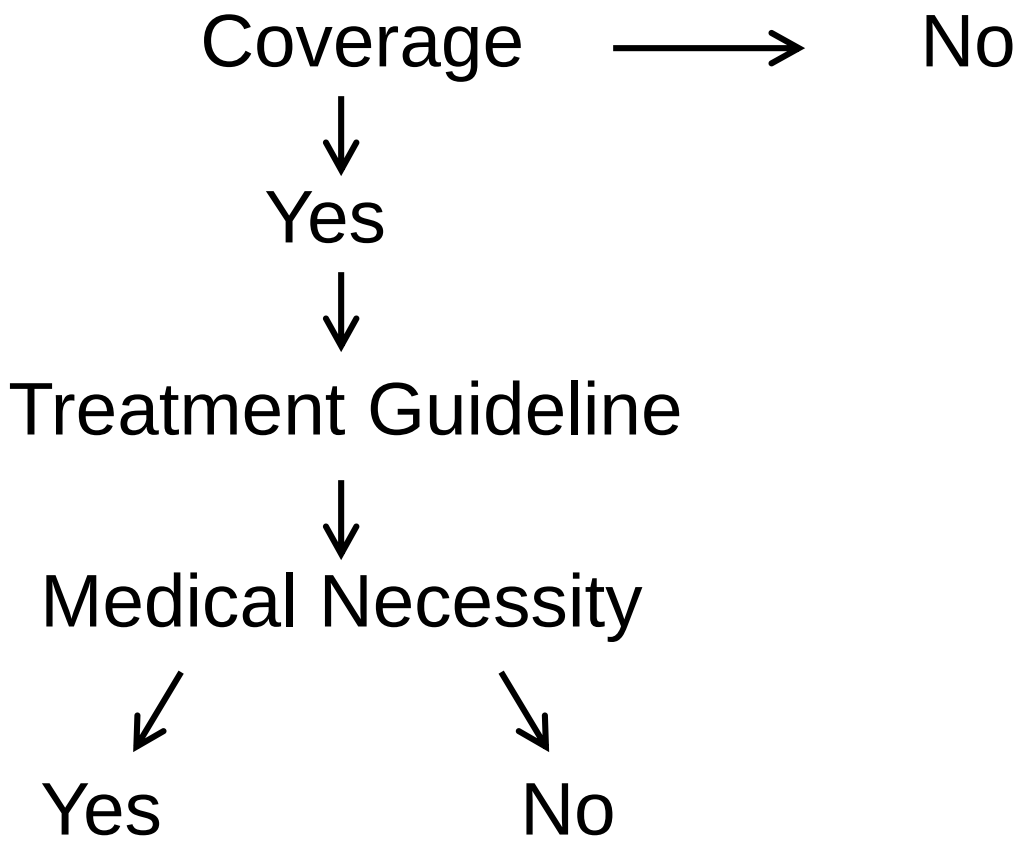
Strategic Focus in WA State

- **Use best evidence to pay for services that improve outcomes and reduce harms for injured workers-Treatment Guidelines, HTA's**
- 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-COHE's, Healthy Worker 2020

Federal Oversight	**Drugs**	**Medical Devices**	**Surgical Procedures**
Required for FDA approval	2 prospective, placebo controlled RCTs	"Substantial equivalence" to preexisting device	No approval requirements
Study outcomes	Disease-related endpoints	Engineering performance only	None
Published studies with patient-oriented endpoints?	Common	Uncommon	Not Considered
Patient population	Narrowly defined set of conditions (e.g., depression, dementia)	Varies widely (e.g., implantable defibrillators, laparoscopes)	Not Considered
Post-marketing evaluation?	Sporadic, sometimes high quality	Rare, usually low quality	None

Evidence-Based Decisions in Workers Compensation

- A Conceptual Framework



WA State Authority for Evidence-Based Decisions

2003-SSB 6088-Established the Prescription Drug Program for all agencies-uses evidence within drug classes to determine coverage

2003-SHB 1299-all agencies to conduct formal assessment of scientific evidence to inform coverage, track outcomes

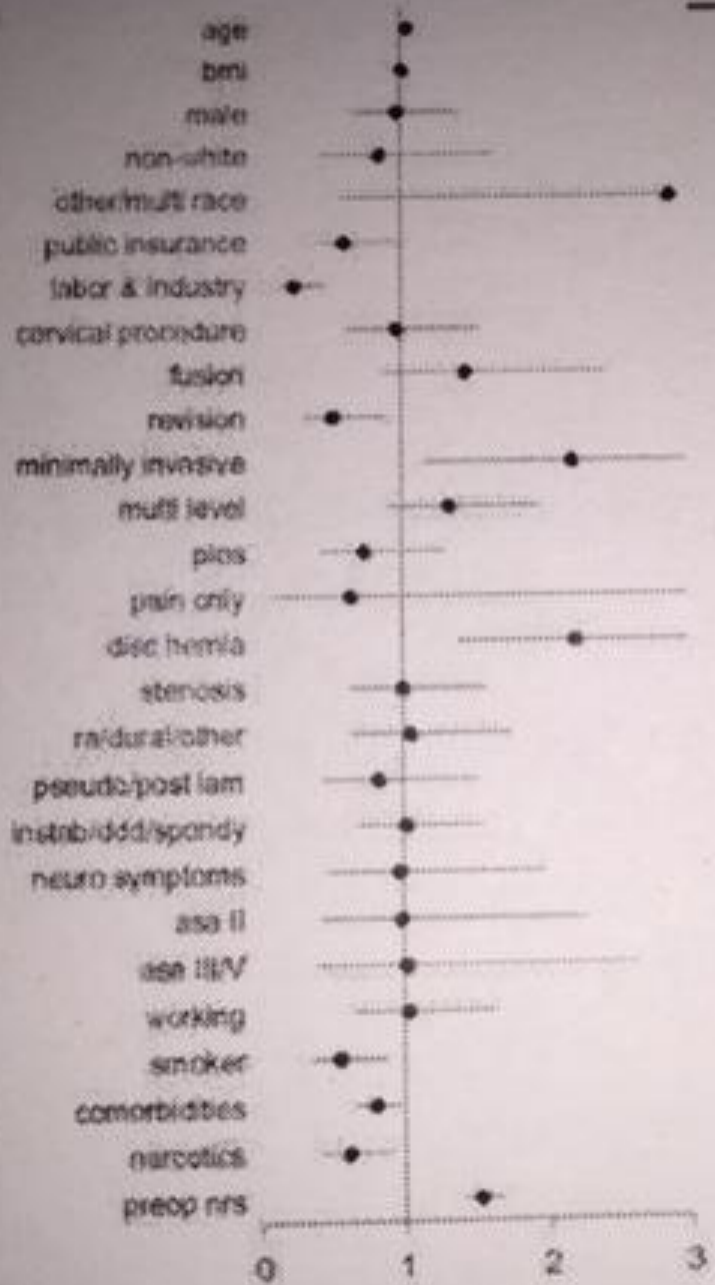
2005-Budget proviso-Agencies to collaborate on coverage and criteria (guidelines)-off-label neurontin done 8/05; opioid dosing guideline in progress; off-label antipsychotics planned

2006-Gov request legislation-HB2575/SB6306 to establish State Health Technology Assessment

2011-ESHB 1311-Public/private collaborative on guidelines-Bree Collaborative

WA Laws-ESSB 2575
2006

“A health technology not included as a covered benefit…shall not be subject to a determination in the case of an individual patient as to whether it is medically necessary..”



NRS Improvement

6-months

Lumbar Fusion
WA HTA-Jan, 2016

- Lumbar fusion for degenerative disc disease uncomplicated by comorbidities is not a covered benefit.
- The population addressed in this decision includes individuals > 17 years of age with chronic (3 or more months) lumbar pain and uncomplicated degenerative disc disease; excluded conditions include radiculopathy, spondylolisthesis (> Grade 1) or severe spinal stenosis, as well as acute trauma or systemic disease affecting the lumbar spine (e.g., malignancy).

Workers' Compensation: Poor quality health care and the growing disability problem in the United States
Franklin et al, Am J Ind Med 2014 (Sept 30)

Table II. Ultimate SSDI status for compensable cohorts 1997-2007		
	Incident Claim Years	
	1997	2007
Percent compensable claims with SSDI by 2012	2.1%	2.9%
Percent compensable claims with SSDI or at risk for SSDI by 2012	5.4%	9.2%

THANK YOU!

For electronic copies of this presentation, please e-mail Laura Black: ljl2@u.washington.edu

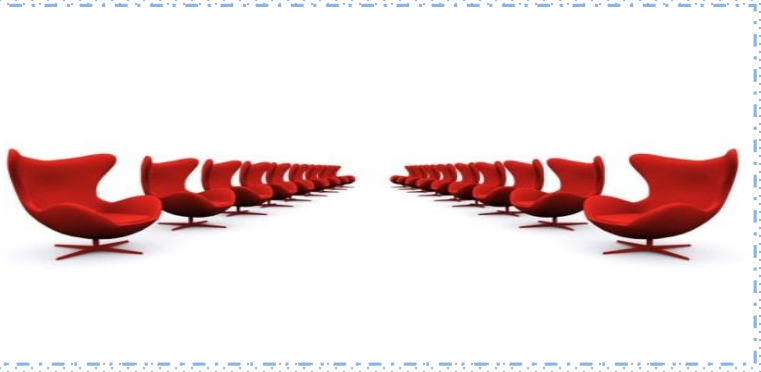
For research questions, please e-mail Gary Franklin meddir@u.washington.edu

SI-L&I Colloquium
Updates on Quality Initiatives

6/29/16

Dianna Chamblin, MD

IIMAC



Industrial Insurance Medical Advisory Committee

RCW 51.36.140:

"Shall 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** review of coverage decisions and technology assessments, review of medical programs, and review of rules pertaining to health care issues."

Subcommittee

Draft

Guideline(s)

IIMAC

IIMAC
Feedback

Public
Input

IIMAC
Vote

L&I Approved Surgeries before and after Guidelines Implemented

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

Shoulder Conditions Diagnosis and Treatment Guideline

http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALguidelineShoulderConditionsOct242013.pdf

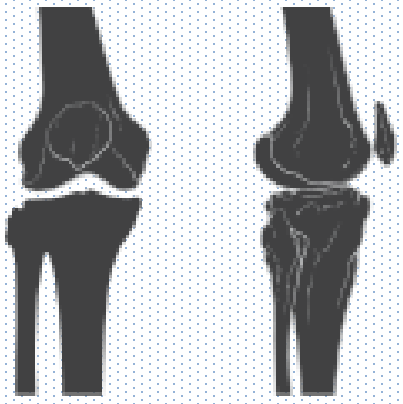
- Major changes:
  - Rotator cuff tear repair
    - Distal clavicle resection as a routine part of acute rotator cuff tear repair is not covered.
    - Repeat cuff tear repair after previous rotator cuff surgery. One revision may be considered. Second and subsequent revision is not covered if massive tear.
    - Smoking/nicotine use is a strong relative contraindication for rotator cuff surgery
  - Partial claviculectomy must have documented pain relief with an anesthetic injection as well as …
  - Total/hemi shoulder replacement if post traumatic issues related to severe proximal humerus fracture.
  - Diagnostic arthroscopy not covered

Diagnosis and Treatment of Cervical Radiculopathy and Myelopathy

http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/2014CervicalGuideline-FINAL.pdf

Highlights:

- Criteria for selective nerve root blocks.
- 3 or more levels will be reviewed by a physician.
- Surgery for adjacent segment pathology and cervical fusion will generally not be accepted unless directly related to prior surgery (such as hardware issues)
- Repeat surgery for pseudoarthrosis, must wait a year
- Repeat surgery at same level, not due to pseudoarthrosis require case review and must have documented substantial improvement in pain and function after first surgery before a second surgery will be approved.
- Nicotine use strong contraindication. Cervical fusions and repeat fusions for radiculopathy must abstain from nicotine for 4 weeks before surgery.



Surgical Knee Guideline effective August 1, 2016

- What's a KL score?
- When is a full or partial meniscectomy covered in a degenerative knee
- What do you do if a total knee replacement is requested and a patient has a BMI (body mass index) is greater than 40?

http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/KneeGuidelineFINAL2016.pdf

Other initiatives

- Input on care of injured workers with special needs such as from:
  - catastrophic injuries
  - additional behavioral health issues update with new DSM-r rules
  - ongoing use of opioids

Opioids and acute pain

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.)

Early opioid use increases risk of disability in L&I population.

Spine 2008;33:199-204.

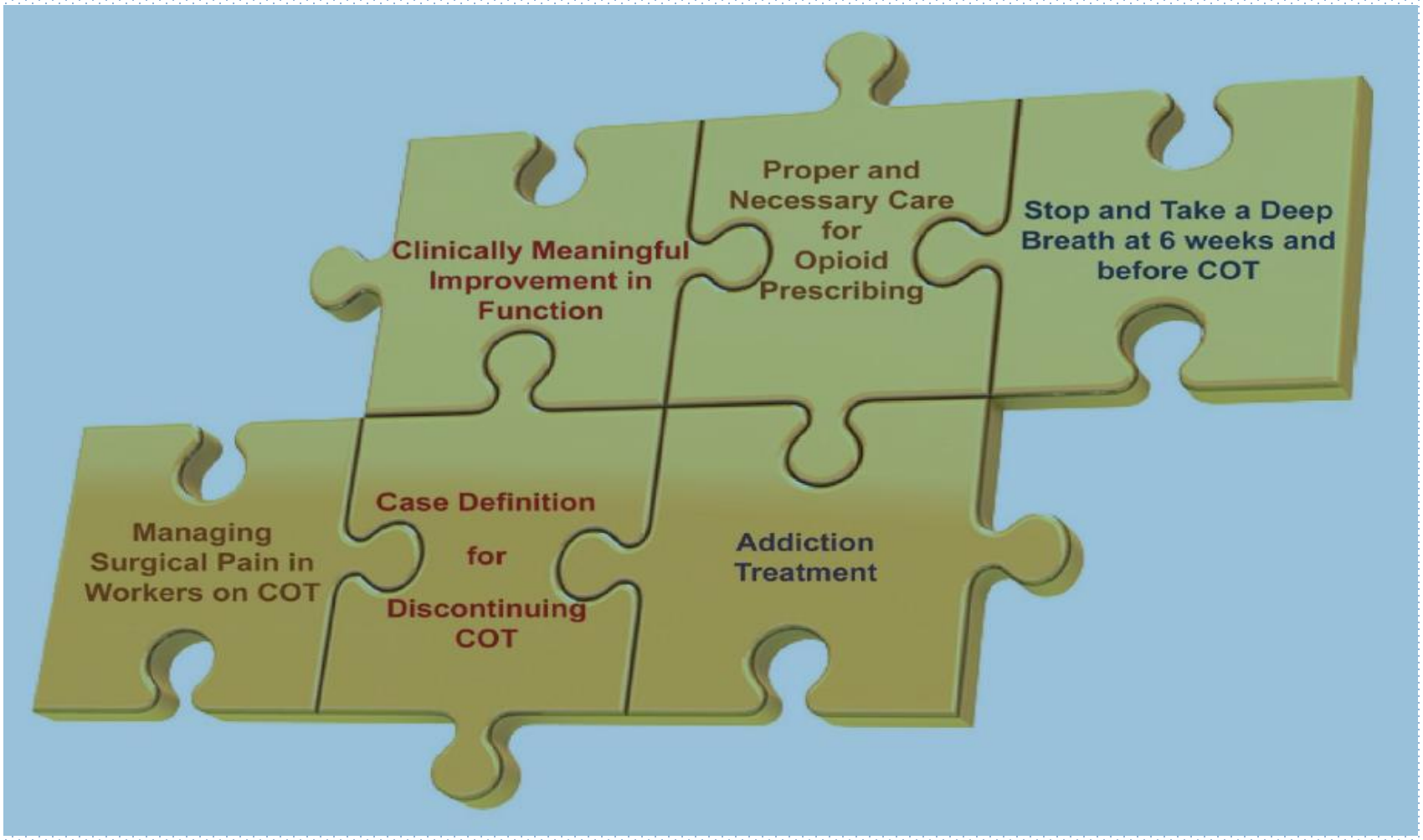
Opioid use in Workers Compensation

- Dramatic increase in opioid use to treat non-cancer pain over past decade.
- In Washington, **42%** of workers with compensable back injuries received an opioid prescription in 1st year after injury. **16%** of those continued on opioids after one year.

Franklin, G.M., Rahman, E.A., Turner, J.A., Daniell, W.E., and Fulton-Kehoe, D., *Opioid use for chronic low back pain: A prospective, population-based study among injured workers in Washington state, 2002-2005.* Clin J Pain, 2009. **25**(9): p. 743-51.

Guideline for Prescribing Opioids to Treat Pain in Injured Workers

Effective July 1, 2013



L&I OPIOID GUIDELINE HIGHLIGHTS

- Effective use of opioids must result in "clinically meaningful improvement in function" and if continued after development of a severe adverse outcome: [this] "**is not proper and necessary care in the Washington State workers' compensation system**."

- The department or insurer will cover opioids for **up to 6 weeks** when prescribed to treat acute injury or after surgery

- Use of chronic opioid therapy requires regular monitoring and documentation, such as screening for risk of co-morbid conditions with validated tools, checking the Prescription Monitoring Program database, assessing **clinically meaningful improvement in function** and administering random urine drug tests

…L&I OPIOID GUIDELINE HIGHLIGHTS

- Use after surgery
- Help to discontinue
- Addiction management

Advisory Committee on Healthcare Innovation and Evaluation

- Representatives from business, labor, IIMAC and IICAC providers to advise on L&I healthcare programs such as…
  - Provider Network
  - Centers for Occupational Health and Education, COHEs
  - Top Tier
  - Support SI participation in COHEs and/or other healthcare initiatives.

The Solution

Continuous Process Improvement Through Collaboration

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Industrial Insurance Chiropractic Advisory Committee

Practice Resources

Washington State Department of Labor & Industries

Industrial Insurance Chiropractic Advisory Committee (IICAC)

RCW 51.36.150

"…shall advise the department on matters related to the provision of safe, effective, and cost-effective chiropractic treatments for injured workers…"

Industrial Insurance
Chiropractic Advisory Committee

- Nine members with occ health & evidence-based practice experience
- Two standing subcommittees:

Policy, Practice & Quality

- Occupational health best practice evidence summaries
- Conservative care practice resources

Provider Education & Outreach

- Non-clinical resources
- Continuing education

Practice Resources vs. Guidelines

- ***Guidelines*** tend to address issues that need (and are more likely to be resolved with) yes or no decisions
  - Surgery is authorized under these conditions
  - Implementable by payers with fee schedules and/or authorization approaches (e.g. UR)

Practice Resources vs. Guidelines

- ***Resources*** tend to address issues that are more nebulous, have multiple acceptable options, may not be as black and white as a pre-authorization decision, nor as likely to have significant experimental research design.
  - A hand diagram is more useful for ruling in median nerve entrapment than a Phalen's test
  - Evaluation and management is reimbursed under more global codes rather than procedure specific codes

IICAC Resource Development

L&I with IICAC decide on topics

Clinical topics process

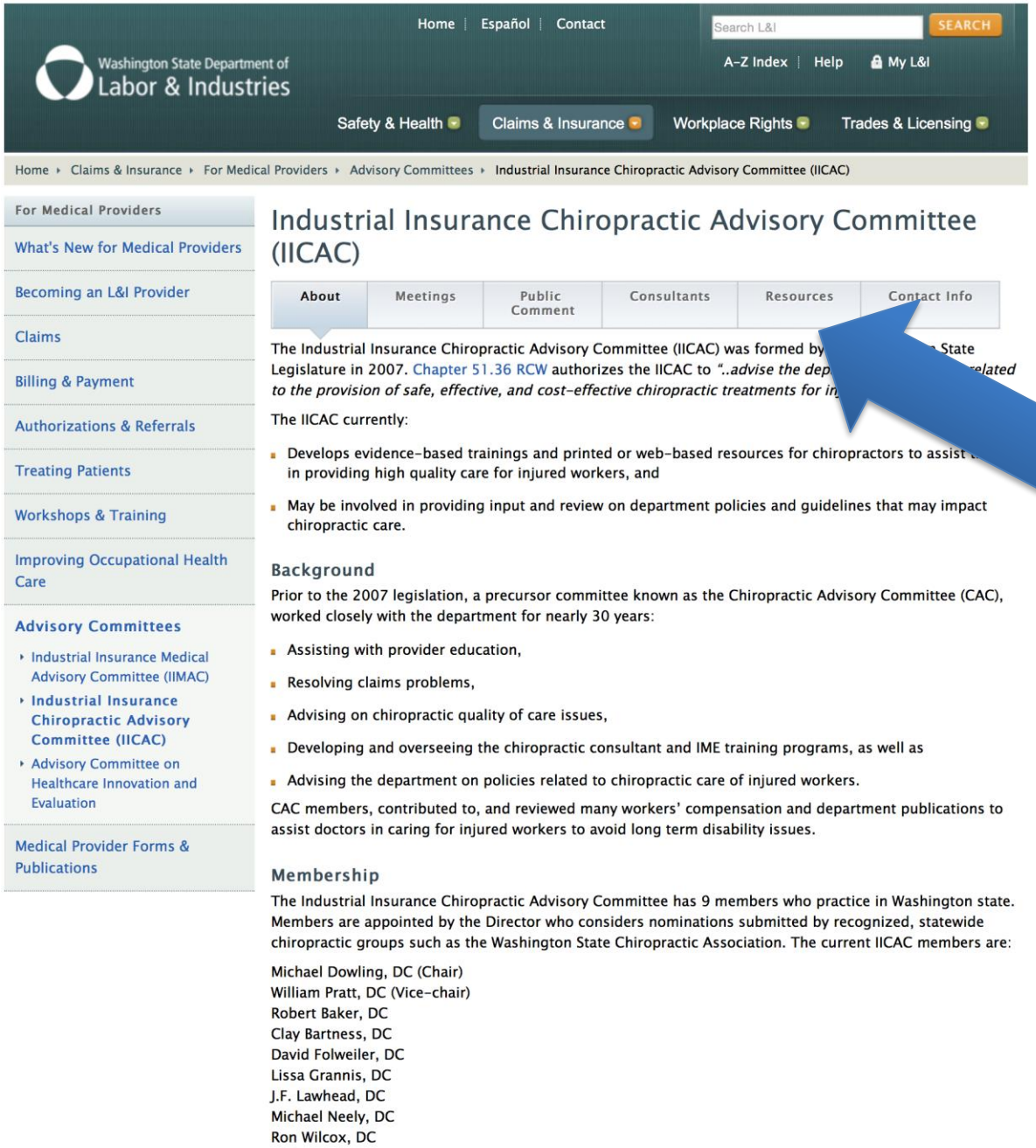
- Subcommittee with expert consultant(s)
- Systematic literature review
- Drafts with content expert review
- Public comment period
- Consideration and approval by full IICAC
- CE questions

IICAC Resource Development

Non-clinical topics process

- Subcommittee preparation & drafting
- Key informant meetings/discussions
- Systematic literature review (as needed)
- Drafts reviewed by content experts
- Consideration and approval by full IICAC
- CE questions developed

Resources Online



"Resource" Tab

Clinical: Best-Practice Resources

Industrial Insurance Chiropractic Advisory Committee (IICAC)

About	Meetings	Public Comment	Consultants	**Resources**	Contact Info

Practice Resources for Attending Providers

IICAC occupational health practice resources

- 2016 Documentation Best Practices for Washington State Workers' Compensation (756 KB PDF).
- 2015 Work-Related Foot and Ankle Conditions (1.82 MB PDF).
- 2014 Work-Related Mechanical Shoulder Conditions (700 KB PDF).
- 2014 Occupational Carpal Tunnel Syndrome (347 KB PDF).
- 2014 Documenting Functional Improvement (439 KB PDF) plus Functional Scales (558 KB PDF).
- 2014 Work-Related Epicondylosis (297 KB PDF).
- 2011 Active Rehabilitation for Work-Related Low Back Conditions (256 KB PDF).

Non-clinical: Optimize Your Practice

Tools for working with employers and other providers

Optimize your practice to help injured workers

- 2012 Attending Doctors Handbook
- Information About L&I Centers for Occupational Health and Education (COHE)
- Information and resources for providers about the Stay at Work program

Non-clinical: Work With Employers

Optimize your practice to work with employers

- 2015 Notice to Employer of Injured Worker Assessment & Treatment
  This template can be used to notify employers that your are attending one of their employees for an industrial injury. It lets you document important information and request the employer's assistance with return to work. It also includes useful information for the employer on what to do when they have a claim.
- 2015 Employer Contact Resource for AP's Office
  This workflow table identifies what your office staff and you need to do and document when you have a patient with a new work injury.
- 2012 Attending Providers Return To Work Desk Reference
- Return To Work Assistance For Employers
- Information and assistance with self-insured employers
  (including lists of self-insured employers and their third party administrators.)

Non-clinical: Providers, etc

Optimize your practice to work with other providers

- 2015 Attending Providers Referral Practices Quick Reference Card
- 2015 Attending Providers Referral Form
- 2013 PT/OT Referral Form

Upcoming continuing education seminars

Information on upcoming seminars can be found here.

Additional department resources and publications

- Medical Examiners' Handbook (F252-001-000).
- Medical Payment Policies and Fee Schedules.
- Coverage Policies and Guidelines.

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

This form is an optional communication tool.

ATTENDING PROVIDER'S REFERRAL FORM

For:
- ☐ 2nd Opinion Consultation
- ☐ Specialty/Surgical Consultation
- ☐ Concurrent Care (authorization required)
- ☐ Transfer of Care Consultation
- ☐ Closing Exam and Impairment Rating

Attending Provider: Do not request referral or consultation if IME has been ordered. Obtain CM authorization for concurrent care before scheduling patient. Consultations (other than mental health) do not require prior authorization. Send copy of this entire form to L&I and give bottom section to the worker.

Staff of Provider Complete

Worker's Name	Accepted Condition(s) (*Include ICD Codes*)	DOI	Claim #

Worker's Occupation	Current Work Status:
	☐ Full duty ☐ Not working for medical reasons ☐ Modified Duty ☐ Not working – light duty not available

Claim Manager's (CM) Name	Phone	
		☐ CM Notified of Referral ☐ CM Agreed to Concurrent Care ☐ Other CM Assistance requested

Attending Provider's Name	Phone	Referral/Concurrent Care Provider's Name* (*For WA, must be in L&I Provider Network*)	Phone

Business Address	Specialty
Required Attachments ☐ Accident Report ☐ Activity Prescription Form(s) ☐ Imaging, Laboratory Reports ☐ Consultation, IME, Progress Reports ☐ CM Authorization(s)	Business Address
	Appointment Date: Appointment Time:
	*To review the claim file, contact the CM to obtain temporary access to the Claim and Account Center

Complete

Referral Reasons (*Mark all that apply*)	**If Concurrent Care requested:**
☐ Diagnostic uncertainty ☐ Treatment plan uncertainty ☐ Progress stalled, care options sought ☐ Return-to-work issues ☐ Consultation for appropriateness of continuing care (*required prior to 120 days following 1st visit or beyond 20 visits*) ☐ Assessment for maximal improvement ☐ Other	Role of concurrent care provider: Specific clinical/functional improvement goals for concurrent care: Expected duration of concurrent care:

New Resource
Psychosocial Determinants Influencing Recovery

- First Joint IIMAC/IICAC project
- Evidence review of psychosocial factors that impact recovery
- Psychiatrist, psychologist, physiatrist, chiropractors
- Addresses screening tools and interventions by attending doctors and referral/support options
- Final draft under review; will be considered by both committees this month

Additional IICAC Work

Continuing Education

- Seminars
- On-line modules

Chiropractic Second Opinion Resource

- Chiropractic consultant program
- Chiropractic IME

Occ Health Best Practices Implementation

- Office workflows
- IICAC members and Consultants piloting
- Anticipate working with COHEs in future

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Self Insurance Colloquium
Strategic Vision on Quality Care

Washington State Department of
Labor & Industries

Strategic Vision on Quality Care

L&I Will:

- Describe how L&I's medical management focus is on Quality Care – a different focus than typical insurance
- Describe the impact using this strategy has on our state fund
- Describe why disability reduction is key
- Provide an update on COHE results and
- Explain how L&I is expanding its strategy to include more best practices and use the evidence based collaborative care model

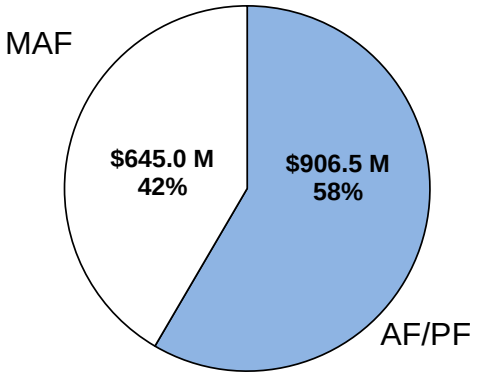
Group Health Will:

- Describe Group Health's experience with collaborative care, especially in the context of being a self-insured health care delivery organization and participating in COHE

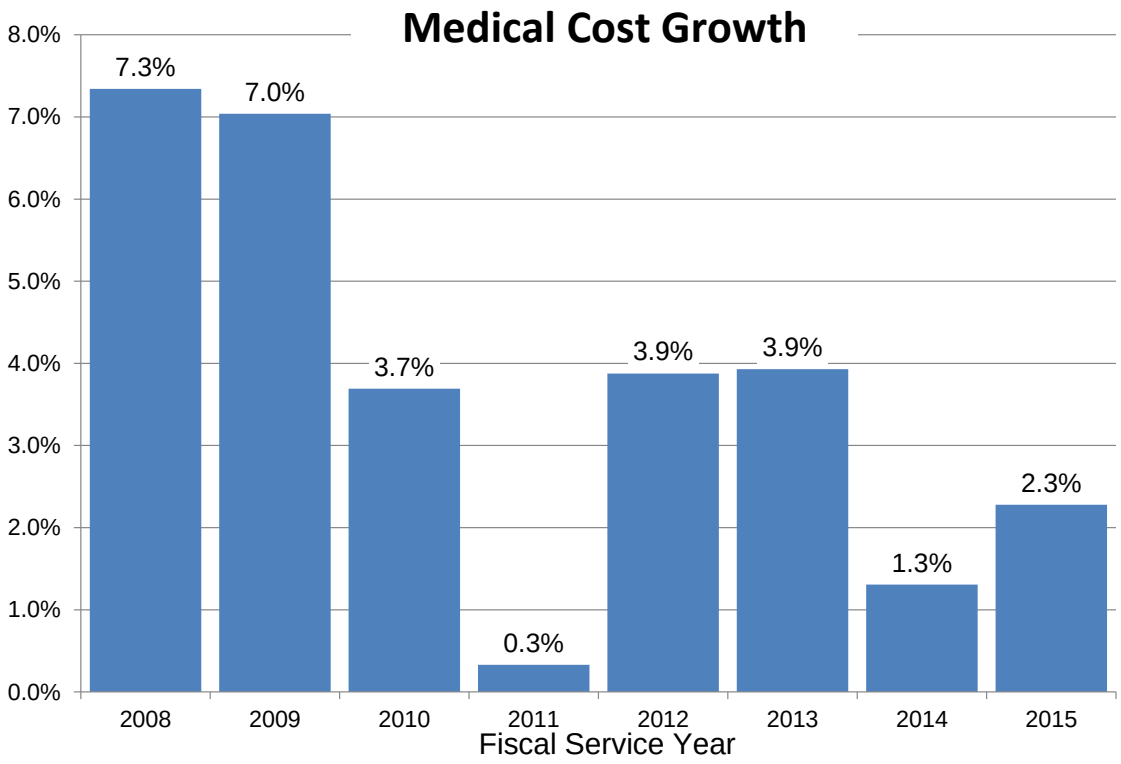
MEDICAL MANAGEMENT – typically balancing interests

Size and Growth of WA Medical Aid Fund

Benefits Incurred for Accident Year Ending 12/31/15

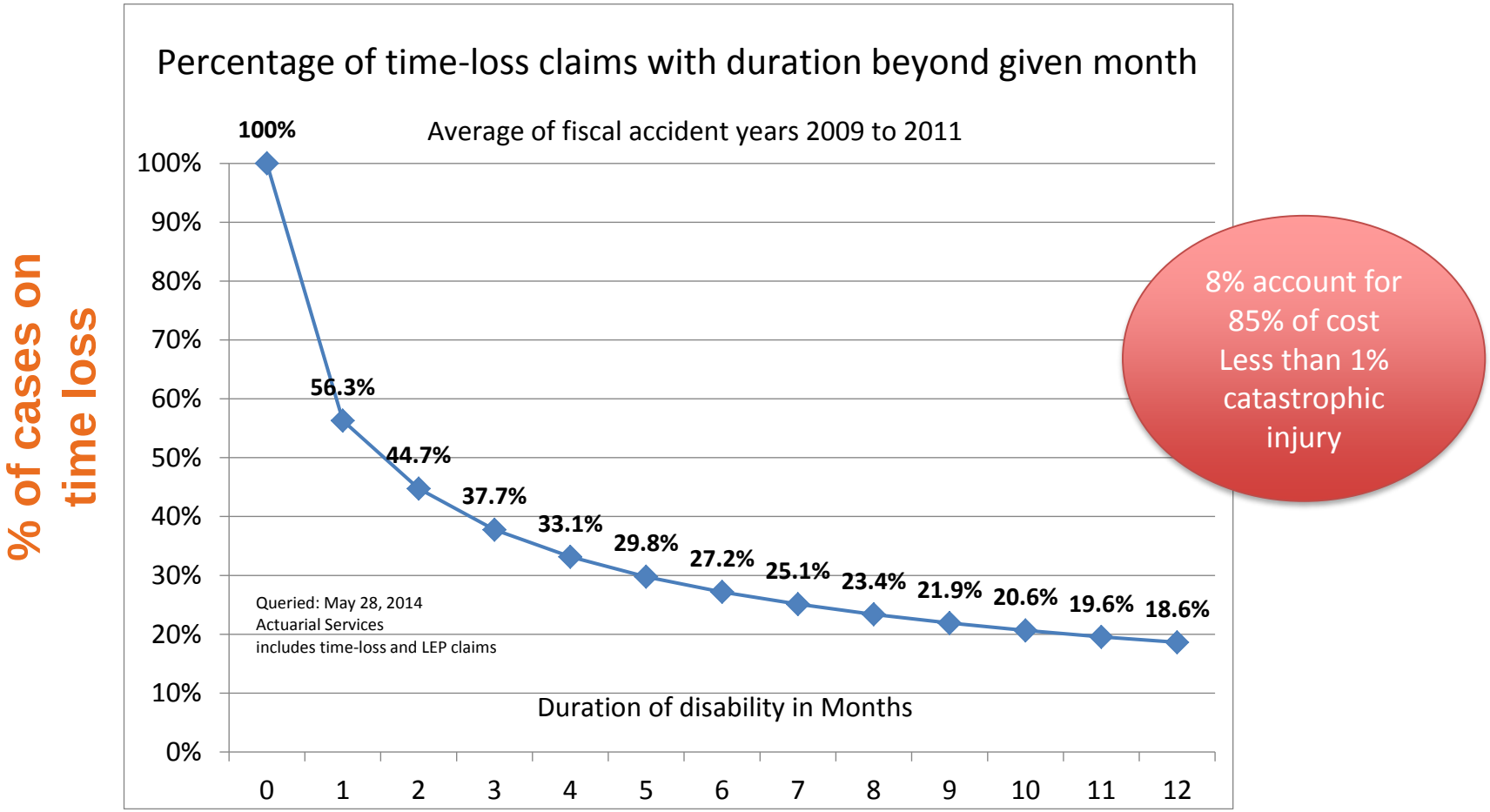


MAF – Medical Aid Fund
AF – Accident Fund
PF – Pension Fund



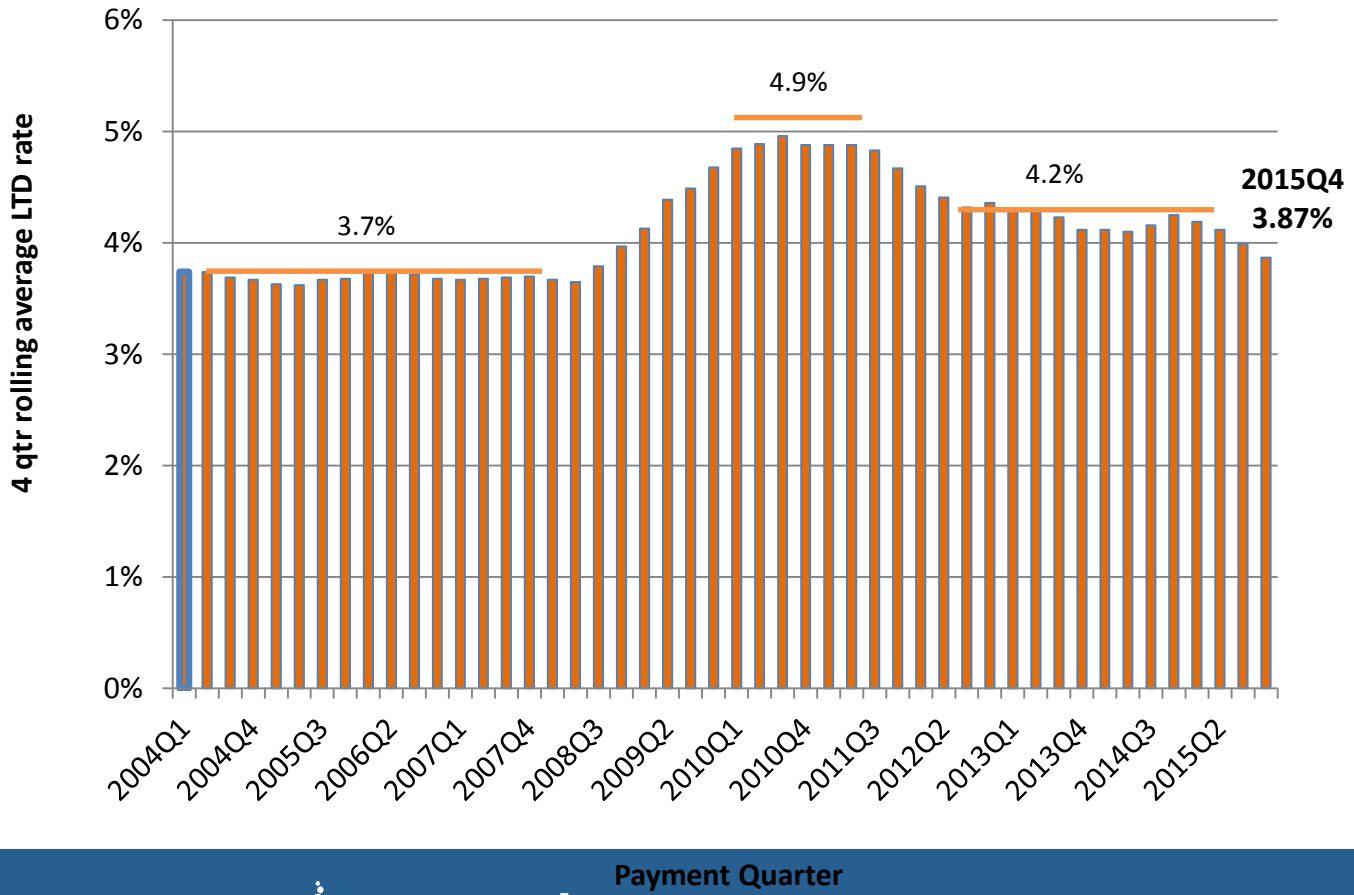
*Goal is under 4%

Disability Prevention is the Key Medical Management and Health Policy Issue



Our ultimate goal is to reduce the number of injured workers who experience long-term disability.

Long-term disability is the share of ultimate claims that receive a time-loss payment 12 months from injury.



The goal is to decrease this number.

Washington's Strategies to Prevent Disability

Payer Basics

- Fee Schedule
- Provider Education and Outreach
- Provider Network

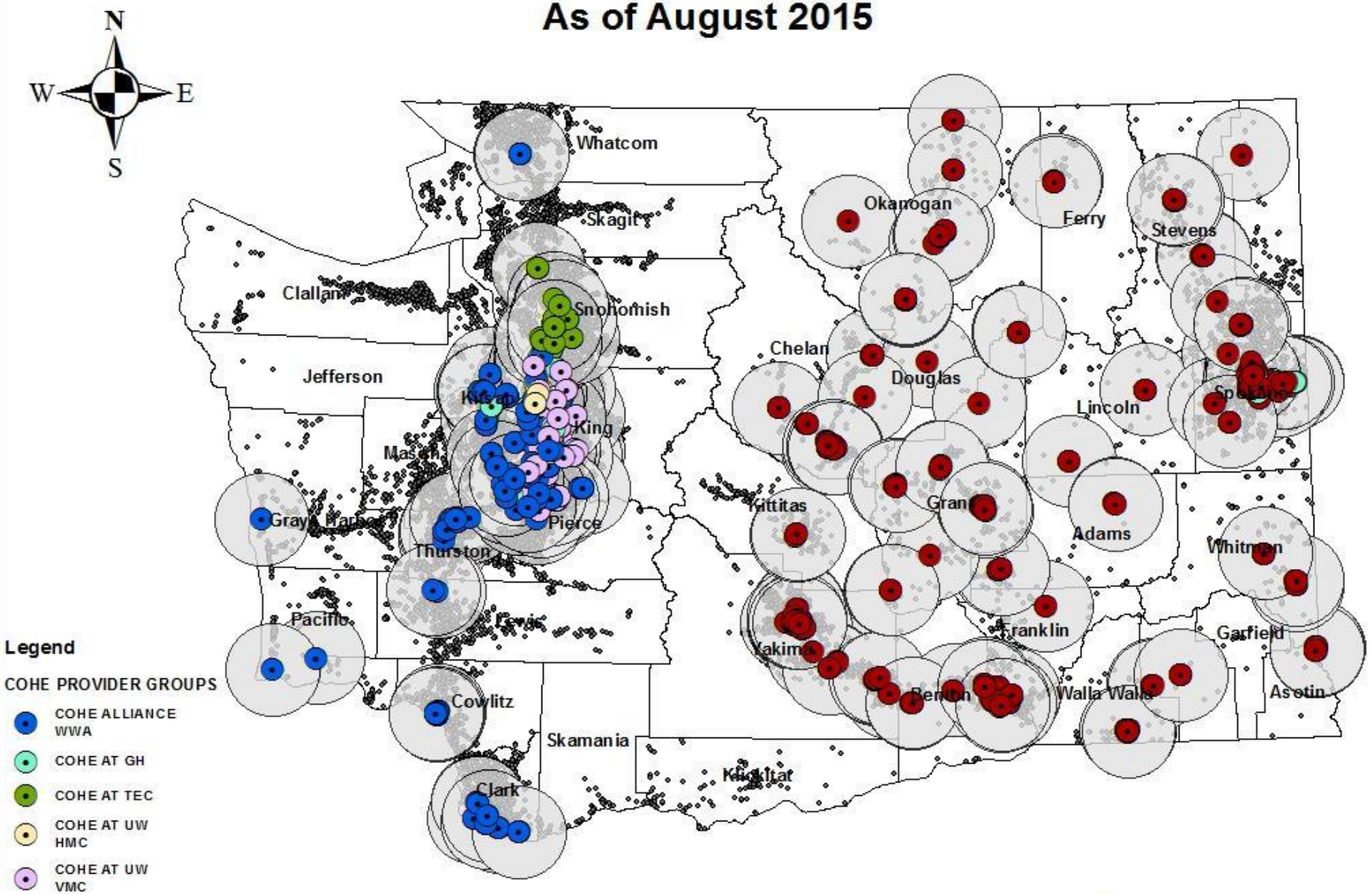
Reduce Harm

- Risk of Harm
- Utilization Review
- Treatment Guidelines

Identify and Pay for Quality Clinical Care

- Centers for Occupational Health and Education (COHE)
- Top Tier
- New Evidence Based Best Practices

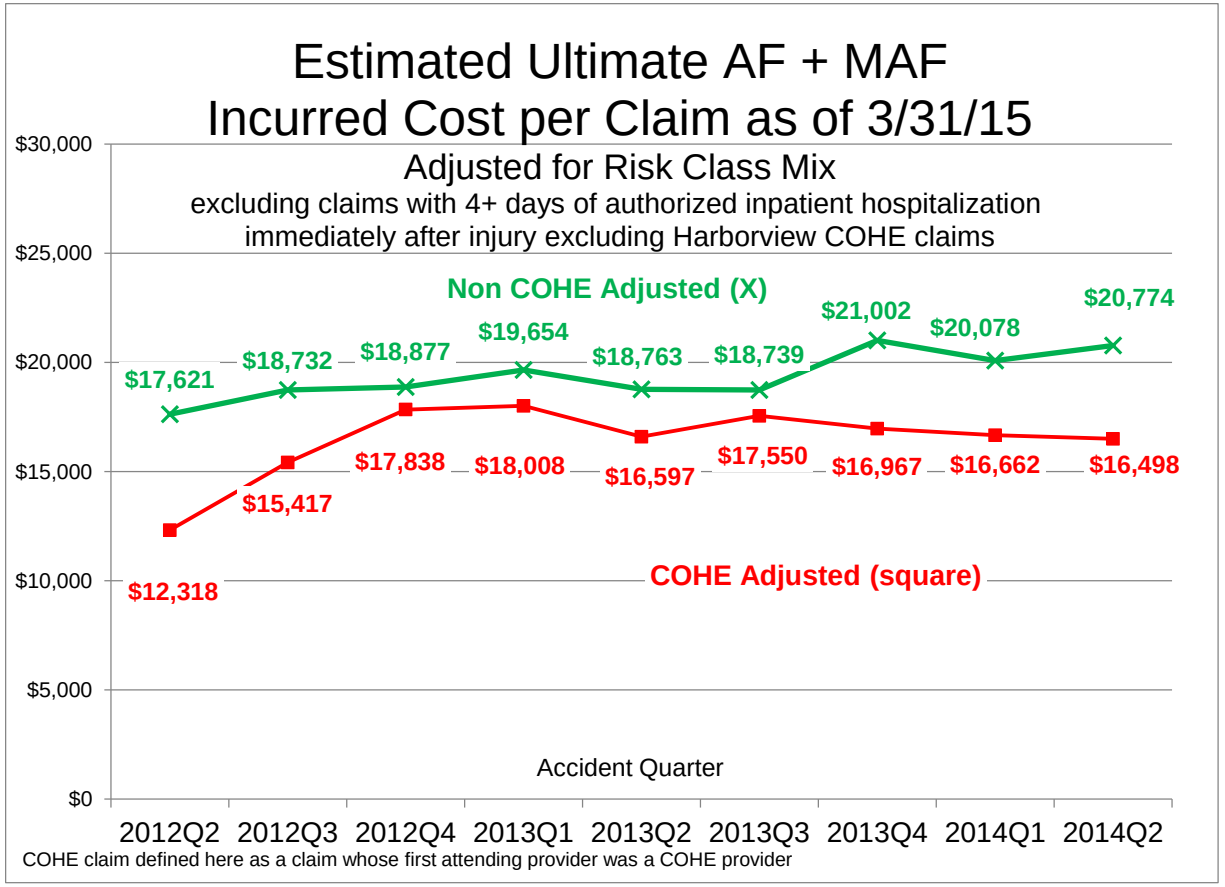
All Injured Workers With 15-mile Radii From Current Active COHE Providers As of August 2015



Washington State Department of Labor & Industries

Prepared by Calvert & Maskell, HPPM

COHE Results

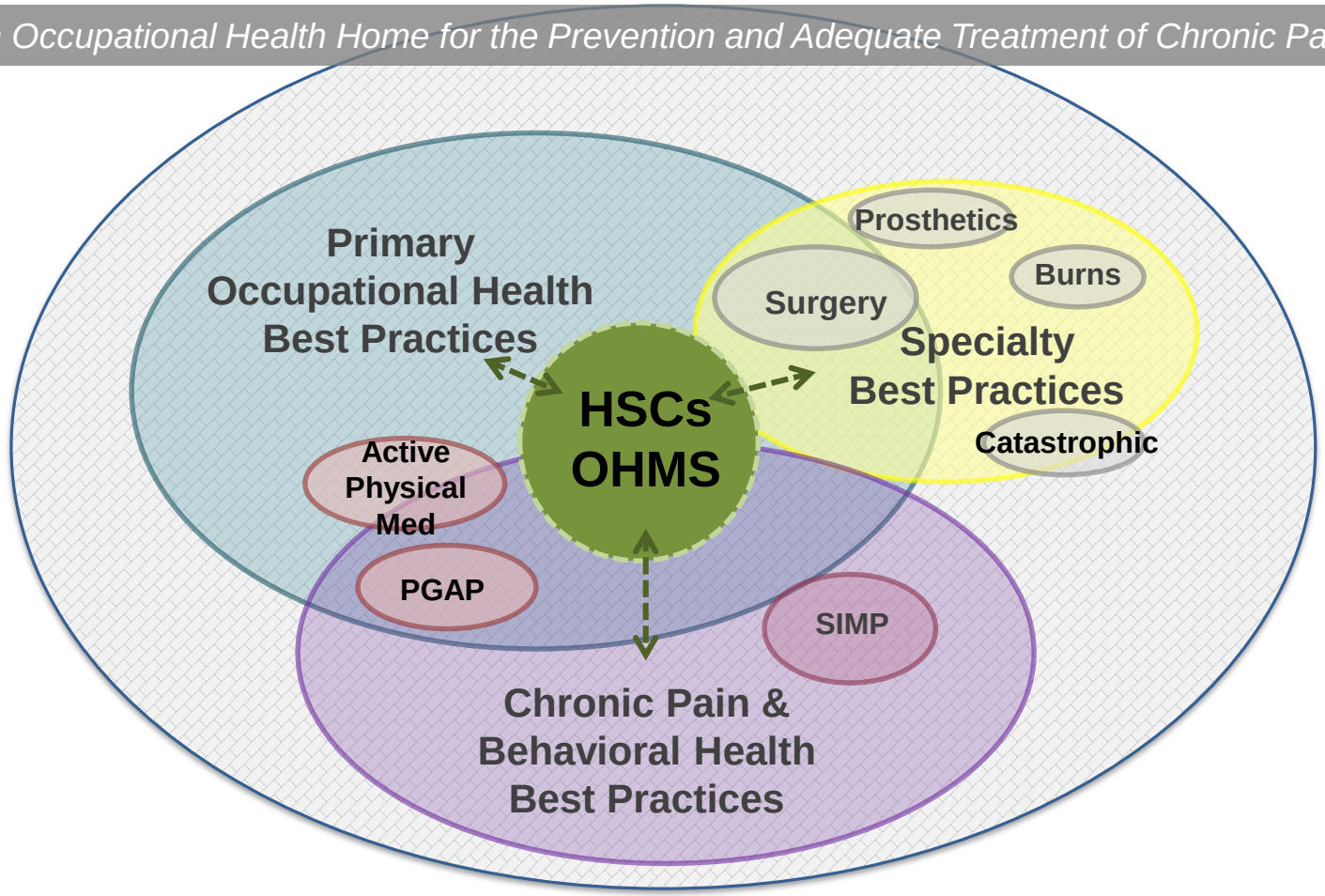


- About 50% of claims initiated with COHE Provider
- About 3,000 COHE providers (out of 25,000 Network providers)

WA Healthy Worker 2020

Innovation in Collaborative, Accountable Care

An Occupational Health Home for the Prevention and Adequate Treatment of Chronic Pain



Questions

Contact:
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360-902-4996

Evidence Based Medicine & Pain Management: New Challenges in a Changing Healthcare Environment

Steven Stanos, DO
Medical Director, Swedish Pain Services
Medical Director, Occupational Medicine Services
Swedish Health System
Seattle, WA

Disclosures

Consulting:
Collegium
Daiichi Sankyo
Endo
MyMatrixx
Pfizer
Scilex
Teva

Research:
Grunenthal

Overview

- Recent challenges in pain medicine
- Evidence Based Medicine: Defined or Misinterpreted?
- Evolution of EBM
- Guideline Review
  - AHRQ Guidelines for Treatment of Low Back Pain
  - CDC Guidelines for Opioids in Primary Care
  - HCA HTCC Spine Injections Re-review
- Future Options for Applying EBM in Pain Management
- System-wide approach to EBM for LBP

Legislative & Healthcare System Current State

- Unsustainable growth of health costs, poor outcomes
- HITECH Act (American Recovery and Reinvestment Act of '09
  - $19 billion in subsides for Meaningful Use of EHR
- Patient Protection and Affordable Care Act of 2010
- Centers of Medicare and Medical Services (CMS) creating shared-savings programs for ACOs
  - Reduce cost and improve quality
  - Penalize hospitals for avoidable readmissions
  - Base reimbursement on quality measures
- Shift from fee-for-service to greater financial and clinical accountability
- National Pain Strategy released March 2016

National Pain Strategy

A Comprehensive Population Health Level Strategy for Pain

CMS.gov

Centers for Medicare & Medicaid Services

MACRA / MIPS

Sept 28, 2015

SWEDISH

National Pain Strategy

A Comprehensive Population Health Level Strategy for Pain

- Education, research, and treatment have focused on the pathophysiological mechanisms involved in chronic pain
- Approach inadvertently encourages a “magic bullet” approach
- Deemphasizes other factors, making treatment and rehabilitative efforts futile
- Widespread use of unnecessary diagnostic tests and procedures and relatively ineffective and potentially harmful treatments linked to high costs

2. Pain Prevention and Care

- Characterize benefits and costs of current prevention and treatment approaches
  - Need thorough benefit-to-cost analysis
  - Identify and create incentives for use of interventions with high benefit-to-cost ratios
  - **Low or little evidence**, low benefit-to-risk ration should be identified through clinical studies and **dis-incentivize** their use
- Develop nation-wide pain self-management programs
  - Good evidence, but under utilized
  - Programs should be integrated into the health care system
  - Goal setting problem solving, decision making and psychosocial aspects should be included
- **Develop standardized, consistent, and comprehensive assessments and outcome measures**

4. Service Delivery and Reimbursement

Vision:

Chief among the supporting policy approaches would be **reimbursement incentives** and **payment structures** that **support population-based care models** of proven effectiveness, especially in interdisciplinary settings, and encourage multimodal care geared toward improving a full range of patient outcomes.

SWEDISH

4. Service Delivery and Reimbursement

- Incongruency between **high-quality evidence base** care and real world clinical practice
- Single modality treatments (meds/ injections) often fail as stand alone interventions
- Shift towards more integrated, team approach
- Current system **incentivizes specialty care**

Priorities:

Service Delivery & Reimbursement

1. To develop public policy recommendations that defines future payment, and incentives, for **evidence-based integrated** multimodal care and interdisciplinary team care of persons with chronic pain**.**
2. Target CMS with policy and guideline recommendations on how to achieve policy.
3. Determine impact of deliverable on quality, access and cost

4. Service Delivery and Reimbursement

Objective 2:

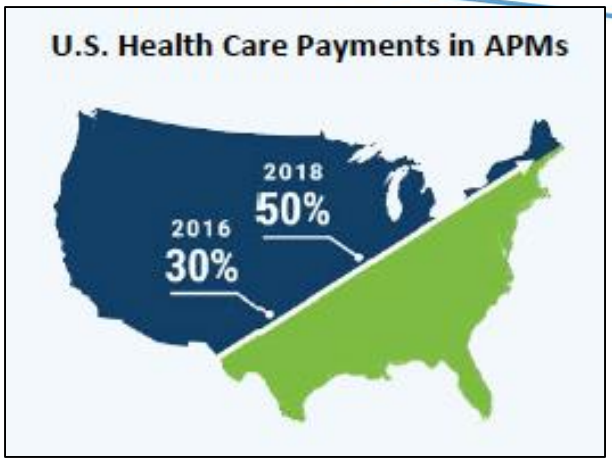
Enhance the **evidence base** for pain care and integrate it into clinical practice through defined **incentives** and **reimbursement strategies**, to ensure that the delivery of treatments is based on the **highest level of evidence**, is population-based, and represents real-world experience.

4. Service Delivery and Reimbursement

Objective 3:

Tailor reimbursement to promote and incentivize high-quality, coordinated pain care through an integrated biopsychosocial approach that is cost-effective, comprehensive, and improves outcomes for people with pain.

MACRA Proposed Rule



- Alternative Payment Models (APMs)
- Merit-Based Incentive Payment System (MIPS)
  - CMS will begin collecting measurement data January 1, 2017 as basis for adjusting payments beginning January 1, 2019
  - Performance period is one calendar year
  - Payment adjustments can be positive, neutral, or negative and will affect up to 4% of payment in 2019, phasing up to 9% of payment in 2022

Is “evidence” making a comeback?

- National Pain Strategy & MACRA
- Incentives changing for all stakeholders
- Population health vs. fee for service
- Healthcare and outcomes are more complicated

What is a guideline?

"Guidelines are recommendations intended to assist providers and recipients of health care and other stakeholders to make informed decisions. Recommendations may be related to clinical interventions, public health activities, or government policies."

WHO 2004, 2007

Six Domains of Appraisal of Guidelines for Research & Evaluation

1. Explicit scope and purposes
2. Stakeholder involvement
3. Rigor of development
4. Clarity of presentation
5. Applicability
6. Editorial independence

IOM. Clinical practice guidelines we can trust. In: Graham R, et al. Washington, DC: National Academies Press:2011;33-4.

Growth of Clinical Practice Guidelines

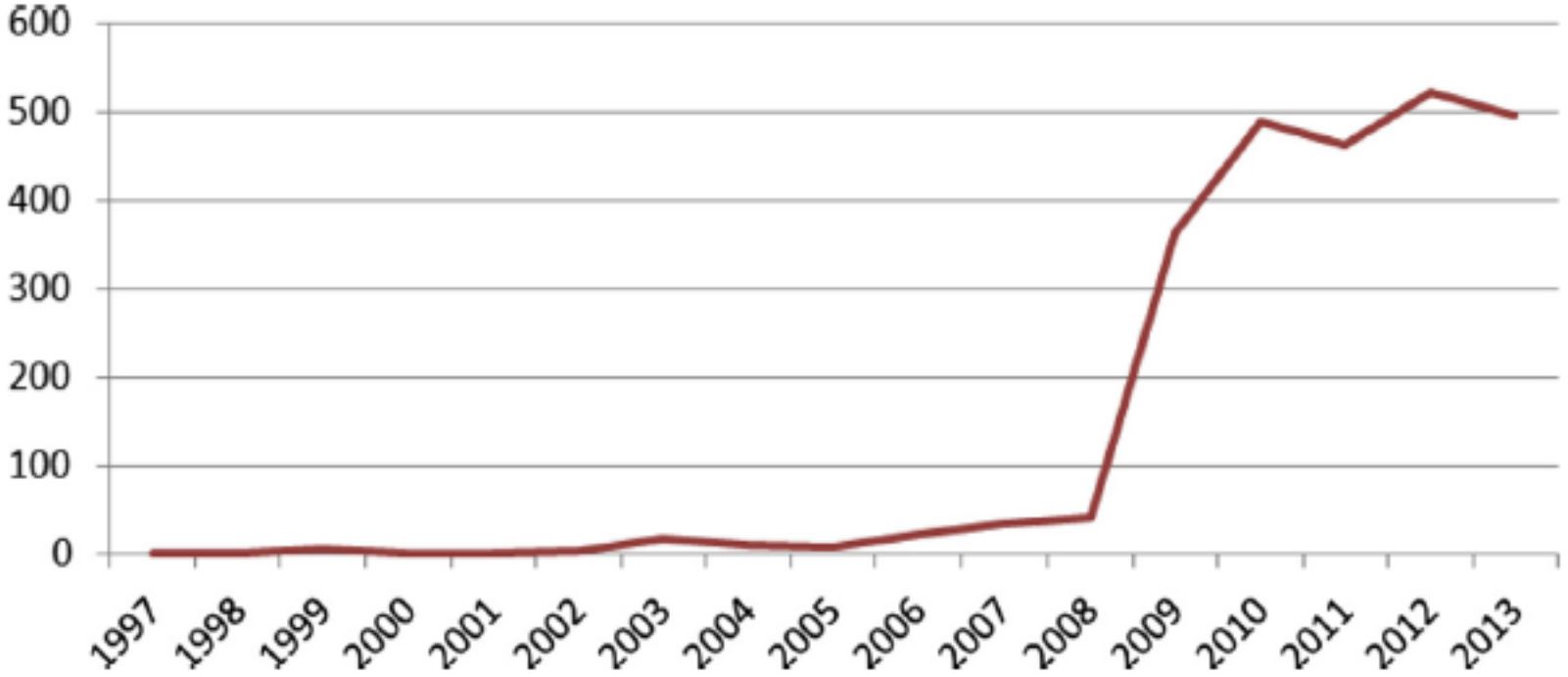


Fig. 1. Number of new guidelines published each year on the NGC. (*Data from* Javaher SP. National Guideline Clearinghouse. Available at: www.guideline.gov. Accessed December 13, 2014.)

Javaher S. *Phys Med Rehabil Clin N Am* 2015;26:427-434.

IOM Standards for Practice Guidelines

1. Establish transparency
2. Management and disclosure of conflict of interest
3. Guideline development group composition
4. Evidence based on systematic review of literature
5. **Strength of rating for the clinical recommendations**
6. **Articulation of clinical recommendations in standardized form**
7. External review
8. Keeping guidelines updated

IOM. Clinical Practice Guidelines We Can Trust. In: Graham R, et al. Washington, DC: National Academies Press:2011;33-4.

Guidelines “Issues”

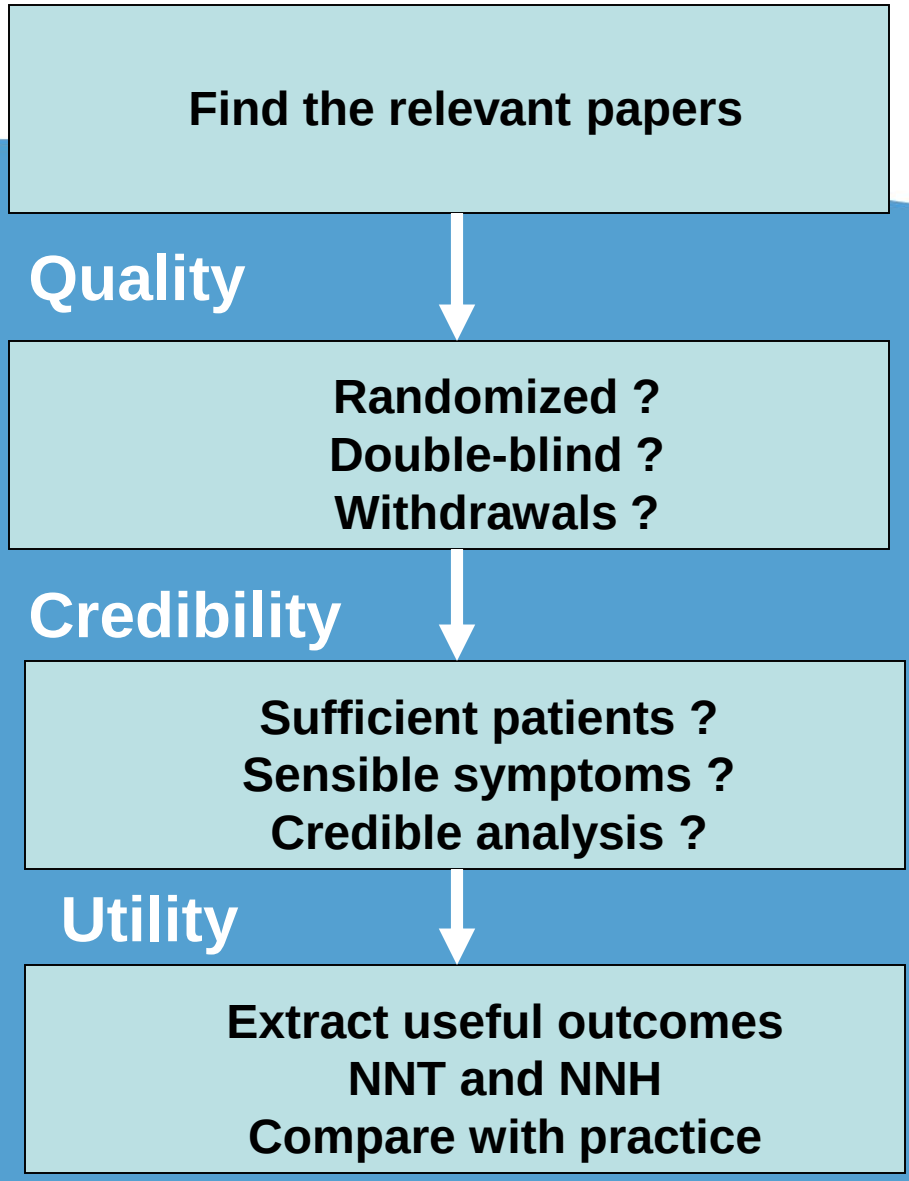
- Practice variation based on scientific uncertainty or differences in values
- Adherence to unacceptable standards and unwillingness to changed based on conflicts of interest
- Inconsistency among guidelines can also arise from variations in values, tolerance of risks, preferences, and risks

What is Evidence Based Medicine (EBM) ?

Evidence-

Based Medicine

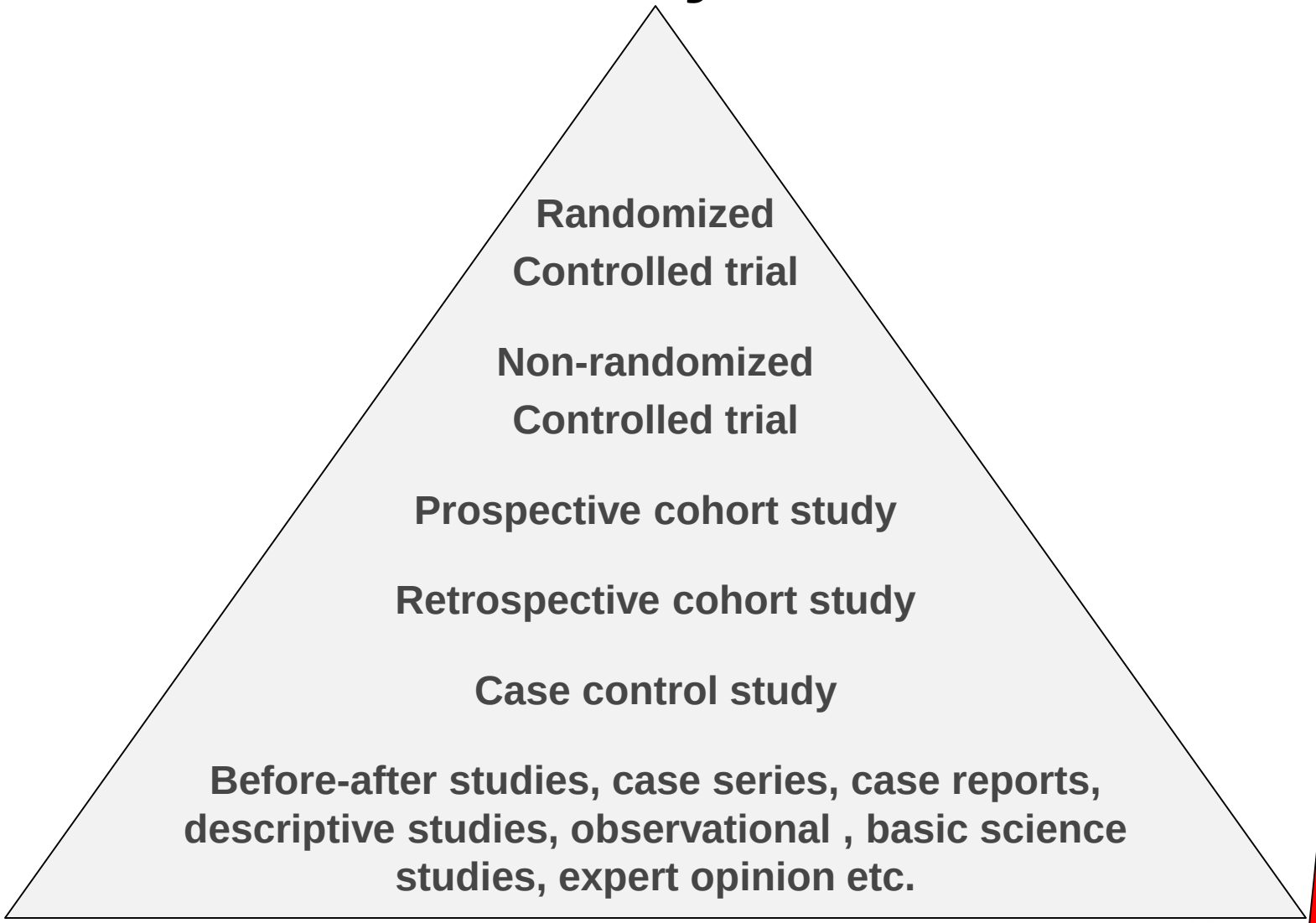
(EBM)

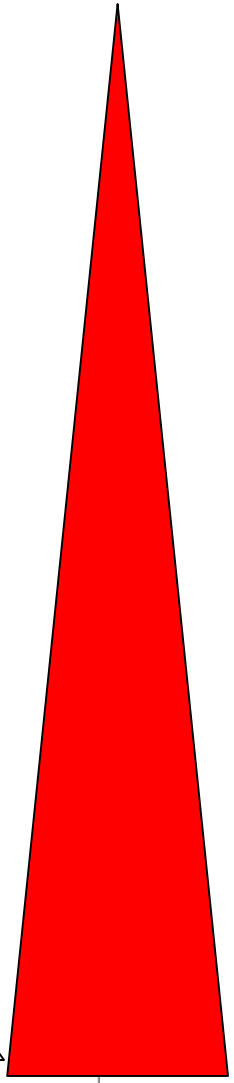


Moore A, McQuay H. *Bandolier's Little Book of Making Sense of Medical Evidence.*

Evidence Hierarchy

BIAS





SWEDISH

Criteria for Levels of Evidence and Grade of Recommendation

Level of Evidence	Grade
Level I: Large randomized trials with clear-cut results	**A**: Supported by at least one Level I randomized trial
Level II: Small randomized trials with uncertain results and moderate risk of error	**B**: Supported by at least one Level II
Level III: Nonrandomized, contemporaneous controls	**C**: Supported only by Level III, IV, or V evidence
Level IV: No controls, case series only	

Sackett, 1989.

“Evidence Based Medicine”

“Method of integrating individual clinical expertise with the best available evidence from systematic research.” [1]

“The *conscientious*, *explicit* and *judicious* use of current best evidence in making decisions about the care of individual patients.” [2]

1. Straus SE, et al. *Evidence-Based Medicine*. 3rd ed. Edinburgh: Churchill Livingstone, 2005.
2. Evidence-based medicine. A new approach to teaching the practice of medicine. *JAMA* 1992;268:2420-5.

Definitions

Efficacy: impact of an intervention as determined through a clinical trial

Effectiveness: impact of intervention in real work situation

Definitions

Usual Practice (standard of care): the diagnostic and treatment process that an average, prudent provider in the community should follow.

Best Practice: strives for optimal care of the patient recognizing wide variations in medical practice exist

Evidence Based Practice **(EBP)**: centers on a specific question. The integration of best research evidence combined with clinical expertise and patient values.

Priority Areas for National Action: Transforming Health Care Quality. IOM Website, January 2003.

Evidence Based Practice (EBP): 5 Steps

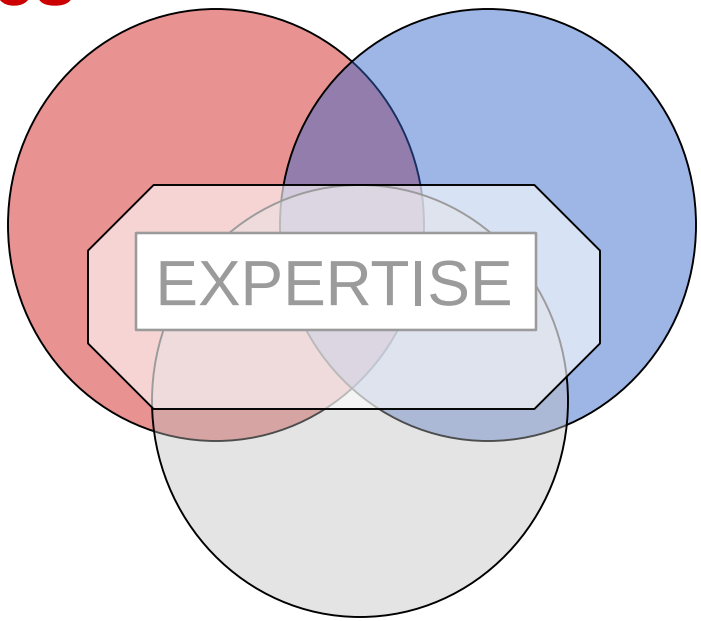
1. Conversion of need for information into specific, structured, and answerable question
2. Identification of the best evidence to answer the question
3. Critical evaluation of the evidence for validity
4. Integration of the critical evaluation with one's clinical expertise, patient's biology, values, and circumstances
5. Re-evaluation of the previous 4 steps, emphasizing improving effectiveness and efficiency of process

Cohen A, et al. *Int J Med Informatics* 2004;73:35-43.

Evidence Based Healthcare Decisions

Clinical State & Circumstances

Population Values & Preferences



Research Evidence

Haynes RB, *ACP Journal Club* 2002;Mar-Apr:136.

Drivers of EBM

- Presence of marked variation in treatments
- Increasing cost, overutilization of services/ procedures
- Improvement in ability to measure and analyze outcomes
- Payor and federal mandates to improve quality and measure outcomes

Chou R, et al. Noninvasive Treatments for LBP. Comparative Effectiveness Review No. 169. AHRQ Publication No. 16-EHC004-EE. Rockville, MD. AHRQ; February 2016.

EBM Methodologic Superstructure

- **ASK**
- **ACQUIRE**
- **APPRAISE**
- **APPLY**

Concerns

- Now ubiquitous term
- Co-opted by working groups, professional societies, and authors
- Adhere?
- Hippocratic Oath integration

Evidence Based Medicine

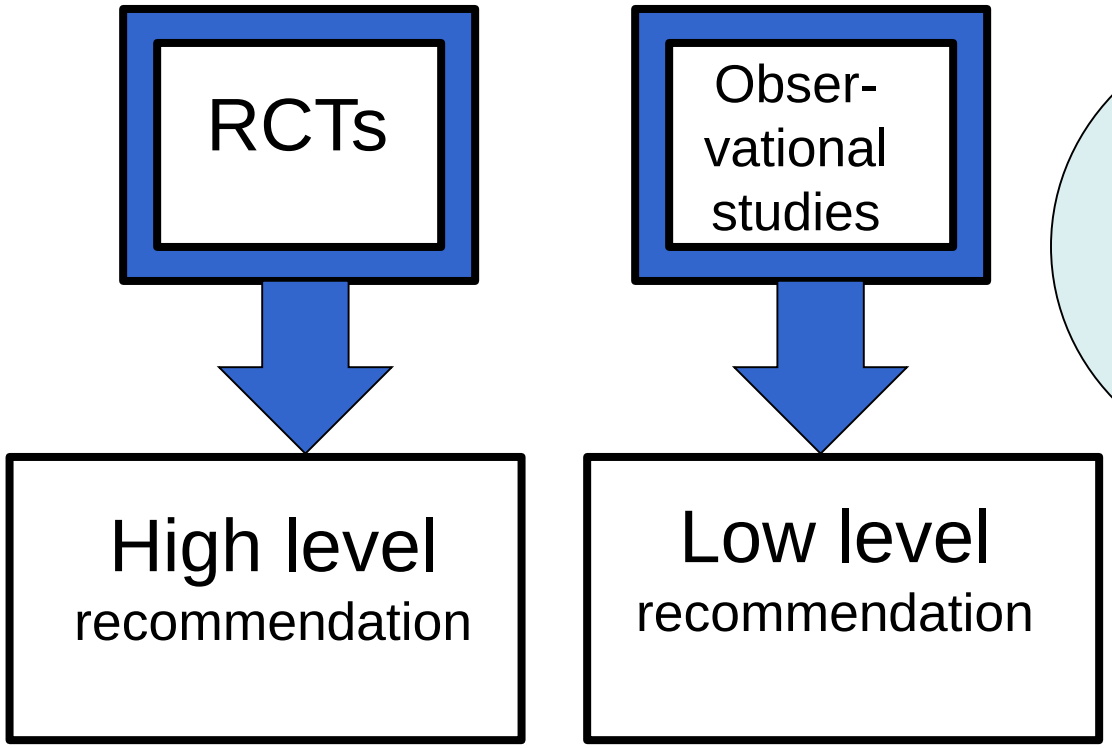
Is there a gap between what is known and what is done?

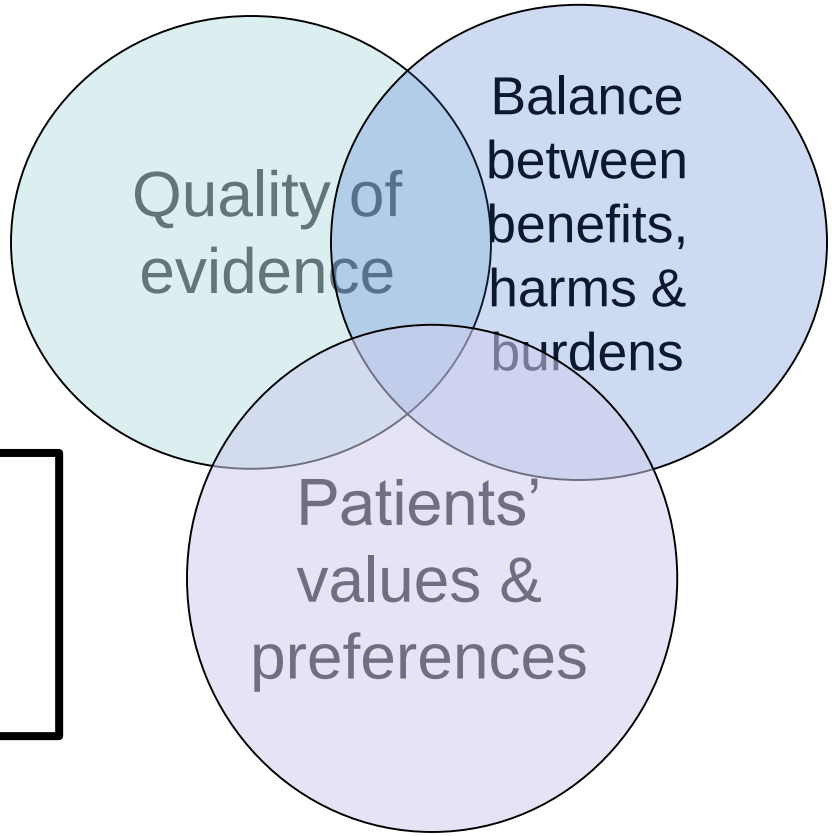
Knowledge Translation

Multidimensional, active process of ensuring new knowledge is gained through the course of research ultimately improves lives of people and involves knowledge validation and dissemination

Groah S, et al. *PM&R* 2009;1:941-50.

From Evidence to Recommendations





Old System

GRADE

SWEDISH

GRADE

Grades of **R**ecommendation **A**ssessment, **D**evelopment and **E**valuation

Aim: develop a common, transparent and sensible system of grading quality of evidence and strength of recommendations

International group of guideline developers, methodologists, and clinicians

http://www.gradeworkinggroup.org

GRADE Evidence Type or Quality

1. **Randomized clinical trials (RCTs)** or overwhelming evidence from **observational studies**
2. **RCTs** with important limitations or exceptionally strong evidence from **observational studies**
3. **Observational studies** or **RCTs** with notable limitations
4. **Observational studies** with important limitations, **RCTs** with several limitations, clinical experience and observations

Methodology for Categorizing Evidence

Study design	Initial evidence type	Criteria for moving DOWN	Criteria for moving UP	Final Evidence Type
Randomized Controlled Trial (RCT)	**1**	Risk of bias	Strength of Association	**1**
		Inconsistency	Dose-Response	**2**
Observational Study	**3**	Indirectness	Direction of all plausible residual confounding or bias	**3**
		Publication Bias		**4**

GRADE: Final Evidence Type

Evidence Type	
1	One can be very confident that true effect lies close to that of the estimate of the effect
2	True effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
3	Confidence in the effect estimate is limited and the true effect might be substantially different from the estimate of the effect
4	One has very little confidence in the effect estimate, and true effect is likely to substantially different from estimate of effect
Insufficient evidence	No studies are present

GRADE: Final Recommendations (ACIP)

Types

Category A: Apply to all persons in a specified group and indicate most patients should receive the recommended course of action

Category B: Indicates that there should be individual decision making; different choices will be appropriate for different patients, so clinicians must help patients arrive at a decision consistent with patient values, preferences, and specific clinical situations

Category A Recommendation:

Based on type 3 and 4 evidence when advantages of a clinical action greatly outweigh disadvantages based on 4 factors

Category B Recommendation:

When advantages and disadvantages of a clinical action are balanced

“Active Ingredients”

- ‘active ingredient’: element within a pharmacologic intervention (PI) that is responsible for its therapeutic action
- Active ingredients reported significantly less often in titles for non-pharmacologic intervention (NPIs)
- NPIs are more complex, contain several interacting components that are all necessary for the intervention to be effective
  - Many different behaviors from HC professionals or participants
  - Many different types of outcome measurement
  - Tailored to different contexts or settings within one study

Craig P, et al. *Developing and Evaluating Complex Interventions*: New Guidance, London: Medical Res Council; 2008.

Different descriptions of ‘behavioral counseling’ as an intervention

Study 1	Study 2
Feedback on diaries	Assessment of readiness to change
Reinforcement	Attitude change
Recommendations for change	Goal setting
Answers to questions	Specific behavior advice
General support	

Craig P, et al. *Developing and Evaluating Complex Interventions*: New Guidance, London: Medical Res Council; 2008.

EBM: to the Test

1. AHRQ Comparative Effectiveness Review. Noninvasive treatments for low back pain

2. CDC Guidelines for Opioid Prescribing in Primary Care

3. WA HCA Re-review of Decision on Spinal Injection Procedures

1.

Key Questions: Comparative benefits and harms of:

1. Different phamacological therapies for acute or chronic nonradicular low back pain, radicular, or spinal stenosis?
2. Nonpharmacologic therapies including multidisciplinary rehabilitation, exercises, modalities, devices, psychological therapies, acupuncture, massage, yoga, magnets.

Chou R, et al. Noninvasive Treatments for LBP. Comparative Effectiveness Review No. 169. AHRQ Publication No. 16-EHC004-EE. Rockville, MD. AHRQ; February 2016.

Pharmacotherapy for Acute LBP

Table B. Pharmacological therapies versus active comparators for acute low back pain

Drug	Pain: Magnitude of Effect	Pain: Evidence	Pain: SOE	Function: Magnitude of Effect	Function: Evidence	Function: SOE
Acetaminophen vs. NSAID	Unable to estimate	1 RCT	Insufficient	Unable to estimate	1 RCT	Insufficient
NSAID vs. NSAID	No difference	6 RCTs	Moderate	--	--	--
Opioid vs. NSAID	Unable to estimate (inconsistent)	3 RCTs	Insufficient	No difference	1 RCT	Insufficient
Long-acting opioid vs. long-acting opioid	No clear difference	4 RCTs	Moderate	No clear difference	4 RCTs	Moderate
Long-acting opioid vs. short-acting opioid	No clear difference*	6 RCTs	Low	--	--	--
Benzodiazepine (diazepam) vs. skeletal muscle relaxant	No difference	1 RCT	Low	--	--	--
Skeletal muscle relaxant vs. skeletal muscle relaxant	No clear difference	1 SR (2 RCTs)	Low	--	--	--

CI = confidence interval; NSAID = nonsteroidal anti-inflammatory drug; RCT = randomized controlled trial; RR = relative risk; SOE = strength of evidence; SR = systematic review; SSRI = selective serotonin reuptake inhibitor.

Chou R, et al. Noninvasive Treatments for LBP. Comparative Effectiveness Review No. 169. AHRQ Publication No. 16-EHC004-EE. Rockville, MD. AHRQ; February 2016.

Findings

- Acetaminophen no more effective than placebo for acute low back pain
- Duloxetine is more effective than placebo for pain and function in patients with chronic low back pain
- New evidence for pregabalin for radicular pain is inconsistent to reliably estimate effects
- Tricyclic antidepressants not effective vs placebo for pain relief or function
- More specific types of exercises are effective
- Similar conclusions of multidisciplinary rehabilitation and psychological therapies

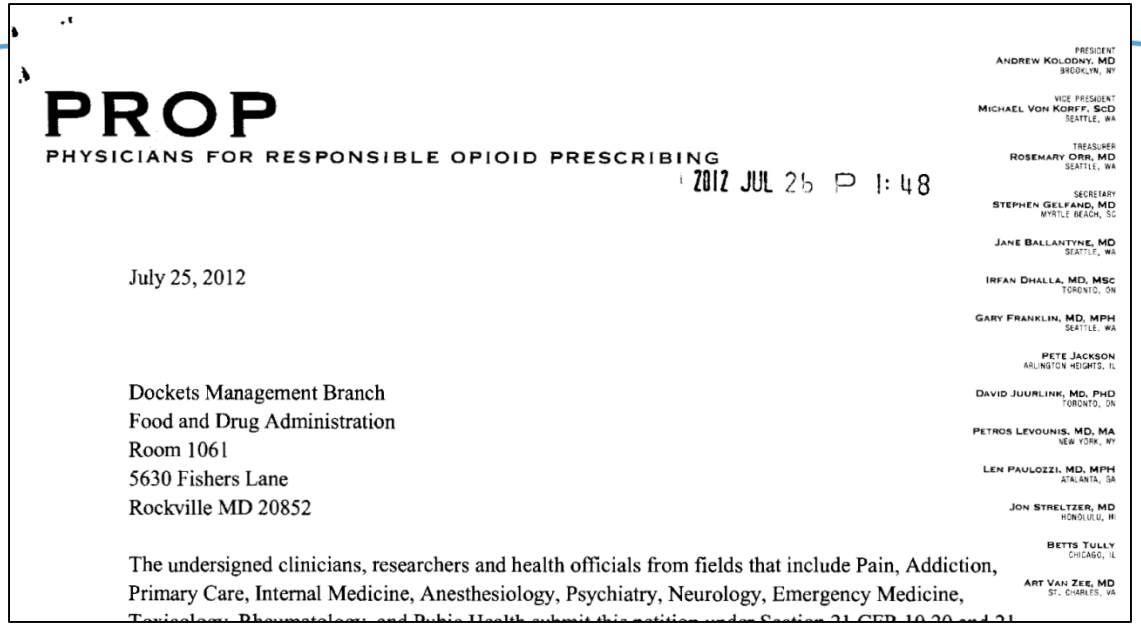
Chou R, et al. Noninvasive Treatments for LBP. Comparative Effectiveness Review No. 169. AHRQ Publication No. 16-EHC004-EE. Rockville, MD. AHRQ; February 2016.

Limitations of the Evidence Base

- Evidence on effectiveness of interventions for radicular low back pain are sparse
- Studies frequently short term
- Many studies report mean changes in outcome measures (i.e. pain and function), not dichotomized outcomes (e.g. > 30% or > 50% pain relief or function improvement)
- Pain treatment responses are bimodal, basing on continuous outcomes could obscure treatment effects
- Additional challenges with non-pharmacologic interventions

2. CDC Opioid Guidelines for Primary Care

SWEDISH



PROP

PHYSICIANS FOR RESPONSIBLE OPIOID PRESCRIBING

2012 JUL 25 P 1:48

July 25, 2012

Dockets Management Branch
Food and Drug Administration
Room 1061
5630 Fishers Lane
Rockville MD 20852

The undersigned clinicians, researchers and health officials from fields that include Pain, Addiction, Primary Care, Internal Medicine, Anesthesiology, Psychiatry, Neurology, Emergency Medicine,

1. Strike the term “moderate” from the indication for non-cancer pain
2. Add a maximum daily dose, equivalent to 100 mg of morphine for non-cancer pain
3. Add a maximum duration of 90-days for continuous daily use for non-cancer pain

DHHS Letter, FDA. Sept 10, 2013.

SWEDISH

Long-Acting (LA)/ Extended Release (ER)Opioids

Indication:

*"ER/LA opioids are indicated for the management of pain **severe enough** to require daily, around-the-clock, long-term opioid treatment and for which **alternative treatment options** are inadequate."*

- Addiction, Abuse, and Misuse
- Life-threatening Respiratory Depression
- Accidental Exposure
- Neonatal Opioid Withdrawal Syndrome
- Interaction With Alcohol

Dosing and Monitoring

Doses >200 mg oral morphine equivalents/day should prompt re-evaluation and increased monitoring.

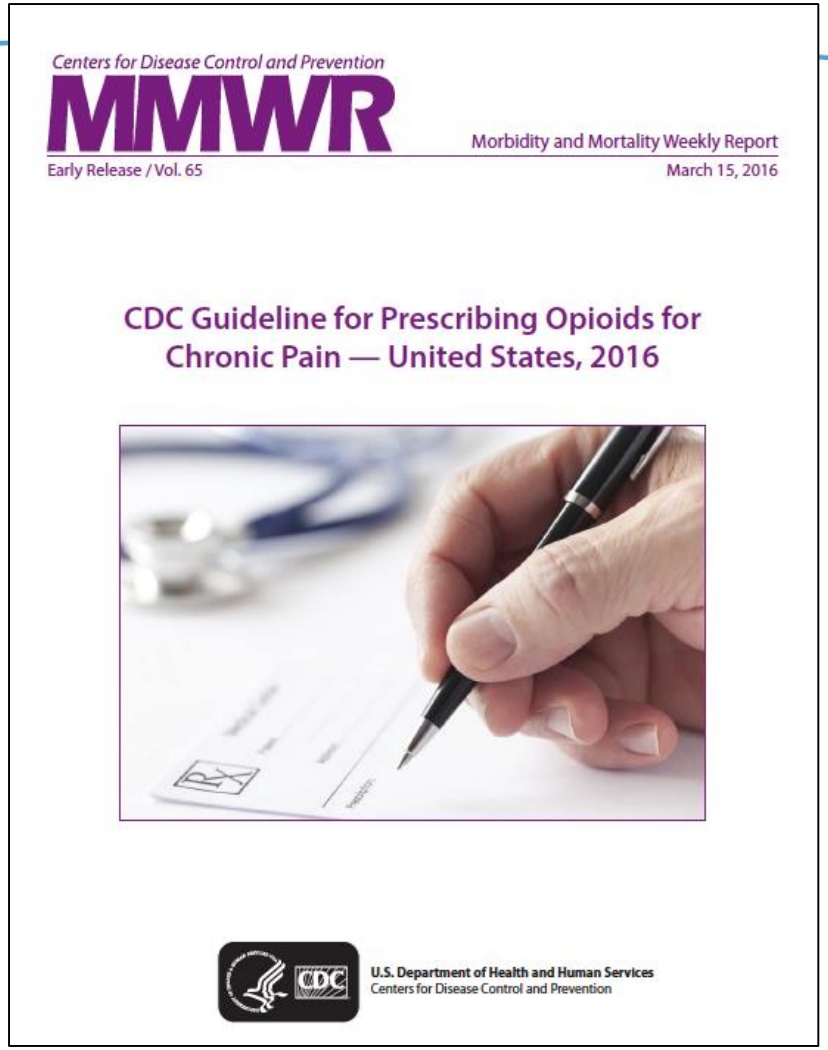
APS/AAPM Opioid Guidelines for Chronic Noncancer Pain

Do not exceed 120 mg of oral morphine equivalents/day without either demonstrated improvements in function and pain or first obtaining a consultation with pain management expert.

Washington State Medical Directors Guideline on Opioid Dosing

AAPM, American Academy of Pain Medicine; APS, American Pain Society.

Chou R, et al. *J Pain*. 2009;10(2):113-130; The Management of Opioid Therapy for Chronic Pain Working Group. *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*. Washington, DC: Department of Veterans Affairs, Department of Defense; 2010; Washington State Agency Medical Directors' Group. *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An Educational Aid to Improve Care and Safety with Opioid Treatment*. Olympia, WA: Washington State Department of Labor and Industries; 2010.



Intended for primary care clinicians who are treating patients with chronic pain (i.e., pain > 3 months or past the time of normal tissue healing) in outpatient settings.

CDC, March 15, 2016.

CDC Guidelines for Opioids: Process

Evidence:

- APS/AAPM Opioid Guidelines 2009
- AHRQ systematic review of 2014

Process:

- Core Exert Group (CEG)
- Stakeholder Review Group (SRG)
- Draft Document, Federal Review (80 FR 77351)

  Public comment through Jan 13, 2016
- National Center for Injury Prevention & Control (NCIPC) Board of Scientific Counselors
- Opioid Guideline Workgroup (OGW)

MMWR, March 15, 2016, Vol. 65. 1-50.

Draft CDC Guideline for Prescribing Opioids for Chronic Pain, 2016: Summary of Stakeholder Review Group Comments and CDC Response

JASON CHAFFETZ, UTAH
CHAIRMAN

ONE HUNDRED FOURTEENTH CONGRESS

ELIJAH E. CUMMINGS, MARYLAND
RANKING MINORITY MEMBER

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

- Transparency in process, no empathy for patients, not patient-centered, ignored Federal Advisory Committee Act
- Opposing evidence of dose limitations at 50 and 90 MME/day
- Evidence built on systematic reviews from 2009 and 2014
- Changed study criteria to 1 yr, and then “no evidence” claim

cdc.gov

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

DETERMINING WHEN TO INITIATE OR CONTI

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient

When to initiate or continue

Selection of opioids, dosage, follow-up, and discontinuation

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pa… immediate-release o… for the expected dura… less will often be suf…
7. Clinicians should eva… of starting opioid the… should evaluate bene… months or more frequ… therapy, clinicians sh… taper opioids to lowe…

Risk Management

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

MMWR, CDC Guidelines for Prescribing Opioids. March 15, 2016, Vol. 65. 1-50.

1. When to initiate or continue opioids

#	Recommendation	Evidence Category/ Type
1	Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids used, should be in combination with non-opioid pharmacologic therapy.	A , 3
2	Establish treatment goals. Continue only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.	A, 4
3	Discuss with patients known risks and realistic benefits of opioid therapy and responsibilities of patient and clinician.	A, 3

2. Selection of opioids, dosage, duration, follow-up, and discontinuation

#	Recommendation	Evidence Category, type
4	When starting opioids, prescribe immediate release instead of ER/LA opioids	A, 4
5	Prescribe lowest effective dose. - Use caution at any dosage. - Carefully reassess benefits and risks when increasing ≥ 50 MME/day - Avoid increasing > 90 MME/day or carefully justify a decision to titrate ≥ 90 MME/day	A, 3
6	Long term begins with treatment of acute pain. Prescribe no greater quantity than needed for expected duration of pain - 3 days or less will often be sufficient - > 7 days is rarely needed	A, 4
7	Evaluate benefits and harms within 1-4 wks Re-evaluate every 3 months or more frequently IF benefits do not outweigh harms, taper down or discontinue	A, 4

3. Risk management: assessing risk & addressing harms

#	Recommendation	Evidence Category, type
8	Evaluate risk factors for opioid related harms. Consider offering naloxone with increase in risk for overdose, substance abuse history, higher opioid dosages > 50 MME/day, benzodiazepine use	A, 4
9	Check PDMP for high dosages and prescriptions from other providers.	A, 4
10	Use urine drug testing to identify prescribed substances and undisclosed use	B, 4
11	Avoid concurrent benzodiazepine and opioid prescribing	A, 3
12	Arrange treatment for opioid use disorder if needed, including office-based treatment in combination with behavioral therapies for patients with opioid use disorder	A, 2

"While we are largely supportive of the guidelines, we remain concerned about the evidence base informing some of the recommendations, conflicts with existing state laws and product labeling, and possible unintended consequences associated with implementation, which includes access and insurance coverage limitations for non-pharmacologic treatments, especially comprehensive care, and the potential effects of strict dosage and duration limits on patient care."

Patrice A. Harris, MD, the AMA board chair-elect

Implications for Patients

- More cautious and thoughtful approach for using controlled substances
- Greater education for patient and family members of the dangers of misuse, abuse, and diversion
- Possible undertreatment of pain for patients
- Stigmatization of “chronic pain patients”
- Providers “not treating chronic pain patients” and overwhelming pain medicine resources, access
- Increase mortality and adverse events with use of other pharmacologic agents

CDC Guidelines for Prescribing Opioids for Chronic Pain

- CDC's recommendations are made on the basis of a systematic review of best available evidence.
- Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient's clinical situation, functioning, and life context.
- The recommendations in the guideline are voluntary, rather than prescriptive standards.
- Clinicians should consider the circumstances and unique needs of each patient when providing care.

MMWR, March 15, 2016, Vol. 65. 1-50.

Washington State Health Care Authority

3. Spine Injections

Number and Coverage Topic

20110318B – Spinal Injections

HTCC Coverage Determination

Therapeutic Medial Branch Nerve Block injections, Intradiscal injections and Facet injections are **not a covered benefit**

Therapeutic Lumbar Epidural Injections; Cervical-thoracic Epidural Injections and Sacroiliac Joint Injections are a **covered benefit** for the treatment of chronic pain

HTCC Reimbursement Determination

- **Limitations of Coverage**
  - Therapeutic Epidural Injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met:
    - For treatment of radicular pain
    - With fluoroscopic guidance or CT guidance

WA HCA Health Technology Assessment re-review

- Increase in spinal injections ‘94-’01 > 200%
- Key questions (4)
- Public comment
- Spectrum Research, Inc. re-review Dec ’15
- Public comment by MPW (Multispecialty Pain Workgroup)
- Public meeting March 18, 2016

Comments on Re-Review and EBM

- Assertion of nonspecific nature of back pain
- Evidence base restriction to RCTs
  - High-quality prospective studies excluded
  - Misinterpretation of Friedly at al not an efficacy but comparative effectiveness between 2 techniques
- Importance of subgroup analyses for each question
- Importance of reliance on categorical date, not continuous data

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

AHRQ-Funded Study Finds Little Benefit From Corticosteroid Injections for Common Cause of Spine-Related Pain

Electronic Newsletter, Issue 431

AHRQ's Electronic Newsletter summarizes Agency research and programmatic activities.

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 3, 2014 VOL. 371 NO. 1

A Randomized Trial of Epidural Glucocorticoid Injections for Spinal Stenosis

CONCLUSIONS

In the treatment of lumbar spinal stenosis, epidural injection of glucocorticoids plus lidocaine offered minimal or no short-term benefit as compared with epidural injection of lidocaine alone. (Funded by the Agency for Healthcare Research and Quality; ClinicalTrials.gov number, NCT01238536.)

- "At 6 weeks, both the glucocorticoid-lidocaine-alone (GL/LI) groups had improvement in the RMDQ score compared to baseline, but there was no significant difference between for RMDQ and intensity of leg pain."
- 67% of GL/LI ESI group vs 54% of lidocaine ESI group reported being "very or somewhat satisfied" with treatment

Friedly J, et al. *NEJM*.2014. 371:11-21.

Can health system(s) improve clinical care and evidence-based medicine along the way?

What Is Driving Spine Care Conversations In Washington?

Group	Recommendations
Hospitals / Clinics	• Support or sustain a LBP quality improvement program that includes **measuring patients' functional status over time** using the Oswestry Disability Index • **Use a validated screening tool** such as the STarT Back tool or Functional Recovery Questionnaire (FRQ) no later than the 3rd visit to identify patients that are not likely to respond to routine care • Take steps **to integrate evidence-based guidelines, scripts, shared decision making, and patient education materials** into clinical practice and workflow • Take steps to integrate **comprehensive patient education** and effective messaging into clinical practice and workflow for low back pain patients
Individual Providers	• Establish **referral relationships with physical medicine and rehabilitation** physicians, also known as physiatrists • Incorporate **comprehensive patient education and expectation-setting** into care for low back pain patients, particularly when the patient is requesting care that is not recommended by evidence-based guidelines

What Are The Bree Requirements For The Lumbar Fusion Bundle?

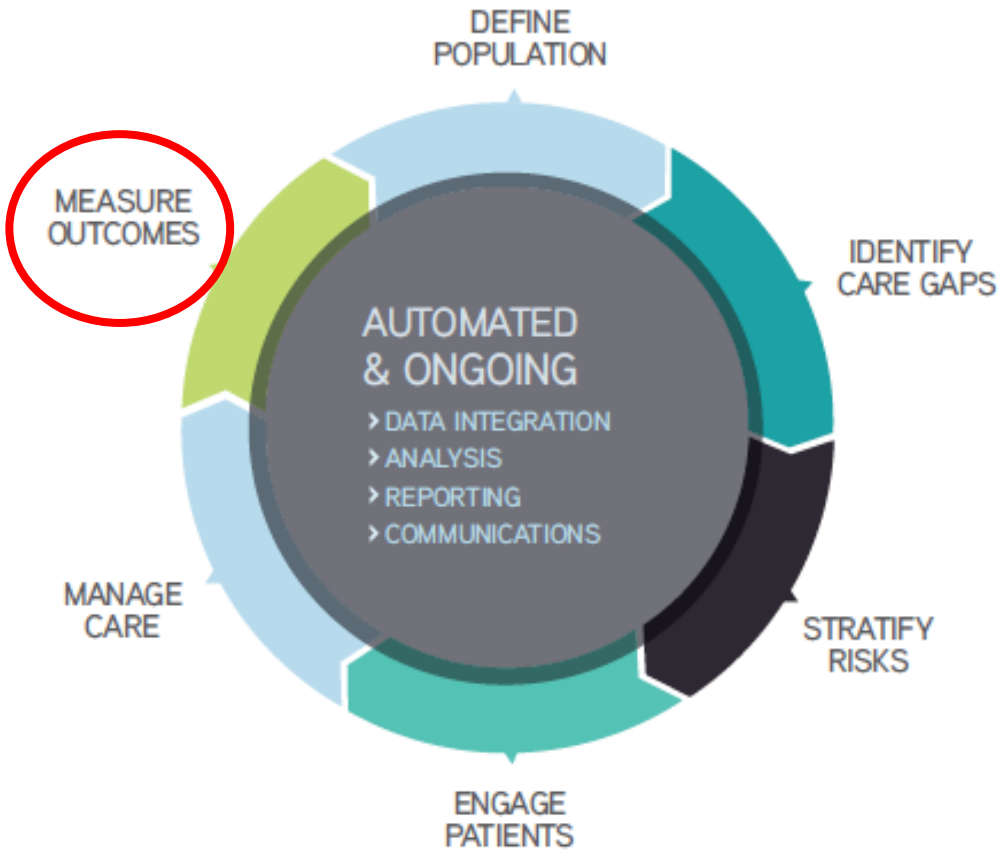
Disability Despite Non-Surgical Therapy

-Document disability (e.g. ODI)
-Document imaging findings on standard scale
-Document >3 months structured non-surgical therapy by collaborative team
-Document persistent disability despite therapy

Fitness for Surgery

-Document 13 requirements related to patient safety (e.g. BMI < 40, A1c)
-Document patient engagement (e.g. designation of personal care partner)
-Document optimal preparation for surgery (e.g. cardiac fitness, delirium)

Population Health: Automation & Data



Swedish Eastside Integrated Spine Program

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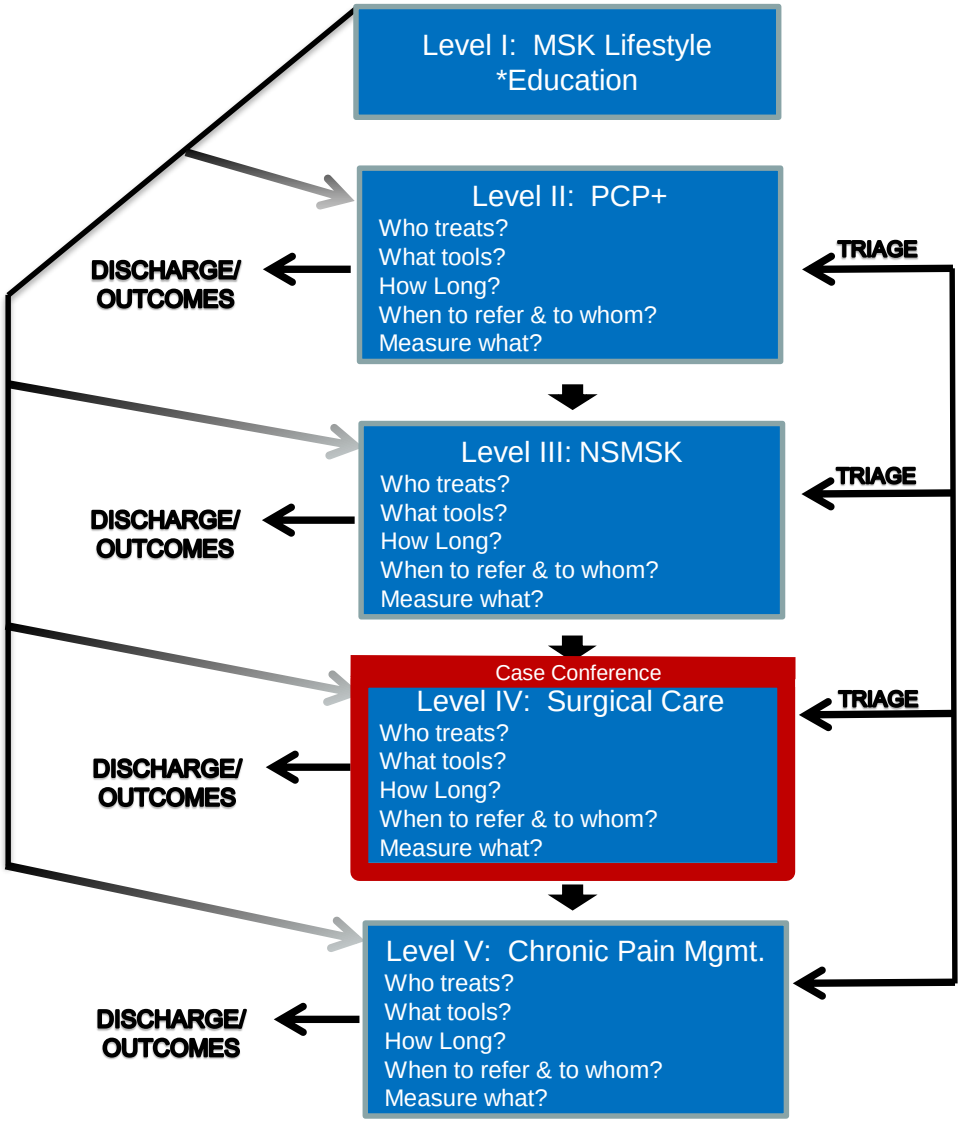
EBM Care Pathways for LBP



Low Back Pain Metrics

Metric Set	Patient Reported Outcome (PRO)Tools TONIC	Process Measures *(IT analytics)*
ICHOM	PAIN	**Use of Medical Resources:** IMAGING, MEDICATIONS, PT, INJECTIONS, SURGERY
SCOAP	FUNCTION	TIMELINESS OF CARE
PROMIS	QUALITY OF LIFE	ADHERENCE TO PATHWAY
CERTAIN	SATISFACTION	TIME TO RECOVER
STRONG FOR SURGERY	ABSENTEEISM	PATHWAY ENTRY AND EXIT

Swedish Eastside Integrated Spine Program

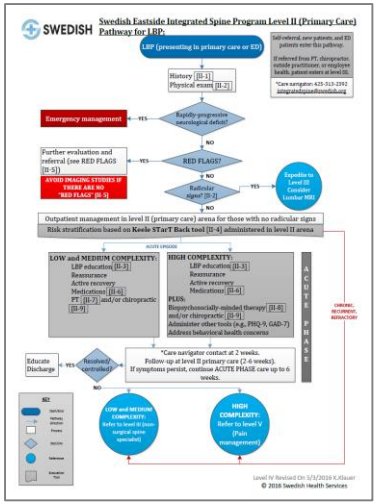
Level I *MSK Lifestyle (Under development)*

Level II *Primary Care providers and extenders*

Level III *Non-surgical MSK specialists*

Level IV *Surgical specialists*

Level V *Chronic pain management specialists*



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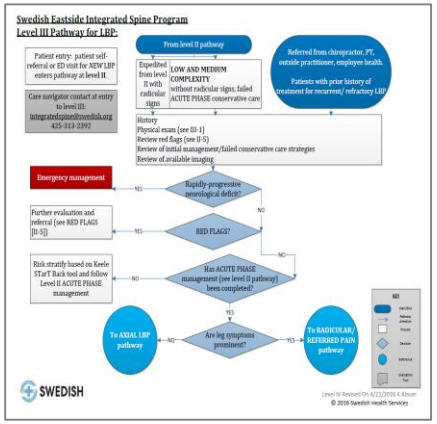

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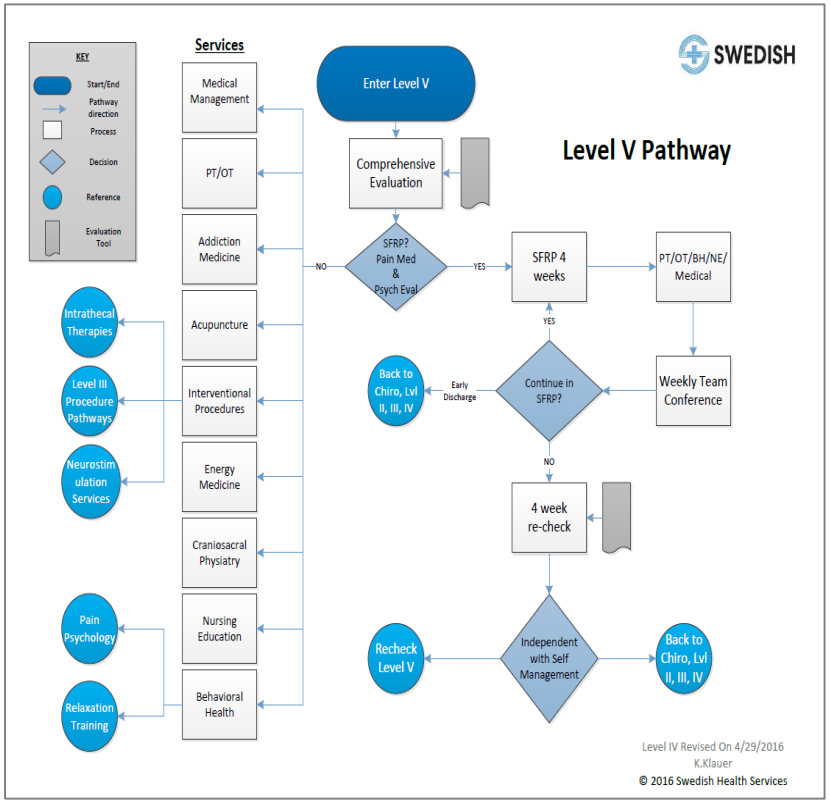


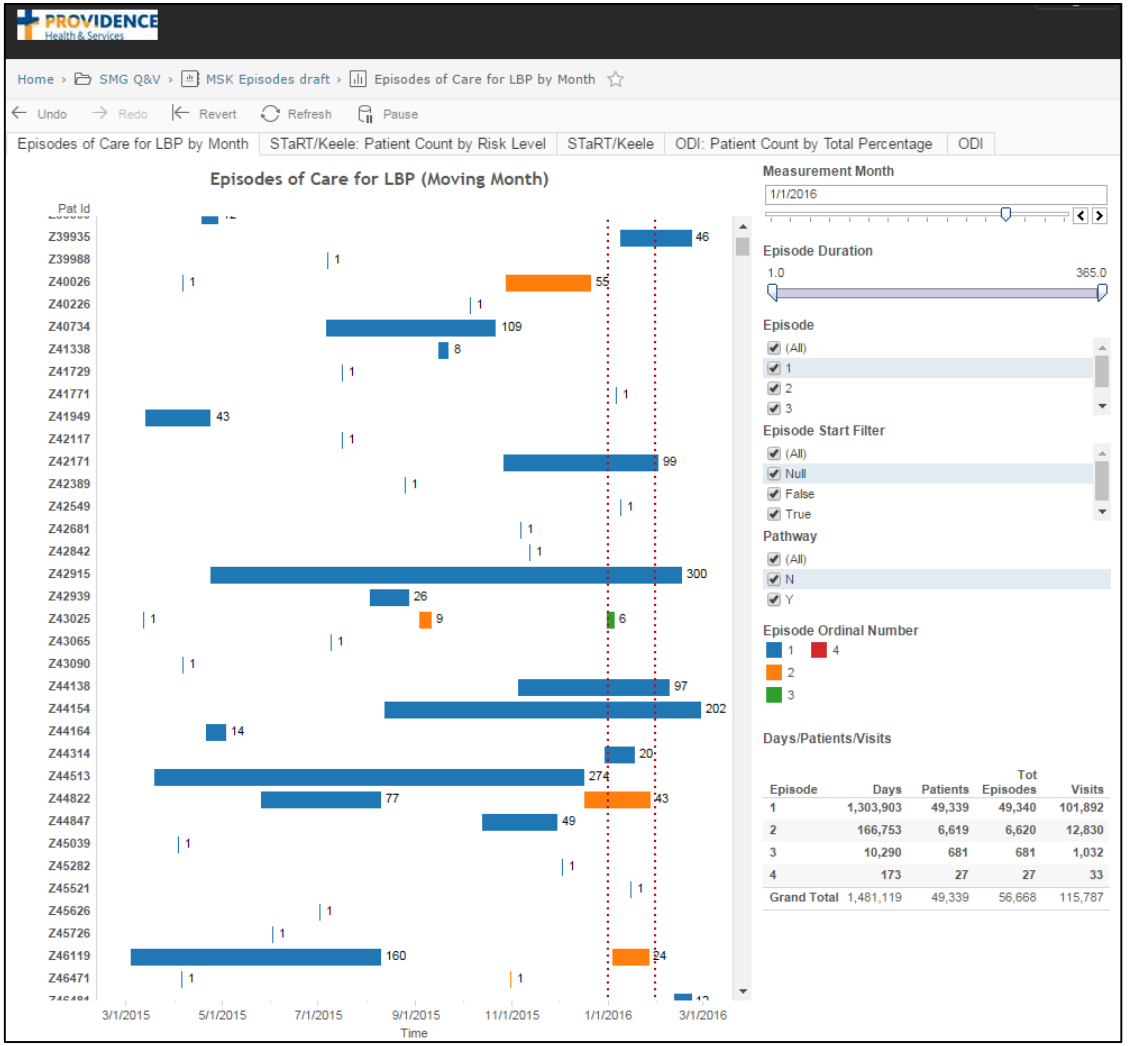
Preliminary Analysis of Swedish Low Back Pain Pathway

Quality & Value

Low Back Pain Episodes at Swedish

- 49,000 patients with 56,000 episodes of LBP in past year
- Approx. 4,500 LBP episodes per month
- Average length of LBP Episode: 26 days

- *LBP Episode: a consultation or series of consultations for low back pain preceded and followed by 3 months without consultation for low back pain*[1]

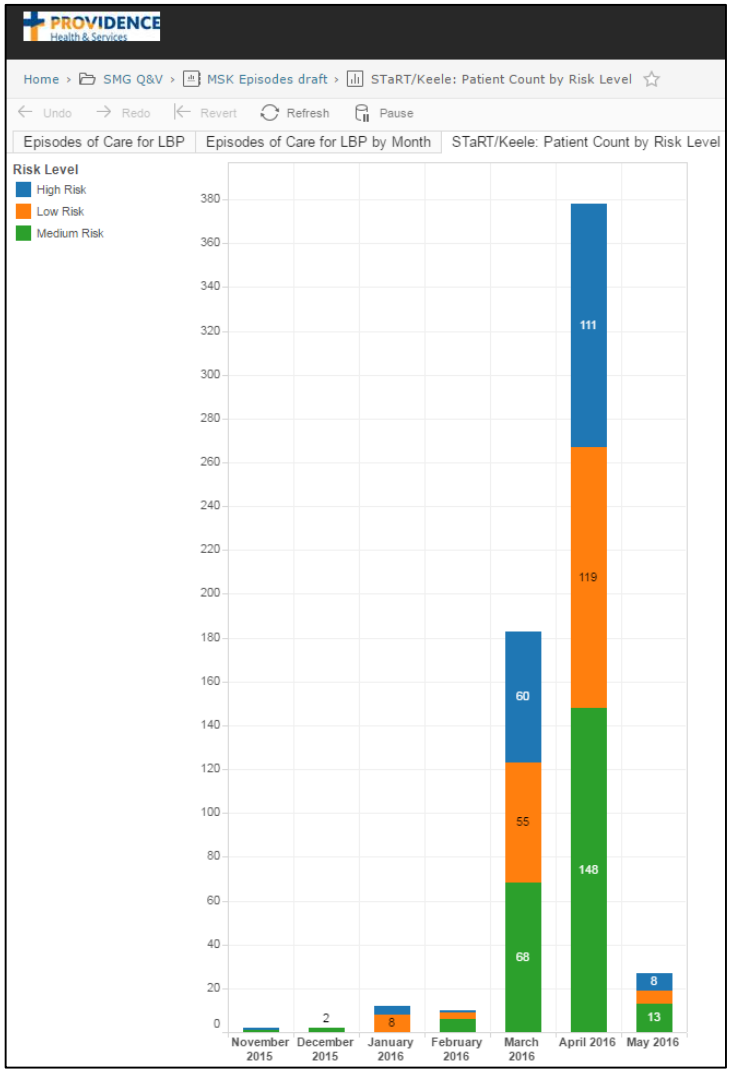


1. de Vet HC, Heymans MW, Dunn KM, Pope DP, van der Beek AJ, Macfarlane GJ, Bouter LM, Croft PR. Spine (Phila Pa 1976). 2002 Nov 1; 27(21):2409-16.

SWEDISH

STarT Back Screening Tool for Risk Assessment

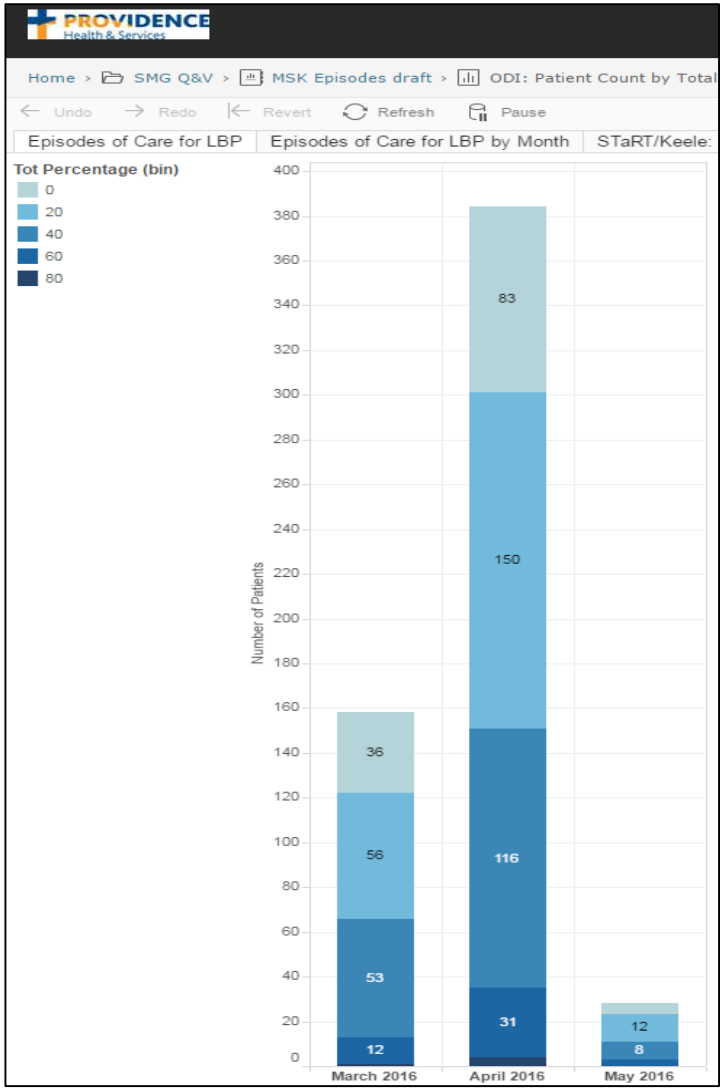
- Implementing STarT Back Screening tool for risk assessment and treatment pathway assignment
- 614 STarT Backs completed to date
  - 31% Low Risk
  - 39% Medium Risk
  - 30% High Risk



SWEDISH

Oswestry Disability Index

- Quantifying disability with the Oswestry Disability Index (ODI)
- 570 ODIs completed:
  - 22% Minimal Disability
  - 38% Moderate Disability
  - 31% Severe Disability
  - 8% Crippling Back Pain
  - 1% Bed-bound



SWEDISH

Providence Occupational Medicine Program

"Working together for a healthier workforce"

(Internal initiatives on behalf of employers)

Development of specific care pathways

- ED, UC, PCP, Ortho, Neuro, Outpatient Therapy
- ✓ Increases access
- ✓ Facilitates utilization of the appropriate care setting
- ✓ Efficiently coordinates care reducing over utilization of services
- ✓ Expedites return to employment process
- ✓ Enhances Outcomes

Provision of integrated services

- Combined medical specialty with onsite outpatient therapies specific to this patient population
- ✓ Promotes convenience, productivity
- ✓ Expedites

Standardization of paperwork

- Centralized management of claim initiation documents
- ✓ Enhanced patient experience
- ✓ Reduction in claim length
- ✓ Enhances outcomes

Employer Engagement

- Creation of Employer Advisory Committee
- ✓ Aligns the needs of employers with the delivery system
- Collaboration with third Party Administrators and Retro

Added Services

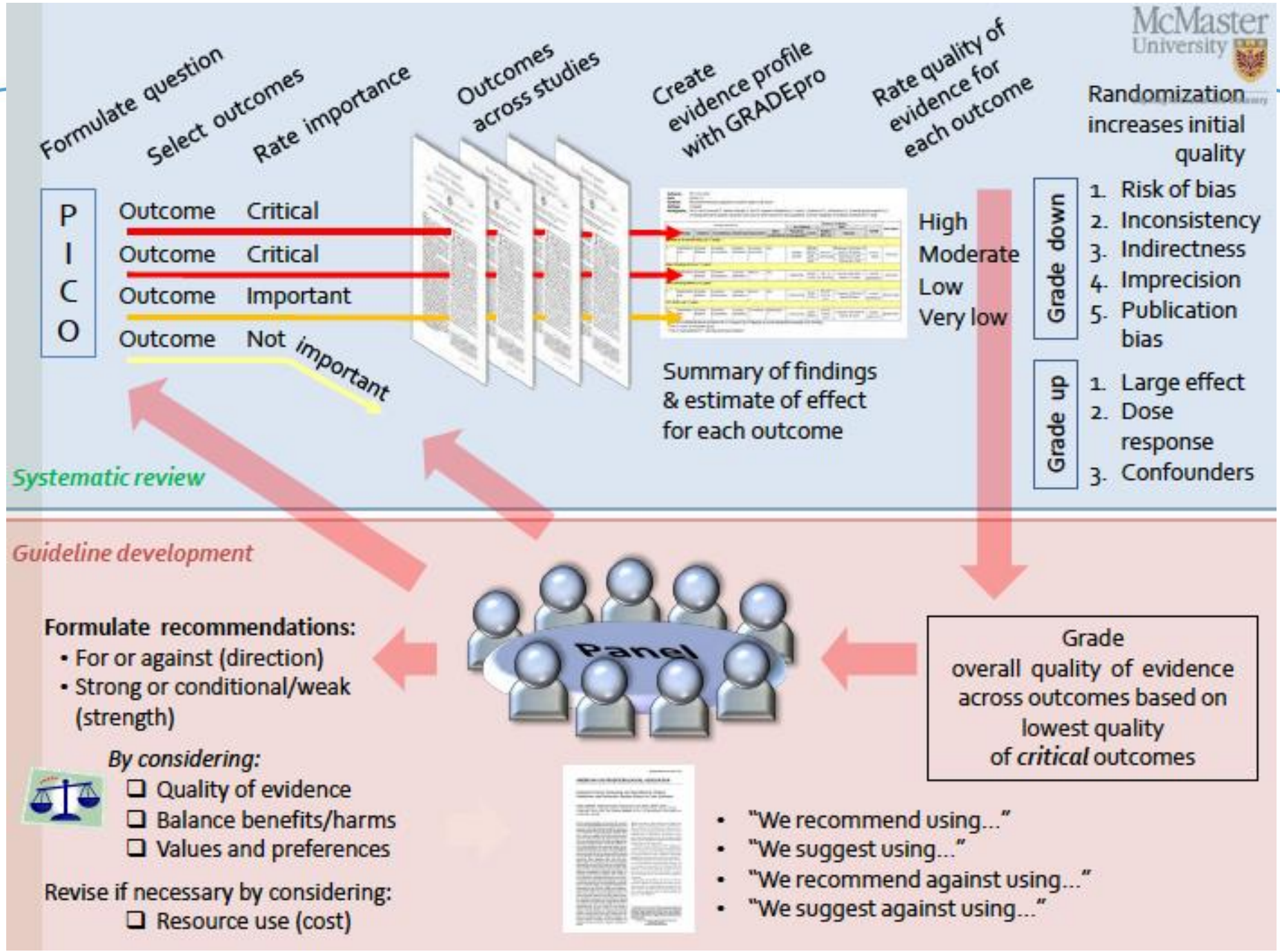
- In clinic impairment ratings
- Onsite exposure / inoculation response team
- Comprehensive bloodborne pathogen program

Product Development

- Customized Employer Reporting
- ✓ Utilization, Cost Prevention, Safety, Wellness
- Employer protocol data base
- ✓ Identification and adherence to specific employer processes
- System outcome tracking
- ✓ Best practice

Summary

- EBM is at a “tipping point”
- Incentives from payors, federal, state, and hospital systems are helping to shift EBM from an academic exercise to more pragmatic “patient” vs “subject” outcomes
- National Pain Strategy and MACRA in line with focus on EBM
- Need to adjust “hierarchy” of evidence, value of observational data, “active ingredients”
- Critical need monitor for bias and “misuse” of evidence



Schunemann H. CDC, McMaster Univ. Sept 9, 2011.

Evidence Based Medicine

"The *conscientious*, *explicit* and *judicious* use of current best evidence in making decisions about the care of individual patients."

1. Evidence-based medicine. A new approach to teaching the practice of medicine. *JAMA* 1992;268:2420-5.

Thanks

steven.stanos@swedish.org

Evidence-Based Resources

- Centre for Evidence Based Medicine: http://www.cebm.net
- Cochrane Reviews: http://www.thecochranelibrary.com/view/0/index.html
- JAMA evidence: www.jamaevidence.com
- Johns Hopkins University Welch Medical Library: Evidence Based Medicine Resources: http://www.welch.jhu.edu/internet/ebr.html
- National Guideline Clearing House: http://guideline.gov/
- University of Washington Healthlinks: Evidence-Based Practice: http://libguides.hsl.washington.edu/ebp

Reducing Harm from Inappropriate Opioid Prescribing
-WSIA Colloquium-

Patrick C Reiman, CPCU,CIC,AIC
Director/Claims/WC/WA
Sedgwick Claims Management Services

Gary M. Franklin, MD, MPH
Medical Director, WA Dept of Labor and Industries
Research Professor, UW

Two major policy streams nationally

- PREVENT the next cohort of our citizens receiving opioids inappropriately during acute/subacute pain
  - To achieve this we must also pay for alternatives to opioids for acute/subacute/chronic pain
- TREAT patients with severe dependence by 1) withdrawal, and/or 2) Medication-assisted treatment (eg buprenorphine)

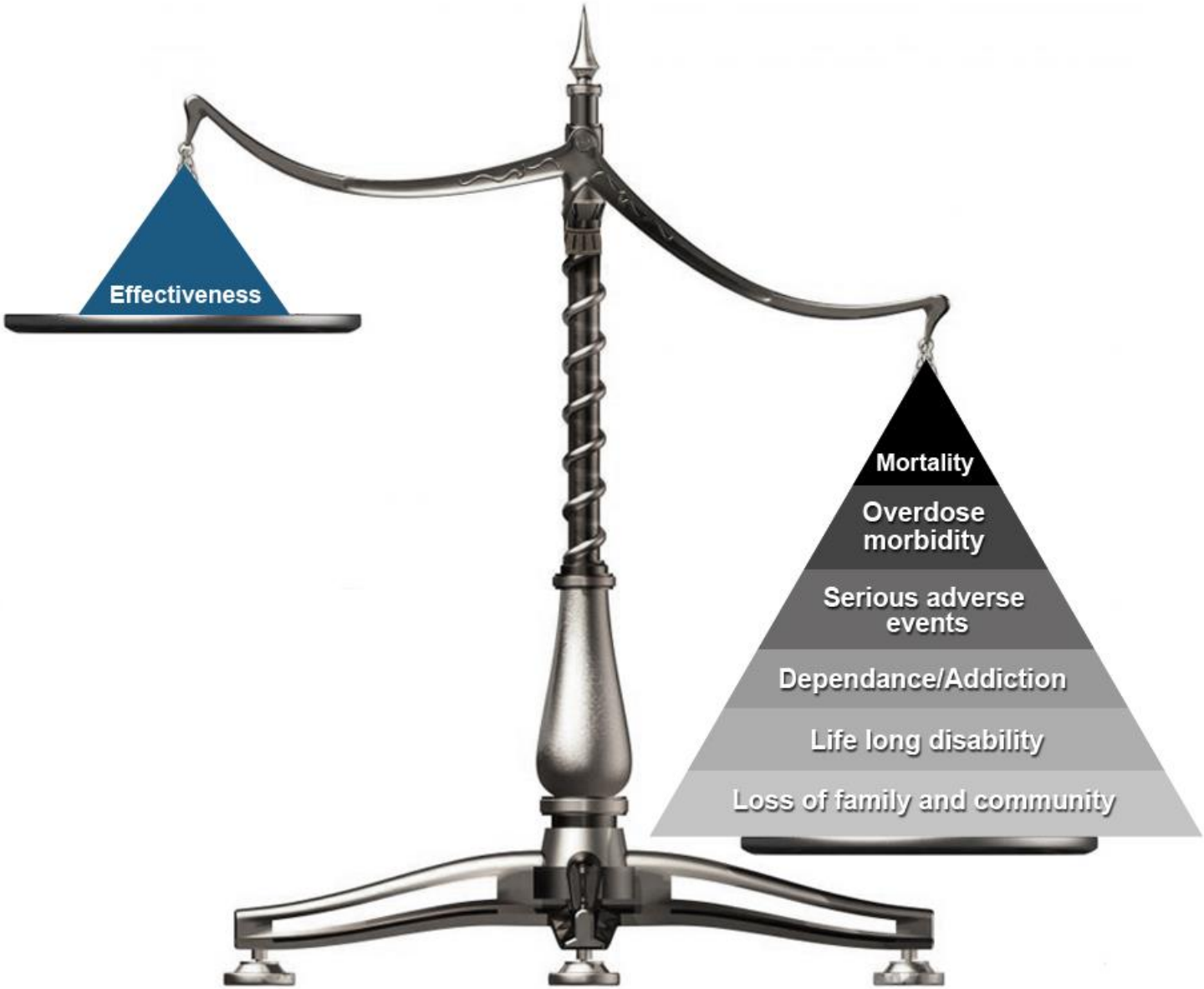
National Governor's Association Implementation Ideas

- Endorse/implement CDC guidelines, supplemented by other state guidelines that address gaps (eg, peri-op opioids, ED guidelines)
- Avert inappropriate acute prescribing
  - Focus on 3 days/10 tabs 5 mg hydrocodone for teens </= 20 (extractions, sports injuries)
  - EMR hard stops, pre-auth (eg, allow </= 3 days but need auth for more in acute injuries)
- Fund/develop regional capacity for MAT
  - Safety net clinics urgently need assistance
  - Add telehealth
- Reportability of overdose events
- Enhanced PDMP-mandatory use, facility sign-up, public agency use,inter-operability with other states, VAHS, military
- Develop stepped care/collaborative care and effective alternative Rxs for pain
- Develop set of metrics for both quality improvement at health plan/clinic level and "state of the state" progress

Evidence of effectiveness of COAT

The Agency for Healthcare Research and Quality's (AHRQ) recent draft report, "The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain," which focused on studies of effectiveness measured at > 1 year of COAT use, found **insufficient data on long term effectiveness to reach any conclusion, and "evidence supports a dose-dependent risk for serious harms"**. (AHRQ 2014; Chou et al, Annals Int Med, 13 Jan 2015).

Risk/Benefit of Opioids for Chronic Non-Cancer Pain
-Franklin; Neurology; Sept 2014-Position paper of the AAN-



Risk/Benefit of Opioids for Chronic Non-Cancer Pain -Franklin; Neurology; Sept 2014; AAN Position paper-

Opioids should not be used routinely for the treatment of routine musculoskeletal conditions, headaches or fibromyalgia*

*WA DLI opioid guidelines, 2013 http://1.usa.gov/1nYlarL

CDC Opioid Guidelines-March 2016

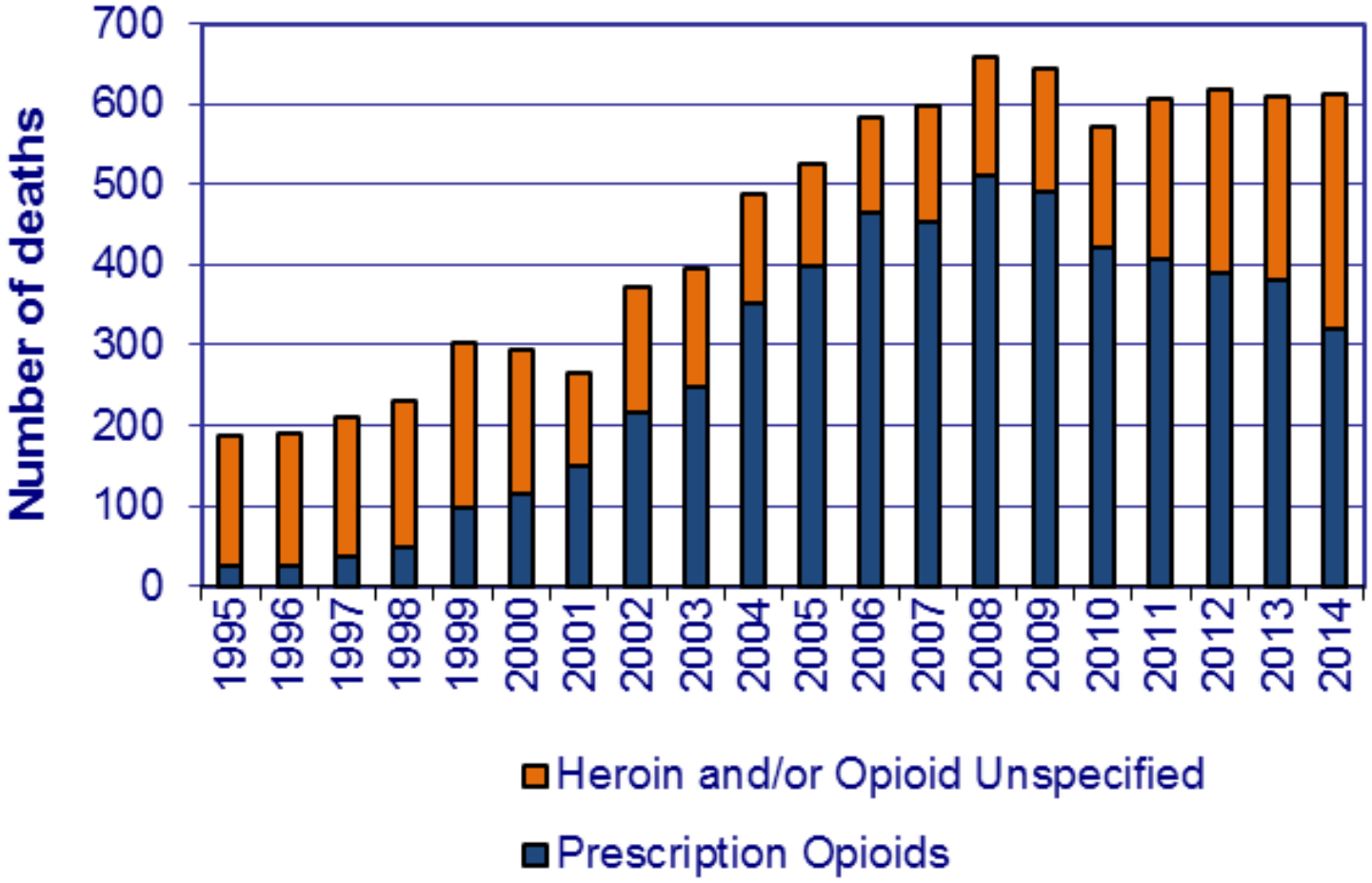
- **Determining When to Initiate or Continue Opioids for Chronic Pain**

  1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

  2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

  3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Unintentional Opioid Overdose Deaths
Washington 1995-2014
40% sustained decline largest in the US



Source: Washington State Department of Health, Death Certificates

Rise in Heroin Deaths not due to Increasing Regulation

- Rise started well before ANY regulation
- Occurring in all states, most of which have done no regs
- Main rise in heroin deaths in 18-30 year olds
- Main increase in prescription opioid deaths in 35-55 year age groups

From: **The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years**

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

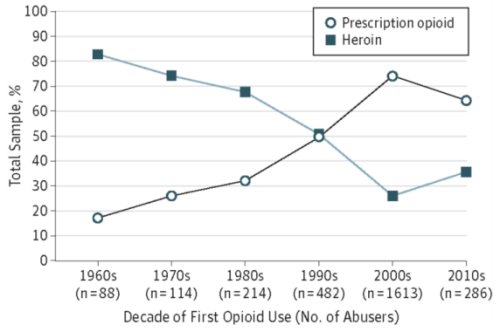


Figure Legend:

Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of AbuseData are plotted as a function of the decade in which respondents initiated their opioid abuse.

CDC Opioid Guidelines-March 2016

- **Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation**

  4.When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

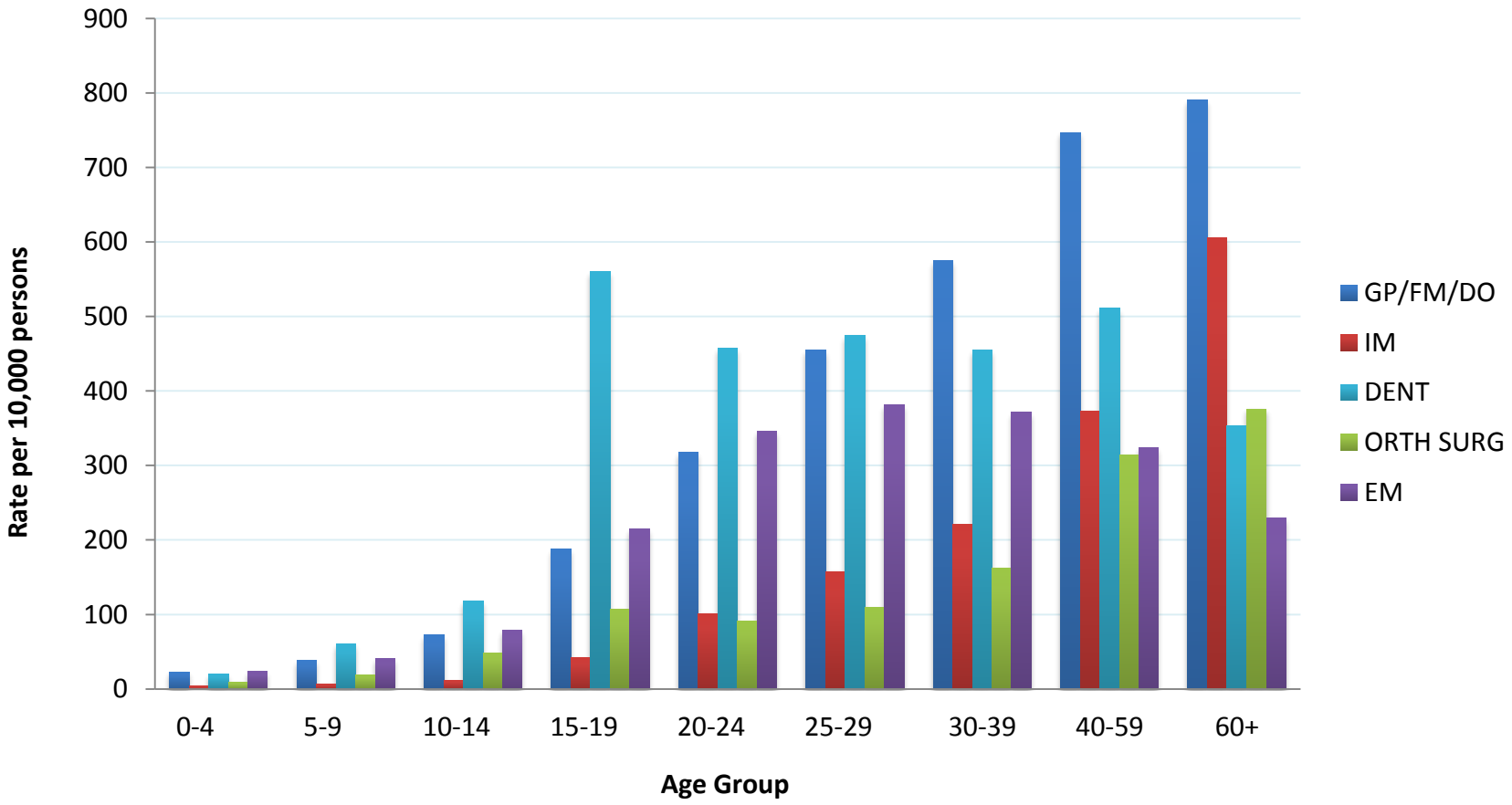
  5.When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

  6.Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

  7.Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Dentists and Emergency Medicine Physicians were the main prescribers for patients 5-29 years of age

5.5 million prescriptions were prescribed to children and teens (19 years and under) in 2009



Source: IMS Vector ®One National, TPT 06-30-10 Opioids Rate 2009

Mieche et al, Pediatrics,Nov 2015: Prescription opioids in adolescence and future opioid misuse

- Prospective panel data from the Monitoring the Future Study
- N=6220 surveyed in 12th grade and followed up through age 23
- Legitimate opioid use before high school graduation is independently associated with a 33% increase in the risk of future opioid misuse after high school. This association is concentrated among individuals who have little to no history of drug use and, as well, strong disapproval of illegal drug use at baseline.

Rapidly increasing mortality in middle aged, lower educated whites

Case and Deaton, PNAS, 2015

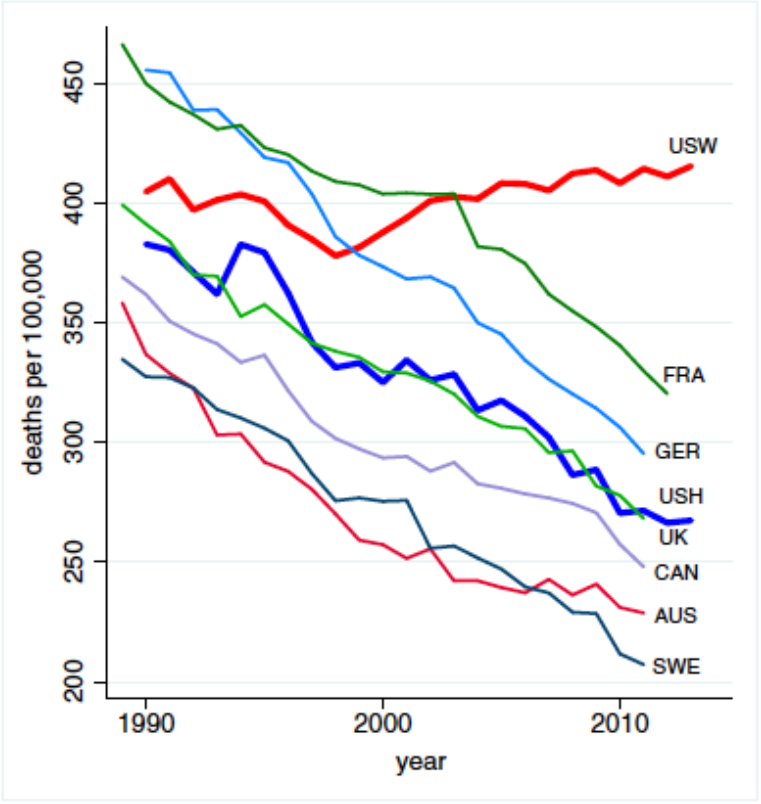


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Rapidly increasing mortality in middle aged, lower educated whites

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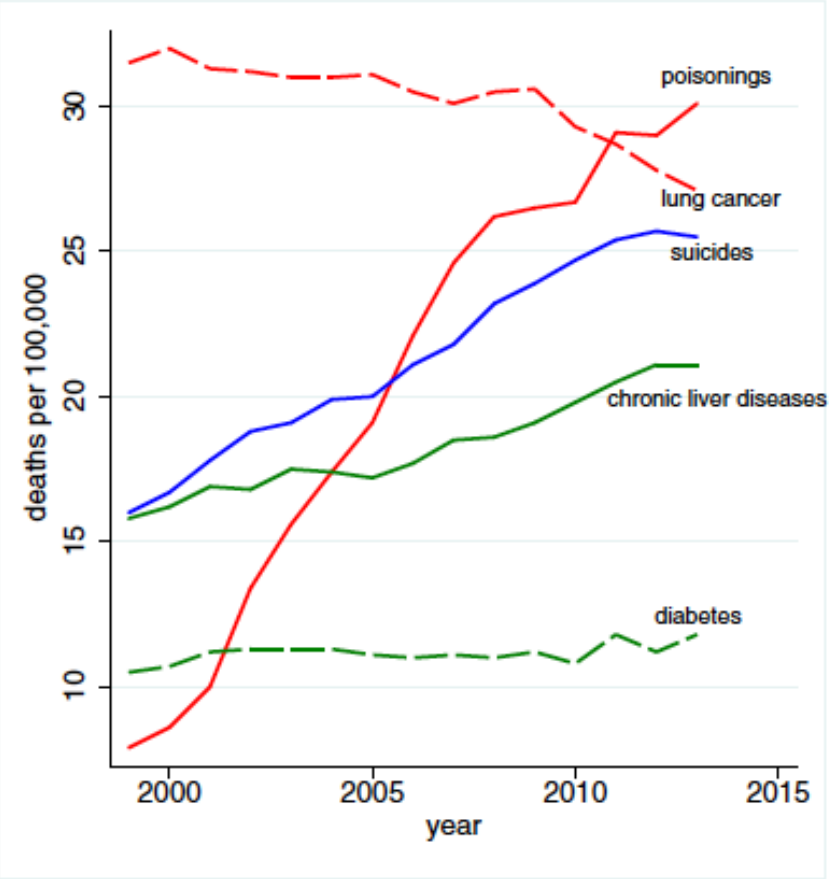
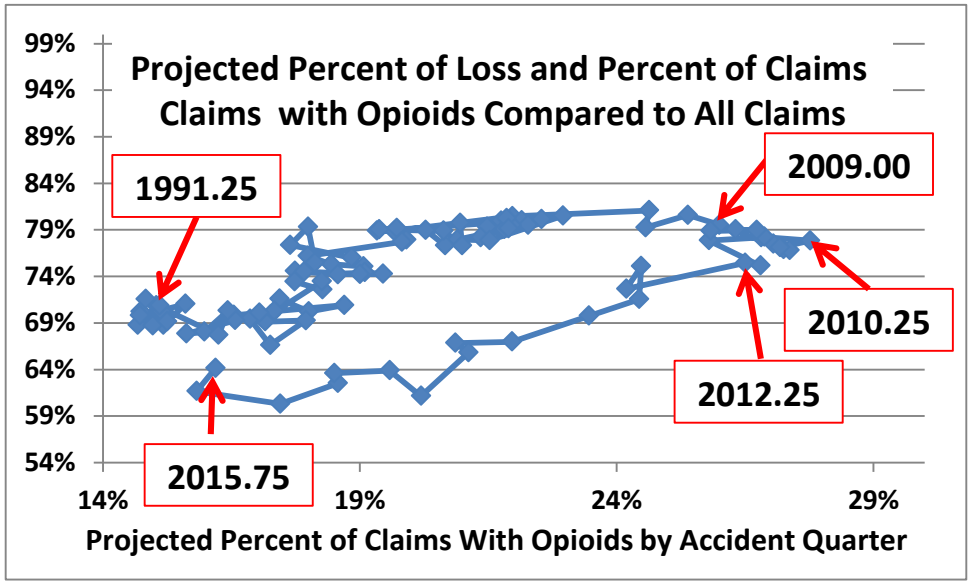


Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

The Mercier-Franklin Opioid Boomerang, 1991-2015



THANK YOU!

For electronic copies of this presentation, please e-mail Laura Black

ljl2@uw.edu

For questions or feedback, please e-mail Gary Franklin

meddir@u.washington.edu

Opioid Management

Patrick Reiman Director of Claims from Sedgwick responsible for the Boeing account will discuss the implementation of Department guidelines on opioid use in claims management.

WSIA's INDUSTRIAL INSURANCE UNIVERSITY

WWCP

Opioid Management

- How did you approach opioids prior to the opioid guideline?
- What kind of success did you experience?
- What were your greatest challenges?
- How has Sedgwick Boeing used the guideline?
- Have you seen improvement since implementation?
- What value has the opioid guideline added to the way you do business?
- What kind of challenges are you still facing?
- Why did you choose to focus on this topic for training with L&I staff earlier this year?
- What changes are you making based on the interaction with L&I staff?
- What future plans do you have in this area?

WSIA's INDUSTRIAL INSURANCE UNIVERSITY

WWCP

Qualis Health
Utilization Review:
A Physician's Perspective

June 29th, 2016

Margaret M. Baker, MD, FACS, FAAOS
Assistant Medical Director, Qualis Health

Introduction

Outline

- Introduction to the UR (utilization Review) process
- UR versus IME (Independent Medical Examiners)
- The Qualis Health UR process
- 3 short illustrative case studies

Qualis Health

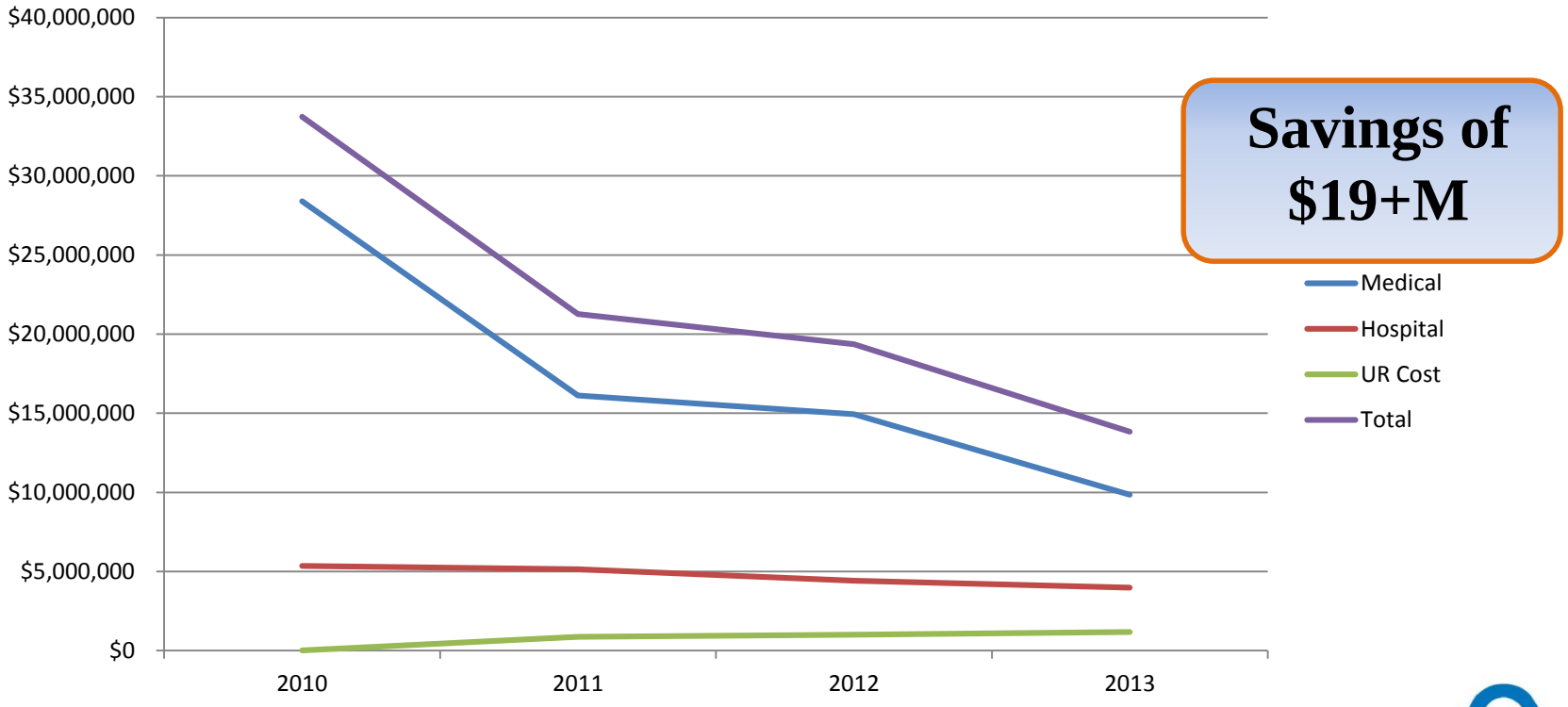
- A private nonprofit organization
- Headquartered in Seattle, WA
- Our products and services directly influence care delivered to over 12 million people
- Teleworkers-WA Based Team
- **NOT** incentivized for outcomes of reviews
- Hours 8-5 PST/PDT

Qualis Health History with Washington State Department of Labor and Industries (L&I)

- Collaborating with the Department since 2002
- Ensure medical care for occupationally injured and ill workers is of highest quality
- Complete approximately 90,000 UR annually for the Department
- Review all inpatient admissions and select outpatient procedures
  - Elective surgery
  - Advanced imaging
  - PT, OT, WC, MT, Chiro
  - Admissions/Length of stay
  - Spine injections

Qualis Health Outcomes for L&I

- Dramatic reduction in advanced imaging (MRI, CT) costs over a four-year period



What is Utilization Review (UR)

- Compares requests for medical services ("utilization") to treatment guidelines deemed appropriate for such services
- Includes a recommendation based on that comparison

Qualis Health reviews are
- Objective-Independent
- Evidence-based
- Consistent

Advantages of Utilization Review (UR) over an Independent Medical Exam (IME)

- UR=Objective and Independent, No financial link to outcome
- UR=Uses evidence-based criteria and Medical Treatment Guidelines
- UR=Increased speed of answer (Days vs. weeks)
- UR=Less expensive (IME $1,000-$2,000/review)

The Qualis Health UR Process

- Case submitted for review and loaded by non-clinical staff into care management software
- First Level Review completed by either Registered Nurse (RN) or Physical Therapist (PT) : 73% approved at this level
- Secondary reviews completed by Physician Advisor (27% of all cases)
- Potential denials offer the opportunity for a MD to MD discussion to provide additional information
- Outcome of Review communicated to client
- Re-Review of Denied Case (Rate < 1%)
    - Internal peer-matched
    - External peer matched

The Role of the Physician Advisor in UR

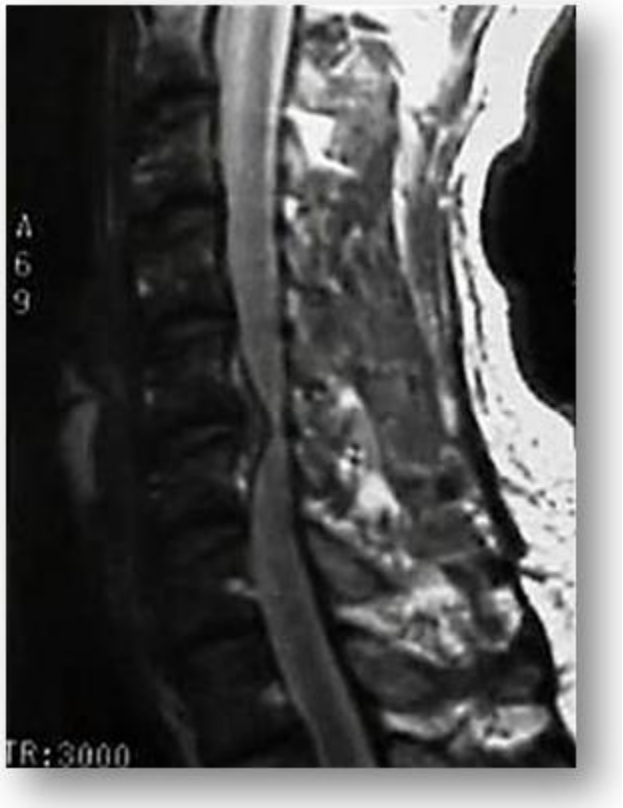
- Review for medical/surgical necessity using
  - Medical Treatment Guidelines
  - Interqual Criteria
  - Clinical Judgement/experience
  - Current Literature Review
- Evaluate appropriate level of care and LOS
- Occasional standard of care issues

Case Study #1

- 53 y.o. Injured work with neck injury after a fall
- Request for C4-7 ACDF (neck fusion)
- Active smoker
- Left upper extremity C-7 radiculopathy
- C4-5 extruded disc on MRI
- Failed conservative care
- Failed to meet MTGs on RN review
- Forwarded to Physician Advisor

Case Study #1: Physician Review

- MD review:
  - 5.4 mm AP canal diameter
  - Complete CSF (cerbreospinal fluid) effacement
  - Spinal cord signal changes
  - Early myelopathy on exam
- Case approved for surgery
- Approval expedited



Case Study #2

- 60 y.o. Injured work with low back pain after lifting
- History of prior laminectomies x 2
- Chronic low back pain for 10+ years
- Has had an MRI within the last month
- Presents to ER with increased pain, requesting more narcotics
- ER exam: no new neurological findings
- MRI done in ER, requested retroactively
- Failed to meet MTGs on RN review
- Forwarded to Physician Advisor

Case Study #2

- 60 y.o. Injured work with low back pain after lifting
- Physician Advisor review:
  - Chronic pain & narcotics use
  - No significant new trauma
  - Complaint of urinary incontinence
  - No sign of Cauda Equina Syndrome on physical exam
  - No new radicular complaints
  - No new neuro deficits on exam
  - Current Mri within the last month
  - New MRI showed no acute findings
- MRI denied, retroactively
- Offered MD to MD discussion: declined

Case Study #3

- 46 y.o. injured worker with shoulder pain, crepitus, weakness, loss of function
- T-12 paraplegic
- Has irreparable rotator cuff tear
- Superior capsular reconstruction with allograft requested
- Failed to approve at RN review because of lack of guidelines
- Forwarded to Physician Advisor

Case Study #3: Physician Review

- Superior capsular reconstruction with allograft denied after MA review
- Peer-Matched MD to MD:
  - Lives independently
  - Now unable to transfer to/from WC
  - Had SCR on opposite side with excellent outcome
  - SCR approved, allograft denied

Summary

- Introduction to the UR (utilization Review) process
- UR versus IME (Independent Medical Examiners)
- The Qualis Health UR process
- 3 short illustrative case studies

Questions / Comments
1-800-541-2894

Treatment Guidelines At the Board of Industrial Insurance Appeals

by Jessica Creighton,
Co-OMD Advisor

This opinion represents my own considered analysis as an Assistant Attorney General assigned to represent L&I of Labor & Industries. However, it is not an official opinion of the Attorney General's Office.

Medical Treatment Guidelines are developed by the Office of the Medical Director (OMD) and IIMAC – the Industrial Insurance Medical Advisory Committee.

This is a statutory committee – RCW 51.36.140:

"The department shall establish an industrial insurance medical advisory committee. The industrial insurance medical advisory committee shall 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, review of coverage decisions and technology assessments, review of medical programs, and review of rules pertaining to health care issues. . . .

The industrial insurance medical advisory committee must consider the best available scientific evidence and expert opinion of committee members. The department may hire any expert or service or create an ad hoc committee, group, or subcommittee it deems necessary to fulfill the purposes of the industrial insurance medical advisory committee. In addition, the industrial insurance medical advisory committee may consult nationally recognized experts in evidence-based health care on particularly controversial issues."

Current IIMAC Membership

Dianna Chamblin, MD (Chair)

Andrew Friedman, MD (Vice-chair)

Greg Carter, MD

Gregory Gutke, MD

Monica Haines, DO

Kirk Harmon, MD

Chris Howe, MD

Robert G.R. Lang, MD

JC Leveque, MD

Linda Seaman, MD

David Tauben, MD

Stephen Thielke, MD

G. Robert Waring, MD

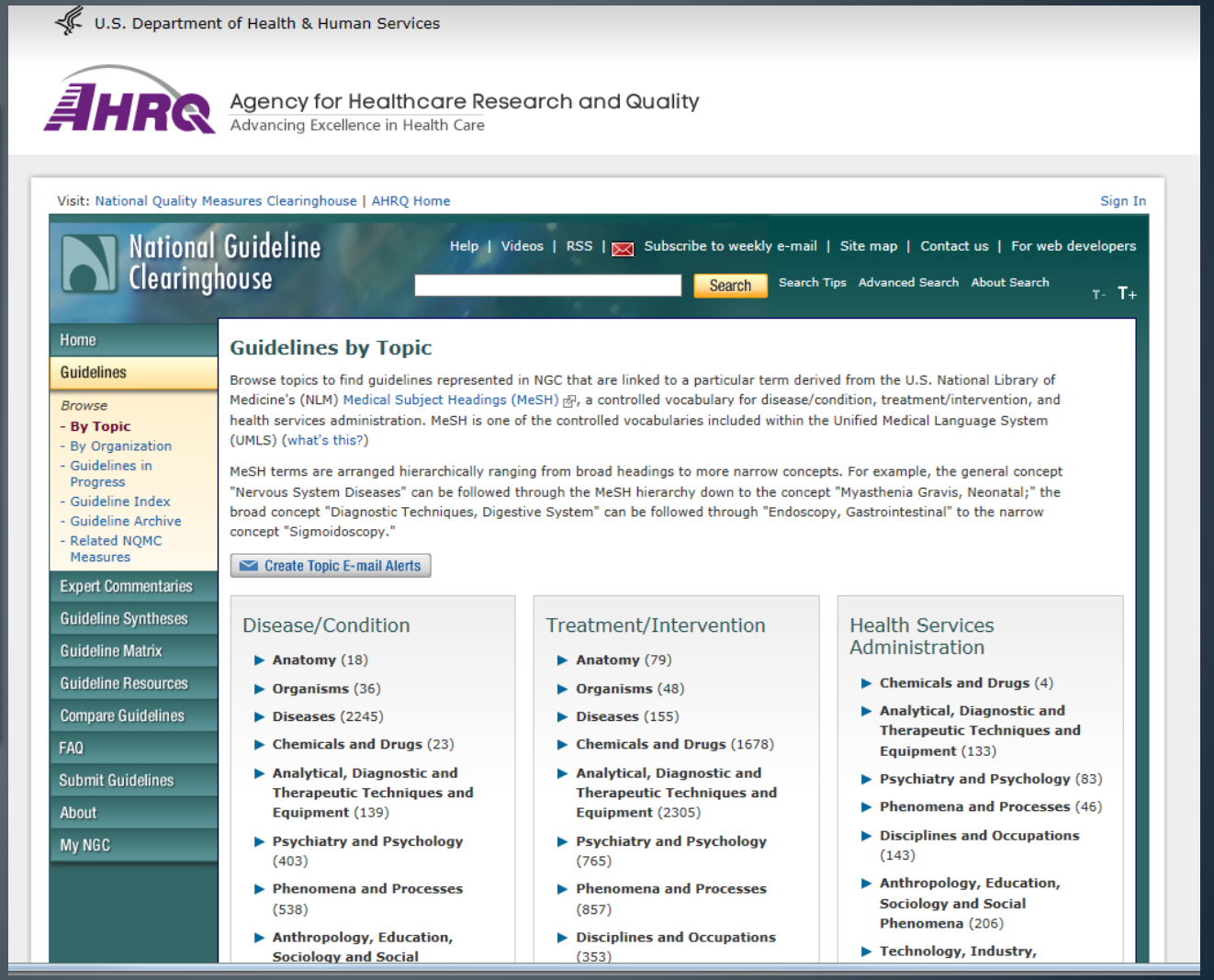
The Medical Treatment Guidelines are found on the L&I website.

http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/TreatGuide/default.asp

Many of our guidelines are published by the National Guideline Clearinghouse.

The National Guideline Clearinghouse is a public resource for evidence-based clinical practice guidelines; it's "an initiative of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services."

The rigorous inclusion criteria is extensively detailed on the NGC website; one requirement is a systemic review of evidence in a way that can be verified by reviewers.



The Medical Treatment Guidelines are ***Kind of a* Big Deal**, they even get archived.

Making guidelines is part of the Department's job description.

RCW 51.04.020,
Powers and duties

The director shall:

(1) Establish and adopt rules governing the administration of this title

***

(4) Supervise the medical, surgical, and hospital treatment to the intent that it may be in all cases efficient and up to the recognized standard of modern surgery

RCW 51.04.030,
Medical Aid

"The director shall supervise the providing of prompt and efficient care and treatment. . . at the least cost consistent with promptness and efficiency, without discrimination or favoritism, and with as great uniformity as the various and diverse surrounding circumstances and locations of industries will permit and to that end shall, from time to time, establish and adopt and supervise the administration of printed forms, rules, regulations, and practices for the furnishing of such care and treatment."

A legislative mandate makes it the attending provider's job to follow the guidelines.

RCW 51.36.010:

"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."

Failing to follow the guidelines is a reason for denial or removal from the network:

WAC 296-20-01050(j): "The provider has been materially noncompliant with the department's rules, administrative and billing policies, evidence-based coverage decisions and treatment guidelines, and policies and other national treatment guidelines appropriate for their patient (based on severity, recency, frequency, repetition, or any mitigating circumstances)."

See *also* WAC 296-20-015, Who May treat

WAC 296-20-01002, Proper and necessary

(2)(a): Reflective of accepted standards of good practice, within the scope of practice of the provider's license or certification

(2)(b): Curative or rehabilitative. Care must be of a type to cure the effects of a work-related injury or illness, or it must be rehabilitative. Curative treatment produces permanent changes, which eliminate or lessen the clinical effects of an accepted condition. Rehabilitative treatment allows an injured or ill worker to regain functional activity in the presence of an interfering accepted condition. Curative and rehabilitative care produce long-term changes.

(4):In no case shall services which are inappropriate to the accepted condition or which present hazards in excess of the expected medical benefits be considered proper and necessary. Services that are controversial, obsolete, investigational or experimental are presumed not to be proper and necessary, and shall be authorized only as provided in WAC 296-20-03002(6) and 296-20-02850.

The Board's View

- The Treatment Guidelines are not rules. Rather they are analogous to policies and are not binding on the Board.
- RCW 51.36.010, which entitles an injured worker to proper and necessary treatment, supersedes the Department's Treatment Guidelines.
- Therefore, if a worker can show by a preponderance of the medical evidence that the requested treatment is proper and necessary, then the Board will authorize treatment despite Department guidelines to the contrary. This is because "proper and necessary" is defined by rule whereas the guidelines are considered a Department policy.

Board Decisions

In re Paul Fish, BIIA Dec., 10 18494 (2010): Department guidelines do not provide the basis for determining whether surgical treatment of nTOS was proper and necessary, rather, the Board must consider the medical evidence presented to it.

Note, the denial of treatment was upheld here.

Paul Fish is a Board Significant Decision

In re Nena Boyer, Dckt. No. 13 19364 (December 2, 2014): Reversed a PD&O that had relied on the guideline's requirement for objective findings to verify nTOS diagnosis.

What happened: Turning from the guidelines, the Board emphasized reliance on the medical evidence before it. It determined that the experts were discussing two different conditions, an acute form of TOS and a "nonspecific" version. They cited to the numerous medical professionals that supported Dr. Johansen's version. They reasoned that the two testifying medical experts who supported the unspecified version were both properly qualified and credentialed.

What did not happen: no treatment was authorized by this decision, it was only about acceptance and we know that is a low bar. This is not a significant decision.

Before you get to the Board

Make sure you are familiar with the applicable guidelines.

Send the guideline to the AP.

Send the guideline to the IME physician and ask them to use the guideline in their analysis and report.

At the Board:

- Remind the Board of the legislative directives regarding the Department's authority to establish guidelines and the requirement that treatment for any condition must be by a network physician (where applicable) who must adhere to the Department's guidelines.

- Emphasize the role of the IIMAC and the large the number of physicians who signed off on the particular guideline.

- Have your medical witness testify about the guidelines.

Thank you for your time and attention.

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Self Insurance Colloquium
Strategic Vision on Quality Care

Washington State Department of
Labor & Industries

Strategic Vision on Quality Care

L&I Will:

- Describe how L&I's medical management focus is on Quality Care – a different focus than typical insurance
- Describe the impact using this strategy has on our state fund
- Describe why disability reduction is key
- Provide an update on COHE results and
- Explain how L&I is expanding its strategy to include more best practices and use the evidence based collaborative care model

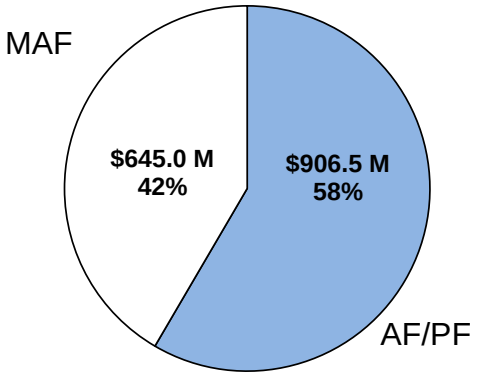
Group Health Will:

- Describe Group Health's experience with collaborative care, especially in the context of being a self-insured health care delivery organization and participating in COHE

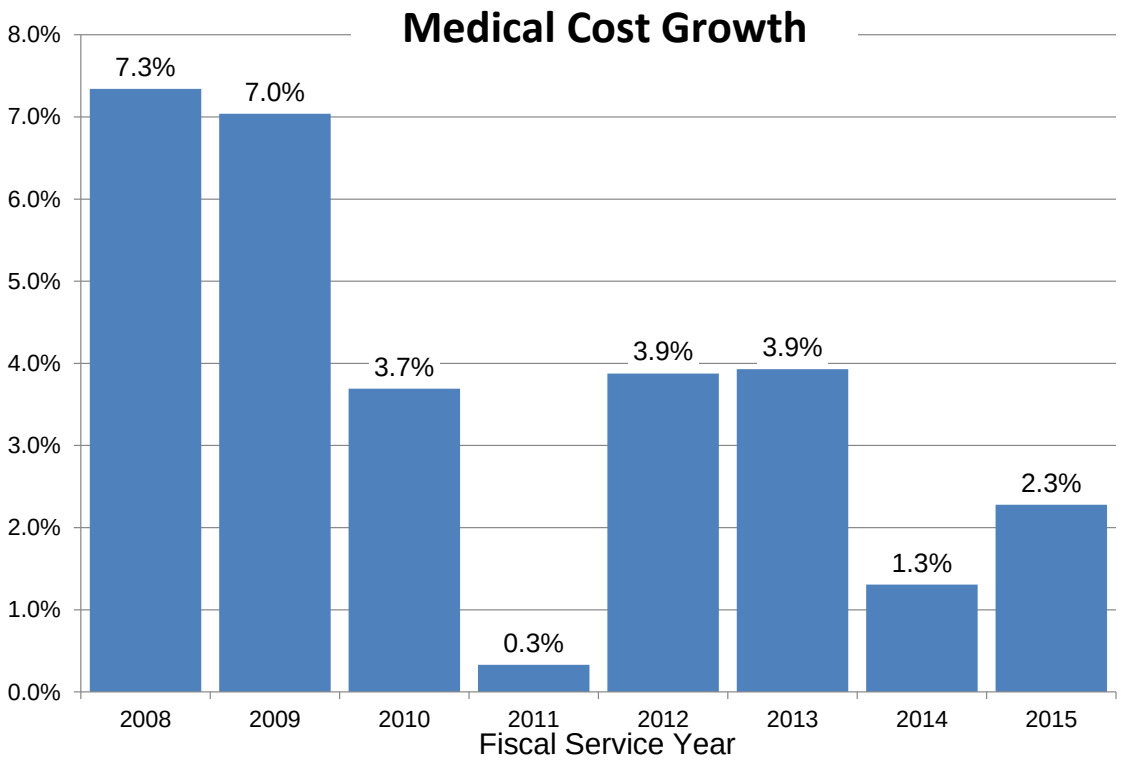
MEDICAL MANAGEMENT – typically balancing interests

Size and Growth of WA Medical Aid Fund

Benefits Incurred for Accident Year Ending 12/31/15

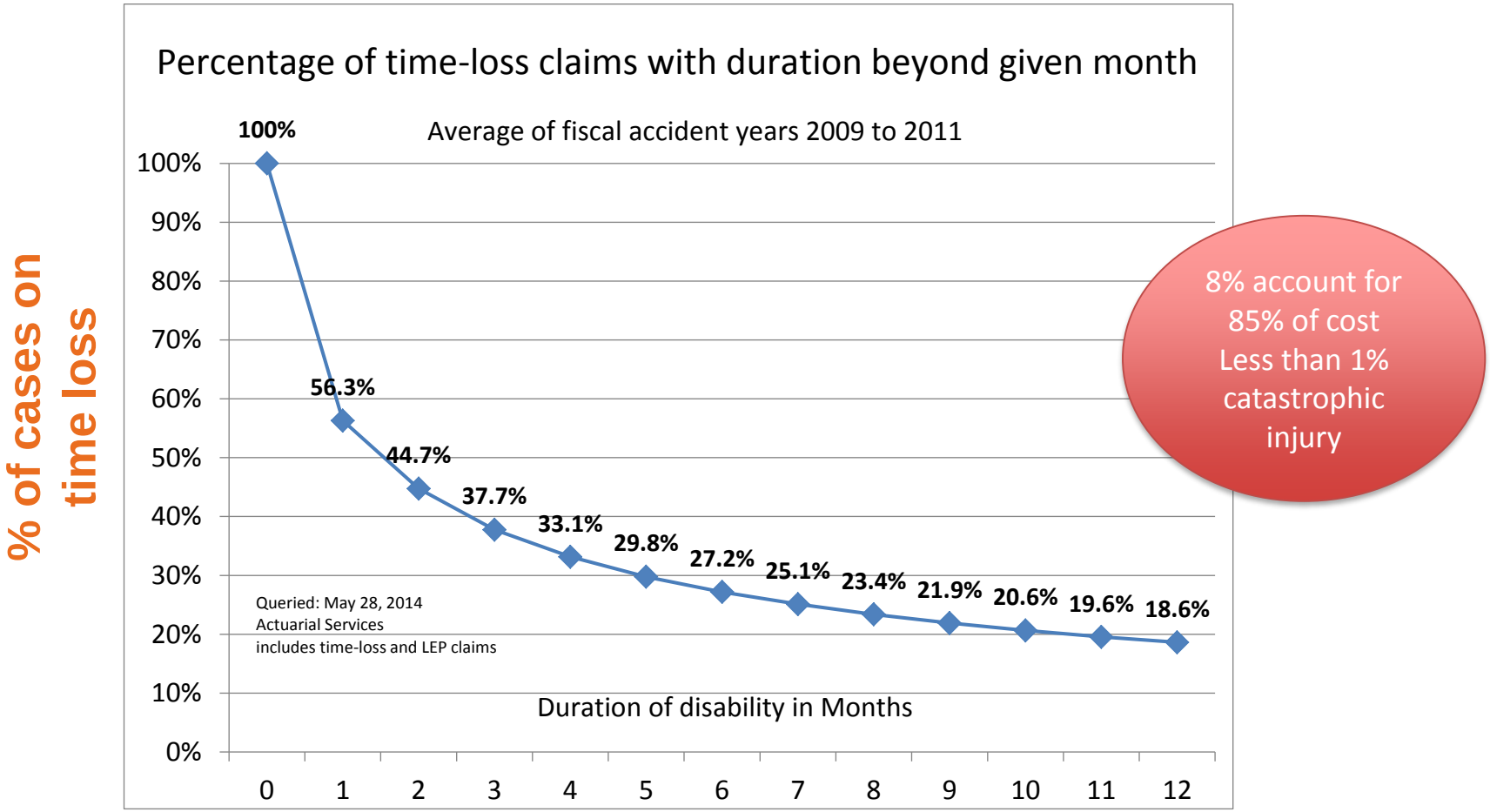


MAF – Medical Aid Fund
AF – Accident Fund
PF – Pension Fund



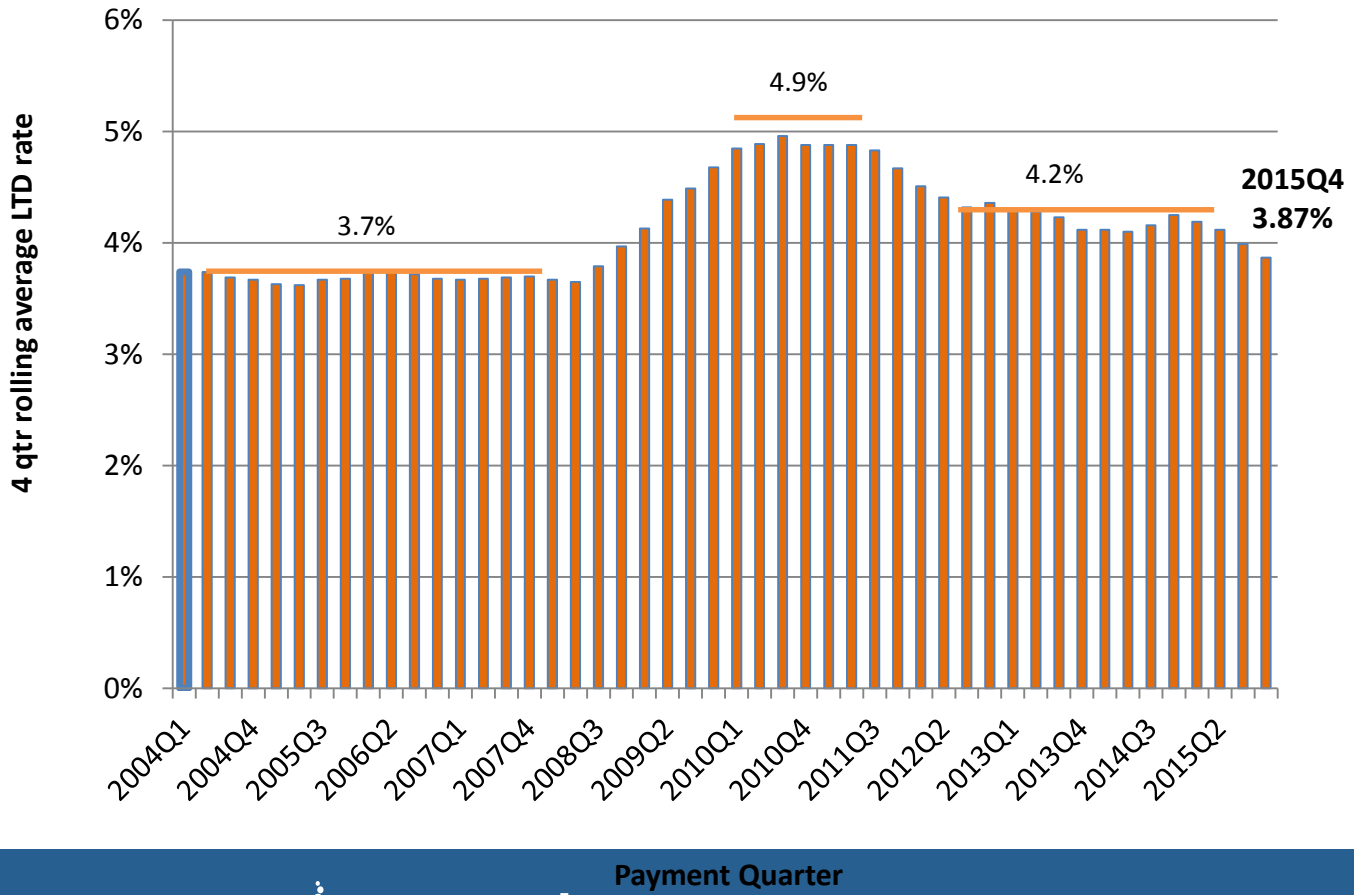
*Goal is under 4%

Disability Prevention is the Key Medical Management and Health Policy Issue



Our ultimate goal is to reduce the number of injured workers who experience long-term disability.

Long-term disability is the share of ultimate claims that receive a time-loss payment 12 months from injury.



The goal is to decrease this number.

Washington's Strategies to Prevent Disability

Payer Basics

- Fee Schedule
- Provider Education and Outreach
- Provider Network

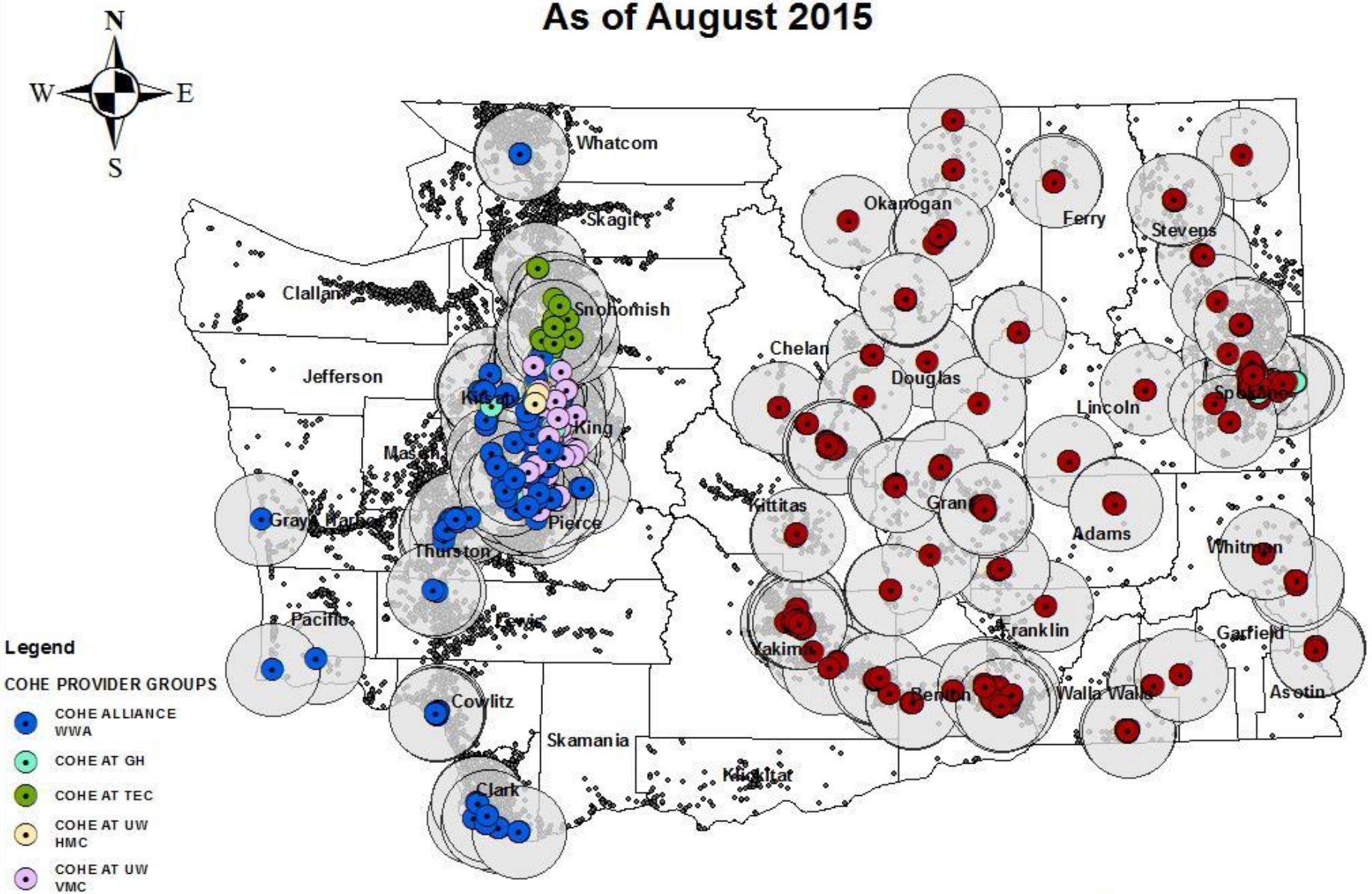
Reduce Harm

- Risk of Harm
- Utilization Review
- Treatment Guidelines

Identify and Pay for Quality Clinical Care

- Centers for Occupational Health and Education (COHE)
- Top Tier
- New Evidence Based Best Practices

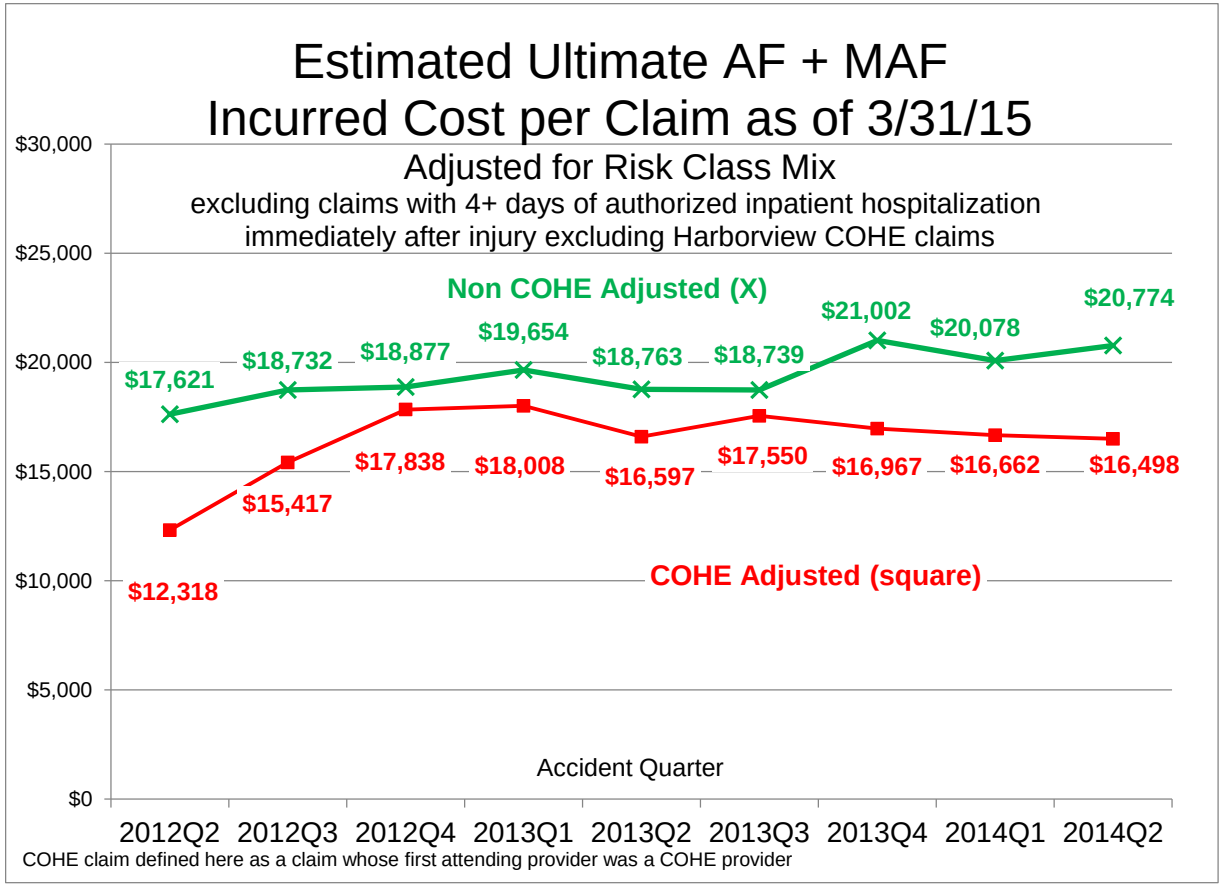
All Injured Workers With 15-mile Radii From Current Active COHE Providers As of August 2015



Washington State Department of Labor & Industries

Prepared by Calvert & Maskell, HPPM

COHE Results

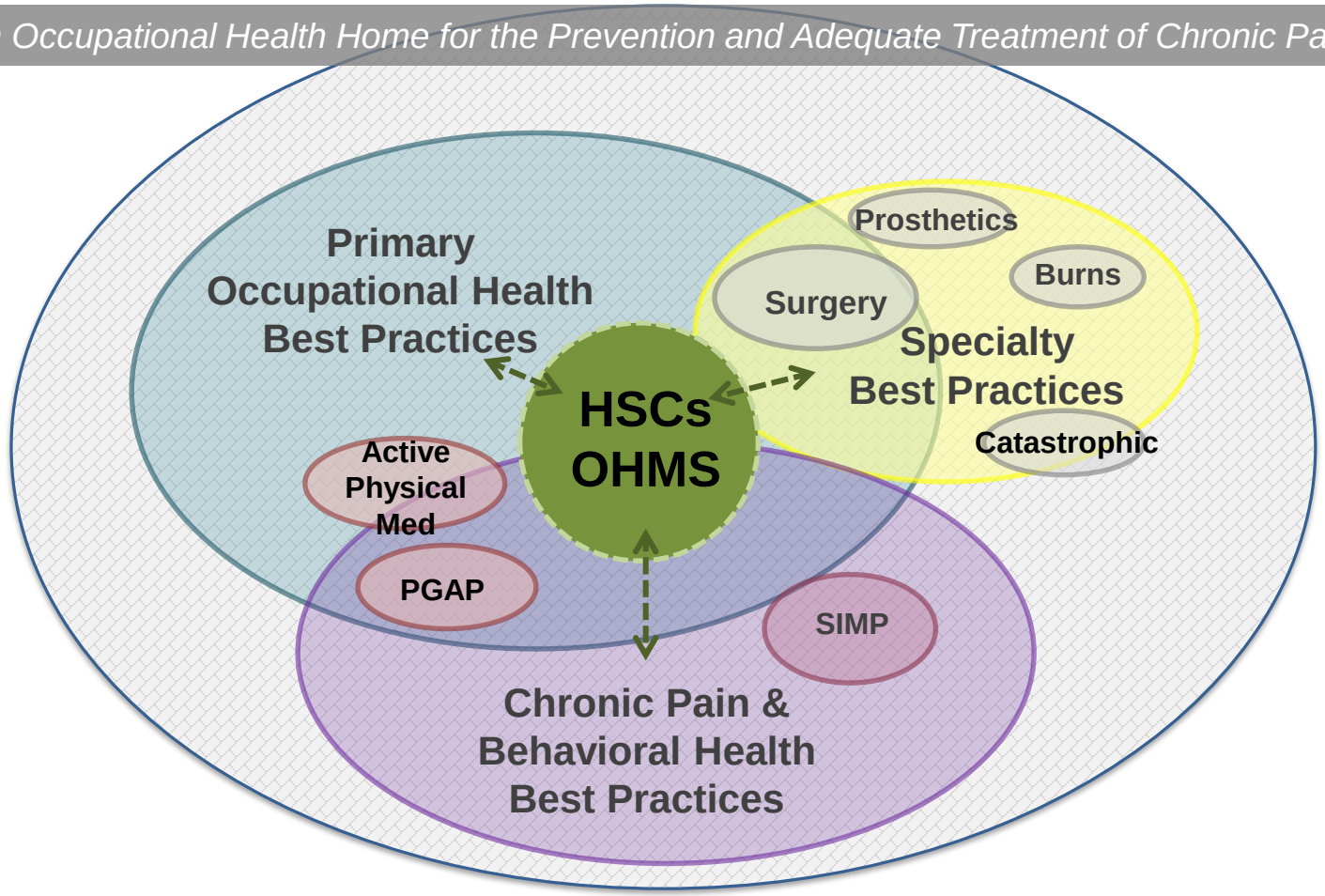


- About 50% of claims initiated with COHE Provider
- About 3,000 COHE providers (out of 25,000 Network providers)

WA Healthy Worker 2020

Innovation in Collaborative, Accountable Care

An Occupational Health Home for the Prevention and Adequate Treatment of Chronic Pain



Questions

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