

## GUIDE TO CONDUCTING STATE PILOT PROGRAMS TO IMPROVE SAW/RTW OUTCOMES IN OCCUPATIONAL HEALTH

The “Replicating and Adapting COHE Strategies” Policy Working Group (PWG) of the U.S. Department of Labor’s Office of Disability Employment Policy’s Stay-at-Work/Return-to-Work (SAW/RTW) Policy Collaborative explored the policy considerations of adopting or adapting the RTW strategies of the Washington State Department of Labor & Industries’ (L&I’s) Centers of Occupational Health & Education (COHE). The PWG recommended that other states consider using the COHE model as the platform for building an effective system for delivering quality healthcare that promotes RTW. In addition to recommending that a state should build on existing systems and initiatives and make strategic use of the state workers’ compensation regulatory apparatus, the PWG made several key suggestions for how a state should proceed with implementation:

1. **Start with a pilot program.** Begin comprehensive adoption/adaption on a small scale by implementing a pilot program.
2. **Begin with small steps that address key components.** In states where implementing the COHE model may not be immediately feasible, adopt a goal that incorporates as many components of COHE as feasible.
3. **Engage all key stakeholders.** Regardless of whether implementing the full COHE model or starting with small steps, it is important to recognize that engaging all key stakeholders is critical to initial and continued success for RTW initiatives and programs that work.

This document provides a guide for policymakers and state administrators on how to put such a pilot program in place. This guide is based on the State of Colorado’s experiences and the policy steps it took to implement a pilot test of the COHE model and the decision-making and implementation steps that went into the process.

### Colorado’s Strategy: Using the COHE Model as a Platform

Colorado’s workers’ compensation healthcare system is composed of medical programs, such as fee schedules and treatment guidelines, developed through a principle-based approach. Under this approach, policy and regulatory decisions are based on the application of all the principles outlined in the [Colorado’s Workers’ Compensation Act](#). Physician accreditation (Rule 13), medical utilization standards (Rule 16), medical treatment guidelines (Rule 17), and the medical fee schedule (Rule 18) are examples of Colorado medical programs that advance the principles of quick and efficient medical care at a reasonable cost.

Colorado considered its existing programs as possible vehicles for rollout of its new quality-based

vision of healthcare. Ultimately, the Colorado Division of Workers’ Compensation (CO DOWC) chose to promote a *new* healthcare delivery system as the platform for its quality healthcare vision. Washington’s COHE program was an ideal model for Colorado to consider using because it is an evidence-based healthcare delivery model that focuses on collaborative and coordinated care and aligns with CO DOWC’s commitment to achieve all the principles of quality healthcare.

Meetings with Washington’s L&I staff, as well as review of other research on evidence-based models recommended the implementation and design of a complete healthcare delivery system. Having identified COHE as the ideal platform for promoting quality healthcare, CO DOWC made the decision to implement the platform in a more controlled, low-risk way by conducting multiple pilot programs.

Because incorporation of additional elements of quality and promotion of a COHE delivery model represented a significant change in the existing workers' compensation healthcare system, CO DOWC promulgated a new regulation effective January 1, 2017, Rule 18-8(D), ([Attachment 1](#)) that opened a pipeline for stakeholders to propose pilot programs on quality initiatives such as COHE.

## Why Conduct a Pilot Program?

There are numerous benefits to conducting pilot programs as opposed to system-wide, regulatory implementation of a new initiative.

- **New and untested concepts can be proven on a smaller scale.** This minimizes the effects of unforeseen or undesirable consequences to stakeholders in the system.
- **Pilot programs provide stakeholders (including the regulatory agency) greater flexibility in shaping important details of the idea to be tested.** In Colorado's case, the pilot program regulation provides the flexibility for CO DOWC to work with stakeholders to precisely define the parameters of any COHE delivery model proposal. CO DOWC has taken advantage of this benefit by steering stakeholders in the direction of developing "full-blown" COHE delivery models, versus testing isolated components of the COHE model.
- **Multiple pilot programs can be conducted to examine different aspects of an idea—pilots allow examination of "variations on a theme."** For example, one set of COHE pilots could compare results for different diagnoses covered under the COHE delivery model. Another set of COHE pilots could test the efficacy of payer-based Health Services Coordinators versus provider-based Health Services Coordinators.
- **Pilot programs are better suited for integration into process improvement.** For example, pilots are shorter in duration and easier to build into a continuous improvement process than programs dictated by regulations.
- **Voluntary pilot programs identify stakeholders who are willing to champion and promote ideas like COHE, versus compelling stakeholders to "accept" and implement programs**

**mandated by regulations.** Pilot programs are a collaborative, voluntary approach for stakeholders to test an idea, which is arguably better received than a compulsory, directive approach.

Colorado officials emphasized that they were not trying to test the COHE strategy itself (which has already been shown to be [effective](#).) but to test how it works in a different state context, what logistics would be involved, and importantly, how to select the right partners. CO DOWC recognized that it is essential to identify leaders and champions within *all* key stakeholder groups, as it is unrealistic and impractical to assume that any one stakeholder group or organization could effectuate a system-wide shift to quality on its own.

## Conducting Pilot Programs in Colorado

With the previously mentioned promulgation of Rule 18-8(D), Colorado invited payers to submit pilot healthcare proposals related to coordination of care, and created an opportunity for stakeholders to propose the testing of new, innovative ideas that were focused on quality of care. Proposals could be submitted any time after January 1, 2017. The goal was to solicit proposals that would improve quality of care by focusing on early communication and coordination, functional outcomes, incorporation of RTW principles, and reducing costs for injured workers at high risk of job loss.

The next steps taken by Colorado in its plan to implement pilot programs to improve SAW/RTW outcomes in occupational health have included:

**Communicate closely with prospective bidders.** Because this was a voluntary opportunity, and because a focus on quality is a paradigm shift for Colorado's workers' compensation healthcare system, CO DOWC anticipated challenges in finding qualified bidders. To address that challenge, CO DOWC worked closely with carefully selected stakeholders to develop promising pilot proposals. CO DOWC focused its efforts on identifying and helping develop COHE-type proposals that focused on coordinating communication among injured workers, medical providers, and employers, and coordination of care among healthcare providers.

Among the strategies used to communicate the state’s vision and assist potential bidders in understanding the requirements of the desired pilot program was the preparation of guidance materials for interested stakeholders. For example, a document such as “Guidance for Developing Rule 18-8(D) Pilot Program Proposals Related to Coordination of Care” ([Attachment 2](#)) could be provided to anyone interested in submitting a proposal or offered when meeting with stakeholders on the pilot program rule. Another tool Colorado used was conducting “pitch meetings” with payers and other interested parties that described the coordinated care model and the goals of the pilot program, often including a simple presentation ([Attachment 3](#)).

In some cases, the intense efforts surrounding proposal development have continued up to and beyond the point of finalizing a contract to conduct a pilot program. The proposal included as [Attachment 4](#) shows the amount of specificity a bid like this demands – for example, the huge amount of detail regarding how the Health Services Coordinator position is operationalized – and why ongoing discussions like this are a critical step in the process. Colorado has learned that it is impossible to overstate the importance of putting in the work

to make sure that all the details are covered and everybody is in agreement about what to do next.

**Obtain input from all stakeholders through public meetings.** In addition to communications with potential bidders, it is important to hear from all other stakeholders, such as employers, healthcare providers, unions, and members of the general public. Like other states with SAW/RTW programs like COHE (for example, Washington and Montana), Colorado held public meetings to explain the program and to identify what the important issues are for workers and others who may be affected by state decisions about healthcare quality and care coordination.

**Ensure that all key decision-makers are in the room.** Colorado has found it essential to identify the key players and make sure they are all at the table. If an important decision-maker is missing, it can slow down the process or even derail it entirely. For a program like COHE, individual payers, providers, and other relevant parties will eventually serve as the program’s champions within their respective organizations. Colorado found that you need champions from every stakeholder group (even the regulatory agency) to ensure successful implementation.

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The Stay-at-Work/Return-to-Work (SAW/RTW) Policy Collaborative was established by the U.S. Department of Labor’s Office of Disability Employment Policy (ODEP) to support the development of policies, programs, and practices that encourage the continued employment of workers likely to leave the workforce due to injury, serious illness, or disability. The Collaborative consists of a Community of Practice to provide input and real-time feedback on specific policy topics related to SAW/RTW, and Policy Working Groups (PWGs), led by Subject Matter Experts (SMEs) and supported by IMPAQ International, who explored policies and practices that curtail long-term work disability and job loss due to injury and illness, provide policy recommendations to key stakeholders, and develop resources to support policy action. The 2017 PWGs focused on three topics: (1) Replicating and Adapting the State of Washington’s Centers of Occupational Health and Education (COHE) Model; (2) Musculoskeletal Conditions and Pain Management; and (3) Transition Back to Work. This document is a product of the Adapting/Replicating COHE Strategies PWG co-led by Dan Sung (SME Lead) and Kay Magill (IMPAQ Lead).

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For more information about the work of the Stay-at-Work/Return-to-Work Policy Collaborative, see ODEP’s website at: <https://www.dol.gov/odep/topics/SAW-RTW/research-publications.htm> and IMPAQ’s website at: <http://www.impaqint.com/stay-workreturn-work-policy-collaborative-swr2w>



**ATTACHMENT 1: Rule 18-8(D)**

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- P Physician's Office (includes HMO non-hospital facility, clinic, etc.)
- R Residence
- S Scene of Accident or Acute Event
- X Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes HMO non-hospital facility, clinic, etc.)

(6) Mileage

Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. Payment is allowed for all medically necessary mileage. If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Use code "1" as the mileage for trips of less than a mile.

**18-7 DENTAL FEE SCHEDULE**

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2016 (CDT-2016). However, surgical treatment for dental trauma and subsequent, related procedures may be billed using medical codes from the RBRVS. If billed using medical codes as listed in the RBRVS, reimbursement shall be in accordance with the Surgery/Anesthesia section of the RBRVS and its corresponding conversion factor. All dental billing and reimbursement shall be in accordance with the Division's Rule 16, Utilization Standards, and Rule 17, Medical Treatment Guidelines. See Exhibit #6 of this Rule for the listing and Maximum Fee Schedule value for CDT-2016 dental codes.

Regarding prosthetic appliances, the provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

**18-8 QUALITY INITIATIVES**

(A) CHRONIC OPIOID MANAGEMENT

(1) When the authorized treating physician prescribes long-term opioid treatment, s/he shall use the Division of Workers' Compensation Chronic Pain Disorder Medical Treatment Guidelines and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids." Urine drug tests for chronic opioid management shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for chronic opioid compliance monitoring.

- (a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.
- (b) When drug screen tests are ordered, the authorized treating physician shall utilize the Colorado Prescription Drug Monitoring Program (PDMP).

- (c) While the injured worker is receiving chronic opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include the following:
    - (i) Concern regarding the functional status of the patient
    - (ii) Abnormal results on previous testing
    - (iii) Change in management of dosage or pain
    - (iv) Chronic daily opioid dosage above 100 mg of morphine or equivalent
  - (d) The opioids classified as Schedule II or Schedule III controlled substances that are prescribed for treatment longer than 30 days shall be provided through a pharmacy.
  - (e) The authorized treating physician may consider whether the injured worker experienced an opiate-related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7, C.R.S. (2015). For reimbursement for an opiate antagonist, please see Rule 18-6(N)(3)(c).
  - (f) The prescribing authorized treating physician shall review and integrate the screening results, PDMP, and the injured worker's past and current functional status on the prescribed levels of medications. A written report will document the treating physician's assessment of the patient's past and current functional status of work, leisure activities and activities of daily living competencies.
- (2) Codes and maximum fees for the authorized treating physician for a written report with all the following review services completed and documented:
- (a) Ordering and reviewing drug tests
  - (b) Ordering and reviewing PDMP results
  - (c) Reviewing the medical records
  - (d) Reviewing the injured workers' current functional status
  - (e) Determining what actions, if any, need to be taken
  - (f) Appropriate chronic pain diagnostic code (ICD-10)

Bill using code DoWC Z0765 \$75.00 per 15 minutes – maximum of 30 minutes per report

NOTE: This code is not to be used for acute or sub-acute pain management.

**(B) FUNCTIONAL ASSESSMENTS**

- (1) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, chiropractor or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following 3 elements are required:
  - (a) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

- (b) Pre-and post-injection procedure shall have at least 3 objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaeslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.
  - (c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least 8 hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.
- (2) If all three elements are documented, the billing codes and maximum fees are as follows:
- DOWC Z0811                      \$60.00 per episode for the initial functional assessment of pre-injection care, billed along with the appropriate E&M code, related to spinal or SI joint injections.
- DOWC Z0812                      \$31.44 for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection pain data, including a pain diary.
- DOWC Z0814                      \$31.44 for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(C) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

- (1) Medical providers who are Level I or II accredited, or who have completed the Division-sponsored Level I or II accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical providers must utilize both a validated psychological screen and the validated functional data provided by the injured worker or another health care provider. The medical provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:
  - (a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;
  - (b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the provider;
  - (c) Meaningful discussion of actual or expected functional improvement between the provider and the injured worker.

If these elements have been met, the billing code and maximum fee are as follows:

DOWC Z0815 \$ 80.00 for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816 \$ 40.00 for subsequent visits during which the injured worker provides follow-up functional data which could alter the treatment plan. The provider may use this code if the analysis of the data causes him or her to modify the treatment plan. The provider should not bill this code more than once every 2 to 4 weeks.

- (2) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(D) PILOT PROGRAMS

- (1) Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in C.R.S. 8-43-602 and shall include:

- (a) Beginning and end date for the pilot program.
- (b) Population to be managed (e.g. size, specific diagnosis codes).
- (c) Provider group(s) participating in the program.
- (d) Proposed codes and fees.
- (e) Process for evaluating the program's success.

Participating payers must submit data and other information as required by the Division to examine such issues as the financial implications for providers and patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

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**Editor's Notes**

7 CCR 1101-3 has been divided into smaller sections for ease of use. Versions prior to 01/01/2011 and rule history are located in the first section, 7 CCR 1101-3. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 18: Exhibit 1.

**History**

*[For history of this section, see Editor's Notes in the first section, 7 CCR 1101-3]*

## **ATTACHMENT 2: Guidance for Developing Rule 18-8(D) Pilot Program Proposals Related to Coordination of Care**

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**COLORADO**  
Department of  
Labor and Employment

## **DIVISION OF WORKERS' COMPENSATION**

### **MEDICAL POLICY SECTION**

#### **GUIDANCE FOR DEVELOPING RULE 18-8(D) PILOT PROGRAM PROPOSALS**

#### **RELATED TO COORDINATION OF CARE**

### **BACKGROUND**

Effective January 1, 2017, the Division of Workers' Compensation added a new section to Rule 18, which invites payers to submit pilot healthcare proposals to the Division. The purpose of Rule 18-8(D) is to encourage stakeholders to test new, innovative ideas in Colorado's workers' compensation healthcare system that focus on quality. The Division hopes stakeholders will test a range of ideas, whether small or large, and that Rule 18-8(D) will serve as a "pipeline" for implementing new policies and programs on a system-wide basis that will advance Colorado's workers' compensation healthcare system.

Proposals should focus on healthcare quality because timely, efficient, safe, effective, patient-centered, equitable healthcare for workplace injuries translates into lower medical and indemnity costs for employers and payers, better outcomes (earlier return-to-work and return to pre-injury functional status) for injured workers, and a rewarding system for healthcare providers to practice medicine. In short, implementing policies and programs that focus on healthcare quality allows the Division to deliver increased value to all workers' compensation stakeholders.

The Division believes a pilot proposal centered on coordination of care could yield significant benefits for participants, and system-wide implementation could lead to dramatic improvements to Colorado's workers' compensation healthcare system. To guide stakeholders interested in developing such a pilot program, key elements are described below.

## KEY DESIRED ELEMENTS OF COORDINATION OF CARE PILOT PROGRAM

Certain workplace injuries (e.g. low back, chronic pain) are more likely to result in higher medical/indemnity costs if not managed properly. These pre-determined conditions and diagnoses would be handled under a “coordination of care” pilot program, whereby a designated coordinator would provide specialized support for administrative and clinical coordination of care. Elements of a strong coordination of care pilot proposal will include:

1. **Pilot Participants.** The payer and healthcare provider(s) must be specifically identified, and the resources allocated to this project must also be clearly defined. For example, the payer will need to identify the work units (e.g. claims, bill pay, utilization review) participating in the pilot and describe the process(es) for implementing the pilot program.
2. **Identification of a Health Services Coordinator (HSC).** This element will be the key part of any coordination of care proposal. Ideally, an HSC will be a staff resource from the provider organization participating in the pilot program with a clinical background (e.g. physical therapist, nurse). The person serving as the HSC for the pilot program will need to be specifically identified, along with submission of documentation that demonstrates the HSC’s strong skills, qualifications, and experience.
3. **HSC Duties.** The duties of the HSC should be clearly delineated in the proposal. Duties should include, but are not limited to: initial intake interview of injured workers managed under the pilot; coordination and communication with payer and employer on administrative and clinical matters; coordination of care and communication with the authorized treating physician and all other providers involved in the care of injured worker(s) participating under a coordination of care pilot program.
4. **Fee Schedule for HSC services.** A fee schedule that outlines reimbursements for the HSC and/or providers participating in a coordination of care pilot program.
5. **Data Collection.** The payer and healthcare providers should submit a sample report and/or data elements that will be collected as part of the pilot. Specific measures might include, but are not limited to: number of patients managed, number of HSCs, patient satisfaction, time to return-to-work (RTW), time to maximum medical improvement (MMI), medical costs, indemnity costs, functional evaluation metrics, employer satisfaction, and provider satisfaction.

## ATTACHMENT 3: Presentation

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COLORADO  
DEPARTMENT OF  
LABOR AND EMPLOYMENT

# Colorado Workers' Compensation: Healthcare Quality Pilot Program

October 11, 2016

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## Today's Agenda

1. Discuss goals of healthcare pilot program
2. Overview of State of Washington COHE program
3. Discuss framework of Colorado's healthcare pilot program
4. Identify participating organizations for Colorado's pilot program
5. Next steps

2



## Pilot Goals



- Quality Focus
- Test Coordination of Care Delivery Model
- Other goals?

3



## Washington's COHE Program

<http://www.lni.wa.gov/claimsins/providers/projresearchcomm/ohs/>

The screenshot shows the website for the Centers of Occupational Health & Education (COHE). The page has a green header with the Washington State Department of Labor & Industries logo. Below the header, there is a navigation menu and a main content area. The main content area includes a list of COHE centers, a section titled 'COHE - In More Detail' with a photo of Kathryn Viser, and a section titled 'A Provider Organization Benefits from COHE's Services'.

4



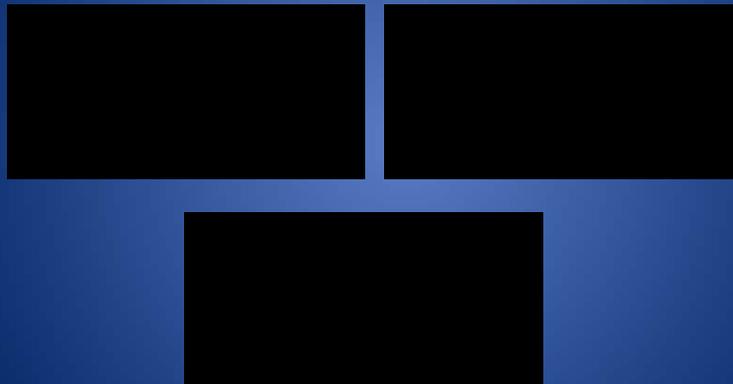
## Aspects of Colorado's Healthcare Pilot Program

- Healthcare delivery model
  - Focus on coordination of care
- Inclusion/exclusion criteria?
- Clinical Patient Advocate (CPA) duties?
- Documentation and reporting requirements?
- Data collection and metrics?
- Reimbursement?

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## Participating Organizations



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## Process and Timeframe for Pilot Implementation



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## Next Steps



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**ATTACHMENT 4: Proposal**

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# ACE- Advanced Care and Education Proposal to Improve Care Coordination for WC Patients

## **Background**

It has been recognized that a small minority of Workers Compensation (WC) patients account for a large majority of costs. Some of these expensive cases are patients with major injuries. However, there is also a subset of Injured Workers (IWs) who do not achieve good outcomes even though their injuries and overall medical conditions suggest that they should do well.

Other states have implemented programs to try and identify this high-risk group of IWs and to provide them with additional services to improve their care, reduce their return to work (RTW) time, and to reduce costs. This proposal addresses creating a pilot for such a program in Colorado.

## **The ACE Program**

The acronym ACE, for “Advanced Care and Education” was selected for the proposed program because:

- 1) We plan to focus on improving outcomes for IWs through the use of advanced care modalities (based on national evidence-based best practices), and
- 2) To provide substantially expanded education to all patients to improve their knowledge and understanding of the WC system, their injuries, and the rationale for the treatments being provided to improve their outcomes.

Keys elements of the program will include:

- Support for the patient
- Timeliness of reports
- Focus on Function
- Connection with employer
- Rapid Return to Work
- Attention to disability risk

## **Primary Goals of the Program**

For the IWs enrolled in the program our goals are to:

- Improve care for the injured worker
- Create a more efficient and effective communication system among the providers (and all other stakeholders)
- Improve the patient’s understanding of the WC system
- Improve the patient’s confidence in the system and personal sense of wellbeing
- Reduce system costs (medical and indemnity)
- Reduce long-term disability in high-risk (non-catastrophic)

- Improve functional outcomes
- Accelerate Return To Work (RTW)
- Improve adherence with established Colorado WC Medical Treatment Guidelines
- Improve patient experience
- Improve provider satisfaction
- Improve employer experience with the treatment and RTW processes
- Make it easier and more advantageous for providers to continue to treat WC patients

### **ACE Care Philosophy**

ACE team members will approach their activities with the patient (IW) at the center of all their work. They will focus on forming meaningful and trusting relationships with their patients. This bond is critical to the success of the program. When patients trust their caregivers they have substantially improved understanding and engagement in their care, and we believe this is the key to improved processes and outcomes.

### Specific Job Duties for the ACE Coordinators

#### Initial:

- Initial introduction to the IW (within 24 hours of patient entering the program)
- Advanced Intake Interview (an expanded data collection process to help better understand the IW's unique issues and needs)- Note: this may occur over 1-3 conversations
  - Work history (recent and going back at least five years)
  - Expanded medical history (focusing on health issues known to impact care and outcomes for patients injured on the job)
  - Socioeconomic factors (based on national literature)
  - Opioid risk assessment
  - Baseline Functional Assessment (QPOP) (including status right before injury and current status)
  - Verifies First Report of Injury (FROI)
  - Explaining the overall ACE process and expectations
    - Patient responsibilities
    - ACE Coordinator responsibilities
- Going with the patient to their next (hopefully their first) visit with their Primary Treating Physician (PTP)
  - Ace Coordinator goes over their role, shares their baseline data, leaves contact information
- Meeting with Employer (and IW's supervisor) within 1 week of engagement start
  - Update on IW status
  - Begin formation of a RTW plan

- On-site visit to the work environment to help facilitate rapid RTW (when appropriate)

Ongoing:

- Completing paperwork (correctly)- especially for providers who aren't as experienced:
  - 164 (every visit when appropriate)
  - QPOP evaluation (every visit when appropriate, at a minimum once a month)
  - First Report Of Injury (FROI) (if appropriate)
  - Opioid risk assessment (initially, and at least monthly if appropriate)
  - E/M template
- Initially daily, and always at least weekly meetings and/or phone calls with the IW:
  - Encouragement and support
  - Answering questions
  - Problem solving
  - Confirming upcoming appointments, treatments, medications
  - Social support (arranging child care, rides to appointments, etc.)
- Consistent interaction with all providers:
  - Coming to some office visits, PT appointments, etc. (when appropriate)
  - Supporting the providers in understanding and following the Colorado WC Treatment Guidelines
  - Weekly written update on the patient's progress and current care plan with all (appropriate) providers
  - Calls and/or letters to providers with specific information (as appropriate)
  - Occasionally arranging and leading conference calls between providers to facilitate care
- Consistent interaction with the employer:
  - Every 1-4 weeks: Provide a written update on the IW's progress, current work restrictions, work status, and estimated timeline on the IW's return to regular duty (if possible)
  - Regular calls with the employer and/or supervisor for updates, reassurance about the IW's progress toward regular employment, etc.
- Payer:
  - Monthly written update on the IW's progress, treatment plan, RTW status, and any other pertinent issues
  - Phone calls to the adjustor when appropriate to facilitate IW care
  - Troubleshooting issues that may impact the IW's ability to receive care (e.g. transportation, obtaining prescriptions), payments to the IW, etc.
  - The ACE Coordinator may be able to help negotiate payment for certain services (not automatically covered by WC)

## **The ACE Coordinator**

The program's success will be closely tied to the skill and performance of the actual people who serve as the ACE Coordinators. We must be careful to select individuals with appropriate training, experience, and personality.

Characteristics of an optimal ACE Coordinator include the following:

- Background, training, and experience:
  - Must have a clinical background and clinical experience (5+ years)
  - Appropriate backgrounds:
    - Vocational rehab specialist
    - PT/OT
    - Nursing
    - NP or PA
  - Helpful to have a background in Occupational Med (WC)
- Exposure to WC insurance
- Extensive knowledge of how WC works
- Great communication skills
- Very warm, engaging, personable, supportive, diplomatic
- Great communication skills, personable, friendly
- Well organized
- Very comfortable with a frequently-changing work environment
- Flexible, adaptable
- Multilingual very helpful
- Note: We will talk with Washington state WC program and ask how they select their HSAs

## **ACE Coordinator Training**

It is likely that no one individual will have all of the knowledge and expertise necessary to be maximally successful in the role as an ACE Coordinator.

Therefore, we will develop a formal training program to standardize and expand each person's knowledge base.

This training process will (at a minimum) include education in the following areas:

- Some version of the Level 1 training
- WC insurance operations, rules, etc.
- The basics of claims management
- Overall organization and functioning of the Colorado WC system
- Coding
- Colorado WC Treatment Guidelines/principals of care
- Shared Decision-Making
- Opioids
- Functional Outcomes (QPOP)

## **Program Metrics**

In order to track progress and to ultimately establish proof of concept for the program, it will be important to track a variety of metrics related to the patients care processes and outcomes (clinical, social, work-related, and financial).

- Data will be collected initially to establish the patient's baseline metrics and then on an ongoing basis to document progress toward the patient's and the program's goals.
- The specific set of metrics will be established in cooperation with the DOWC staff.
- Whenever possible, additional data will also be obtained to allow the creation of metrics to allow comparisons between patients who are engaged in the ACE program with patient receiving standard care.
- The ACE team will meet with the DOWC staff at least monthly to review and improve ongoing data collection, analyses, metric creation, and to formulate appropriate improvements to the program in response to this information.

Examples of possible program metrics include the following:

- Overall Program Metrics
  - Number of coordinators
  - Volume of patients being managed
- Individual IW Metrics
  - Patient Satisfaction
  - Time to Return to Work (RTW)
  - Time to MMI
  - Medical Costs
  - Indemnity Costs
  - Progress on Functional Evaluation
- Other Metrics
  - Employer Satisfaction
  - Provider Satisfaction

## **Initial ACE Pilot Program**

We propose to create a new company to implement the ACE pilot program. The program will work closely with the DOWC to create an organization and a care team that can effectively improve care for IWs and improve outcomes for the patient and the system while closely following the policies, procedures, and philosophy of the DOWC.

To this end we will establish regular working meetings with DOWC staff and ensure that all elements of the program as established per the Division's standards and expectations.

## **Initial ACE Program Focus**

- We propose to work with the DOWC to identify one or more specific self-insured companies (who are both the employer and payer) with a relatively high volume of WC claims annually
  - Type of industry is to be determined (this may be less important than the type of injuries they are seeing)
  - Also important will be a relatively high frequency of IWs who are not reaching optimal outcomes when receiving care through the traditional WC processes
- Types of Injury
  - We propose to focus initially on patients with injuries to the lower back (lumbar) region. Rationale:
    - LBP (low back pain) is a common problem in WC patients and represents the highest costs to the WC system
    - Many of these patients experience slow RTW, high costs, and sub-optimal outcomes
    - There is often extensive social overlay that exacerbates LBP injuries. Our program may be especially helpful in these cases.
- Timing of ACE Involvement
  - We propose to get involved with the patients immediately after FROI, hopefully within 24 hours of the injury itself
  - Our primary focus will be on providing services to the patient during their first 8-16 weeks after injury, but this may be extended up to 12 months with approval by the DOWC
- Other Inclusion Criteria:
  - The IW will need to have some time off work (time loss claims)
  - The IW will have work restrictions
  - The IW has not sustained “catastrophic” injuries
  - Projected RTW > 60 days by Reed (or ODG with Projected RTW > 60 days)
- Exclusion Criteria:
  - Patients who are several weeks or longer out from their injuries are likely not appropriate for the (initial) pilot program
  - Other criteria will be determined in cooperation with the DOWC

**Pilot Program Fee Schedule/Reimbursement**

- These will be established by the Colorado DOWC

### Miscellaneous Program Issues:

- Advantages to providers when an ACE coordinator is involved with the patient's care:
  - Help with WC 164 completion
  - Optional: Providers will be reimbursed 50% more if 164 is completed correctly and submitted within 24 hours of the IW's visit
  - Optimized E/M code completion (to ensure the provider is being compensated optimally)
  - Help with completion of the QPOP reports (and guidance on how to bill them appropriately)
  - Optional: Primary Treating Provider will receive an additional 10% on all billings for working with the ACE program (can this be done?)
- Make available high level physician experts to answer questions, help manage challenging patients
- All the ACE Coordinators will agree to protect all PHI
- All email from ACE Coordinators will be done via secure email
- Consider adding some financial incentives for certain activities:
  - Submitting WC forms within 48 hours (50% increase in the fee)
  - Seeing the patient initially within 12 hours? 24 hours?
  - Doing a comprehensive intake evaluation (defined by the DOWC)
  - Functional outcomes testing every visit
- The ACE Coordinator will set clear expectations with the IW at the beginning of the process:
  - This is what we're going to cover
  - This is what we're not going to cover
  - You can count on me to do this, but
  - I can't be responsible for these things:
    - (Need to do this verbally (in person), but also on paper)
    - Ongoing- explain the WC process, system, etc.
- Also need a list of resources to tap into:
  - A champion (in the clinic)
  - DOWC
  - Claims
  - Clinical
  - Functional Outcomes
- Need this triad: HSC- Clinical Champion – Administrative person