

Improving the Quality of Care for Injured Workers in Washington State: Challenges and Approaches to Incorporating Best Occupational Practices on a Community-Wide Level

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Abstract

The search for new and better approaches to delivering health care in order to improve quality and outcomes is now being widely pursued. Like general medical, workers' compensation is developing and testing new models aimed at improving the quality of care delivered to injured workers. For the past several years, the Washington State Department of Labor and Industries, in collaboration with researchers at the University of Washington, has been engaged in an ongoing quality improvement project known as the Occupational Health Services (OHS) project. The OHS project represents a community-wide delivery system intervention aimed at improving health outcomes and reducing disability among workers. Fundamental to the project has been the development of quality (performance) indicators to establish expectations, and explicit benchmarks, for the delivery of generic occupational health services and for care related to three specific conditions—carpal tunnel syndrome, low back sprain, and extremity fractures. The OHS project is currently being tested in two pilot sites in western and eastern Washington. In each site, a center for occupational health education has been developed to recruit health care providers for the pilot and to provide activities aimed at improving quality, including patient care tracking, case coordination, continuing medical education, case consultation, and provider mentoring. Preliminary data from a process evaluation for one pilot site indicate significant favorable change in provider behavior for the quality indicator related to submission of the report of accident. Future analyses will be conducted to assess both process performance and outcomes for the OHS pilot.

Introduction

The search for new approaches to improve the quality of health care has taken on added importance in recent years with mounting evidence of serious errors and deficiencies in the delivery of health services.¹⁻⁴ Within the field of workers' compensation, the quality of occupational health care has been a longstanding concern. Studies indicate that the outcomes of care for workers' compensation are worse than the outcomes for similar procedures provided for non-work-related conditions.⁵⁻⁷ Not only are treatment outcomes worse for workers' compensation than for general medical care, medical costs for the treatment of similar conditions are higher.^{8,9} Further, workers' compensation faces the difficult task of preventing and managing serious and costly disability. Workers who are unable to return to productive employment within three to four months of an injury have a dramatically reduced chance of ever returning to meaningful work.¹⁰ Yet the workers' compensation system has paid relatively little attention to the important issue of disability prevention.

The recent Institute of Medicine (IOM) report, Crossing the Quality Chasm,³ called attention to the critical need for system redesign to address health care quality problems. Many of the problems and recommended strategies set forth in the IOM report apply directly to workers' compensation health care delivery. Practitioners both within and outside the workers' compensation system confront many challenges in their efforts to develop effective quality improvement interventions, yet they have little systematic evidence to guide them.

This paper describes an ongoing workers' compensation quality improvement project in Washington State, discusses the challenges and problems to improving quality on a community-wide basis, highlights the approaches used to address these problems, and reports preliminary data for one of the performance indicators being tracked by the project.

Prior Workers' Compensation Delivery System Interventions

Washington State uses a state fund system to provide workers' compensation insurance. This form of organization requires employers who do not self-insure to purchase workers' compensation insurance through the state fund, which is administered by the Department of Labor and Industries (L&I). L&I provides workers' compensation insurance for approximately two-thirds of the nonfederal workforce in the state. In fiscal year 2000, L&I expended \$472.4 million for medical care and an additional \$683.3 million for temporary and permanent disability payments.

In 1993, L&I initiated a major delivery system intervention, described in detail elsewhere,¹¹⁻¹³ to assess the effects of providing injured workers medical

treatment through designated occupational health care networks under managed care arrangements. Known as the Managed Care Pilot (MCP), this intervention changed the method of payment from traditional fee-for-service, based on the L&I fee schedule, to experience rated capitation. It also introduced important changes in the organization of care. The delivery of care at the clinic level was changed from the traditional model, in which the worker could choose to see any willing authorized attending doctor, to an occupational medicine model, in which care is provided by a limited network of physicians who have some training in occupational medicine and work under the supervision of an occupational-medicine medical director. This model emphasizes coordination of care and ongoing follow-up aimed at getting the injured worker back to work in a timely manner.

A comprehensive evaluation of the MCP was conducted by a research team at the University of Washington. This evaluation compared the experience of patients under managed care with that of a comparison group of patients who received traditional fee-for-service care. The evaluation found managed care to be associated with: (1) a 22% reduction in medical cost per claim ($p < .01$);¹⁴ (2) increased employer satisfaction ($p < .05$) with regard to the timing and quality of information provided by managed care physicians;¹⁵ and (3) decreased patient satisfaction ($p < .05$) in regard to access to care.¹¹ No statistically significant differences were observed in either short-term¹¹ (six-week and six-month) or long-term¹⁶ (two-year) health outcomes (SF-36 measures and upper body subscale of the Health Assessment Questionnaire [HAQ]) between the managed care and fee-for-service groups.

In addition to the above findings, a further important finding emerged from the evaluation. Disability compensation for time lost from work was 45% lower in the managed care group than the fee-for-service group ($p < .01$)^{13,14} (workers in Washington State are eligible for disability payments if they miss four or more days of work due to an injury). This reduction in disability costs was due to a 24% decline in the number of workers in managed care going on disability (19.2% versus 14.7%, $p < .05$), and to shorter stays on disability, which resulted in lower disability costs per time loss claim (\$2,332 versus \$3,466, $p < .05$).

The health plans providing the managed care were not at risk for disability payments—L&I made disability payments to injured workers in the usual way. Thus, there was no financial incentive for the plans to work actively to prevent or reduce worker disability. What then accounted for the findings regarding the favorable disability outcomes associated with managed care? We believe the explanation lies in improved integration and coordination of care and in more frequent communication achieved by the managed care plans through the occupational medicine model.¹⁴ The MCP made extensive use of treatment guidelines and protocols, which were used concurrently as well as retrospectively to perform utilization management functions. Further, managed care providers received training through the health plans that enhanced their occupational medicine expertise.

The MCP provided valuable information suggesting that health care quality and disability prevention could be improved by organizing care based on an occupational medicine model. However, Washington Industrial Insurance Laws guarantee workers freedom of choice to select their own attending physician precluding the use of managed care arrangements that might limit worker choice in some way (L&I obtained a temporary waiver to establish physician networks for the MCP). L&I undertook a 12-month policy study to examine options for developing a quality improvement initiative that would preserve the fundamental right of workers to choose their provider, yet offer the important benefits of organizing care around an occupational medicine model.¹⁷ Recommendations generated by this policy study provided the foundation for a major quality improvement initiative, known as the Occupational Health Services (OHS) project, which is currently ongoing.

Design of the OHS Project

The primary goal of the OHS project is to improve health and disability outcomes for injured workers. A major design activity of the OHS project was to develop quality indicators to (1) establish expectations for the delivery of occupational health care, and (2) provide information to support the development of quality improvement activities. Expert panel meetings were convened in Seattle over a 6-month period beginning in May 1999 that reviewed existing scientific and clinical literature and treatment guidelines and, based on this review, developed quality indicators. Both generic occupational health performance indicators and condition specific indicators related to three common conditions, low back sprain, carpal tunnel syndrome and fractures, were developed.¹⁸ Table 1 lists the final set of performance quality indicators adopted by the OHS project. To promote occupational health care practice patterns consistent with the OHS goal of quality improvement, L&I developed financial incentives for selected quality indicators, including reimbursement for certain previously unreimbursed activities, as well as increased fees for procedures and activities that were previously reimbursed.

The OHS project was designed as a community-wide delivery system intervention and was implemented on a pilot basis through the development of two centers of occupational health and education (COHE). One was established by a large hospital, located in the south Seattle metropolitan area, that had an active occupational health program already established. This region represents a competitive urban health care market with an established manufacturing and industrial business environment. The other COHE was established by a rehabilitation hospital in Spokane, Washington that serves a large geographic area in eastern Washington. This region offers a more rural industrial base with a different industrial mix oriented toward agriculture and a more geographically dispersed but less competitive health care environment. The Seattle COHE has been fully operational since July 2002. The Spokane COHE becomes

operational in April 2003. Thus, the current analysis draws largely on our experience in developing the Seattle COHE.

Figure 1 shows a schematic of the OHS-COHE organization. The COHE is expected to recruit community physicians, including primary care providers and specialists, and chiropractors for the pilot; to track care delivered by these providers; to sponsor provider training in the form of continuing medical education (CME); to arrange provider mentoring by local senior clinicians; and, when needed, to initiate care coordination activities. In short, as its name implies, the COHE is to function in a central role with regard to providing the community of workers, employers, and providers with occupational health education, expertise, care coordination and clinical services. Its role is essentially that of a catalyst for quality improvement within the community and as the identified entity working to resolve problems and issues that may result in (avoidable) long-term disability.

Other components of the OHS-COHE organization shown in Figure 1 include the COHE advisory group, which consists of business and labor representatives, and the University of Washington research team, which is conducting a two-phase evaluation of the OHS pilot. Phase I involves a process evaluation designed to document the implementation and early operational experience of the COHE and to determine the extent to which care provided by OHS participant physicians is consistent with quality indicators developed for the pilot. Phase I covers the initial 12-month operating period of the COHE. Phase II of the evaluation will assess outcomes over a 24-month period.

As indicated in Figure 1, the OHS project represents a community-level quality improvement intervention. Its goal is to improve the quality of occupational health care on a community-wide basis rather than in a single organization or treatment setting. As discussed further below, this feature of the project poses significant challenges because, among other things, it requires establishment of cross-institutional collaborations (relationships between hospital emergency departments, urgent care facilities, specialty medical groups, etc.) and recruitment of a broad base of community physicians.

With this brief summary of the key design features of the OHS project, we discuss in more detail some of the important impediments to quality that workers' compensation systems typically face, and the approaches taken by the OHS project to address these problems.

Identified Impediments to Quality Improvement in Washington's Workers' Compensation System and Strategies for Overcoming Them

Improving the quality of workers' compensation health care (and general medical care) at a community level requires systematic interventions that address the major impediments to quality. Based upon analysis performed as part of the OHS research and development work, we identified a selected set of factors we believed were (1) important impediments to quality and (2) modifiable through a community-wide delivery system intervention. Table 2 shows these

impediments and the targeted activities incorporated into the OHS project to address them.

By their nature, workers' compensation systems are somewhat regulatory and burdensome due to the fact that they have evolved in part as publicly and politically negotiated liability systems, with significant emphasis on workplace factors. The clinical and administrative problems that result are frequently not part of general provider training, and failure to address them in a timely fashion when industrial injuries occur increase risk of chronic disability.¹⁰ Although specifically developed within the Washington State workers' compensation regulatory and health care environment, the identified impediments and strategies have substantial applicability for general health care settings as well as other workers' compensation systems.

Infrequent Use of Best Practices Resulting in Poor Quality

Poor quality includes the provision of too little care, too much care or the wrong care,¹ essentially lack of inclusion of best clinical, administrative or procedural practices for given conditions or patient populations. Problems regarding quality have been widely documented for general medical care¹⁻⁴ but understanding is less developed for workers' compensation health care. What evidence is available⁵⁻⁷ suggests that quality problems are widely present in the workers' compensation system. Examples of quality occupational health best practices include provider communication with employers about return to work, early detection of impediments to recovery, timely access to care and diagnostic procedures, timely decisions on the value of surgical interventions, and adequate occupational history information that will delay adjudicative decisions that can postpone necessary treatment. Because workers' compensation, unlike general medical care, provides disability payments for lost work time, the financial consequences of poor quality are significant.

Efforts to address quality problems through the OHS project focus largely on improving technical aspects of care, though we recognize the importance of the interpersonal aspect of care.¹⁹ The OHS project has sought to improve the quality of care by several methods. The OHS quality indicators, described earlier, are intended to address problems and deficiencies in the provision of occupational health care. For these quality indicators, acceptable quality is considered to be demonstrated if an OHS participant provider meets the performance measure 80% of the time within a given period. It was anticipated the OHS project would track the degree to which each OHS provider achieved the quality benchmarks and feed back this information on a periodic basis. As discussed below, this has not yet occurred due to delays in the development of a patient tracking system. Other target activities listed in Table 2 that were to address the problem of poor quality include the provision of CME, making available mentoring of OHS participant providers by senior clinicians, and conducting academic detailing.

Ineffective Disability Prevention

Improving disability prevention is a key goal of the OHS project. Concerns associated with disabilities in worker populations parallel those in general medical practice. Chronic disability from work-related conditions has devastating health and quality of life consequences for affected workers; early identification of care for clinical and biopsychosocial issues that can lead to long term disability are critical concerns for providers to assure successful patient outcomes.

In an earlier study, we showed that injured workers with musculoskeletal injuries who had not returned to work by three to four months were unlikely to return to meaningful employment.¹⁰ More recent analysis of workers receiving disability compensation for carpal tunnel syndrome shows a similar pattern.²⁰ To address the problem of long-term disability, workers' compensation insurers and self-insured employers often rely on external case managers to perform "disability management" after a case has incurred several months of time loss. This form of delayed, reactive case management offers little real chance of preventing long-term disability and returning the worker to meaningful employment.

The OHS project addresses disability prevention through several related activities. Selected quality indicators require time-linked action, e.g., ordering nerve conduction tests to determine presence of carpal tunnel syndrome if the patient is expected to be off work for two or more weeks. One indicator specifies that workers off work for four weeks have an in-depth assessment to identify important barriers to return to work. Other quality indicators promote the use of occupational best practices aimed at getting the patient back to work in a timely manner. For example, two quality indicators address the need for provider communication with the employer and the use of activity prescriptions if the patient is off work or expected to be off work. Each of these activities is intended to promote more effective disability prevention.

Administrative Delays

Delays in claim authorization commonly occur because the report of accident is not filed in a timely manner by the physician or because it lacks the necessary information for the claims manager to make a determination of work-relatedness. Such delays can pose significant barriers to the initiation of prompt treatment and ultimately increase the patient's risk of incurring extended disability. The problem of administrative delays is addressed by two quality indicators pertaining to submission of the report of accident form and appropriate documentation on the form of work-relatedness (see Table 1).

Poor Communication among Providers, Employers and Administrative Parties

Poor communication is a significant problem in workers' compensation. Rarely do providers communicate with employers about return to work issues or job modification. Communication between providers and claims managers is often sporadic and ineffective. Such communication represents another impediment to quality. The OHS project addresses this problem through a two-fold strategy. First, it provides case coordination through the COHE to facilitate improved communication among clinical and administrative parties. Each COHE has at least one FTE case coordinator to provide this function. Having an identified person on-site who is knowledgeable about the local health care system and workers' compensation administrative procedures is critical to improving communication. Second, the area of provider-employer communication is addressed directly by one of the OHS quality performance indicators (see Table 1).

Inadequate Reimbursement and Misaligned Financial Incentives

The need to align financial incentives to promote quality is a central theme of the IOM report *Crossing the Quality Chasm*. This same problem arises within workers' compensation. Inadequate reimbursement and misaligned financial incentives pose significant impediments to quality improvement. The OHS project aligns financial incentives with quality improvement objectives and increases provider reimbursement for selected occupational health services linked to the quality indicators. For example, OHS participant physicians can receive from \$14 to \$42 for time spent making telephone contact with employers or other parties to coordinate care or discuss return to work matters.

Heavy Provider Administrative Burden

Providers treating workers' compensation patients are very vocal about the onerous administrative burdens imposed by the system. These burdens can lead to delays in medical care as well as decrease the willingness of providers to treat workers' compensation patients. The OHS project is responding to this quality impediment by making available to OHS participant providers case coordination through the COHE. This activity is designed to relieve providers of some undue administrative burdens and thereby reduce the occurrence of treatment delays that arise from administrative problems. In the OHS project, care coordination activities that providers choose to delegate include tracking of delays in return to work, identification of impediments to return to work, and facilitation and coordination of return-to-work with employers who may not have established return-to-work or ergonomic resources.

Lack of Patient Care Tracking Data

Quality improvement requires the systematic collection of reliable performance data at the individual provider level on patient care activities. While such data are sometimes collected in integrated (HMO) delivery systems, they are almost never collected in the general fee-for-service system because this system lacks the necessary organizational infrastructure. The development of information technology to track patient care and to feed back patient care data to OHS participant providers on a routine basis is an important component of the OHS project. Data tracking systems that allow providers and their staff to determine how they are performing on quality indicators and real-time reminders for key clinical and administrative tasks are central functions of the COHE.

Lack of Evidence-Based Care

The need for improved clinical and scientific evidence to guide clinicians in their patient care activities is widely recognized.^{21,22} Significant progress has been made in recent years using evidence-based care to treat certain chronic illnesses such as diabetes and asthma.²³⁻²⁵ However, the field of occupational medicine has lagged far behind these developments. The OHS project has sought to address this impediment to quality by developing evidence-based quality indicators¹⁸ and using these indicators as the foundation for quality improvement. In addition, as new evidence-based treatment guidelines become available, the COHE will distribute them to OHS participant providers.

Key Challenges To Implementing Community-Wide Quality Improvement Interventions

The above discussion has highlighted some of the key impediments to quality facing workers' compensation and the approach we used through the OHS project to address them. Our experience to date with the OHS project suggests that other efforts to develop community-wide quality improvement initiatives are likely to face three important challenges. These challenges include:

- Developing information technology to track patient care,
- Recruiting a broad base of community physicians and other health care providers, and
- Fashioning cross-institutional collaborative relationships in markets heavily influenced by competitive forces.

Each of these challenges can be reflected differently within various practice systems, community business environments and regulatory environments.

Information technology is critical to the success of quality improvement because it allows patient care activities to be tracked and measured against

explicit quality indicators or benchmarks. It is important that this information be fed back in real time to providers so that accommodations can be made. Though its importance is widely accepted, the many practical challenges to developing information technology for quality improvement purposes on a community level—including developmental costs—may either not be recognized or undervalued. Off-the-shelf patient tracking software programs are now available and represent attractive alternatives to systems that have to be developed de novo. Although most off-the-shelf software programs aren't flexible enough to accommodate all of the particular information needs of a given quality improvement initiative, they may meet enough of the information requirements to merit consideration.

The Seattle pilot site has encountered significant problems and delays in developing its information technology system, which has limited its ability thus far to perform needed patient tracking. It is expected that the system will become fully implemented in the near future. However, the time, cost and total effort required to make this happen are far in excess of what was anticipated at the beginning of the project. It is well beyond the scope of this paper to offer technical guidance regarding the many complex issues related to development of information technology. We would simply emphasize the complexity of this task and stress the risks involved in attempting to develop highly sophisticated patient tracking systems that promise much but all too often deliver less at higher than expected cost. Prioritizing adequate resources for the task, as well identifying contingencies for back-up systems, is critical.

The OHS quality improvement model assumed that a broad base of physicians within each pilot site could be recruited. Even though the project provided increased reimbursement, case coordination to reduce provider administrative burden, clinical consultation and other benefits, provider recruitment has proven to be a significant challenge. One obstacle is the fact that a large proportion of community physicians treat relatively few workers' compensation patients. L&I data show that in 2001, 84% of the attending doctors in the Seattle pilot site served 24% of the patients. Six percent of the attending doctors served 60% of the patients. The practical implication of this treatment pattern for workers' compensation quality improvement is the need to conduct targeted physician recruitment to identify the high volume providers who are more experienced in and perhaps more committed to serving workers' compensation patients. However, the quality of occupational health care among low volume providers with minimal exposure to, or interest in, occupational health best practices may have significant impact on disability for a quarter of the workers in this urban area. The logistics of outreach for such a large number of physicians with minimal interest offers another set of challenges.

Another important challenge arises when community-level quality improvement initiatives are established in markets characterized by a high degree of competition. In such markets, the tasks of coordinating care and tracking patients across provider groups and organizations, as well as forging institutional relationships, become more difficult. Providers and health care administrators are more acutely attuned to short-run financial considerations and

therefore more skeptical of initiatives aimed at benefiting the patient population at a community level. Health care markets in many areas are quite competitive, and there is no easy method of resolving this issue. However, we believe in workers' compensation there is a strong business case to be made for quality. Health care organizations participating in quality improvement initiatives may be better able to differentiate themselves from their competitors on the basis of quality and therefore gain stronger financial viability.

Preliminary Data from OHS Process Evaluation

The Seattle OHS pilot site began active recruitment of providers in June 2002 and by December 2002 recruited 88 physicians and chiropractors. Over this same seven-month period, these providers served as the attending doctor for 2,670 patients. The process evaluation is tracking several quality indicators via L&I's computer claims system, including the submission of the report of accident, which is viewed as an important marker related to reducing administrative delays that often lead to unnecessary time loss. As shown in Table 1, this quality indicator specifies that the report of accident be submitted within two business days of the first office visit. Physicians submitting the accident report within two days receive 50% higher payment (\$36 instead of \$24). Preliminary data covering the period June through December 2002 show that 55% of the OHS physicians met this quality benchmark. In the year prior to June 2002, only 8% met this quality benchmark. At the same time, the proportion of physicians submitting the accident report later than one week dropped from 24% to 11%. While admittedly limited, these preliminary data showing favorable changes in physician behavior are encouraging.

Conclusions

This paper has summarized our experience over the past several years in designing and implementing a community-wide quality improvement intervention in Washington State. Guided by a set of quality (performance) indicators, the OHS initiative has sought to address key problems in the delivery of workers' compensation health care, with the aim of improving outcomes and reducing disability. Targeted quality improvement activities provided through the OHS pilot centers for occupational health and education (COHE) include case coordination, patient care tracking, continuing medical education, case consultation, and provider mentoring. An important underlying assumption of the OHS project is that occupational health care provided in the first month or two of a claim is of critical importance for disability prevention. After this time, chances of preventing long-term disability diminish rapidly. This assumption is consistent with a recent randomized clinical trial of back pain management showing that early occupational intervention with back pain patients who had been absent from work for four weeks was significantly more effective than usual clinical care ($p < .05$) in returning patients to regular work.^{26,27}

Efforts aimed at developing community-wide quality improvement interventions may face special challenges. Our experience to date in Washington State suggests the development of information technology for patient tracking, physician recruitment, and formation of cross-institutional relationships may pose particular challenges to community-based quality improvement interventions. These challenges may be less relevant for interventions developed outside Washington State under different environmental conditions, e.g., within a managed care organization or an existing physician network.

Regardless of the environmental or organizational circumstance, workers' compensation quality improvement interventions aimed at reducing worker disability must address three critical issues: the targeting of the intervention, its timing and the appropriate expertise to employ. It is clearly inefficient to target all patients for disability prevention. Rather, the strategy should be to target those most at risk for long term disability.²⁸ While there is some knowledge of population-level risk factors (e.g., older age), overall understanding is limited. The timing of disability prevention actions is also important—early intervention is critical. With regard to the issue of intervention expertise, there is evidence^{14,26,27} indicating the value of having providers with at least some formal training in occupational medicine deliver care. If case coordination is performed, it should be done by individuals knowledgeable about workers' compensation and the characteristics of the local health care delivery system. Whatever model is chosen for quality improvement, we would stress the need to have an effective mechanism to identify and intervene in cases at risk for prolonged disability.

Is quality improvement in workers' compensation justified on economic grounds? Although recent data have cast doubt on whether there is a "business case for quality" in general medical care,²⁹ workers' compensation may be an important exception. Our data from the managed care pilot,^{14,15} as well as recent analysis of patients' treatment experience in relation to disability outcomes,³⁰ suggests that there may be a strong business case for quality in workers' compensation in terms of reducing costly, preventable disability. Future analyses from the OHS pilot evaluation will address this important issue in-depth.

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Table 1. Quality Indicators Developed for OHS Project

Quality (Performance) Indicators

Timeliness of submission of the report of accident: percent of claims for which Report of Accident was received within two (2) business days of the first office visit

Two-way communication with employer about return to work: percent of claims for which two-way communication between the provider and employer about return to work is accomplished at the first visit when the worker is off or expected to be off work

Activity prescription at each evaluation: percent of workers for whom activity prescription discussed and documented at each evaluation (no more than once per week) when the patient is off work or expected to be off work

Assessment for impediments to return to work: percent of workers on time loss who have received assessment or referral for assessment of impediments to return to work by four (4) weeks of work loss

Timeliness of access to care: percent of workers seen within three (3) business days of the worker's first contact

Probability of work-relatedness adequately specified on the Report of Accident: percent of claims for which the probability of work-relatedness is adequately specified on the Report of Accident

Condition-specific quality indicators: Twelve indicators adopted for the three OHS target conditions, 2 for carpal tunnel syndrome, 4 for low back injury, and 6 for fractures. Following indicators presented for illustrative purposes: (1) nerve conduction studies to corroborate presence/absence of CTS if time loss > 2 weeks or surgery is being considered; (2) exam screens for presence/absence of radiculopathy for patients with low back injuries (using recognized, reliable criteria) at the first visit; (3) need for advanced imaging (low back injuries) to be adequately justified; and (4) fracture severity graded by documenting key elements at initial visit.

The specific measure is: percent of claims with specific conditions (CTS, low back injury or extremity fracture) for which each indicator is documented in the medical record

Table 1 (con't)

Quality (Performance) Indicators

Continuity of care: percent of workers who have not returned to work who have health care provider visits every two (2) weeks for the first two months, and at least one visit 2-4 weeks following return to work

Table 2. Quality Impediments and Target Activities Undertaken by OHS Project to Address Impediments

<u>Quality Impediment</u>	<u>Target Activities Performed to Address Impediment</u>
<ul style="list-style-type: none"> • Infrequent use of best practices resulting in poor quality 	<ul style="list-style-type: none"> • Tracking care through quality/performance indicators relative to established quality benchmarks; providing mentoring, CMEs and academic detailing
<ul style="list-style-type: none"> • Ineffective disability prevention 	<ul style="list-style-type: none"> • Initiate time-linked clinical management action to promote return to work; provide systematic patient reviews to assess barriers to return to work; follow occupational health best practices
<ul style="list-style-type: none"> • Administrative delays 	<ul style="list-style-type: none"> • Promote timely submission of report of accident and improve provider documentation of work-relatedness to facilitate quicker claim authorization
<ul style="list-style-type: none"> • Poor communication among providers, employers and administrative parties 	<ul style="list-style-type: none"> • Initiate case coordination within local health care system; encourage two-way communication between provider and employer; promote more effective use of electronic communication
<ul style="list-style-type: none"> • Inadequate reimbursement and misaligned financial incentives 	<ul style="list-style-type: none"> • Use financial incentives linked to quality indicators
<ul style="list-style-type: none"> • Heavy provider administrative burden 	<ul style="list-style-type: none"> • Use case coordination to reduce provider administrative burden
<ul style="list-style-type: none"> • Lack of patient care tracking data 	<ul style="list-style-type: none"> • Develop information technology to track patients, coordinate data and provide feedback to providers
<ul style="list-style-type: none"> • Lack of evidence-based care 	<ul style="list-style-type: none"> • Use quality indicators; distribute treatment guidelines

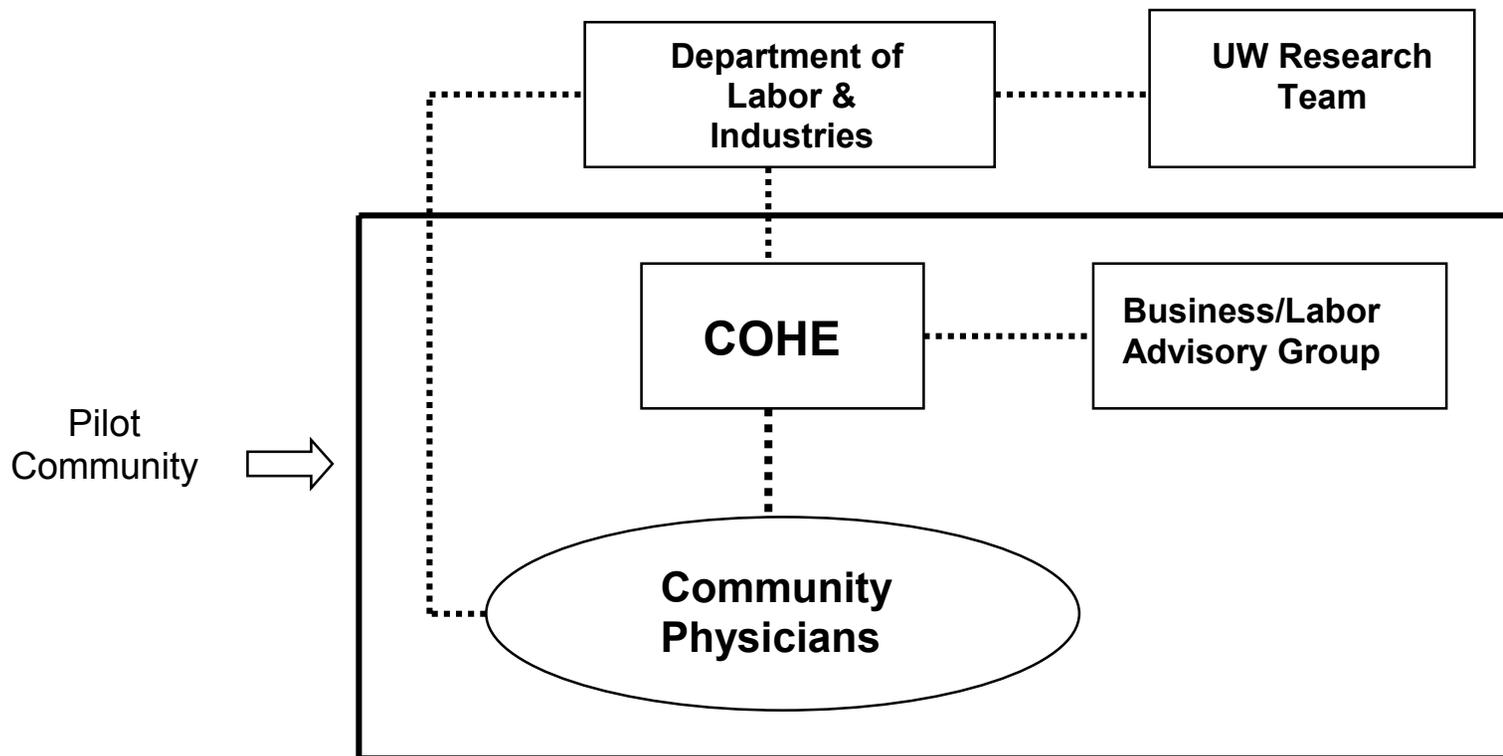


Figure 1. OHS-COHE Organization.