Rhode Island Department of Labor and Training

TECHNICAL RESOURCE CENTER

The first step of the project was to institute the Technical Resource Center (TRC) so it could achieve its overall goal, to establish a health care quality monitoring process for RI Worker's Compensation system and help stakeholders use that information to benchmark the RI system and guide policymaking.

The TRC built the program around the commitment of the Workers' Compensation Advisory Council (WCAC) to participate as our Stakeholders. This centralized group is composed of representatives from major stakeholders in the RI Workers' Compensation system and carries considerable responsibility for changes in the Workers' Compensation law. Although the WCAC has broad representation, based on feedback from the RWJ site visit team, we recruited additional members, for example, private insurers and health care providers, who serve on the TRC Steering Committee and participate as Stakeholders with the WCAC.

Table 1: Summary of Objectives, Deliverables, and Activities

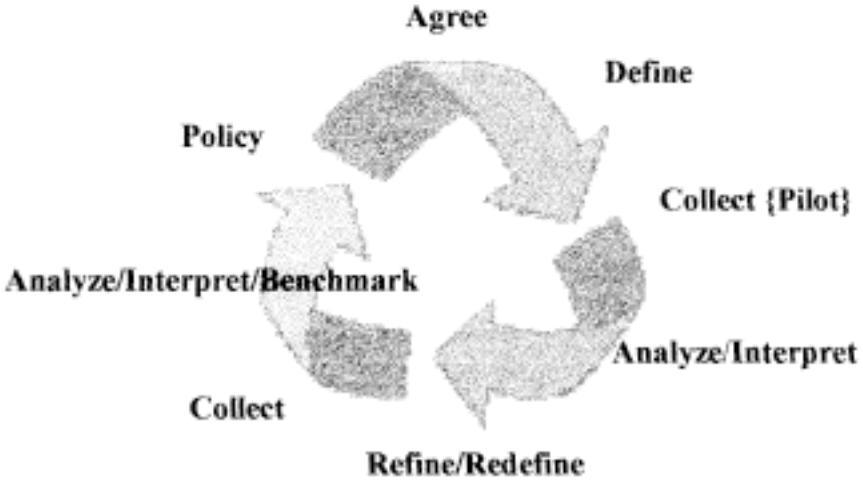
RWJ Objective for Technical Resource Center (TRC)	TRC Deliverables & Activities	Met Year 1	Met Year 2
1 .Increase understanding among stakeholders about workers' compensation (WC) medical care, quality of care, and performance measurement.	A. Annual report (Governor's Advisory Council on Healthcare, Department of Labor & Training tDLT 1)	Yes	Yes
	B. Statewide conference		Yes
	C. Stakeholder leadership assessment to determine relevant interests and areas of need. (Stakeholder Needs Assessment)	Yes	
2. Promote widespread adoption of innovations.	A. Web-based clearinghouse of other States' initiatives and best practices.		Yes
	B. Summary of best practices and initiatives provided to Governor's Workers' Compensation Advisory Council (WCAC).	Yes	
3. Improve State government agencies' ability to assemble data and undertake policy studies of WC medical care.	A. Rhode Island (RI) Stakeholder Needs Assessment Report with recommendations for additional measures on specific 'research questions (Blueprint for DLT).		Yes
	B. Technical Support Service		Yes
4. Promote community-based initiatives to improve access to WC medical care.	A. Internet website includes multi-lingual explanation of health care provider WC access regulations and employees rights, as well as listing of State-approved employer Preferred Provider Networks.		In progress
5. Support leadership development in. design and evaluation of WC medical care arrangements.	A. Stakeholder Needs Assessment	Yes	
	B. Statewide Conference		Yes
6. Expand researcher capacity to evaluate and communicate findings regarding impact of recent changes on health care quality and costs.	A. Website clearinghouse to include linkages to relevant studies, WC health care system outcome data, and initiatives		Yes

(Table I presents the full set of specific objectives, deliverables, and activities approved by the Foundation and the Workers' Compensation Health Initiative (WCHI) NPO. As shown., Objectives 1, 3, and 5 were met through completion of the Stakeholder Needs Assessment, the design of the "Blueprint" for DLT, the provision of technical support to DLT, and the presentation of initial results at the statewide TRC Annual Conference. Objectives 2, 4, and 6 were met by the launch of the TRC website (www. d1t. state.ri.us/wc/wc_programs.htm) and by delivery of a number of presentations about the TRC to a variety of professional organizations locally, regionally and nationally)

The TRC adopted a Quality Improvement Model in working with the Stakeholders to accomplish its mission (see Figure 1). This consensus approach began by achieving agreement on both the importance of quality monitoring and the need to work together to define the quality dimensions of most relevance and greatest priority to the RI Worker's Compensation system. The Stakeholders Needs Assessment was the vehicle used to accomplish these first two steps of the model. This needs assessment involved a series of meetings with the Stakeholders to accomplish a number of objectives within the limited timeframe of the grant (see Table 2.) Professionals with expertise in healthcare quality and performance measurement spoke at each meeting to increase understanding. Between the Stakeholder meetings the TRC worked with four Work Groups and three Subcommittees to gather information and report it back to the Stakeholders. The Work Groups identified key issues, concerns and strengths regarding quality of care and access to care afforded injured workers (IW) in Rhode Island and translated this into quality dimensions and indicators. The Subcommittees accomplished three goals. First, they researched how other states were addressing quality of healthcare in Workers' Compensation by identifying and describing other projects that may be relevant to the mission of the TRC. Second, they researched the current state of data relevant to quality of care and access to care within the RI Workers' Compensation System by identifying key data sources, the availability of the data and potential data collection methods. Third, they provided expertise on performance measurement and methodological issues relevant to the project. Please refer to the Annual Report from the first year of the grant and the TRC website for a more detailed discussion. of the Stakeholder Needs Assessment.

Figure 1.

Quality Improvement



At the completion of the Stakeholders Needs Assessment, the Stakeholders had selected the top five Quality Dimensions and their Indicators for performance measurement (see Table 3) and had an understanding of the current state of the data within RI Workers' Compensation system. Specifically, while data exists that is pertinent to the measurement of healthcare quality, this data is collected by a number of different entities using different metrics and with wide variations in infrastructure related to the data collected. Second, the measurement of some indicators can only be accomplished through survey data and there was no mechanism in place to gather this data. They also had achieved the consensus

necessary for the TRC to proceed with its mission of defining the "blueprint" for data collection by choosing realistic metrics for the measurement of the selected indicators (see Bibliography). As part of this process the TRC had to design the surveys necessary to complete the data set. The TRC relied heavily on the work of another RWJ project (URAC: Measuring Quality in Workers' Compensation Managed Care Organizations) and modeled our IW Survey after their instrument. However, we divided our survey into two parts; a Knowledge section designed to assess basic understanding of the workers' compensation healthcare delivery system in RI and an Experience section designed to ascertain respondents' experiences within the workers' compensation healthcare delivery system in RI. The TRC also designed an ER Survey and a HCP Survey following the same conceptual framework so information could be solicited from these important constituencies of the RI Workers' Compensation system (see Bibliography). The TRC then provided technical support to DLT during the next two steps of the Quality Improvement Model, pilot data collection and data analysis and interpretation.

Table 2: Summary of Stakeholder Needs Assessment

Meeting	Goals and Objectives	Completed
Introduction for TRC Steering and Ad Hoc Committees	1. Overview of Project 2. Introduction to issues of health care quality 3. Goals of TRC 4. Purpose of Stakeholder Needs Assessment	**December 10, 1999**
Orientation for Stakeholders	1. Role of Stakeholders 2. Increase awareness and understanding of health care quality 3. Process of Stakeholder Needs Assessment	**February 17, 2000**
Stakeholder Summit	1. Report on other States Initiatives related to health care quality 2. Report from Work Groups on Performance Categories and Indicators 3. Stakeholder consensus on Performance Categories and Indicators	**May 22, 2000**
Stakeholder Reality Retreat	1. Orient Stakeholders to performance measurement 2. Data Subcommittee report on the state of data in Rhode Island	**October 5, 2000**

Pilot data collection began in the spring of 2001. Review of the Department of Labor database for calendar years 1999 and 2000 revealed the number of lost time injuries per month to be equally distributed across the year. Thus, we chose the pilot sample to be all injured workers with a date of injury in September 2000 as a representative sample (8.2% of injuries for the year). Injuries within this timeframe also permitted both a reasonable time for recall by survey participants and sufficient time for the development of the claim. As outlined in the "blueprint", existing data on this sample was solicited from insurance carrier administrative and billing databases through a "data call" and new data was obtained through the supplemental surveys to injured workers, healthcare providers, and employers.

The injured workers pilot sample defined the employer sample and the carriers solicited in the "data call". This insured that the employers surveyed had experience with a workplace injury within the same timeframe as the injured workers and addressed convergent validity. Linking carrier data to the self-report data from the surveys also addressed convergent validity. Unfortunately, current Rhode Island databases do not collect and store healthcare provider data in a readily available format so identification of the healthcare provider who treated the injured worker sample was not feasible. Therefore, a random sample of healthcare providers was selected from Preferred Provider Networks approved by the RI Workers' Compensation Medical Advisory Board (MAB).

The following describes the pilot sample: 591 injured workers were surveyed with 224 responding (38%), 438 employers were surveyed with 203 responding (46%), 401 healthcare providers were surveyed with 138 responding (34%), and 6 insurers were solicited in the "data call" representing 69% of the injured worker sample. Analysis of the respondents revealed that they were representative of the pilot sample and representative of the population of injured workers for calendar year 2000 with respect to age, length of incapacity, nature of injury and size of employer (see TRC website Annual Meeting presentation for more detailed results).

Table 3: Performance Measurement: Quality Dimensions and Indicators

QUALITY DIMENSIONS	QUALITY INDICATORS
Access to Care	• Informed choice of Health Care Provider • Informed choice of procedures and treatments • Timely availability of appropriate information to assist with provider and treatment selection • Health care provider refusal to treat a workers' compensation case • Needs of vulnerable populations, especially language (translation, multilingual providers), culture, age, marginally employed • Impact of PPN and medical gates/employer directed care
Appropriate Clinical Care	• Assessment of usage of MAB Protocols (i.e., jurisdictional standards) • Impact of MAB Protocols on quality and cost • Timely utilization of Evidence-Based Practice (Best Practices) for diagnostics and treatment • Timely identification of factors/"red flags" that put case at risk
Injured Worker Satisfaction	• Perception of quality of health care received • Perception of clinical outcome • Perception of impact of injury on quality of life • Knowledge about and expectations of health care experience within the Workers' Compensation system
Timeliness	• Length of time to assessment of problem • Length of time to initiation of treatment • Length of time to issuance of reports • Time to RTW grouped by treatment type and grouped by type of injury
Work-Related Outcome	• Timely and **appropriate,** RTW • Rate of RTW grouped by level of work (full or modified) by Employer (same or different), by treatment type and by injury type • Employment status at key points (e.g., 6 months after RTW; 1 year after RTW) • Impact of Vocational Rehab Plan on RTW • Employer-Employee relationship after RTW (e.g., is relationship good, are restrictions followed etc.) • What type of health care occurs after RTW, for

QUALITY DIMENSIONS	QUALITY INDICATORS
	how long and at what cost • Impact of factors thought to influence RTW: case management, ergonomic intervention, vulnerable populations, MD viewing job site or video of job • Impact of non-injury related influences (e.g., worker does not like supervisor, personal problems, job satisfaction • Use of proper RTW form or at least specific documentation

Table 4: Performance Measurement: Highlighted Results of Pilot Sample

QUALITY DIMENSIONS	RESULTS
Access to Care	◦ 67% of IW, 89% of ER and 73% of HCP knew that IW have the right to choose their first HCP ◦ 5% of IW indicated a HCP refused to treat because of workers' compensation (WC) ◦ 11% of HCP perceive that HCP are v reluctant to treat IW ◦ 9% of IW, 23% of ER and 32% of HCP perceive a problem filling prescriptions 11% of HCP perceive language barriers to affect care ◦ 5 5% of ER encourage IW to use designated HCP at time of injury 6 of the 14% of IW who wanted to change HCP, 37% reported difficulty doing so
Appropriate Clinical Care	◦ 86% of HCP report using MAB Protocols to guide care, set limits on care, assist with IMEs, seek insurer authorization ◦ 85% of HCP report recommending care outside of MAB Protocols 10% or less of the time ◦ Mean number of days to major diagnostic for low back pain = 68 days (Protocol = inappropriate within 4 weeks of injury) ◦ 75% of low back cases had 9 or less physical therapy visits (Protocol recommends 9 visits)
Injured Worker Satisfaction	* 72% of IW were very satisfied with overall health care ◦ 79% of IW were very satisfied with HCP who gave them the majority if their care
Timeliness	* 86% of IW were satisfied with promptness of care they received ◦ Average number of days to first visit = 4* ◦ Median number of days to first visit = 2* ◦ 48% of IW were seen on the day of or day after report of injury* * excludes emergency room visits
Work-Related Outcome	◦ 80% of IW had RTW ◦ 85% of IW who RTW did so with same ER ◦ 90% of IW who RTW were working the same of hrs as before Injury ◦ 84% of IW who RTW were earning the same wage as before injury ◦ ER rated IW performance post-injury the same or better in 88% of cases * 9 1 % of HCP will release to modified duty ◦ 85% of ER offer modified or transitional employment * 44% of IW reported that modified duty enabled them to RTW sooner * 25% of IW were still in modified duty

Challenges

A major challenge was the timeline for the project. If RI had not already had an established Stakeholder Group connected to its policy making with a history of working together to arrive at consensus across all constituencies, the TRC would not have been able to accomplish the Stakeholder Needs Assessment within one year. Instead of being able to begin the process of evaluating needs and heightening awareness about the importance of measuring health care quality, the TRC would have had to devote considerable time, education, and resources to establishing a Stakeholder body. Related to this, the commitment the Rhode Island Workers' Compensation system made to this project when it was first proposed has been a factor that has enabled the TRC to successfully accomplish its objectives. The Stakeholders contributed their time by attending half-day and day-long meetings, offered assistance to the project by sending staff to work on committees, and did all this in a timeframe that met the needs of the project.

The climate in Rhode Island was critical to the success of this project. RI workers' compensation system is not in crisis, and has operated smoothly since the1992 legislative changes. Workers' compensation premiums have been stable and workers' compensation paid medical costs (one year developed) decreased 51% from 1995 to 1998. However, Stakeholders are aware that this trend of decreasing medical costs says nothing about the quality of care received by injured workers. Because Rhode Island has made a commitment to make no further significant changes in the Workers' Compensation Act without data, the TRC and its objectives are consistent with the philosophy of the system and will permit the WCAC to base recommendations for change on information relating access and quality of health care as well as cost.

Additionally, Rhode Island passed legislation in 1998 mandating the measurement and public reporting of data on the quality of health care delivered by all health care facilities licensed by the Department of Health. More recently key figures in the state have initiated a statewide "Quality Institute" dedicated to working with all aspects of the health care system in RI to improve health care quality and reduce medical errors through the development and implementation of innovative programs. In general, the climate in Rhode Island is one of
focusing on the importance of the quality of health care and so the TRC and its initiative is being viewed with interest and support.

Collaborations with other organizations

Numerous organizations within the State of Rhode Island are participating in this project, ranging from the Workers' Compensation Advisory Committe to individual carriers writing workers' compensation in the state. While we have received overwhemingly positive feedback and clear commitment to the project, there have been barriers to obtaining the data from the carriers' administrative and billing databases. Some data requested has still not been received by the Department of Labor and Training. Specifically, the infrastructure of each carrier is different so there was no uniform way to identify and transmit the data requested. In some cases data requested is in paper rather than electronic format and the time and manpower necessary to retrieve the requested data was prohibitive. Another common problem was the relative lack of systematic collection and reporting of medical data that is used to measure the quality indicators selected, For example, some carriers provided screen prints of data, which the DLT had to re-enter into a new database. Additionally, some carriers subcontract medical billing and so data requested was held by another entity with all of the problems in format and ability to transfer that apply to the primary carrier. Finally, some concerns were raised regarding confidentiality. While theses concerns appear to be surmountable, the exact approach is still being evaluated. These challenges resulted in delays in receiving the requested pilot data and have delayed the TRC's ability to proceed with the next 2 steps of the Quality Improvement Model, refine/redefine and full data collection.

While the barriers to this collaboration have been significant, there remains commitment on the part of the carriers to work with the DLT to accomplish this data transfer. To paraphrase one carrier, we are refining our databases and as we learn what the data DLT will be requesting, it can be built into our system.

Accomplishments

The TRC demonstrates that a state workers' compensation system can successfully collaborate on the design and collection of data related to the quality of health care delivered to injured workers. It further demonstrates that a Quality Improvement Model can be adopted and provides a format for the implementation of such a resource center.

The project demonstrates that a "real world" application that addresses scientific concerns can be accomplished when a clear model is used and adoption of the model is given priority. Pilot data from the project suggests that meaningful data is available and accessible, although there remain numerous challenges and barriers to obtaining it. Pilot data also suggests that measures defined by the project are sensitive to the quality dimensions targeted.

With respect to the RI Workers' Compensation system, pilot results suggest that injured workers rate the quality of the health care they receive and their health care providers highly. These results benchmark well with available data regarding the general health care system. Health care appears to be delivered promptly. The use of the RI Workers' Compensation MAB Protocols are used by a majority of health care providers (76%) for a variety of reasons and are not perceived as overly restrictive. The initial assessment of care patterns suggests that low back care falls within the MAB guidelines. Return to work rates appear high and modified duty is used frequently. An interesting finding that may have merit for other systems is the suggestion of a "policy-practice disconnect". For example, in surveying injured workers, employers, and healthcare providers about their understanding of the RI Workers' Compensation system as it relates to obtaining health care, there was less than adequate understanding. Only 46% of injured workers, 52% of employers and 56% of healthcare providers scored a "passing grade" (75% correct) on the knowledge portion of the survey. Pilot data also suggests that there are several potential problem areas that need to be more thoroughly explored. These include difficulty accessing prescription medication, problems in identifying the carrier of record for authorizations, and concerns about access for the non-English speaking population.

Finally, the RI Stakeholders maintained active participation throughout the 2 year grant and have recently placed the TRC as a continuing item on the agenda of the WCAC, suggesting their awareness of the importance of monitoring quality of health care data has been heightened as was an objective of the project.

Important Lessons Learned

A number of factors are necessary for successful adoption of a "Statewide Technical. Resource Center". First and foremost, there needs to be a stakeholder group that represents all parties within a particular WC jurisdiction, with an interest in and concern for the health care quality, and the authority to support implementation and utilization of the center. If such a group does not exist, it needs to be created. The RI experience suggests a consensus model works better for this group to define health care quality parameters and set priorities than a regulatory model. Within a consensus model, the needs of insurers for financial success, of injured workers for quality health care, of health care providers for reasonable compensation and control over health care decisions, of employers for timely return to work, and of the administrators for adequate infrastructure to support the system, can be addressed. Even with this model, stakeholders need to be educated throughout the project regarding concepts of health care quality and performance measurement for the project to be successful. Adequate funding and realistic expectations regarding the timeframe for implementation is critical because of the numerous challenges that exist with respect to obtaining health care quality data.

Post-Grant Plans

The TRC intends to complete the steps outlined in the Quality Improvement Model and work with the policy-makers to utilize this data. Next steps include the following:

- Revise survey instruments, considering development of an instrument for surveying carriers
- Evolve the data collection process, including documenting the necessary specifications
- Review and revise the TRC database structure
- Administer surveys to full samples of IW, ER, HCP
- Conduct full sample data analyses
- Enhance educational efforts based on the results of the analyses
- Re-engineer DLT annual report to include quality as well as cost data,
- Focus on dissemination of results - web-site development; presentations to WCAC, and local, regional and national professional organizations; publish results in professional journals