

## **APPENDIX III – UNITED KINGDOM AND STATE OF WASHINGTON**

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This appendix provides details about the Washington State COHE program and the evolution of events in the United Kingdom prior to launch of its new Fit for Work Service. It begins with a summary overview of these two innovative initiatives. Then, more details are provided for each one, including background information and a chronology of events. Some of this information is derived from written materials, and some comes from personal conversations with people who helped get these initiatives off the ground during meetings in February and March of 2015.

A surprising point about both the Washington and UK histories is that these successful change initiatives were initially conceived and driven by physicians inside the agencies involved. There are some clinicians with the intellectual skill to diagnose problems in populations as well as individual people, who can come up with interventions that can heal whole groups at a time, and who can design system-level programs to accomplish it – and who strongly desire to make a substantial contribution. Many US physicians with these talents possess an MPH degree. They are most common among medical directors in large healthcare delivery organizations, in corporate medical directors, in occupational medicine programs, in aerospace medicine, and in public health. We recommend engaging more of them in this arena.

### **OVERVIEW**

#### **State of Washington COHE Program**

Washington State's Centers of Occupational Health & Education (COHE) program was developed to provide better care (and outcomes) for employees who are hurt at work and file workers' compensation claims. A physician has led the initiative: Gary Franklin, MD, a professor at the University of Washington who is also the medical director of the Washington Department of Labor & Industries (L&I). L&I handles workers' compensation for all insured employers in the state. Dr. Franklin and Dr. Tom Wickizer came up with the idea of crafting a breakthrough solution that would employ evidence-based methods to improve the quality of healthcare and outcomes for injured workers while staying true to a set of principles that the stakeholders held dear. After more than a year of sharing the science, socializing the idea, and consulting with stakeholders on how they thought it should look, the COHE idea appeared. The legislature accepted the idea and granted authority to pilot it.

The COHE program consists of community-based organizations contracted by the state, each with a governing board comprised of employer and labor representatives, and a board-certified occupational medicine physician as medical director. Each COHE recruits as many treating physicians as possible within its geographic area which may be large (up to 17 rural counties in one) to become members. Member physicians are encouraged to employ a set of 4 best practices in caring for newly injured workers in return for modest fees. The main work of the COHE is done by the Healthcare Service Coordinators who support treating physicians, their injured worker patients, and those workers' employers by coordinating communications and doing minor problem solving, eliminating common small problems that could otherwise lead to protracted delays or bad outcomes. Services last for no longer than twelve weeks.

The COHE program was thoroughly piloted, gradually expanding over a decade, and being evaluated at several intervals. It will soon cover the entire state and serve all workers whose

employers buy workers' compensation insurance. The COHE program has demonstrated the feasibility and effectiveness of these early services in improving health and functional outcomes for workers, helping them keep their jobs and stay in the workforce. Based on 12 years of data, the COHE program appears to have reduced inflow to SSDI by 25%. The COHEs also reduce total case costs by an amount that far exceeds the extra costs of running the program (Wickizer et al. 2004; Wickizer et al. 2011).

We see no serious barriers to using the COHE experience as an indicator of what is possible to achieve in other states and benefits systems.

See more details about the background, history and the documented impact of COHE starting on Page 3.

### **The United Kingdom's New Fit For Work Service**

Over a period of about 15 years, the United Kingdom has undergone a gradual revolution in its approach to long-term work disability. A civil service physician in the Department of Work & Pensions (DWP, analogous to a combined Department of Labor and Social Security Commission here in the US) began it all by deciding to take on the issue of avoidable work disability. He orchestrated a slow and thorough campaign for both internal and external change, commissioning evidence-based reviews and holding events, getting more and more people involved.

The issue eventually became a Cabinet-level concern with cross-party support. Two Cabinet members (Health and DWP) agreed to jointly sponsor a Health, Work and Well-being initiative. Soon after, another physician heading up the Health, Work & Well-being Initiative delivered two independent policy reports to Parliament with recommendations for action. The government used those reports, along with some prior scientific reviews which buttressed them, to craft its strategy going forward. They spent several years on small initiatives and experiments, none of which managed to make a substantial impact, and arguing for a more substantial approach.

More recently, DWP consolidated all of what had been learned and drew up a specification for a novel assessment and advisory service for people absent from work for four weeks. The government recently awarded a 5-year contract to a large service provider, which launched the first bits of the new Fit For Work service in early 2015. This national service is being rolled out with solid foundations. It has many specific features that proved most successful and cost-effective in a series of 11 local pilots (for example, reliance on telephonic intervention), but without a prior successful demonstration that it will work in its current configuration. The best way to interpret this, given the government's years of effort and substantial investment to date, is that they have achieved sufficient social agreement that harm is being done by inaction, that there is solid evidence about the effectiveness of certain helping interventions, and that action is necessary now to justify proceeding with an evolving model.

See more details about the background, history and learnings of the UK initiative that might be useful to the launch of a similar initiative in United States starting on Page 9.

## More Details - Background and History

### Washington State's COHE Program

In Washington State, workers compensation insurance is only available from a state-run insurance entity housed in the Department of Labor & Industry (L&I). L&I pays and manages all claims (except those of self-insureds), but provides no medical or other services directly to injured workers. They believe in research and experimentation, and have a long history of testing new initiatives to improve the quality of care delivered through workers' compensation. L&I began a program over ten years ago to establish community-based Centers for Occupational Health & Education (COHE), which provide services much like those we propose here. The COHEs have demonstrably improved outcomes for workers and reduced costs for work-related injuries as well as materially reduced the inflow onto SSDI – a quite substantial 25% reduction. New COHEs have been added over time and now collectively cover the entire state.

This section describes some of the program's history, its key features, its results, and relevant findings from the lengthy process of implementing the COHE program and operating COHE centers at a local level for more than decade.

The COHE program was preceded by a managed care pilot program that improved outcomes and reduced lost work days along with medical and disability costs. However, worker satisfaction declined and the tightly controlled network of healthcare providers did not fit well with the state's tradition of free choice of physician. Requirements were laid out for a better approach that avoided these problems. An acceptable solution would need:

1. Administrative and financial incentives to encourage medical care leading to improved quality and injury outcomes, but allowing individual's to choose their physician.
2. Enhanced provider accountability.
3. Involvement of multiple employers and a large proportion of a community's physicians in order to have impact, indicating that a community-based public health approach to quality improvement and disability prevention, even though implementation challenges would result.
4. Mechanisms to ensure injured workers would not get "lost" in the system even when treated by many different providers.
5. A new approach to meet the differing—and often conflicting—interests of both employers and workers.

Those principles led to the core of the COHE concept: a community-based organization positioned as a center of excellence and a higher quality alternative to the status quo that would appeal to both workers and their employers – and improve outcomes.

The first two pilot COHE's were launched in 2001, in Renton, a suburb of the Seattle metropolitan area and in Spokane on the other edge of the state. L&I funded a comprehensive evaluation, conducted by researchers at the University of Washington which generated important information used to make adjustments in the program from time to time.

To launch a new COHE, L&I requests proposals from existing healthcare organizations, providing very clear and detailed specifications. COHEs are selected by competitive bid,

contracted with L&I for three year renewable terms. Their governing boards must include both labor and management members.

The COHEs are carefully positioned as local centers of excellence in occupational health which provide assistance to community physicians as well as access to occupational medicine expertise. COHEs are membership organizations for community physicians, especially those at the entry point of care for work-related injuries (family, general and primary care practice; urgent care centers, emergency rooms; occupational health and industrial injury clinics). The COHEs also recruit specialist consultants, especially those most commonly required for problematic musculoskeletal injuries: orthopedists, neurologists, and neurosurgeons.

COHE facilities are administrative offices with a small staff of four types of professionals:

- Administrative personnel who manage operations.
- Provider relations specialists who recruit and manage relations with community physicians.
- A medical director qualified in occupational medicine who serves as a mentor for member physicians and a resource for COHE staff.
- Healthcare service coordinators (HSCs) who work on specific cases, working solely via telephone, email, and a shared data system. There is no face to face contact with workers. The HSCs monitor all new work-related injuries being treated by the member physicians. As needed, they facilitate multi-way communication among the patient, employer, physician and L&I. They also coordinate the activities needed to resolve uncertainties and remove obstacles to progress. They assure that a short list of specified best practices for physicians are followed during the early post-injury period.

Four desired physician best practices are strongly encouraged and rewarded:

1. Timely notification to L&I – within 36 hours - that a new episode has begun.
2. Providing newly injured workers with explicit guidance recommending appropriate levels of activity and work as part of the medical treatment, using an activity prescription form and a conversation "script" with four key informative messages.
3. Actively communicating with other parties, especially with the HSC and employer to discuss work capacity, return to work plans, and how to move things forward.
4. If recovery seems delayed (typically if return to work has not occurred by 4 weeks), deeper analysis and thinking about possible causes and remedies.

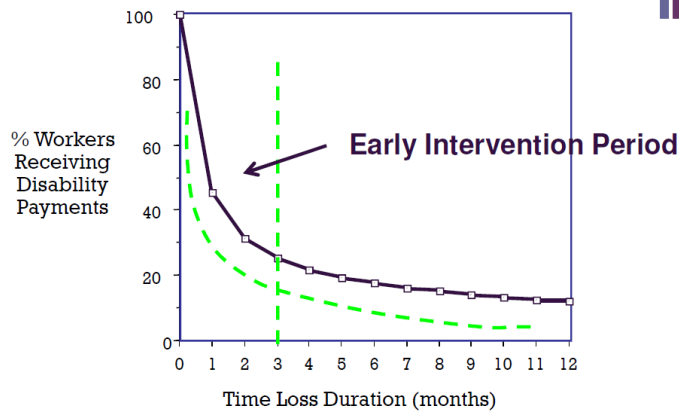
L&I assigned each a billing code and modest fee, averaging \$60 total per case, which incents the physician to do the right thing, and provides a data record that the task was done, allowing compliance monitoring and quality improvement feedback.

Other key best practices, which evolved over time during the initial pilot years, include:

- Use of a community-based and collaborative public health approach:
  - The COHE is an active player in the local healthcare delivery community.

- It maintains positive everyday working relationships with physicians and employers in its service area, and routinely collaborates with them on the care of injured workers.
- Workers see COHE as caring and professional, helping them not “get lost in the system”.
- Employers appreciate that COHE intends to improve outcomes and enhance efficiency. L&I has intentionally not emphasized cutting costs or calculating return on investment.
- Physicians see COHE membership as a source of new revenue and free labor (the HSCs) to help them reduce hassle and achieve better outcomes for their patients.
- The COHE actively monitors the entire cohort of workers with new injuries being cared for by member physicians, responding as appropriate.
- Emphasizes care coordination and use of a “teamlet” (physician + helper) approach to care management.
  - Research shows that lack of these two things in today’s healthcare system causes much harm, and adding them makes a positive difference on healthcare quality, costs and outcomes.
  - The HSC assists the physician by reducing delays in authorizations for care, coaches physicians unfamiliar with administrative requirements, reminds them when specific best practices are called for. They meet annually with physicians to review overall performance and point out missed opportunities for best practices and associated revenue. The HSC serves as a communications hub, keeps things on track and everyone on the same page, senses when to simply observe and when to intervene, takes a problem solving and collaborative approach to addressing obstacles to progress, and keeps driving the case situations forward towards the best possible resolution. In practice, that means identifying open issues or uncertainties, providing missing information or correcting misperceptions, finding the answers to questions, or educating, reassuring or encouraging an inexperienced or hesitant participant.
  - An HSC must be familiar with the kinds of things that can go wrong, how to spot them, and how to get things back on track. They need a strong commitment to reducing the period of time a worker’s life is in limbo, and a belief that getting them back to some kind of work as soon as medically safe usually leads to the best outcomes.
  - Many HSCs have backgrounds in vocational rehabilitation or similar professions, with decades of experience in healthcare and the workers’ compensation system.
- Focuses on making the right things happen during the critical first few weeks.
  - COHE involvement is currently limited to the first 12 weeks after injury or until surgical referral, whichever occurs first. HSCs know a rapid operations tempo is a must.

## Changes in Disability Status among Injured Workers in WA State



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

- A pilot program now underway is expected to increase the duration of COHE involvement for a sub-set of patients at higher risk, and expand the list of physician best practices.
- Powerfully shares information, provides infrastructure tools to do so.
  - Carefully designed forms are used to capture and transfer information between parties.
  - HSCs know they personally function as critical communication hubs.
  - L&I invested in two key enabling technologies: (1) a connection from the COHEs and their member physicians to L&I's own claim system, and (2) a COHE-specific information system for all the COHEs to share.
- Establishes and actively manages accountability for outcomes.
  - Physician adherence to best practice activities is tracked via billing data, and discussed with them regularly.
  - COHE volumes and claim outcomes data are tracked, compared, discussed and reviewed.
  - Program performance is reported to the legislature and to research collaborators at the University of Washington, supporting changes needed and resource requests.
  - Since the COHEs inception, L&I has steadily contracted with health systems researchers to document the program's progress and analyze available data to evaluate its impact.

All of each COHE's revenue comes from L&I. During start-up, L&I provides a modest amount to allow initial hires and start recruiting physicians. After that, revenue comes in two ways: flat per case fees, and billable services.

A flat cash payment of \$33 is received for every new injury being treated by a COHE member physician, intended to cover COHE fixed costs. This creates some distortions. Physicians treating few injured workers look less attractive as COHE members, even though they may need COHE

help more than others. Higher recruiting costs in sparsely populated areas are made even worse by lower per case revenues as well.

The COHE also receives time-based payment for billable services performed by the HSCs, primarily interactions with workers, employers, and physicians (phone calls and emails) with a maximum cap per case. This revenue is intended to cover COHE variable costs. HSCs are not paid for interactions with L&I staff or for research or computer work. There is reasonably good incentive alignment here because it encourages the HSCs to deliver more rather than less service and to focus on interactions with people. Due to the high caseloads per HSC, they must quickly identify the cases likely to require more support. Over time, they learn which physicians are more expert than others, and which employers have better return to work processes than others.

The COHE's vary widely in their organizational affiliation and relationship to the healthcare systems in their community. They also face different challenges and constraints based on circumstances in their geographic locale.

Some of the key configuration options and operational implications are these:

- If the COHE is part of a healthcare delivery system or is associated with a medical practice, it can earn increased revenues for its physicians through the extra L&I payments and potential increase in patients using their services, both of which can offset any COHE losses. But if there are competing healthcare systems in the area, they may not want to join the COHE.
- If the COHE is standalone, it may not earn enough to make ends meet, as payments from L&I are not lavish, but it will have an easier task recruiting physicians that may otherwise compete with each other.
- If the COHE is in a rural area with low patient volumes, fixed costs of recruiting and training member physicians may be high and difficult to offset with available revenues, as physicians in these areas may only rarely see workers compensation patients.
- If there are no large physician organizations, recruiting and contracting expense will be relatively higher.

Until recently, the financial model for the COHEs was non-sustainable on a stand-alone basis. The two original COHEs had operated in the red for more than a decade. The modest losses experienced by the Renton COHE were more than compensated for by increased patient volume and revenue to the medical practices and ancillary services in other operating units in the sponsoring healthcare system. This incentive created a strong incentive to be a COHE. In contrast, the Spokane COHE had no medical practices or ancillary services to feed since the sponsoring organization offers none (it operates a helicopter transport service and a rehabilitation hospital). Spokane remained a COHE despite its financial losses because the CEO of the sponsoring organization has a genuine commitment to serving the community and is also aware the public relations value of being a visible supporter of initiatives to improve both quality of care and reduce costs.

As the COHE program has grown and demonstrated a satisfactory return on investment for Washington L&I, the COHEs banded together to lobby for official changes to their fees which now means they have a chance to be self-sustaining on a standalone basis if well managed.

Dr. Wickizer has evaluated and written about the program’s design and results in several articles. At the first evaluation in 2004, the results looked very promising. Acceptance by workers and employers was good. The payments to the COHE physicians for the “4 best practices” services averaged only \$60 per case, yet the average total cost per claim (medical care plus disability payments) was reduced by \$500. These early findings led to expansion of the program. After a couple more years, the results were even better:

The average COHE case had 9 fewer disability days than comparison-group cases. The estimated total cost savings per claim for the first two COHEs were \$819 and \$1,279 which represented an increase in savings of approximately 50% from the initial one-year follow up. The increased cost savings result, in part, from episodes failing to resolve (claims remaining open) in the comparison groups. New outcome measures revealed large and statistically significant differences favoring the COHE model: fewer rejected claims, fewer reopened claims, fewer protests, less frequent use of attorneys, and a lower long-term disability pension rate.

Those who are most interested in the implications of this model for Social Security Disability will be interested in the statistically significant reduction (by half) of the percentage of cases still out of work at the 12, 18, 24 and 36 month intervals.

*Table 1. Percent of Cases on Time Loss at Different Follow-up Points*

Follow up time	Renton		Spokane	
	COHE (n=10,725)	Comp. Group (n = 11816)	COHE (n=7,359)	Comp. Group (n=3,865)
30 days	5.6%**	8.0%	5.3%**	8.2%
90 days	3.7%**	5.8%	4.1%**	6.3%
180 days	2.7%**	4.6%	3.1%**	4.8%
12 months	1.7%**	3.2%	2.5%**	3.5%
18 months	1.4%**	2.4%	1.9%**	2.9%
24 months	1.1%**	2.1%	1.4%**	2.6%
36 months +	0.7%**	1.5%	---	---

Differences are statistically significant: \* p < .05 \*\* p<.01

+ Follow-up time for Spokane extends 24 months rather than 36 months because this COHE site started one year after the Renton COHE site.



The most recent analysis, now with 12 years of data, showed that the size of the favorable difference between outcomes of claims managed in a COHE versus “usual care” has continued to grow. And the number of cases going onto SSDI has dropped by 25%.

In 2010, the state legislature declared that the COHE pilots had proven success and directed L&I to roll it out statewide. As of 2015, there are now 8 COHEs in existence, including 3 new ones that have recently come on line. In total, their geographic reach now covers the entire state.

### **The United Kingdom: History of the Fit For Work Service.**

- In the United Kingdom, the politically-appointed Secretary of State for Work and Pensions, assisted by a civil servant Permanent Secretary and roughly 400,000 other employees, is responsible for carrying out the nation’s employment, unemployment, and disability benefits laws and programs. The U.S. equivalent would be a combination of the Department of Labor plus the Social Security Administration. Most of the leadership and energy for change in UK policy on how work disability is handled has come from DWP.
- When asked to speculate about the reason for near total lack of leadership by the United States SSA compared to the leading role that DWP has played in driving towards change, a current DWP manager surmised that it is because that DWP is responsible for both unemployment and disability benefits. Faced with high unemployment, the government feels compelled to address the problem. That person further commented that the department has come to see the best indicator of the health of the economy as the levels of those two programs combined. This is evidence of the magnitude of the turnaround in the internal culture at DWP, which originally resisted the ideas coming from its own clinical leaders. (It is also food for thought for the US, since SSA operates quite independently and in a very narrow silo with no real accountability except to make timely and accurate eligibility decisions and pay benefits on time.)
- From a strategic perspective, and well before the concept of the Fit For Work service was born, a few visionary and influential UK clinical leaders led by a physician got things moving. Professor Sir Mansel Aylward, then at DWP, was the catalyst. He set out to build solid support for change in the area of work disability prevention. They began work around the turn of the century so it took them almost 15 years. They carefully orchestrated the creation of an evidence-based foundation of shared understanding and agreement.
  - A series of reports were produced, written in plain language and aimed at all stakeholders. Some of these proved to be essential assets. They included reviews of the existing scientific evidence on major issues as well as reviews summarizing stakeholder observations about existing programs, all conducted by credible and respected clinicians.
  - Informal conversations and formal meetings were held with a wide variety of stakeholders to discuss the action implications of the reports.
  - Conferences were convened to explore the issues in more detail from a clinical, policy, and program perspective.

The broad conversation that this foundation enabled eventually created widespread agreement in most quarters that a new and very different approach was needed – because it was evidence-based, because it was good for both people with disabilities and the country, and it made good sense.

- A particularly influential review of the evidence was entitled “Is Work Good for Your Health and Well-Being?” Commissioned by the Department for Work & Pensions (DWP) during Dr. Aylward’s tenure, it was authored by Drs. Gordon Waddell and Kim Burton. We heard this 2006 report spontaneously described as “the best thing DWP has ever done.” In simple yet powerful language, backed up by detailed data tables, it summarized the best quality data then available on the impact of worklessness on health. The report concluded definitively that prolonged worklessness is an unfortunate outcome because it increases both morbidity (ill health) and mortality (the death rate). Importantly, the review revealed, for the first time, that regaining work can reverse the adverse health effects of worklessness. Unfortunately, that review did not include an exploration of the evidence concerning the impact of worklessness on the incidence of risky behaviors, marital and family life disruption, and socio-economic decline although these consequences are well understood here in the U.S. We recommend the development of an expanded US version of this document.
- Drs. Waddell and Burton, along with other well-regarded experts, authored several short informational and educational pieces intended for physicians, patients, and their employers. They then conducted other evidence reviews to determine the nature and relative effectiveness of interventions to help people with common health problems to return to work. The bottom line is that effective interventions are those that are delivered early, based on biopsychosocial principles with a combination of work-focused healthcare and workplace accommodation. Furthermore, it was found that a case-managed model for delivering assessment and advice to help people return to work can be safe and effective.
- In addition to summarizing the scientific evidence, DWP supported two other highly publicized information-gathering projects on the “state of the state”, first with regard to disability and second with regard to sickness absence. The reports to government of findings from these two projects were very helpful in clarifying the nature of problems, what might effectively address them, and building widespread support for government action. Both were led by another physician-leader, Dame Carol Black. She had recently been recruited to lead the new Health, Work, and Well-Being Initiative, co-sponsored by the ministers of the national Department of Health and the DWP.
- The UK had also amassed and disseminated the evidence on the kinds of interventions that can avert or undo the process of over-disablement. The DWP launched a program aimed at individuals already on Incapacity Benefits (usually after six months work loss) that employed a personal advisor to collaborate with the disabled individual using a biopsychosocial model of assessment and intervention to help them improve their lives and get back to work. It proved expensive yet effective at increasing exit from benefits both in pilot and national roll-out, but results fell off over time.
- Next, in order to learn the best configuration and timing for intervention services, the UK solicited proposals from local jurisdictions and allowed them more or less free rein to design pilot Fit for Work projects. These produced mixed results but some excellent learning. The associated work-focused changes to statutory absence certification forms, along with national training for the

doctors in the basic concepts of work-focused healthcare, proved insufficient at noticeably moving the needle. The DWP then consolidated what had been learned, both from the scientific studies and the practical experiences, and drew up a specification for a novel assessment and advisory service for people absent from work for four weeks..

- The United Kingdom's new nationwide Fit for Work (FFW) service is still in the process of launching. It has two main parts:
  1. A telephonic assessment and advice return-to-work service which reaches out to the worker to agree on a plan for how to get back in work. This part of the service is intended for people who have very recently developed medical conditions expected to keep them out of work at least 4 weeks. Treating doctors and to a lesser extent employers are expected to refer individuals to the service. This part of the FFW service is going to roll out slowly across the country. It is projected to evolve considerably based on experience gained in the early phases.
  2. A call-center and web-based advice line that responds to in-coming questions about fitness for work and the stay-at-work and return-to-work process from doctors, workers, or their employers. It launched in early 2015.
  3. The government recently awarded a 5-year contract to a provider, which has just launched the first bits of the new Fit For Work service. It is funded by the DWP. The Fit for Work service has been contracted out to a provider, Health Management Systems, an occupational health company recently acquired by Maximum, a U.S. company. The original tender (request for proposal) was for a maximum total amount of £170 million pounds and a five year contract period.

Submitted by: Jennifer Christian, Thomas Wickizer, and Kim Burton

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