REPORT TO THE 2002 LEGISLATURE

ON

COORDINATED CARE ORGANIZATIONS
ACT 166
NINETEENTH LEGISLATURE, 1998

Prepared
by

Coordinated Care Organization
Review Task Force

December 12, 2001
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PREFACE

Act 166, effective July 14, 1998, allowed the creation of coordinated care organizations (CCO) to provide workers’ compensation medical benefits to injured workers. This measure was intended to reduce the cost of delivering health care services to injured workers, lower workers’ compensation premiums, ensure high quality health care to injured workers, and assure adequate protection to injured workers’ rights within a CCO system. The CCO system envisioned by this Act would accomplish these goals by:

1. minimizing workplace injuries and promoting workplace health and safety;
2. providing efficient, cost effective, and timely treatment through a coordinated and comprehensive system of quality health care;
3. providing a high level of quality care;
4. providing an understandable, accessible, and user friendly system of care;
5. providing a range of treatment, including but not limited to office, clinic, laboratory, hospital, rehabilitative, emergency and other essential care;
6. making available a variety of specialties;
7. providing a prompt and appropriate return to work program;
8. providing a vocational rehabilitation program; and
9. providing a program of internal dispute resolution.

This Act established a coordinated care organization review task force (CCOTF) administratively attached to the Department of Labor and Industrial Relations to monitor and study the CCO system established by this Act. The charge of the CCOTF was:

1. to ensure a sufficient level of quality care;
2. to evaluate the effectiveness of each registered CCO;
3. to make recommendations to strengthen the CCO system;
4. to compare workers’ compensation insurance premiums paid by employers before and after utilizing CCOs; and
5. to make recommendations to the Legislature as to whether or not to extend this Act beyond June 30, 2002.
While two hospitals formed Coordinated Care Organizations (CCO), Kaiser On-the-Job in December 1998 and Straub in April 1999, no Workers' Compensation Insurance Carriers contracted with either CCO to offer the product to employers.

Insurance carriers had no incentives to offer a CCO product to employers at a lower premium primarily because of the "opt out" provision which allowed an employee to change a physician, hospital or specialist for any reason to one outside of the CCO after a definitive diagnosis or three visits. This "opt out" provision therefore eliminates any potential cost savings which may be derived in a CCO environment.

CCO barriers to participation included the $10,000 CCO registration fee and lack of financial rewards for a CCO to participate since they are paid only for medical services and are not rewarded for early return to work. The insurance carriers have no incentive to incur additional costs to establish and operate a CCO in order to comply with legislatively mandated requirements.

While employers did not have the opportunity to purchase a CCO insurance plan, theoretical disincentives to their participation may have included cost of a safety program, employee education and enrollment expenses, and with the "opt out" provision and experience rating process, smaller employers may not have immediate premium savings.

While there was no CCO experience to report on, there have been valuable lessons learned. While both Straub and Kaiser could not report any results on a formal CCO program, they were both able to report positive results based on their experience with injured workers treated in their "informal" CCO environment.

The features embedded within the informal CCO environment which probably had significant positive impact include an active safety and prevention program, return to work and vocational rehabilitation focus, emphasis on communication between employers, injured workers and the health care provider to facilitate case management and return to work, timely dispute resolution processes, and case management and treatment guidelines to expedite timely, quality care to injured workers.
Kaiser On-the-Job

Kaiser, which treated over 7,000 injured workers in their informal CCO environment, reported average days of work lost of 5.2 per worker compared to a 19.5 state average. Kaiser also reported a 71.5% patient satisfaction experience based upon 589 surveys returned.

Straub

Straub reported results based upon their experience with the Oahu Transit Services, Inc. program established under section 386-3.5, HRS, which allows collectively bargained programs. Under this program Straub reported reduction of lost time from 8% of scheduled hours in 1992 to less than 2.5% in 1999. Straub reported approximately 77% patient satisfaction rate. OTS also reported a reduction in workers' compensation cost from $6.6 million to $3.8 million.

CONCLUSION

The CCOTF believes section 386-A in Act 166 identifies the key elements necessary for cost effective delivery of quality health care and rehabilitation services to our injured workers.

The failure of insurance plans to offer a CCO product may be attributed to several factors. First, reductions in premiums for conventional workers’ compensation insurance in recent years may have eliminated potential cost savings that could have been derived in a CCO environment. Additionally, the barriers to participate identified in this report resulted in the lack of interest in CCOs. If Act 166 is to extend beyond June 30, 2002, the committee recommends that the Legislature modify the act to provide immediate incentives to encourage insurance carriers, physicians and injured workers to participate.
COORDINATED CARE ORGANIZATION REVIEW TASK FORCE MEMBERS

Leonard Agor  Department of Labor and Industrial Relations Director
Wayne Metcalf  Insurance Commissioner
Dr. Bill Boyd  Center for Labor Education and Research
Robert Dove  Hawaii Employers' Mutual Insurance Company
Marianne Dymond  Kaiser Foundation Health Plan, Inc.
Guy Fujimura  ILWU
Shelley Hee  Case Management Options, Inc.
Clyde Mark  Kamehameha Schools
Betty Sestak  Hawaii Rehabilitation Counseling Assn
Ronald Gackle, MD  Kaiser Permanente
Keith Fukumoto  Legislative Reference Bureau
APPENDIX A
Honolulu, Hawaii

MAY 11, 1998

RE:  S.B. No. 2386
     S.D. 2
     H.D. 2
     C.D. 1

Honorable Norman Mizuguchi
President of the Senate
Nineteenth State Legislature
Regular Session of 1998
State of Hawaii

Honorable Joseph M. Souki
Speaker, House of Representatives
Nineteenth State Legislature
Regular Session of 1998
State of Hawaii

Sir:

Your Committee on Conference on the disagreeing vote of the
Senate to the amendments proposed by the House of Representatives
in S.B. No. 2386, S.D. 2, H.D. 2, entitled:

"A BILL FOR AN ACT RELATING TO COORDINATED CARE
ORGANIZATIONS,"

having met, and after full and free discussion, has agreed to
recommend and does recommend to the respective Houses the final
passage of this bill in an amended form.

The purpose of this bill is to allow the creation of
coordinated care organizations (CCO) to provide workers’
compensation medical benefits to injured workers.

This measure introduces managed care into the workers’
compensation system by providing the required medical and
rehabilitation services. Managed care is a term that describes
health care systems that integrate the financing and delivery of
appropriate health care services to covered individuals by
arrangements with selected providers to furnish health care
services. However, your Committee has deliberately refrained
from characterizing this bill as managed care, preferring to allow a CCO the latitude to determine its own method for delivery of services.

Your Committee believes that this bill will reduce the costs of delivering health care services to injured workers, lower workers' compensation premiums, ensure high quality health care for injured workers, and assure adequate protection to injured workers' rights within a CCO system. Your Committee envisions that cost savings will also be realized through appropriate and timely return to work, requiring workplace health and safety programs, and minimizing the adversarial nature of the workers' compensation system.

As to reducing workers' compensation claims and insurance premiums, your Committee is cautiously optimistic that this bill will lower those costs. Actuarially defensible projections are not feasible because of the lack of claims experience in Hawaii under a CCO system. Therefore, your Committee has deliberately refrained from mandating a rate reduction, but has provided that the task force will also compare workers' compensation insurance premiums paid by employers before and after utilizing CCO.

As to quality of care and related issues, the study by the Legislative Reference Bureau will evaluate the effectiveness of treatment, quality of care, accessibility of medical specialists on all islands, timeliness of receiving care, and extent of implementation of workplace health and safety. The study is intended to provide feedback to the legislature on the medical care issues in order for the legislature to adequately evaluate the CCO system to assure that workers are receiving quality care. The priority of your Committee is that CCO attain and maintain a quality level of care for the injured worker. Without proper medical treatment, this bill is meaningless regardless of any cost savings.

The primary concern of the legislature is that injured workers continue to have a choice of providers, as currently provided under section 386-21(b), Hawaii Revised Statutes, regardless of whether the employer is enrolled in a coordinated care organization. The legislature finds that the health and well-being of injured workers should take precedence over the form of delivery of workers' compensation medical benefits.

Your Committee finds that employers who are subject to negotiated collective bargaining agreements for benefits coverage under section 386-3.5, Hawaii Revised Statutes, should not unilaterally enter into a coordinated care organization system, but instead do so through collective bargaining. The focus of
this bill is for employers who are not subject to collective bargaining, to have access to coordinated care organization.

This measure represents a determined and successful effort by the Senate and the House to reach agreement on this important and controversial issue. This measure is the product of many months of work in the legislature to craft a bill that is equitable, effective, and workable for everyone concerned, including labor, management, medical providers, insurers, and the Department of Labor and Industrial Relations. Your Committee is satisfied that this measure is a balanced approach to preserving the rights and interests of labor and management. The legislature will revisit this issue before the sunset date to evaluate the effectiveness of CCO and to decide whether to continue with the program. Your Committee has expectations for the success of CCO to fulfill its purposes as stated in the measure.

Your Committee upon further consideration has amended S.B. No. 2386, S.D. 2, H.D. 2, by deleting its contents and inserting provisions from H.B. No. 2624, H.D. 2, S.D. 1, with the addition of the following amendments:

(1) Adding that coordinated care shall apply only with the mutual authorization of a collective bargaining unit, if applicable, and the employer;

(2) Changing the terminology from "medical and rehabilitative benefits" to "medical and rehabilitative services" to avoid confusion with insurance, since CCO are not insurers;

(3) Allowing as the formation of a CCO by an association, partnership, or professional corporation of physicians, hospitals, rehabilitation services, and emergency care providers and requiring them to post bond with the Insurance Commissioner for solvency purposes;

(4) Requiring an employer to offer at least two CCOs to employees who may select one or none;

(5) Requiring the employer to provide information to the employee prior to the employee's selection of a CCO;

(6) Allowing an employee to disenroll from a CCO after a definitive diagnosis or three visits, whichever occurs first, and clarifying that the employee's right to a choice of provider under current law is not affected;
(7) Requiring the employer's workers compensation insurer or the self-insured to pay for emergency care for a work injury;

(8) Requiring a "study" rather than a "closed claims study" to be conducted by the Legislative Reference Bureau rather than the Insurance Commissioner, and adding that the study include an evaluation of timeliness of receiving care and extent of implementation of workplace health and safety programs; the requirements of the study;

(9) Changing the repeal date from June 30, 2001, to June 30, 2002, to give adequate time for demonstration of the coordinated care system, and changing the reporting dates for the task force and the Legislative Reference Bureau reports to twenty days prior to the Regular Session of 2002; and

(10) Making technical, nonsubstantive amendments for purposes of clarity and style.

Your Committee on Conference is in accord with the intent and purpose of S.B. No. 2386, S.D. 2, H.D. 2, as amended herein, and recommends that it pass Final Reading in the form attached hereto as S.B. No. 2386, S.D. 2, H.D. 2, C.D. 1.

Respectfully submitted,

MANAGERS ON THE PART OF THE HOUSE

MANAGERS ON THE PART OF THE SENATE

NOBU YONAMINE, Co-Chair

BRIAN KANNO, Co-Chair

ROW MENOR, Co-Chair

SUZANNE CHUN OAKLAND, Co-Chair

CALVIN K. Y. SAY, Co-Chair

CAROL FUKUNAGA, Co-Chair
RELATING TO COORDINATED CARE ORGANIZATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Chapter 386, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

"PART COORDINATED CARE ORGANIZATIONS

§386-A Purpose. (a) A system of coordinated care to provide coverage for the medical and rehabilitative benefits of a policy required under this chapter shall have the following purposes:

(1) Minimize workplace injuries and promote workplace health and safety, through a cooperative effort among the employer, the employer's workers' compensation insurer, the employee, and the coordinated care organization under section 386-K;

(2) Provide efficient, cost effective, and timely treatment through a coordinated and comprehensive system of quality health care, including the use of case management;

(3) Provide a high level of quality of care;

(4) Provide an understandable, accessible, and user friendly system of care, including open and direct
communication and cooperation among the employer, the
employer’s workers’ compensation insurer, the employee,
and the coordinated care organization;

(5) Provide a range of treatment, including but not limited
to office, clinic, laboratory, hospital,
rehabilitative, emergency, and other essential care;

(6) Make available a variety of specialties as may be
necessary and several providers within each specialty
to afford comprehensive care and a choice of provider
to the employee;

(7) Provide a prompt and appropriate return to work program
to assist an injured employee to return to work safely
without unnecessary medical delay, and provide the
employer and the employer’s workers’ compensation
insurer with timely medical information, including work
return status, recommended work restrictions, projected
date of return to work, and degree of maximum medical
improvement;

(8) Provide a vocational rehabilitation program under
section 386-25; and

(9) Provide a program of internal dispute resolution
processes such as mediation to reduce the adversarial
nature of workers’ compensation; provided that the
administrative and appeals process under this chapter shall be available to the injured employee at all times.

(b) The provisions of subsection (a), except for subsection (a)(1), are guidelines to assist a coordinated care organization registered under section 386-D in forming a system of coordinated care and to assist the employer, the employer's workers' compensation insurer, or a collective bargaining unit in selecting a coordinated care organization.

(c) If a conflict arises in any particular case among the listed purposes in subsection (a), then subsection (a)(3) shall prevail.

§386-B Application and authorization. (a) This part shall not apply without the mutual authorization of a collective bargaining unit, if applicable, and the employer.

(b) If there is a mutual authorization under subsection (a), a negotiated agreement under section 386-3.5 may include the use of a registered coordinated care organization to provide coverage for medical and rehabilitative services required under this chapter.

(c) For an employer not subject to collective bargaining, the employer or the employer's workers' compensation insurer or the employer's employer association may contract with a
coordinated care organization registered under section 386-D(a) to provide medical and rehabilitative services required under this chapter. For purposes of this subsection, employer associations may contract for medical and rehabilitative services required under this chapter through coordinated care organizations formed under section 386-C. As used in this subsection, "employer associations" means any legal association of individuals, corporations, partnerships, or associations, except labor organizations, formed for purposes other than insurance.

(d) Captive insurers licensed under chapter 431:19 and self-insureds under section 386-121 may contract with a coordinated care organization registered under section 386-D(a) to provide medical and rehabilitative services required under this chapter.

§386-C Who may form. (a) The following groups may form a coordinated care organization for purposes of section 386-B:

(1) Mutual benefit society certified under chapter 432:1;

(2) Labor organization, as defined in section 386-8.5(a)(1);

(3) Health maintenance organization certified under chapter 432D;

(4) Insurer offering a policy under chapter 431:10A; and
An association, partnership, or professional corporation of physicians and other health care providers, including hospitals, rehabilitation services, and emergency care providers.

For purposes of section 386-B, an organization listed in subsection (a) shall operate under this chapter through a workers compensation insurer providing benefits under chapter 386.

§386-D Registration. (a) A coordinated care organization qualified under section 386-C shall register with the department. The registration shall be submitted on forms specified by the department and shall include the following information:

(1) Name, address, and phone number of the organization;

(2) Identity of members of the organization, including but not limited to, health care providers, clinics, and hospitals or other medical facilities;

(3) Services provided by the organization; and

(4) Description of a plan of organization and operation to implement the purposes under section 386-A.

(b) Registration under subsection (a) shall be a prerequisite for providing coverage for medical and rehabilitative services for purposes of section 386-B. The department shall not accept any registration submitted by an
A coordinated care organization shall file one or more plans or agreements as samples with its registration under subsection (a) for purposes of section 386-A(b). Plans or agreements shall not be subject to approval by the department.

(d) Violation of this section shall nullify any agreement or contract under section 386-B.

§386-E Registration fee. (a) The purpose of this section is to provide for a self-sustaining coordinated care organization system. Employers, insurers, health care providers, and other organizations may realize a cost savings from forming a coordinated care organization. Because these savings accrue to their benefit, a filing fee shall be assessed under subsection (b) so that the State is not burdened with added expense.

(b) Each registration filed under section 386-D shall be accompanied by a registration fee of $10,000.

(c) There is established a coordinated care organization special fund to be administered by the department. Sums received by the department for registration under this section shall be deposited into the fund. The fund shall be used by the department to defray costs and expenses incurred by the department under this part. Unexpended moneys remaining in the
special fund upon repeal of this section shall lapse into the
general fund.

§386-F Solvency and fee schedules. (a) A registered
coordinated care organization may have a negotiated amount paid
by the employer, employer's workers' compensation insurer, or a
collective bargaining unit, as applicable, for all services
provided to all covered employees.

(b) If the negotiated amount under subsection (a) is a
fixed sum for comprehensive care for work injuries, the
coordinated care organization shall be subject to the solvency
requirements, as follows:

(1) For a health insurer under chapter 431:10A, chapter
431:5 shall apply;

(2) For a mutual benefit society, chapter 432 shall apply;

(3) For a health maintenance organization, chapter 432D
shall apply; and

(4) A labor organization under section section 386-C(a)(2)
or an association under section 386-C(a)(5) shall post
bond with the insurance commissioner in an amount which
the commissioner deems sufficient.

A coordinated care organization shall not be subject to
regulation under the insurance code, if:

(1) The negotiated amount under subsection (a) is in the
form of assessments, dues, or contributions; and

(2) The payment to health care providers for rendering health care and service for work injuries is based on fee for each service.

(c) Fee schedules shall be as provided under section 386-21(c).

(d) If an employee disenrolls from a coordinated care organization under section 386-H(d), the coordinated care organization under a fixed sum amount under subsection (b) may retain the earned payment up to the end of the month of the disenrollment and need not refund the earned payment.

§386-G Treatment and utilization protocols. (a) A registered coordinated care organization shall be exempt from the requirements under section 386-26; provided that the frequency and extent of treatment shall not be less than required by the nature of the injury and the process of recovery. Treatment and utilization protocols shall be subject to approval by the department if the department finds that the protocols of a particular coordinated care organization warrant an approval procedure to ensure that a high level of quality of care is provided. The director shall have a health care provider advisory committee to advise the department on approval of protocols.
S.B. NO. 2386

§386-B Choice of coordinated care organization; choice of provider. (a) An employer may select two or more registered coordinated care organizations for purposes of this part. The employee shall have a choice of selecting one or need not select any.

(b) Prior to the employee's selection of a coordinated care organization under subsection (a), the employer shall provide the employee with information about each coordinated care organization that is being offered to the employee. The information shall include a list of names, addresses, and specialties of the individual health care providers who provide services for the coordinated care organization.

(c) A registered coordinated care organization shall provide to an employee in its program a choice of physicians and specialists. The employee may change a physician or a specialist any.

21 §386-C §386-A(a)(9) to ensure that a high level of quality of care is provided.

3 An employer's workers' compensation insurer shall not deny approval of treatment if the treatment is within subsection (a).
as provided in section 386-21(b) within a coordinated care organization.

(d) After a definitive diagnosis or three visits, whichever occurs first, within a coordinated care organization for a work injury during the period of enrollment, the employee may change a physician, hospital, or specialist for any reason to one outside of the coordinated care organization in accordance with section 386-21(b) and upon notice to the coordinated care organization, which shall be deemed to be a disenrollment from the coordinated care organization. An employee who disenrolls may enroll in another registered coordinated care organization offered by the employer, or the employee may select any health care provider for treatment for a work injury. Any further change of physicians, hospitals, or specialists for the disenrolled employee shall be in accordance with section 386-21(b).

(e) Nothing in this section shall limit receiving emergency medical treatment for a work injury from any health care provider or medical services provider. Emergency medical treatment shall be paid by the employer’s workers’ compensation insurer or the self-insured, as applicable.

(f) This section shall not be construed to affect section 386-21(b) with regards to changing a provider.

§386-I Independent medical examination. (a) The employer
the employer's workers' compensation insurer, or the injured
worker may request an independent medical examination for good
cause. A case manager under section 386-J shall refer the
injured worker to an appropriate health care provider for an
independent medical examination outside of the coordinated care
organization. The independent medical examiner shall examine the
injured worker, review the records, and render a medical report.
(b) If the injured worker refuses to accept the health care
provider designated by the case manager under subsection (a), the
coordinated care organization and the injured worker shall agree
upon another health care provider who is appropriately qualified
to perform an independent medical examination.
(c) An independent medical examination under this section
shall be performed within twenty-one days of the referral under
subsection (a).
(d) The employer's workers' compensation insurer or the
self-insured, as applicable, shall pay for the examination and
report under subsection (a). The cost of the examination or
report shall be subject to approval of the director if the cost
is contested. The independent medical examination report shall
be submitted to the coordinated care organization, the employer,
the employer's workers' compensation insurer, and the employee.
§386-J Case management. A registered coordinated care
organization shall assign a case manager to each injured employee to facilitate the accomplishment of the purposes under section 386-A. The case manager shall be a registered nurse who holds a national certification as a case manager or a registered nurse who is otherwise professionally qualified to provide case management services as determined by the registered coordinated care organization.

§386-K Workplace health and safety. (a) An employer under section 386-B(b) or (c) shall have a program of workplace health and safety, as follows:

(1) For each employer with more than ten employees, there shall be a safety committee; and

(2) For each employer with ten or fewer employees, there shall be a safety committee if:

(A) The employer has a lost workday cases incidence rate in the top ten per cent of all rates for employers in the same industry; or

(B) The workers' compensation premium classification assigned to the greatest portion of the payroll for the employer has a premium rate in the top twenty-five per cent of premium rates for all classes as approved by the director; provided that the director shall utilize the most recent
departmental statistics regarding occupational
injuries and illnesses and workers’ compensation
loss cost rates approved for use in this State.

(b) A safety committee under subsection (a) shall have a
membership that has an equal number of employee and employer
representatives who are volunteers for membership and who are
selected by their respective peers. A safety committee shall
have the following duties:

(1) To have a regular meeting schedule; provided that each
meeting shall be recorded in writing by the employer
who shall maintain these records for inspection by the
director; provided further that the employer shall
compensate employee representatives for the time in
attending meetings or the time in attending safety
committee training, at the regular hourly rate;

(2) To inspect the workplace for health and safety on a
regular basis;

(3) To investigate each incidence of accident, illness, or
death in the workplace; and

(4) To prescribe guidelines for the training of safety
committee members."

SECTION 2. (a) There is established a coordinated care
organization review task force that shall be administratively
The task force shall consist of the following ten members:

(1) Director of labor and industrial relations;

(2) Insurance commissioner; and

(3) Eight persons appointed by the director of labor and industrial relations, one to represent each of the following: labor, management, coordinated care organizations, health care providers involved with a coordinated care organization, workers' compensation insurers, nurse case managers, vocational rehabilitation specialists, and the general public.

If a vacancy occurs, the vacancy shall be filled for the unexpired term in the same manner as the office was previously filled. The members shall serve without compensation but shall be reimbursed for all necessary expenses.

(b) The task force shall monitor and study the coordinated care organization system established by this Act to:

(1) Ensure that a sufficient level of quality care is maintained, while giving consideration to balancing the interests of employers and employees;

(2) Evaluate the effectiveness of each registered coordinated care organization in achieving the purposes set forth under section 386-A, Hawaii Revised Statutes
(3) Make recommendations, if any, to strengthen the coordinated care organization system;

(4) Compare workers' compensation insurance premiums paid by employers before and after utilizing coordinated care organizations; and

(5) Make a recommendation to the legislature as to whether or not the repeal date of June 30, 2002, for this Act should be extended.

The legislative reference bureau shall assist the task force in gathering information and data for the study.

(c) All registered coordinated care organizations shall cooperate with the task force in the study by providing information to the task force or the legislative reference bureau upon request. The information shall include the number of employees enrolled in the coordinated care organization, number of disenrolled employees, and the reasons for disenrollments.

(d) The task force shall submit a report of its findings and recommendations to the legislature and the governor no later than twenty days prior to the convening of the regular session of 2002.

SECTION 3. The legislative reference bureau shall conduct a study of coordinated care organizations. The study shall be completed and a report made to the legislature no later twenty
days prior to the convening of the regular session of 2002. The study shall evaluate:

(1) The effectiveness of treatment and quality of care provided by coordinated care organizations;

(2) The accessibility of medical specialist care to injured employees, including considerations of island by island availability of medical specialists who are willing to treat injured employees under chapter 386, Hawaii Revised Statutes;

(3) The timeliness for injured workers to receive care; and

(4) The extent of implementation of workplace health and safety programs.

The legislative reference bureau may rely upon the cooperation of the insurance commissioner, private insurers, and coordinated care organizations to obtain information and statistics in addition to any other sources. Private insurers and coordinated care organizations are urged to cooperate with the legislative reference bureau in its study.

SECTION 4. If any provision of this Act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are
1 severable.

SECTION 5. In codifying the new sections added by this Act, the revisor of statutes shall substitute the appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 6. This Act shall take effect upon its approval and shall be repealed on June 30, 2002.
KAISER PERMANENTE
KAISER ON-THE-JOB

Coordinated Care Organization - CCO

Operations Overview

December, 1998
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  Kaiser On-The-Job CCO Services, Attachment 3
  Workers’ Compensation Coordinated Care Agreement, Attachment 4
Kaiser Permanente Medical Care Program is a comprehensive prepaid group practice health maintenance organization (HMO) that has been serving the people of Hawaii since 1958. Kaiser Foundation Health Plan, Inc. (Health Plan), Kaiser Foundation Hospital (Hospital), and Hawaii Permanente Medical Group, Inc. (Medical Group) jointly operate the Kaiser Permanente Medical Care Program in Hawaii.

Kaiser Permanente provides appropriate high quality health care via an efficient and effective delivery system for approximately 210,000 members who live in the State of Hawaii and throughout the Pacific Basin. In addition, Kaiser Permanente is also the only provider of direct care services in Hawaii for more than 6.4 million mainland Kaiser members who may visit or live in our state on a part time basis. Health care services are also open to non-members in Hawaii and the Pacific Basin.

Kaiser On-The-Job

Kaiser On-The-Job is Kaiser Permanente’s managed or “coordinated” care program for Workers’ Compensation. Initiated in 1986 as JOB CARE, the Occupational Health Program has expanded in terms of providers, services, systems, and case management.

The change in name to Kaiser On-The-Job in 1996, reflects Kaiser Permanente’s national interest in providing consistent and quality programs addressing Workers’ Compensation issues. It also demonstrates Kaiser Permanente Hawaii Region’s commitment to all Hawaii’s employee health care needs, whether work or non-work related, for members and non-members.

Keeping within the HMO philosophy, Kaiser On-The-Job incorporates the same managed care components of the Health Plan. However, managed workers’ compensation requires a specific focus on work-related issues, including specialized occupational health providers, disability containment, case management, and administrative requirements of the Workers’ Compensation system.

Kaiser On-The-Job takes a 4 way approach to meeting our goal of providing better care for injured workers, streamlining the process, and ultimately reducing the cost of workers Compensation.

1. Develop partnerships with employees, labor organizations, and employers through ongoing communication and accurate information.

2. Offer a full continuum of care that:
   - Assists in the prevention of work related injuries and illnesses
   - Provides quality, timely, and appropriate medical care for injured or ill employees
   - Returns injured employees to work as soon as medically appropriate.

3. Integrates administrative and case management services with medical care to meet the needs of Workers’ Compensation system.
4. “Manages” the care to:

- stress quality and appropriate treatment in the right setting and management of services within a network of qualified providers.
- measure the effectiveness of the process in terms of outcomes (return to work, utilization of services, and customer satisfaction).

See Kaiser On-The-Job brochures sample, Attachment 1.

**Provider Network**

Ref: 386-A (5) (6) (8)

**Network Composition**

Kaiser Permanente offers a fully integrated medical delivery system. Within the network, are providers who are essential to the care of work-related injuries and illness. The following list includes the medical and support specialties, facilities, and ancillary services required to provide appropriate and timely treatment for injured employees.

Most types of medical specialties and services are available within Kaiser Permanente. Those unavailable services will be provided through contracted arrangements. Vocational Rehab is one such pending contracted arrangement. Access is available through an established referral process and based on medical necessity.

See Exhibit A.1 for physicians by specialty and services available by clinic location.

**Medical Specialties**

- Allergy/Immunology
- Anesthesiology
- Cardiology
- Dermatology
- Emergency Medicine/Urgent Care
- Family Practice
- Hematology/Oncology
- Infectious Disease
- Internal Medicine
- Neurology
- Neurosurgery
- OB/GYN
- Ophthalmology
- Orthopedics
- Otolaryngology
- Pathology
- Preventive/Occupational Medicine
• Psychiatry
• Physiatry
• Plastic Surgery
• Pulmonology
• Radiology
• Surgery
• Urology

Support Services

• Audiology
• Acupuncture
• Chiropractors
• Clinical Nurse Specialties
• Home Health
• Massage Therapy
• Nutrition
• Occupational Therapy
• Opticians
• Optometry
• Osteopathic Physicians
• Physical Therapy
• Podiatry
• Psychology
• Social Services

Facilities

• Clinics
• Hospital
• Pharmacy Locations

Ancillary Services

• Radiology/Diagnostic Imaging
• Laboratory
Occupational Health Services Clinics - “Hub”

The Occupational Health Services Clinics serve as “hubs” for occupational medicine physicians, case management, safety, prevention, and administration. There are four (4) Occupational/Industrial Medicine clinics on Oahu, one (1) in Kona, Hawaii, and one (1) in Wailuku, Maui. Oahu “hub” clinics are located in Kaiser Permanente’s Punawai Clinic to cover Leeward Oahu, Moanalua Clinic to cover the Airport area, and Honolulu Clinic to cover Ala Moana and Downtown and Kaneohe Clinic to cover Windward Oahu.

As a team, physicians, nurses, nurse case managers, and administrative staff working together in the same location to treat, refer, case manage, gather data, and communicate with the patient and employer. As the Workers’ contact centers, both internal and external customers have a centralized, dedicated, and knowledgeable place to call.

Access To Care
Ref: 386-A (4), H

Physician Access

Occupational Medicine Physicians - “Attending Physicians”

There are seven (7) Occupational Health Services physicians working in the Occupational Health Services Clinic - hubs. These physicians serve as the “Attending Physicians” for Kaiser On-The-Job CCO enrollees and are primarily responsible for the treatment of an injured employee’s injuries. The Occupational Medicine Physicians are Board Certified in Occupational Medicine, Emergency Medicine, Physiatry, and Internal Medicine. See Exhibit B for a listing of Occupational Medicine Physicians.

Choosing an Occupational Medicine Physician

Initial visits for injured employees may be scheduled with any of the Occupational Medicine Physicians. After the appointment employees will select their attending physician which may be the physician they have just seen, or one of the other Kaiser On-The-Job Occupational Medicine Physicians. The attending physician selected will be responsible for all future care. Transfer to another Occupational Medicine Physician is authorized by the approval of the Chief of Occupational Medicine and the Employer.

Kaiser Permanente Health Plan Primary Care Physician

In the event an employee goes to his/her Kaiser Permanente Primary Care Physician for work-related injury or illness care, the employee will be treated, then triaged to an Occupational Medicine Physician for follow up care. After this visit, the employee will select his/her “Attending Physician”. 

4
Specialty Care

Specialty care, support services, and ancillary services are provided with a referral from the Occupational Medicine Physician, or may be referred directly from the Emergency Department. Care is managed by the specialist in conjunction with the Nurse Case Manager until ready to be referred to an Occupational Medicine Physician.

Chiropractic Care

Chiropractic care is provided through a referral to ChiroPlan, Inc., a managed chiropractic IPA. All referral requests are approved by the Occupational Medicine Physician. Referrals are limited to no more than 6 treatments; then patient is referred back to their attending Occupational Medicine physician. Employees may be seen at either the Kaiser Permanente Occupational Health Services Honolulu Clinic or at the chiropractor’s office. See Exhibit C for a listing of ChiroPlan, Inc. chiropractors.

Appointment Access

Emergent/Urgent Care

If the injury is a life threatening, the employee should go directly to the nearest emergency room. If the injury is URGENT, but not life threatening, the employee should go to the nearest Kaiser Permanente Occupational Health Clinic, Urgent Care facility, or the Emergency Department. Patients seen in the Kaiser Permanente Emergency Department or Urgent Care Clinics will be triage to an Occupational Medicine Physician for follow up care.

Should an employee receive care at a non-Kaiser Permanente facility on Oahu, Maui, or the Big Island, the employer/employee should notify the Customer Service Representative. He or she will contact the appropriate nurse case manager who will assist the employee with follow up care at Kaiser Permanente.

Non Emergent Care/Office Visit

The employee should call one of the Occupational Health Services Clinics or any other Kaiser Permanente Clinics for an initial appointment. (See Exhibit A.2.) Follow up visits will be scheduled at the most convenient Occupational Health Services Clinics.

CCO Process Flow

Kaiser On-The-Job process flow outlines the process and roles of the patient, supervisor roles of nurse case managers and appropriate providers. (See Exhibit D.)

Handbooks

Manager/Supervisor Handbook and Employee Access Guides are given each supervisor and employee during orientation to the Kaiser On-The-Job program. See sample Handbooks, Attachment 2.
The case management program identifies, coordinates and evaluates the services required to respond to an injured worker’s medical, psychological, and vocational needs. The goal is to provide cost effective quality care and return the employee to productive work.

**Components of the Case Management Program**

- Communication
- Coordinating, Facilitating and Expediting Medical Care
- Return to Work

**Communication**

As the liaison between employer, employee, carrier and provider, the Nurse Case Manager serves as the primary contact for medical, administrative, and return to work issues, specific to the injured/ill employee. He/She would be the point of contact for the employer and carrier to discuss case status, procedures, and information involving any area of Kaiser On-The-Job. The communication activities for the Nurse Case Manager include:

**Employee**

- Facilitate the understanding of medical care and act as employee contact point to Kaiser On-The-Job during the treatment, and back to successful work placement.
- Phone contact to employee within 24 hours of care.
- Conduct an assessment of employee issues and perspective, then monitor perception of progress between visits.
- Follow up with employee on missed appointments.
- Counsel and educate employee about the Workers’ Compensation system.
- Assist with conflict resolution.

**Employer**

- Phone/fax information on extent of injury, return to work status and physical limitations within 24 hours of care.
- Clarify questions and negotiate uncertainties associated with diagnosis, prognosis, and treatment plan.
- Resolve discrepancies or conflicts among employee, employer, carrier, and provider perspectives as they arise.
- Counsel, clarify, or negotiate modified work options if not currently in place.
- Monitor perspective on employee’s progress toward return to full level of functioning.
- Assist with conflict resolution.
Provider:
• Assist in referral process to expedite specialty care.
• Provide interim follow up information about the employee’s progress and compliance with treatment regimen as indicated.
• Schedule meetings between employer, carrier, provider, and nurse case manager when needed.
• Gather appropriate case information for presentation to the Review Board.
• Recommend IME referral to non CCO provider.

Coordinating, Facilitating and Expediting Medical Care

The Nurse Case Manager works directly with the occupational medicine physician, specialists, employee, and other team members to develop an appropriate treatment plan and facilitate its successful outcome. Management of the case begins at the time of injury and follows the treatment process through successful return to work. Key intervention points are:

• Specialty care involvement
• Multiple referrals
• Hospitalization
• Time loss
• Progress and adherence to the treatment plan
• Psychological issues, pharmaceutical issues, or motivational problems
• High risk indicators and threshold
• All care provided by contract providers or outside Kaiser Permanente network.

System processes that enable the Nurse Case Manager to coordinate, facilitate and expedite care include:

• Treatment guidelines to alert possible intervention points (see Treatment Guidelines, page 11).
• Computerized case management system to monitor individual cases including:
  • visit types
  • services provided
  • admissions to hospital
  • referrals to specialty and ancillary care
  • level of duty
  • return-to-work update
  • historical Worker’s Compensation treatment data
• Case Management Guidelines to assess and define level of case complexity and identify case manager level. See exhibit E.
• Review Board to assist in a team effort to move patient toward maximum recovery.
Return to Work

The Return to Work program identifies limited duty opportunities for placement of injured employees, then coordinates the return to work efforts with employees and employers. The Nurse Case Manager facilitates this process in the following ways:

• Coordinates worksite visits with Occupational Medicine Physicians and Safety Consultants.
• Reviews light/modified duty job descriptions with employer.
• After injury, reviews the job description. If indicated, recommends possible work modifications to the employer that may allow the employee to return to work.

Safety and Prevention
Ref: 386-A, 386-K

Worksite Assessment*

To assess the workplace environment, a questionnaire and tour of the worksite is conducted. See Exhibit F for a menu of optional prevention and safety services designed to:

• Identify existing safety and prevention activities already in place at the worksite.
• Initiate discussion of possible safety and prevention activities and/or services that could impact on the type of work-related injuries and illnesses prevalent in the business. See Exhibit G.
• Gain a better understanding of the worksite and the type of jobs done there.
• Review employer’s modified duty availability and return to work options.
• Review OSHA/DOT regulatory issues.

Safety Committee Assistance*

To assist employers with meeting the safety committee requirements mandated by SB 2386, the following optional services are available:

• Template - Creating a Safety Committee, includes:
• Instructions on how to set up a safety committee
• Policy & Procedure Template
• Agenda Template
• Minutes Template
• Accident Investigation Template
• Workplace Inspection Template
• Training - Creating a Safety Committee, includes:
• Mission Statement
• Membership Selection
• Scheduling
• Agenda and Minutes
• Training - Accident Investigation
• Training - Workplace Inspections

Options to basic CCO program
Quality Management
Ref: 386-A (3), 386-G

Program Description

Kaiser Permanente’s Quality Management Program monitors and evaluates significant aspects of clinical care and administrative services provided to patients. The program takes a broad based approach to monitoring, integrates cross-functional activities, and uses multidisciplinary quality improvements teams. The program includes the continuum of care, including inpatient and ambulatory care and all departments and clinics.

The National Kaiser Foundation Hospitals/Health Plan Boards’ of Directors maintain the ultimate accountability and responsibility for the oversight of the Quality Management Program. The Board has delegated this responsibility to the Board’s Quality Committee which, in turn, holds Hawaii’s Regional Manager and Medical Director accountable for the day-to-day quality management activities and outcomes for the Region.

The Regional Manager and Medical Director co-chair the Quality Council which, through the Quality Information Team, assures consistent and comprehensive reporting up through the organization, provides focus, identifies major organization quality initiatives, and evaluates progress and outcomes. The Quality Information Team has oversight responsibility for:

- Quality metrics (clinical and service measures)
- Accreditation and licensing
- Professional competency and performance (credentialing)
- Practice guidelines
- Utilization management.

Quality Metrics

Monitors clinical quality topics included in the scope of the Quality Management Program for the Region through:

- Medical record review
- Preventive health guidelines
- High-risk, high-volume, chronic, and acute care
- Monitoring of practice (treatment) guidelines
- Over and under utilization
- Adverse outcomes and sentinel events
- HEDIS performance measures
- Problem/risk/concerns generated by staff.
Quality of service reviews included in the scope of the Quality Management Program for the Region are:

- Patient satisfaction surveys
- Access to appointments
- Telephone access
- Patient complaints
- Provider satisfaction survey

Monitoring in relation to Kaiser On-The-Job is based on Workers’ Compensation services provided by Kaiser Permanente physicians and staff. In addition to these Regional reviews, Kaiser On-The-Job specific quality measures include:

- Employer and carrier satisfaction surveys
- Specific work related disease/injury treatments
- Return to work parameters
- Claim/billing management.

**Accreditation and Licensing**

Kaiser Permanente Hawaii earned the National Committee for Quality Assurance’s (NCQA) highest rating - three year full accreditation. NCQA accreditation is a nationally recognized evaluation that purchasers, regulators, and consumers can use to evaluate managed care plans. The NCQA accreditation process reveals how well a health plan manages all parts of its delivery system, including physicians, hospitals, other providers, and administrative services, in order to continuously improve the health of its members/patients. Full accreditation is granted for a period of three (3) years to those plans that have excellent programs for continuous quality improvement and meet NCQA’s rigorous standards.

Additional accreditations include:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- American College of Surgeons for Kaiser Permanente’s Tumor Board and Cancer Program
- College of American Pathologists for Kaiser Permanente’s laboratories
- American College of Radiology for Kaiser Permanente’s mammography facilities.

**Credentialing**

The Regional Credentials and Privileges Committee perform the Credentialing function within the Hawaii Region. This Committee, in conjunction with the chief of the pertinent clinical department or subspecialty, reviews, inquires as necessary, and evaluates the professional competence, educational background, qualifications, ethical standing, physical and mental health, quality of professional practice, adequacy of professional liability protection, character, behavior and personality of the applicant, as relative to the membership or privileges requested. Each provider is properly credentialed prior to providing care or service to a patient.
Recredentialing is performed biennially. The Credentials Department collects and shares data from a variety of sources including Quality Metrics, Risk Management, Operations Support and Consulting Resources, Medical Records, Utilization Management, and ancillary departments with the candidate’s clinical department chief. The Department Chief and Credentials Committee reviews, then recommends approval, denial or deferral of reappointment to the Quality Council. The data used for this process is kept in a confidential, quality peer review file.

**Practice/Treatment Guidelines**

Treatment or practice guidelines have been developed to provide a plan of treatment for use by Kaiser Permanente physicians for the most common work-related injuries and illness. The guidelines for care and expected return to work parameters are based on a given type of injury category, providing the foundation for consistent and expected outcomes. Developed by Kaiser Permanente physicians in the Northwest and Hawaii regions, these guidelines are updated annually based on best practices. These seventy-five (75) treatment guidelines include:

- Supporting evidence (subjective and objective) for the specific guideline
- Diagnostic study recommendations
- Follow up criteria
- Referral criteria
- Return to work recommendations

The Nurse Case Managers use these treatment guidelines to target outcomes for utilization and return to work. (See Exhibit H).

**Utilization Management**

All utilization management efforts are managed jointly by physician-manager partnerships. These partnerships focus on improving systems and processes of care through collaborative initiatives within the Region. Kaiser Foundation Health Plan (KFHP) - Hawaii does not encourage or reward over-or-under-utilization of services.

Clinical practice/treatment guidelines are made available to the Hawaii Permanente Medical Group (HPMG) providers through the new physician orientation and the HPMG provider manual. Clinical practice guidelines, including specific work-related treatment guidelines are distributed by the clinical department chiefs. All HPMG physicians and staff have access to InterQual ISP criteria, Severity of Illness/Intensity of Service, as well as Miliman & Robertson Health Care Management Guidelines.

Preauthorization for hospitalization is not required when managed or directed by HPMG physicians, referrals to Kaiser Permanente specialists, or special procedures which are provided by Kaiser Permanente physicians. Preauthorization is required for all in-Region care at contract facilities and these referrals are reviewed and authorized by the clinical Department Chief for Oahu or the Neighbor Islands Physician-in-Charge for Maui and
Hawaii. Referrals to non-Kaiser Permanente providers are redirected to HPMG physicians when the capacity or capability exists within the group. Preauthorization is required for all services which are provided outside the Hawaii Regions’ service area.

The Utilization Review functions and protocols are performed by the Managed Care Coordination staff, physician advisors and appointed designees. For Workers’ Compensation cases, the Nurse Case Manager works in tandem with the Managed Care Coordination staff and physician advisors to monitor cases on a concurrent and retrospective basis. The Nurse Case Manager works with the staff to insure that the discharge and movement of patient to a lower level of care is timely and appropriate.

**Review Board**

The Review Board facilitates resolution and closure of complex cases with multiple medical and/or employee, employer, or carrier issues. The Board reviews cases that extend beyond treatment guideline from all Occupational Health and specialty departments and provides treatment recommendations from timely resolution of the case.

The Review Board is chaired by the Chief, Occupational Health Services. Board members include representatives from Occupation Health Services department, neurology, orthopedics, physical/occupational therapy, chiropractic, mental health and other invited professionals as indicated.

The Review Board convenes monthly or as needed to review cases which have:

- Exceeded medical or return to work guidelines
- Identified as complex or problem issues by Nurse Case Manager
- Significant patient/physician conflict
- Multiple claims
- Remained in treatment beyond 6 months
- Involved employee, employer, or carrier dissatisfaction or logged complaint
- Reached level II in formal dispute resolution process (see page 13).

**Dispute Resolution**

Ref: 386-A (9)

Dispute Resolution for consumer complaints follows Kaiser Permanente’s customer service complaint and appeal program for verbal and written issues, including the collection, response, and appeal process.

Patient’s issues regarding Workers’ Compensation are sent to the Occupational Health Services clinic for action, then triaged to appropriate Occupational Health Services area for review. See Exhibit I for Dispute Resolution Process Flow:
**Level I:**

Types of Issues: Resolve employee, employer or carrier concerns, complex return to work placement, complex time loss issues, treatment plan issues, facilitate IME.

Resolution process/staff: Problem resolution at Worker’s Compensation Regional level by Workers’ Compensation Appeal Coordinator.

Response time: Within 3 working days.

**Level II**

Types of Issues: Unresolved medical problems work related or otherwise. Work issues include ability to do required job modifications. Family problems, other conflicts including financial. Issues surrounding scheduling appropriate consultations, and investigations. All medical legal issues.

Resolution Process/Staff: Problem resolution at regional level is done by multi-disciplinary team - Review Board, which is the final decision-making step. (See Review Board, page 12).

Response Time: Within 10 working days.

Dispute resolution decisions and instructions for subsequent appeal rights are communicated to those employees given the Employee Handbook and with initial acknowledgment of any complaint. Customer Service Representatives are available to assist employees in contacting Occupational Health Staff who will triage and initiate the resolution process at the appropriate level. For Level I, communication will be verbal or written. For Level II, communication will be written.
Employee Injured.

Employee reports to supervisor/manager.

Emergency Care (life threatening)
- Go directly to Kaiser Permanente Moanalua Medical Center or the nearest Emergency facility.


If not seen in OHS clinic, employee referred to OHS clinic of choice.

Employee treated at OHS clinic; attending physician selected, and employee given duty status.

Not life threatening, but Urgent
- Go to Kaiser Permanente Moanalua Medical Center, Urgent Care Clinic, or OHS Clinic.

Non-Emergency Care
- Call for initial appointment at one of the Occupational Health Services (OHS) clinics or primary care clinics.

Employee faxed by the next working day:
- Diagnosis
- Plan of treatment
- Return to work status
Nurse Case Manager reviews against guidelines and transitional duty opportunities.

If referral to specialty care is required, fax information to employer.
Nurse Case Manager checks treatment guidelines; facilitates appointment with specialist.
- Chiropractic care is referred for no longer than 6 treatments.

Employer faxed the status of specialty visit and hospitalization, if necessary.

Specialty care/chiro completed, referred back to OHS attending physician.
Nurse Case Manager checks treatment guidelines and modified duty options.

Physician recommends referral to vocational rehab. Nurse Case Manager notifies employer of status. Consults with carrier.

If medical still open, M.D. continues to treat.

Nurse Case Manager follows case to closure.

Employee returns to work, case resolved.

Medical case closed.

EXHIBIT D

CCOPRCES.GFC 12/16/98
## Kaiser On-The-Job
### Hawaii Division
#### Case Management Guidelines
#### Levels of Case Management

<table>
<thead>
<tr>
<th>Nurse Case Manager I</th>
<th>Nurse Case Manager II</th>
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<tbody>
<tr>
<td><strong>CM Indicators</strong></td>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Uncomplicated treatment.</td>
<td>Case are not complex but required clinical judgment.</td>
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<tr>
<td>RTW same day after treatment.</td>
<td>Injury requires more than 4 days but less than 4 weeks of lost time off work or special RTW placement.</td>
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<tr>
<td>RTW with modified duty.</td>
<td>Treatment requires referrals, but care continues to be managed by OHS provider.</td>
</tr>
<tr>
<td>Care not to exceed 3-5 visits.</td>
<td>History of previous injuries.</td>
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<tr>
<td>No more than 4 days of lost time.</td>
<td>Anticipated recovery may be full or partial.</td>
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<tr>
<td>Expected full recovery.</td>
<td>Complex billing issues.</td>
</tr>
<tr>
<td>Uncomplicated billing issues.</td>
<td>Employer issues with care of services</td>
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<tr>
<td>Authorization for treatment (tests &amp; procedures)</td>
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<table>
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<th>Example</th>
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Kaiser On-The-Job

Worksite Assessment Questionnaire

Company: _____________________________________________________________

Representative Name: ________________________________________________

Title: ______________________________________________________________

Address: ___________________________________________________________

Phone: _____________________________________________________________

Carrier/Rep: _________________________________________________________

1. Safety Program: ____________________________________________________

   Regular Safety/Manager Meetings: ___________________________________

2. Job Descriptions: _________________________________________________

   # Employees/Categories: ___________________________________________

   Safety Sensitive Positions: __________________________________________

   Job Function Analysis: _____________________________________________

3. Transitional Duty: _________________________________________________

4. Equipment Used: _________________________________________________

5. Protective Equipment Used: _________________________________________

6. Regulatory Compliance Needs: _________________________________

   OSHA, DOT: ______________________________________________________
Kaiser On-The-Job

Worksite Assessment Questionnaire

7. OSHA Log Information: Injury trend analysis:


8. Safety/Prevention Concerns:


9. Worksite Walk Through: Date: ____________ Time: ____________


Comments:


10. Action Plan:


Completed By: __________________________ Date: ____________

workques.doc 12/9/98
# KAISER ON-THE-JOB PREVENTION AND SAFETY SERVICES

## EMPLOYMENT PHYSICALS
- Post Offer
- Return to Work Evaluation
- Periodic Basic
- Periodic Comprehensive
- CDL (Commercial Driver’s License)
- Crane and Hoist
- Coast Guard
- Respirator Clearance
- Chest x-ray
- Asbestos Screening

## SUBSTANCE ABUSE TESTING
- NIDA/Non-NIDA Panel 5 Drug Screen
- NIDA/Non-NIDA Panel 10 Drug Screen
- Urine Specimen Collection
- Breath Alcohol Screen
- Blood Alcohol Testing (NIDA)
- Urine Alcohol Testing

## IMMUNIZATIONS
- Hepatitis B
- Hepatitis A
- Tetanus/Diphtheria
- TB/PPD
- Influenza

## ONSITE SAFETY AND PREVENTION CLASSES
- Back Injury Prevention
- Safety Awareness in the Workplace
- Workplace Ergonomics
- Hearing Conservation
- Hazard Communication
- Respiratory Protection
- Blood Borne Pathogens
- Carpal Tunnel Syndrome

## ENVIRONMENTAL HEALTH AND SAFETY SERVICES
- Ergonomic Worksite Analysis
- Indoor Air Quality Investigations
- Occupational Noise Survey
- Illumination Survey
- Safety Inspections
- Safety Committee/Consultations

## WORKSITE WELLNESS PROGRAM
- Health Fair
  - Blood Pressure
  - Body Fat
- Expanded Program
  - Add Cholesterol and Glucose Testing
Kaiser On-The-Job

Dispute Resolution Process Flow

Complaint or disputed services.

Dispute to be reviewed by Kaiser's Workers' Compensation Appeal Coordinator with a response time of three (3) working days.

Unresolved issues go to Kaiser's Review Board, which is Kaiser's final decision making step, with a response time of ten (10) working days.

Should the complainant still not be satisfied with the proposed resolution, they may appeal to Dept. of Labor.

Dispute resolved.
Kaiser On-The-Job

CCO Services
Ref: 386-D (3)

Quality Care:
- Quality Management Program:
  Monitors and evaluates significant aspects of clinical care and administrative services. Components include clinical and service measures, accreditation, credentialing, treatment guidelines and utilization management.

Range of Treatment/ Variety of Specialties
- Medical Providers:
  Integrated network of providers, including dedicated Occupational Health, Primary, Specialty, Ancillary Care, Hospital, Optical, and Pharmacy, serving Oahu, Maui, and Hawaii, in seventeen (17) clinic locations.

Efficient, Cost Effective, Timely Care:
- Case Management:
  Dedicated Nurse Case Managers assigned to each patient. Primary interface on all clinical, return to work and administrative issues for carriers, employers, providers and patients.
- Communication:
  24-48 hour notification of visit status, including diagnosis, return to work status, and follow up appointments for additional treatment.
- Treatment Guidelines:
  Treatment Standards and Protocols, specific to work related injuries. Addresses evaluation, treatment, return to work and length of disability, criteria for referral to specialty care, and frequency of care.
- Return to Work:
  Coordination of limited duty opportunities to assure successful and safe return to work of injured employees.

Service/Dispute Resolution:
- Internal Dispute Resolution: Formalize Appeal/Complaint Procedure.
- KOTJ Review Board: Team process to resolve and close complex cases.
- Survey: Patient satisfaction study.
- Data Collection: Tracking: number of employees enrolled in the CCO, disenrolled employees, and the reasons for disenrollments.
- Reporting Summary and Detail Case reports.
Understandable Process for Care:

- Training:
  
  Open enrollment session, formalized supervisor and employee training sessions, supported by handbooks on how to access care within KOTJ CCO.

- Safety & Prevention
  
  Full array of safety and prevention services geared to reduce the incidence of injury and illness. Includes variety of work-related physical and surveillance exams, drug testing, immunizations, worksite health and environmental safety consultations, trainings, and health appraisals/screening activities.
APPENDIX D
STRAUB HEALTHWORKS
COORDINATED CARE ORGANIZATION

Introduction

I. Access and Process
   A. Locations
   B. Accessibility
   C. Monitoring and Tracking
   D. Case Management
   E. Information
   F. Fee Schedule

II. Credentialed Providers

III. Treatment Guidelines

IV. Quality Control

V. Health Promotion and Injury Prevention

VI. Appendix
   A. Coordinated Care Organization Process Flow
   B. Work Status Report
   C. Ready, Able and Working Program
   D. Primary Treating Physicians
   E. Specialty Physicians
   F. Workers’ Compensation Treatment Guidelines
   G. Dispute Resolution Process Flow
   H. Workers’ Compensation Coordinated Care Dispute Investigation Form
Introduction:

Straub was founded in 1921 when Dr. George F. Straub formed a partnership with four other physicians known simply as “The Clinic.” In 1952, the organization was renamed Straub Clinic. In 1973, when the hospital was opened, it was renamed Straub Clinic and Hospital.

Today, Straub Clinic and Hospital, Inc. is one of the oldest and largest private group medical practices in Hawaii, with approximately 160 physicians representing nearly every medical specialty, 1,581 employees, and a 159-bed hospital. Although the majority of Straub’s patients are from the island of Oahu, the multi-specialty clinic treats many people from the neighboring islands, the mainland USA, Pacific islands and Asia, as well as visitors from around the world.

Straub’s main facility is in Honolulu on South King Street. The main clinic and eight satellite clinics on Oahu and one each on Lanai and Hawaii make primary care and certain specialty care convenient for Hawaii residents in key population areas. Straub’s eleven clinics are located in Honolulu, (the one at King Street and one in the financial district on Alakea Street), Hawaii Kai, Kailua, Kaneohe, Kapolei, Mililani, Pali Momi, Westridge, Lanai, and Kailua-Kona on the Big Island. The King Street operation includes three connected clinic buildings built in 1933, 1952 and 1963, a six-story hospital completed in 1973, and another three-story clinic building completed in 1981. The six-story hospital facility connected to the main clinic buildings provides a full range of inpatient diagnostic and other acute services, with the exception of obstetrics, pediatrics, and psychiatry. Straub hospital provides limited inpatient care for these three services.

Workers’ Compensation services are provided at all locations with specialty Workers’ Compensation service at Beretania, Kapolei, and Westridge.
I. Access and Process

A. Locations

1. Primary Treatment Center (PTC)

   Straub Beretania
   839 S. Beretania St.
   Honolulu, HI  96813
   Phone:  522-4320

   Straub Kapolei
   Kapolei Building, next to the Post Office
   1001 Kamokila Blvd., Suite 115
   Kapolei, HI  96707
   Phone:  674-2930

   Straub Westridge
   Westridge Shopping Center
   98-150 Kaonohi St.
   Aiea, HI  96701
   Phone:  488-8431

2. Other Straub Treatment Centers

   Straub Doctors On Call
   Bank of Hawaii Waikiki
   Phone:  971-6000

   Straub Financial District
   801 Alakea St., Ground Floor
   Honolulu, HI  96813
   Phone:  545-5850

   Straub Hawaii Kai
   Koko Marina Shopping Center
   7192 Kalanianaole Hwy.
   Honolulu, HI  96825
   Phone:  396-6321

   Straub Hilo
   670 Ponohawai Street, Suite 208
   Hilo, HI  96720
   Phone:  (808) 935-4199
Straub Kailua
641 Kailua Rd.
Kailua, HI 96734
Phone: 262-2377

Straub Kailua-Kona
75-170 Hualalai Road
Kailua-Kona, HI 96740
Phone: (808) 329-9211

Straub Kaneohe
Windward Mall
45-056 Kamehameha Hwy.
Kaneohe, HI 96744
Phone: 235-0099

Straub Kapahulu
750 Palani Avenue
Honolulu, HI 96816
Phone: 735-9011
(24-hour emergency services)

Straub King Street
888 S. King St.
Honolulu, HI 96813
Phone: 522-4000

Straub Lanai
628B Seventh Street
Lanai City, HI 96763
Phone: (808) 565-6423

Straub Manoa
1904 University Avenue
Honolulu, HI 96822
Phone: 973-5930

Straub Mililani
Mililani Town Center
95-1249 Meheula Parkway
Mililani Town, HI 96789
Phone: 625-6444

Straub Pali Momi
98-1079 Moanalua Rd., 6th Floor
Aiea, HI 96701
Phone: 487-2477
B. Accessibility

Injured workers may be seen at any Straub location during normal working hours and twenty-four (24) hours a day at the Straub King Street Emergency Room and Straub Doctors on Call at Bank of Hawaii Waikiki. Any injuries requiring emergency treatment are seen immediately. Non-emergency cases are seen on a same day walk-in basis at any of the three Primary Treatment Centers or within two working days at all other Straub locations.

C. Monitoring and Tracking

All new Workers’ Compensation cases seen at any Straub location are identified by company and flagged for monitoring and management by Straub’s case coordinators. Case coordinators work with the employee, the employer and the insurance carrier to facilitate case management and return to work.

D. Case Management

An Occupational Health Nurse Specialist will initially review all injuries to workers seen at Straub. See Coordinated Care Organization Process Flowsheet at Appendix A. Uncomplicated case management issues will be provided for employees at no charge. These include:

1. Cases with no more than four (4) lost work days
2. Cases with less than five (5) medical visits

A case management fee of $85 per hour and expenses will be billed for complicated cases which include:

1. Five (5) or more days of lost work
2. Hospitalizations and surgeries
3. Multiple injuries and/or cases
4. Complex diagnostic procedures
5. Dual diagnosis cases, i.e. physical injury with psychological component
6. Referral to specialist

E. Information

1. A work status report (Appendix B) is faxed or called to the employer the same day the employee is seen at a Primary Treatment Center, or within one working day if seen at other locations, with a copy to the employee to return to the employer.

2. Reporting requirements are fulfilled in compliance with Hawaii Workers’ Compensation regulations.
3. Quarterly summary reports will be provided at no charge. Open and/or close case management reports will be provided on request and are subject to a fee of $75 per report. Any additional reports that are requested are subject to fee negotiation.

4. Straub’s early return to work program, Ready, Able and Working, (Appendix C) assists employees in returning to modified work or full duty as soon as medically feasible.

F. Fee Schedule

1. The fee schedule for primary and specialty treating physicians is the State Workers’ Compensation fee schedule. All billing is through Straub’s fee-for-service billing system with the insurance company serving as guarantor.

2. IME evaluations will be provided at $250 per hour. This will be billable for examination, record review, dictation, consultation, and transcription review. Fees for complex IME cases will be negotiated prior to scheduling the exam.

3. Our current staff for IME exams consist of the following physicians:

   Deborah Agles, M.D., Occupational Medicine
   Clarissa Burkert, M.D., Occupational Medicine
   John Endicott, M.D., Occupational Medicine
   Vern Sasaki, M.D., Occupational Medicine
   Lance Yokochi, M.D., Occupational Medicine
   Robert Lindberg, M.D., Orthopedics
   Kenneth Nakano, M.D., Neurology
   William Tsushima, M.D., Psychology

II. Credentialed Providers

Employees requiring urgent treatment may be seen by any Straub physician at any Straub location with monitoring by a Certified Occupational Health Nurse Specialist. Employees are encouraged to select a Workers’ Compensation Primary Treating Physician from (Appendix D). Primary Treating Physicians will refer to specialists (Appendix E when appropriate).

A. Primary Treating Physicians (Appendix D)

Primary Treating Physicians (PTPs) for Workers’ Compensation are coordinated care specialists in family practice, internal medicine, or occupational medicine. PTPs assume the “gatekeeper” function in providing primary Workers’
Compensation services. They also request authorization for appropriate referrals to sub-specialists, ancillary services and hospital services when necessary.

Specifically, a PTP will:

- Coordinate the overall quality of medical care delivered to Coordinated Care patients, including providing primary care and serving as a "gatekeeper."
- Control utilization of health care services.
- Ensure provision of adequate medical services and obtain authorization to render only those services necessary for proper care.
- Provide adequate access to Coordinated Care patients. If the PTP is on leave, the patient may see another PTP.
- Take responsibility for completing summary sheets.
- Participate in peer chart audits.
- Take responsibility for making preventive recommendations to patients and documenting compliance.
- Complete certain forms and other paperwork as required by DOL.

B. Specialty Physicians (Appendix E)

C. IME/PPD Providers

1. Deborah Agles, M.D., M.P.H.

   Board Certified in Occupational Medicine, Board eligible in Preventive and Aerospace Medicine. Graduate of Rush University Medical College, Master’s degree in Epidemiology. Residency in Preventive Medicine at the University of Hawaii John A. Burns School of Medicine.

2. Clarissa Burkert, M.D., M.P.H.

   Board Certified in Internal Medicine, Board Certified in Occupational Medicine, Certified Independent Medical Examiner. Graduate of University of Hawaii John A. Burns School of Medicine. Residency at Tripler Army Medical Center.

3. John Endicott, M.D., M.P.H.

   Board Certified in Occupational Medicine, Certified Independent Medical Examiner. Graduate of Oregon Health Services University. Residency in Occupational Medicine at the University of Washington School of Public Health and Preventative Medicine.
4. Lance Yokochi, M.D., M.P.H.

Board Certified in Internal Medicine, Certified Independent Medical Examiner. Graduate of the University of Hawaii John A. Burns School of Medicine, Master's degree in Environmental Health. Residency in Internal Medicine at the University of Hawaii Integrated Medical Residency Program.

5. Vern Sasaki, M.D., M.P.H.

Board Certified in Occupational Medicine. Graduate of the University of Hawaii John A. Burns School of Medicine, residency in Internal Medicine at the University of Hawaii Integrated Medical Residency Program. Master's degree in Environmental-Occupational Health/Epidemiology at the University of Hawaii, residency in Occupational and Environmental Medicine at the University of California, Irvine.

D. Chiropractic Referral

All chiropractic referrals will be coordinated through the Occupational Medicine Department. Referrals for chiropractic care will follow these guidelines:

1. Soft tissue injuries without neurological complications.
2. Treatment of acute back and neck injuries.
3. Therapeutic trial in patient with no response to traditional treatment and medication.
4. As an adjunct to physical therapy for spinal mobilization.

E. Alternative Care

All alternative Care referrals will be coordinated through the Occupational Medicine Department.

III. Treatment Guidelines

Treatment protocols and utilization guidelines for care of Workers’ Compensation injuries are as developed by the American College of Occupational and Environmental Medicine, Official Disability Guidelines by Work-loss Data Institute, The Medical Disability Advisor and Rehabilitation Guidelines by Therapeutic Associates, Inc. (Appendix F)

IV. Quality Control

A. Annual customer satisfaction surveys are conducted.

B. A quarterly case review of twenty percent (20%) of the total open cases is conducted to assess compliance with guidelines.
C. Complaint and dispute resolution procedures

All complaints and disputes about Workers’ Compensation care at Straub are initially channeled to a Straub Certified Occupational Health Nurse-Specialist who handles the complaint or triages to the Occupational Medicine Department Chief, insurance company or employer, as appropriate. The Certified Occupational Health Nurse-Specialist will investigate, resolve the complaint, and give the employer and or insurance carrier a status report within three working days. (Appendix G) A log of complaints and action taken is maintained by the Certified Occupational Health Nurse-Specialist. (Appendix H)

D. Peer Review

All complaints, problem cases, cases with less than desirable outcomes or cases identified as non-complaint through the Quality Control process are referred to the Occupational Medicine physician group for review with results of review provided to Straub’s Medical Executive Committee and Quality Assessment Committee.

V. Health Promotion and Injury Prevention

Classes and consultations are available on a fee-for-service basis to clients and companies. Straub’s physicians, physical therapists, occupational therapists, health educators, and Certified Occupational Health Nurse-Specialists provide the following:

- Aerobics
- Back injury prevention
- Body fat analysis
- CardioVisit
- Cholesterol, HDL and glucose screening and education
- CPR/First Aid
- DeskWorks
- Ergonomic evaluations
- Functional capacity screening
- Health risk assessment
- Hypertension screening and education
- Influenza immunization
- Nutrition lectures and demonstrations
- OSHA Complaint On-Site Medical Surveillance exams
- Smoking cessation
- Stress management
- Stride analysis
- Weight management
- Worksite health fairs
- Worksite immunizations
STRAUB HEALTHWORKS
Coordinated Care Program

CCO Process Flow

Employee injured. ➔ Employee reports to supervisor/manager. ➔ Employee requires medical care.

Employee goes to Primary Treatment Center or calls for an appointment and selects Primary Treating Physician (PTP).

Primary Treating Physician (PTP)
- Coordinates the overall quality of medical care delivered, including providing primary care and serving as a “gatekeeper.”
- Controls utilization of health care services.
- Ensures provision of adequate medical services and obtains authorization to render only those services necessary for proper care.
- Provides adequate access, if the PTP is on leave, the patient may see another PTP.
- Takes responsibility for completing summary sheets.
- Participates in peer chart audits.
- Takes responsibility for making preventive recommendations to patients and documenting compliance.
- Completes certain forms and other paperwork as required by DOL.

Case Management
- Case is flagged for monitoring and management.
- Case Coordinator works with the employee, the employer and the claims adjuster to facilitate case management and return to work.
- Reporting requirements are fulfilled in compliance with Hawaii Workers’ Compensation regulations.
- Work status report is faxed or called to employer immediately if seen at a Primary Treatment Center or within one working day if seen at other locations. Copy is given to employee to return to employer.

Employee returns to work. Case resolved.
STRAUB HEALTHWORKS
Coordinated Care Program

Dispute Resolution Process Flow

Complaint or disputed services.

Certified Occupational Health Nurse-Specialist will investigate, resolve the complaint, and give the employer and/or insurance company a status report within three (3) working days.

Problem cases and cases with less than desirable outcomes are referred to the Occupational Medicine physician group for case review with a recommendation rendered within ten (10) working days.

Should the complainant still not be satisfied with the proposed resolution, they may appeal to the negotiated Alternative Dispute Resolution (ADR) process.

Dispute resolved.

Dispute resolved.

Dispute resolved.
WORKERS’ COMPENSATION COORDINATED CARE
Dispute Investigation

Call taken by: ________________________ Date/time of call: ________________________
Assigned to: ________________________ Company name: ________________________
Complainant name: __________________ Complainant relationship to patient: ___________
Patient name: ________________________ DOB: ____________ Life No. ____________
Patient’s phone: ______________________
Nature of complaint: __________________________

Person(s)/department(s) involved:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Type of Problem:
☐ Appointment Access ☐ Patient Care - Staff
☐ Telephone Access ☐ Patient Care - Physician
☐ Billing ☐ Claims Payments
☐ Referral Authorization

ACTION TAKEN
What did complainant want done to correct this issue? ________________________________
________________________________________________________________________
________________________________________________________________________
What was done to correct this issue? ________________________________
________________________________________________________________________
________________________________________________________________________

Date complainant called: ________________ Date letter sent to complainant: __________
Was complainant satisfied? _________________________
Other comments: ____________________________

Complaint Handler: ________________________ Date: ____________

WCCC.DOC
Revise: 03/05/99
APPENDIX E
Coordinated Care Organization Review Task Force

CCO Experience
presented by
Kaiser On-the-Job and Straub HealthWorks
Purpose

- Provide Straub and Kaiser Permanente’s perspectives on the success of Coordinated Care Organizations, in respect to enacted legislation, actual experience, results and recommendations.
Agenda

- Background Review
- CCO Description and Goals
- CCO - “Options”
- CCO - Outcomes
- Barriers to Participation
  - Employers
  - Employees
  - Carriers
  - CCO’s (provider)
- Recommendations
- Risks
Background

- Catalyst for change
  - Fee schedule reduction
  - Safety program
  - CCO legislation

- Impact on Workers’ Compensation Costs
- Medical / disability costs
- Coordinated, comprehensive approach to cost containment and care
Background

Cost/Case Trends

Average Cost Per Case
1999% Distribution of Cases: 65,544

- Medical: 62%
- TTD: 22%
- TPD: 3%
- PTD: 1%
- PPD: 8%
- *Other: 6%

1999% Distribution of Cost: $222,056,314

- Medical: 35%
- TTD: 23%
- TPD: 1%
- PTD: 7%
- PPD: 26%
- *Other: 4%
CCO Description

CCO’s provide the framework and components that address how the employee gets to see the health care provider of choice when there is a job-related illness or injury.

This “framework” includes various types of pre-selected medical providers and builds in accountability for care including provider qualifications, service and disability protocols by diagnosis, communication and case management support and dispute resolution processes.
CCO Goals

- Efficient, cost effective, and timely treatment, using case management
- High level of quality care
- Understandable, accessible, and user friendly system of care
- Range of treatment, including office, clinic, lab, hospital, rehab, ER
- Variety of specialties for comprehensive care and employee choice
- Prompt and appropriate RTW, timely medical information, including work return status, work restrictions to employer and carrier
- Internal dispute resolution processes such as mediation
CCO “Options”

- Formalized Legislation

- Informal “agreements” between employers and organized workers’ compensation delivery systems

- Collectively bargained program - Oahu Transit Services, Inc.
CCO Outcomes

Formalized CCO

- No formalized programs are in place
CCO Outcomes
Informal CCO - KOTJ

Participation
- Limited - Letter of Agreement
- Data reflects 7,052 cases
- 22.3% of KOTJ patients had their employer recommend KOTJ for care

Employee Satisfaction
- Period July 2000-June 2001
- 589 surveys returned
  - 71.6% extremely satisfied with care
  - 65.9% definitely recommend for care
  - Quality care and good service top reasons

RTW
- Cases: (% days lost);
  - KP: 12.6%, HI: 25.8%
- Days: KP: 5.2, HI: 19.5
CCO Outcomes
Collectively Bargained - Oahu Transit Service

**Savings**
- Budgetary costs for WC reduced from 6.6 to 3.8 million

**Participation**
- 84% participation in CCO

**Employee Satisfaction**
- Quality of Care: 77% very good or good
- CCO Physician: 80% very good or good

**RTW**
- Lost time reduced from 8% of scheduled hours in 1992 to less than 2.5% in 1999
Types of Injuries:
- primarily musculoskeletal

No. of Injuries:
- 1999: 82
- 2000: 67
- 2001: 68

RTW:
- Days Lost:
  -Straub: 10.2, 4.8, 9.6
  -HI benchmark: 15.2
- Cases (% days lost)
  -Straub: 8%, 4%, 9%
Employee Satisfaction

- Quality of care: 25% excellent; 54.2% good
- 70.8% would recommend the Straub CCO program

Customer Service Satisfaction Survey

- For period: January 1-31, 1999
Barriers to Participation

Employers

- Immediate expense
- No immediate savings
- No CCO “Plan” offered by carrier
- Few self-insured/non-union employers
- Concern about “directing” care
- Complex negotiation

Carriers

- Opt out negates ability to coordinate care, time loss and quality
- Small data pool of CCO models of care
- Systems inability to pull data by “CCO”
Barriers to Participation

**CCO’s**
- Additional costs
  - Legislated requirements (case mgt., education, protocols, surveys, RTW, tracking)
- Registration fee
- Marketing
- Little incentive to continue to provide CCO services
- No recognition of RTW outcomes. Medical fee addresses medical care only

**Employees**
- OTS: 73% of employees would support the continuation of the injured workers program
- CCO survey: 70.8% and 65.9% would definitely recommend program, YET
- Majority of employees are not aware of CCO option and it’s benefits
Assumptions

- The CCO model is an effective way to address Workers’ Compensation cost, quality and service.

- Employers, carriers, employees and providers (CCO’s) have the desire to decrease cost and increase service and quality.

“Success” factors include:

- Employee participation in CCO
- Employer awareness of CCO-provider options
- Carrier involvement
- Commitment to program by all participants
- Benefit realized for all participants (employee, employer, carrier, CCO)
Recommendations

- Remove the barriers to participation by modifying the provisions of the existing bill:
  - Opt out provision
  - CCO registration fee
  - Reflect the CCO’s mandate for RTW, protocols, case management and communication in fee schedule
Risks

- "As is" approach risks:
  - Premium increases
  - No provider participation, in CCO or in any form of WC care
  - No alternative to control overall cost
  - No value to employers or their employees
  - Little medical oversight in the monitoring of care and service
October 2, 2001

Gary Hamada
DCD Administrator
830 Punchbowl Street
Honolulu, HI 96813

Dear Gary:

Thank you for asking about our CCO experience. As you will see, we have had activity in a “semi-CCO” environment and with the Oahu Transit Service negotiated CCO program. Unfortunately, there is little to report on the legislated non-bargaining CCO that we had all hoped to measure.

The good news is that the CCO model has demonstrated success when implemented. The attached Kaiser On-the-Job CCO perspective details those outcomes. We have also included our opinion on why there is a general lack of participation and buy-in to the concept.

We look forward to discussing the findings and recommendations presented in this paper and certainly hearing the perspectives of others on the task force. If you have questions, please call me at 432-2201.

Sincerely,

Marianne Dymond
Manager, Kaiser On-the-Job

enclosure
Purpose: provide a perspective on the success of CCO, in respect to enacted legislation, actual experience, results and recommendations

Background

Rising workers’ compensation premiums and delivery of quality medical care served as a catalyst to review alternative methods that address the cost and the care for Workers’ Compensation. In 1996, legislators attempted to control cost with a 30–54% reduction in the state-mandated workers’ compensation fee schedule and increased emphasis on safety initiatives for employers to reduce worksite injuries. In 1998, additional legislation enabled non-collectively bargained employers to use a Coordinated Care Organization (CCO) to address both the quality and cost of care.

For the period 1995-1999, total workers’ compensation costs did in fact fall from an all time high of $343,079,773 in 1995 to $222,956,314 in 1999. The number of processed cases with cost dropped from 61,352 in 1994 to 43,254 cases in 1999. Because the decline in cost closely parallels the reduction in volume of processed cases, the actual impact of the legislation warrants further examination. (figure 1)

Review of the declining case and cost trends present interesting insights. First, despite declining total costs, average cost per case remained relatively constant, with a slight upward trend in 1998 and 1999. (figure 2)

Secondly, workers’ compensation cases with medical involvement represented 62% of total cases, though actual medical care represented only 39% of total costs. In comparison, temporary total disability, temporary partial disability, permanent and partial disability represented 32% of the cases, but 57% of the costs. The remaining costs involve death, disfigurement, vocational rehabilitation and attendant services. (figures 3&4)

The contribution of disability as the major factor in the total cost of a workers’ compensation case, highlights the importance of approaching cost control from a larger perspective. The established “silos” of responsibility are no longer applicable. For instance, providers do play a role in disability management and are key in returning employees to work. Coordination between the provider, carrier, employer, and patient insure the best outcomes; medically and financially. Focus on only one component (medical cost) has not shown to yield significant or long term savings.

In an effort to provide a means to “coordinate” comprehensive cost containment and care, several options involving CCO’s emerged, including:

1. Formalized legislation for non-collectively bargained employers
2. Informal “agreements” between employers and organized workers’ compensation delivery systems.
3. Collectively bargained program through TheBus (OTS)

To address the purpose of this paper, discussion of all three options follow. Recommendations are based on the experience of Kaiser Permanente’s CCO (Kaiser On-the-Job) in all three scenarios and reflect the opinions of KOTJ management.
1999 % Distribution of Cases: 65,544

*Other: Death, Disfig, Voc, Att

1999 % Distribution of Cost: $222,056,314

Medical 39%
TTD 23%
TPD 1%
PTD 7%
PPD 26%
*Other 4%
CCO Description

CCO’s (Coordinated Care Organization) provide the framework and components that address how the employee gets to see the health care provider of choice when there is a job-related illness or injury. This “framework” includes various types of pre-selected medical providers AND it builds in accountability for care including provider qualifications, protocols, including types of services and estimated disability guidelines by diagnosis, communication and case management support and dispute resolution processes.

Goals of CCO’s

- Provide efficient, cost effective, and timely treatment, using case management
- Provide a high level of quality of care
- Provide an understandable, accessible, and user friendly system of care
- Provide a range of treatment, including office, clinic, lab, hospital, rehab, ER
- Provide a variety of specialties for comprehensive care and employee choice
- Provide a prompt and appropriate return to work program, timely medical information, including work return status, work restrictions to employer and carrier
- Provide a program of internal dispute resolution processes such as mediation
1. Formalized CCO Legislation

Overview

In 1998, non collectively bargained employers were provided legislation that enables them to offer their employees the option of seeking medical care for a work-related injury or illness from an approved CCO. Coordinated Care Organization Legislation’s (SB238) goals incorporate overall CCO goals mentioned above and includes workplace safety and prevention provisions to minimize workplace injuries through a cooperative effort among employer, insurer, employee and the CCO.

Effectiveness

There are no formalized arrangements with employers and carriers under the current CCO legislation. Measurement criteria, including employee satisfaction, savings, return to work and communication improvements are not available.

Employer position

- Immediate additional expense for selection of CCO’s, employee communication/open enrollment for WC, training, safety programs, and employee incentives to use CCO’s
- For employers who are experienced rated, (annual premium over $2,500), there is no immediate cost savings to offset additional expenses required. (rolling 3 year experience)
- Employers who are willing to “wait”, still are at risk, given the “opt out” provision which allows employees to leave the CCO anytime after 3 visits or upon definitive diagnosis. This option negates the ability to appropriately manage the care, the time loss and the quality of that care.
- For employers under $2,500 per year, there may be little individual premium incentive to minimize loss or frequency on a short or long term basis
- No WC carrier offers a CCO “plan” to purchase
- For most self-insured employers, union involvement requires one of the other 2 options. (see TheBus )

Carrier position

- Reluctance to offer lower priced CCO “plan” due to:
  - Opt out provision allows for employees to leave the CCO anytime after 3 visits or upon definitive diagnosis. This option negates the ability to appropriately manage the care, time loss and quality of the care, which again, increases risk for higher cost
  - Providers (CCO’s) reluctance to further discount fees
  - Data collected from informal arrangements with employers (see below) does not represent a statistically significant population of injured employees care for any one carrier
- Must offer WC insurance plan including 2 approved CCO’s and coordinate the effort
- Must redesign systems to accommodate CCO plans
Provider (CCO) position

- Must incur additional costs to meet requirements of legislation, including case management, educational materials, credentialed providers, dispute resolution processes, utilization management/protocols, customer service surveys, return to work programs, marketing and tracking mechanisms
- Current fee schedule (Medicare +10%) addresses only medical costs
- The existing fee schedule is a disincentive for CCO’s to continue or expand their efforts
- The CCO must pay the $10,000 registration fee, with no “savings accruing to their benefit”

Employee position

- Employees have been unable to join a formal CCO and are unaware of the positives or negatives
2. Informal CCO

Overview

Kaiser On-the-Job’s philosophy mirrors the goals of the CCO formalized legislation. As KOTJ is a registered CCO under Section, 386-D, the components of the KOTJ program are in place, including provider specialty availability, full range of treatment, case management and communication, return to work programs, and dispute resolution. All required processes are used in treating employees who choose Kaiser Permanente for their injury care. The CCO services (provider network, case management, return to work, quality review, communication tools, and reporting) are not “sold” to employers and do not require employer formal agreement to realize the benefits.

How do Employees come to KOTJ?

Kaiser On-the-Job is available to all employees, members of Kaiser Permanente’s health plan and members of other health plans. There are several “ways” employees come to Kaiser On-the-Job for their care:

- Employees are members of Kaiser Permanente Health Plan
  - Of the 7,062 cases seen in 2000, 90% were members
  - Employee preference drives this selection
  - All work related injury care seen at Kaiser falls within the framework of KOTJ
- Employee’s employer proactively offers KOTJ as an option for injury care
  - Kaiser Permanente contacts employers to educate them about the process of working with KOTJ. Letter of Agreement is signed, stipulating that a manager/supervisor training will be conducted
  - Employer’s insurance carrier includes KOTJ information in their materials

Effectiveness

Participation: Employer/employee participation is limited.
- 82 employers offer KOTJ as an option when employees are injured
- Over 2900 employers have employees who have chosen to go to KOTJ without employer proactive involvement (reflects KP health plan membership)
- 22.3% of patients surveyed (see below) had their employer or supervisor recommend KOTJ for their work-related injury care

Employee Satisfaction: All KOTJ patients are surveyed upon case closure. For period July 2000 – June 2001, 589 surveys were returned. Of these, 71.6%* were extremely satisfied with the care; 65.9%* would definitely recommend to others, with quality medical care and good service being the top 2 reasons why. *Scale 7 - 1: 7: extremely satisfied, 1: not at all satisfied. Statistics reflect scores of 6&7.

Return to Work: KOTJ time loss physician authorized outcomes for this care are compared below to the latest data in the Hawaii Workers’ Compensation Data Book, 1999 edition. Time loss summary:
- Cases: (% with days lost): KP: 12.6% HI: 25.8%
- Days lost: KP: 5.2 HI: 19.5

Communication: Communication lines opened between carrier, provider, employee and employer, when all stakeholders involved are aware of the process.
Why is there limited participation in a program where outcomes and satisfaction are so positive?

Employer position

• Difficulty in understanding “value” in terms of premium savings with no direct connection to workers’ compensation carrier and any link to premium costs
• Requires training time for supervisor and managers and follow up management
• Concern about recommending/directing, given “employee choice” in WC law

Carrier position

• Unable to pull data by provider and/or CCO to track outcomes
  • Even if information is available, the small participation in CCO’s minimizes opportunity to collect enough data in a group to warrant any adjustment to premium

Provider (CCO) position

• Little incentive for CCO: employers and carriers are not willing to “pay” for additional costs incurred by the CCO to provide all the additional services
• No recognition of providers’ performance in terms of “physicians authorized loss time” or better outcomes
• Expense of marketing CCO concept falls on providers
• Difficulty in bringing widespread awareness of program to the general marketplace

Employee position

• The majority of employees (especially those who are members of other health plans), are not aware that another model of care is even available
3. Collective Bargaining CCO
   TheBus Negotiated Workers’ Compensation Program

Overview

TheBus plan was implemented March 1, 1998, enabled by an amendment (Sect. 386-3.5) to existing legislation in 1995. Program concepts include:

- Modeled after similar programs in Oregon and California
- Commitment to safety by both labor and management
- Emphasis on coordinated healthcare.
- Use of Alternative Dispute Resolution
- Intentional union involvement
- Various levels of incentives

Employees choose their provider option at an annual open enrollment session for WC. Options are:

- Any MD participating in one of the union health plans, or 1 of 3 CCO’s
- Change in providers authorized by ombudsman
- Incentives for choosing a CCO, to encourage employees to utilize the CCO’s
- To change CCO provider, request change to ombudsman for decision

Effectiveness

- Participation: 2001 open enrollment: 84% participation in one of the CCO’s
  - Quality of Care: 77% very good or good
  - CCO Physician: 80% very good or good
- Return to Work: Lost time reduced from 8% of scheduled hours in 1992 to less than 2.5% in 1999
- Savings: Budgetary costs for WC reduced from $6.6 to $3.8 million
- Communication: “Close contact with CCO is very positive. It’s to get to know only 3 points of contact. This leads to quicker turn-around”

Why is there only 1 collectively bargained CCO?

Employer position

- Adding another layer to already complex negotiations with union
- Must take the lead to coordinate CCO’s, carriers, management, and union(s)

Carrier position

- Requires risk arrangement with employer that provides immediate savings. The savings provides dollars to encourage union employees to participate
- Requires risk arrangement with provider (CCO) that rewards favorable outcomes
- Realize a benefit that justifies the work to develop and operationalize the program

Provider (CCO) position

- Not positioned to take the “lead” in coordinating this employer/union joint effort

Employee position

- Based on survey above, 73% of OTS employees would support the continuation of the injured workers program
Recommendations

The CCO model, when used, has shown to be an effective way to address medical and time loss Workers’ Compensation cost, quality and service issues. The key assumption is all employers (in all industries), carriers, employees and providers have the desire to decrease cost and increase service and quality. If this is valid, the next step would be to remove the barriers that hinder those key success factors, (proven in the OTS and informal models).

The success factors are:
- Employee participation in the CCO
- Employer awareness of CCO-provider options
- Carrier involvement
- Commitment to program by all participants
- Benefit realized for all participants (employee, employer, carrier, and CCO (provider))

SB 2386 is sound. It has formed the framework for the development of quality CCO’s in the State. However, the major barriers for successful IMPLEMENTATION include the opt out provision (386-H (d), the registration fee (386-E), and the mandate to offer 2 or more CCO’s.

Modifications to these provisions would enable:

**Employers (above and below minimum premium amounts/all industries/all sizes)**
- To realize immediate premium “savings” to address open enrollment, incentives to join CCO (OTS model), education and other associated costs with the CCO

**Carriers**
- To better understand the risk on the CCO participants and non-CCO participants and be more open to reducing price
- To partner with CCO’s to bring more awareness to the purchasers of their products

**CCO’s (providers)**
- To negotiate appropriate reimbursement with carriers and self insured employers based on performance targets, such as time loss, satisfaction (as there should be a larger population of employees using the CCO’s to monitor and measure)
- To no longer bear the entire $10,000 registration fee, when the benefit accrues to employers and or/their Workers’ Compensation carriers
- Enable willing and qualified CCO’s to enter agreements, even if other CCO’s become unavailable

**Employees**
- To have a familiar health care arrangement involving annual selection (open enrollment, similar to health plan), increase safety awareness and coordinate injury notification processes
- To offer choice of providers; CCO or “other providers”
- To have a vehicle (similar to the OTS model ombudsman) for changing provider
- To be offered an incentive to join the CCO, which would increase participation
Although the informal CCO has demonstrated success as a model of care, the wide spread use is extremely low. Can rates hold without faster intervention? Will the earlier workers’ compensation reforms (lower fee schedules) keep premiums at the previously reduced rates over the next decade? Can CCO’s continue to provide the service levels (disability management, utilization management, and communication efforts) if not paid? The probable answer is NO.

Legislation that enables implementation will take the best of the models (TheBus and the informal programs) and make them more easily available to the entire community.

If we continue with only the informal process, the workers’ compensation system risks:

- Premium increases
- No provider participation, (in CCO or worse, in any form of workers’ compensation participation)
- Note: Hawaii Center for Business Health no longer provides CCO services
- No alternative to keep the costs of WC premiums down (absolutely no room to reduce fee schedules)
- No value to employers, especially those under minimum premium amounts
- Little or no medical oversight in the monitoring of care and service for injured employees
November 7, 2001

Mr. Gary Hamada  
DCD Administrator  
Department of Labor and Industrial Relations  
630 Punchbowl Street  
P.O. Box 3769  
Honolulu, Hawaii 96812-3769

Dear Mr. Hamada:

Dr. Gackle shared your letter and attachments referencing the CCO meeting of October 26, 2001. A few additional comments and clarification follow:

Cost Savings

In an effort to quantify cost savings, we are reviewing literature that provides estimates of the average direct and indirect costs for time away from work due to work-related injury. “Savings” will be determined by average cost x days saved, using the time loss outcome data from Kaiser On-the-Job’s 7,000 cases seen in 2000. The cost savings information will be coming to you by Friday.

Choice

Rather than maintain “choice” through the existing op-out clause, we suggest that “choice” be preserved via an open enrollment process once a year. This mirrors the employee’s health plan selection process. Employees would be given the option to choose from their own provider or a CCO. Any work-related injuries sustained during that year, would be treated by their selected CCO or provider.

Should the employee be dissatisfied with their CCO provider, the following procedures would be followed:

- Initially work with the CCO’s nurse case manager to change physicians in the CCO
- If they were not satisfied with the change, they would go to the next level of review. A dispute resolution process similar to the OTS program uses a 3rd party mediator who hears the reasons why care should be transferred. His/her decision would be binding.
Participation

Increase employer participation by immediate premium savings when utilizing CCO insurance plan.

Increase employee participation by offering an incentive to join, which is funded by the premium savings.

Increase carrier participation by replacing the opt out clause with the dispute resolution process mentioned above. Those employees who agreed to participate in managed or coordinated care would continue with the CCO for that care, unless deemed by a third party that it is no longer appropriate.

Increase CCO participation by formally tying a differentiated fee schedule to return to work outcomes, use of protocols, and case management.

Registration Fee

Recognizing that there are costs associated with the DLIR in administering CCO business, an alternative to the $10,000 fee may be an administrative expense added to the premium (carriers) or paid by the self-insured employer for every CCO program implemented.

The fee could be based on the number of employees who opt for one of the CCO’s, and paid annually. The assumption would be that the fee is low enough to maintain the carrier’s or employer’s ability to keep the premium or total cost below current premium or expense levels without the CCO. However, as the business grew, the sum of the administrative fees would increase to accommodate the additional work.

Thank you for giving us the opportunity to share our ideas and recommendations. We look forward to reviewing your draft letter next week.

Sincerely,

Marianne Dymond
Kaiser On-the-Job

cc:  Ronald Gackle, MD
      Chris Pablo
Kaiser On-the-Job CCO Savings Overview

KOTJ
This overview reflects the newest sample of Kaiser On-the-Job’s Workers’ Compensation cases for the interval January 1 through September 30, 2001. Assumptions include all cases through the system in that period, which reflects the “Processed Cases” for State Comparison.

Cases for period 1-9/01: 6,224
Cases with Days Lost: 15.6%
Average Days Lost: 7.1

Note: Results for this period are consistent with the savings trend established for period January 1 through December 31, 2000. Cases: 7,062, Cases with Days Lost: 12.6%, and Average Days Lost: 5.2

State
The State comparison reflects data from the Workers’ Compensation Data Book 1999.

Total Cost: $222,056,314
TTD Case Cost: $51,550,709
Days Lost: 1,109,149
Processed Cases: 56,927
Average Cases Days Lost 25.8%
Average Days Lost: 19.5

Benefits Provision – 1999
$130- $519 Weekly Benefits
Average Weekly Benefit: $324.50 per week
Average Daily Benefit: $64.90 per day

Savings Comparison
Sample Case Size: 6,224

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<th>State</th>
<th>KOTJ</th>
<th>Savings</th>
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<td>Cases</td>
<td>25.8% - 1,606</td>
<td>15.6% - 971</td>
<td>635</td>
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<td>Days</td>
<td>19.5 - 31,317</td>
<td>7.1 - 6,894</td>
<td>24,423</td>
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24,423 days x $64.90 per daily benefit = $1,585,053

This sample case comparison reflect volume of 11% of total processed cases, providing significant enough volume to reflect the potential overall savings through a managed or coordinated care Workers’ Compensation program. Assuming all cases were “managed”, potential savings could be as high as $14,497,599, with a savings of 6.5% on total cost of $222,056,314, and up to 28% savings on TTD case cost of $51,550,709.
APPENDIX G
May 30, 2001

Gary Hamada, Administrator
Department of Labor & Industrial Relations
830 Punchbowl Street
Honolulu, Hawaii 96813

Dear Mr. Hamada:

Please find enclosed Straub Clinic and Hospital’s Report on the Coordinated Care Organization. We appreciate the opportunity to present this data and welcome your review and evaluation.

If there are other considerations that need to be addressed or if the report needs to be geared to a specific audience, please feel to contact me at the number below.

Most sincerely,

Jay Z. Conley, Director of Clinical Operations
Straub HealthWorks
839 South Beretania Street
Honolulu, Hawaii 96813
Tel: (808) 522-4453
FAX (808) 522-4331
jconley@straub.net
STRAUB CLINIC & HOSPITAL, INC.
COORDINATED CARE ORGANIZATION (CCO)

Oahu Transit Services, Inc.

# of Days

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<tr>
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<td>100</td>
<td>150</td>
</tr>
<tr>
<td>67</td>
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<tr>
<td>68</td>
<td>150</td>
<td>300</td>
<td>500</td>
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# of Injuries per Year

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<td>837</td>
<td>320</td>
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<tr>
<td>68</td>
<td>3006</td>
<td>1089</td>
<td>2643</td>
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<tr>
<td>Regular Work</td>
<td>7303</td>
<td>10993</td>
<td>3653</td>
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Data Collection Period: March 1 - February 28

*Data Collection Period: March 1 - February 28
INJURY TRENDS

As noted in the chart to the right, there were 82 injuries seen in the first year (1998 - 1999). With majority of injuries being musculoskeletal in nature, most were related to sprain/strains to the back. With 11,146 treatment days, 8% of days were due to off work while 26% were modified work days. Regular work days accounted for 66% of the overall treatment days.

The average treatment days for 1998 - 1999 were 136. Average Off work days per injury were 10 days. Average modified work days were 37.

In the second year 1999 - 2000, Straub CCO treated 67 injuries. As with the previous year, musculoskeletal injuries again were noted to be of highest occurrence. Upper extremity injuries proved to be the leader of musculoskeletal injuries with such injuries as epicondylitis, tendinitis, carpal tunnel syndrome, and DeQuervaines syndrome.

Treatment days were 11,146 days: 4% was related to off work; 9% due to modified work days; and 87% due to regular duty days. The average number of treatment days per injury in 1999 - 2000
were 185; average number of modified work
days were 16.25, and average off work days
were 4.8.

In 2000 - 2001, Straub CCO treated 68
injuries. Again, musculoskeletal injuries to the
upper extremities were of highest occurrence.

The total number of treatment days were
6,951 with 9% of days related to off work, 38%
related to modified work, and 53% related to
regular duty days.

The average treatment days per injury
were 102. The average modified duty days per
injury were 38.86 and the average off work
days were 9.63.

**LOST DAYS PER INJURY**

The chart below represents how Straub CCO compares to the State’s benchmark of 15.7 lost work
days per injury. The bar to the right, indicates Straub CCO’s average lost work days per injury. As
noted, each year Straub CCO was well below the State’s average lost work days per injury.

**Average Lost Work Days per Injury**
A customer service satisfaction survey was conducted during the period of January 1, 1999 to January 31, 1999.

The graph to the left represents patients' response to rating the thoroughness of treatment provided by Straub physicians. 50% of responses received rated the treatment at good.

Overall impressions of quality of care rated Straub CCO as 54.2% being good. 70.8% would recommend the Straub CCO program.
The following charts represent respondents experience during an initial visit.

Current customer satisfaction survey results are pending. See attachment 1 - example of current survey questionnaire. The target completion date is projected for June 29, 2001.

Submitted by:
Dara Villanueva, MBA
Return to Work Coordinator

May 29, 2001
**CUSTOMER SATISFACTION SURVEY**

Instructions: This brief survey requests you to evaluate the medical care you received following your recent work-related injury or illness. Check the appropriate box as an answer for each question.

<table>
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<tr>
<th>Question</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tr>
<td>1. Overall, how would you evaluate health care you received at Straub Clinic &amp; Hospital?</td>
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<td>2. Convenience of location of the doctor's office</td>
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<td>3. Hours when the doctor's office is open</td>
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<td>4. Access to medical care in an emergency</td>
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<td>5. Length of time spent waiting at the office to see the doctor</td>
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<td>6. Thoroughness of examinations and accuracy of diagnoses</td>
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<td>7. Thoroughness of treatment</td>
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<td>8. Explanations of medical procedures and tests</td>
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<td>9. Attention given to what you have to say</td>
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<tr>
<td>10. Friendliness and courtesy shown to you by the doctors</td>
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<td>11. Personal interest in you and your medical problems</td>
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<tr>
<td>12. Friendliness and courtesy shown to you by staff</td>
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<tr>
<td>13. The outcomes of your medical care, how much you are helped.</td>
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<tr>
<td>14. Overall quality of care and services</td>
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<tr>
<td>15. Comments:</td>
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I understand that my answers will not be shared with my employer or my doctor. Only trended results will be reported.

Print Name: ____________________________  Signature: ____________________________

Please return this survey to Straub Clinic & Hospital, Inc. Occupational Medicine in the provided envelope or fax it to: (808) 522-4331