By Adrianne Feldstein, MD, MS

Kaiser Works, Inc.: A New Way to Transfer Best Practices in Occupational Health

Introduction

Kaiser Works, Inc. is a management and consulting company created in April, 1996 to help Kaiser Permanente (KP) Divisions and noncompeting health care organizations improve occupational health (OH) and workers' compensation (WC) services. Governed by a Board of Directors, this innovative organization—a for-profit corporation jointly owned by Kaiser Foundation Health Plan of the Northwest and Northwest Permanente, PC—is dedicated to collecting, interpreting, and sharing Best Practices in OH and WC. In the short period since its inception, Kaiser Works has aided six KP Divisions and two noncompeting health maintenance organizations (HMOs).

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Basis for Kaiser Works, Inc.: Kaiser-on-the-Job

In the mid-1980s, KP Divisions were faced with the growing dissatisfaction of employers seeking effective OH/WC services. The Northwest Division's (KPNW) experiences were typical: Employer costs were out of control (Oregon's costs for medical benefits covering work-related injuries were the second highest in the United States), and surveys showed that employers were unhappy with the lack of timely communication, inconsistent case management, and haphazard emphasis on disability management and post-injury return-to-work efforts.

Although many of the factors necessary to provide high-quality OH services had been described, almost no research existed on how to develop OH/WC services within an HMO setting. Therefore, in 1986, without much external direction for assistance, KPNW began its own efforts to improve its OH program. After consulting with OH specialists and evaluating internal capacities, KPNW decided to reorganize OH services by creating OH specialty clinics. From 1987 through 1993, KPNW opened nine such OH clinics throughout Southwest Washington and Northwest Oregon. The clinics were staffed with a core group of board-certified OH physicians and a team of physicians specializing in family practice, emergency medicine, physiatry, orthopedics, and psychiatry. Each clinic employed a lead nurse with formal occupational health training and several board-certified Occupational Health Nurses (COHN). Lead nurses were supported by a regional case coordinator (who was also a COHN).

The Occupational Health Strategic Assessment Team:

Sandy Cardelli
Coordinator of OH Clinics and Systems
Jim Dameron
Senior Kaiser Works, Inc. Consultant
Nhu Dana
Medical Services Analyst
George Marino
President and COO of Kaiser Works, Inc.
Tracy Runge
Manager, Occupational Health
Kathleen Sharp
Supervisor, Claims and Billing

In addition to efficiently matching patients with appropriate specialists, KPNW OH clinics provided the means to ensure good patient access, create standard operating procedures, and build a tracking system for referrals. OH staff and other departments in KPNW began to use the same unified medical records for all KP patients. This standardization, along with a computerized clinical encounter system, helped to preserve continuity of care regardless of whether patients were seen by the same physician or at the same facility.

After implementing these innovations, KPNW in 1991 sought and won approval as a State of Oregon-certified managed care organization (MCO)* under the name Kaiser-on-the-Job. Four KP Divisions (Northwest, California, Hawaii, Southwest) now operate Kaiser-on-the-Job Programs that share many of the same clinical guidelines, care philosophies and processes, and—most important—the same managed care culture.

The overall approach embraced by Kaiser-on-the-Job has provided clear evidence that high-quality OH services can be integrated within an HMO managed care system. Indeed, the Kaiser-on-the-Job Programs have made impressive gains. For example, based on 1994-1995 data from the Oregon State Accident Insurance Fund, KPNW's Kaiser-on-the-Job Program has had 21% lower mean total claim costs than other MCOs. Ninety percent of patients have reported being "satisfied" or "very satisfied" with their OH care. The Washington Department of Labor and Industry Managed WC Pilot Project, in which KPNW's Kaiser-on-the-Job Program participated, had 36% lower total medical care costs for members who stayed in the Program. A 1997

*Employers who contract with an MCO are permitted to direct injured or ill employees to that MCO. As part of its certification requirements, the MCO must document its ability to provide high-quality, cost-effective care. The MCO is also required to contract for acupuncture, chiropractic, and naturopathic services. All outside contractors are expected to follow the rules of the MCO and to participate in utilization review, case management, and quality management.

ADRIANNE FELDSTEIN, MD, MS, is currently Medical Director and CEO for Kaiser Works, Inc. Prior to this she served as Chief of Occupational Medicine for Northwest Permanente, PC from 1990-1997 and as Medical Director of Kaiser-on-the-Job from 1992-1997. E-mail: feldsteinad@kpnw.org

study by the Ernst and Young consulting firm showed that California Kaiser-on-the-Job's mean cost of caring for disabling injuries was 34% less than for cases treated elsewhere; duration of disability was 32% shorter. Savings resulted from cost-effective treatment and rapid return to work. Employer and patient satisfaction with all Kaiser-on-the-Job Programs has been high, and recognition of these Programs is growing.

Kaiser Works, Inc.: A National Focus

By working cooperatively, the Northwest, California, Hawaii, and Southwest Divisions slowly built a West Coast presence for Kaiser-on-the-Job. Unfortunately, the learnings of one Division were not always effectively or efficiently transferred to other Divisions. Many of the same mistakes were repeated, much unnecessary rework done, and Divisions still faced service gaps and lack of standardization. So, although Kaiser-on-the-Job led—Division by Division—to development of innovative OH and WC practices, dissemination and standardization throughout the rest of KP were not keeping pace.

Using Kaiser-on-the-Job as a laboratory, therefore, Kaiser Works was designed to help transfer and standardize OH/WC Best Practices. Collaborating closely with Kaiser-on-the-Job, Kaiser Works' vision is to be

> *the premier provider of management services and systems to promote workers' health and productivity. To this end, it is our mission to share best practices and outcomes in Occupational Health, to cultivate and grow our relationships with our clients into a national alliance of providers, and to build an integrated data base that will lead to performance-based outcomes.*

Start-up capitalization for Kaiser Works was provided equally by Northwest Permanente, PC and Kaiser Foundation Health Plan of the Northwest. Day-to-day operations are directed by a Medical Director/CEO. The company maintains minimal, fixed levels of staffing and uses a project-based, flexible staffing approach.

Services Offered by Kaiser Works

Kaiser Works provides Strategic Situation Assessment, Program Installation, and Shared Services/Consultation.

Strategic Situation Assessment

A multidisciplinary team of experts from Kaiser Works uses structured interviews and other survey tools to evaluate a health care organization's ability to provide OH services. The assessment includes internal evaluation of current and future capabilities and external evaluation of the marketplace. This external evaluation is based on interviews with employers, insurers, brokers, and competitors. Kaiser Works then recommends a course of action and, if appropriate, a service delivery plan.

Program Installation

Kaiser Works contracts with clients to build or improve a service delivery model appropriate to their locale. To make the OH installation a success, areas of consideration can include administrative policies and procedures, job descriptions, clinical and case management guidelines, contract templates, staff training and strategies, and leadership consultation.

Shared Services/Consultation

Kaiser Works acts as a clearinghouse for several activities: updating medical protocols and guidelines, monitoring performance standards and Best Practices, assessing customer satisfaction, sharing sales promotion and advertising materials, monitoring national and regional OH/WC trends, and aiding or supporting new WC product development. In addition, Kaiser Works organizes leadership development conferences, provides consultation for problem resolution, and can provide system capability audits.

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Findings Made by Kaiser Works to Date

Having completed eight strategic assessments, Kaiser Works has evaluated eight local health care entities, including six KP sites and two additional health plans. Locations were in the Northwest, Southwest, Southeast, Northeast, and Hawaii. Local entities varied from 100,000 to 500,000 members and 100 to 2000 physicians. Four entities were fully integrated group-model HMOs, and four were mixed models. Three plans wanted to improve existing Kaiser-on-the-Job Programs, and five plans wanted help in deciding whether to start new OH/WC programs.

Marketplace Findings

In general, WC claims are paid on a fee-for-service basis and represent a major cost for employers. Approximately 120 million workers in the US are at risk for work-related injury and illness. Estimates of total costs exceed $171 billion, making WC injury and illness expenditures as high as those for cancer and cardiovascular disease. In addition, WC costs tend to exceed group health costs for any given diagnostic category.

Given the high absolute cost and the high unit cost for WC care, employers are increasingly interested in managed care approaches. Expenditures for OH/WC medical care vary greatly by state, even after controlling for case mix and state characteristics. The presence of HMOs, general practitioners,

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and rural settings is associated with lower claim costs. Although we found some geographic variation, employers and insurers are generally receptive to having KP offer OH/WC services. Employers in the West are more enthusiastic about managed care, although interest is emerging in the South and East. WC insurers are uniformly enthusiastic about managed care and partnering with HMOs. The situation is made even brighter by the current lack of any serious WC competition to KP from other HMOs. Instead, competition comes from preferred provider organization (PPO) networks, hospital-based medical offices, or freestanding urgent care facilities, which don't appear to achieve the same quality of outcomes.

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Although local markets share an interest in managed OH/WC care, these markets are not completely uniform. For example, four of the eight sites assessed by Kaiser Works have "facilitating" legislation for managed care: at two sites, workers' care is directed by employers for 30 days; at one site, this direction is allowed for the first visit only; and at another site, workers' care is directed for the life of the contract to a certified MCO.

Given this general trend toward managed WC care within a variable local context, what do employers want? Our evidence suggests that an increasing number of WC insurers and multistate employers wish to simplify their relationship with KP. One means of achieving this simplification would be for employers to have a single point of contact when forging agreements among multiple KP Divisions. Multistate employers also desire consistent products and services. Employers and insurers are also looking for OH/WC service providers who offer case management (and utilization review) services that can guarantee outcomes and can link clinicians located over a broad geographic area.

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How well are KP and other assessment sites providing the services that employers want? According to our market assessments, room for improvement exists. Employers are particularly concerned about several areas:

- Lack of timely communication with health plans
- Employers' inability to communicate directly with physicians
- Lack of mutual understanding between employer and health plan about "light duty" and disability management
- Lack of health care providers who understand the employers' particular work environment
- Unwillingness of health plans to collect urine for employers' drug-screening programs
- Absence of clear, concise patient reports to employers
- Employers' uncertainty about how to gain access to OH/WC care
- Poor claims processing by health plans

Internal Health Plan Assessment Findings

In completing our health plan assessments, Kaiser Works also looked for potential internal barriers to successful implementation and improvement of OH/WC programs. Major impediments included the plans' inability to fund capital investment (five of eight plans are losing money on their group health product; and seven of eight plans have severe budgetary constraints). Management teams are overworked and focused on other projects. Seven of eight plans are undergoing mergers and restructuring which results in distraction and low morale among personnel. The plans lack marketing staff trained in WC and have been faced with major constraints on service delivery. Assessment sites were unable to capture all WC revenue.

An important service delivery issue among all plans assessed was that primary care physicians lack adequate training in musculoskeletal medicine and are uncomfortable with this area, which is involved in 90% of all WC diagnoses. Clinical staff had little understanding of WC and no staff training in it. As a result, the clinical staff have no incentive—indeed, they have strong disincentive—to identify WC cases. No guidelines or procedures facilitate patients' return to work. None of the plans we evaluated had WC- or OH-specific Quality Management Programs. In addition, seven of eight plans have difficulty recruiting qualified OH physicians. In six of eight plans, primary care is already fully utilized, preventing primary care clinics from absorbing more WC or OH cases. Four of eight plans do not routinely provide timely access to specialty care.

Plans failed to capture all WC revenues because, among other reasons, they did not correctly identify WC cases; rates of accurate case identification varied from 30% to 50%, and neither physicians nor support staff were adequately trained in case documentation and coding. Plans did not use designated WC billing specialists. Duplicate effort resulted from multiple data point re-entries and manual calculations. Information systems had major problems, including slow access to programmers and lack of data base interfaces. In addition, four of eight plans gave up 25% of WC revenues by using collection agencies.

Although the plans we assessed face important obstacles, we also found important strengths. For example, all plans had integrated systems and a

culture of cost-effectiveness. They established and maintained facilities near industrial sites. In addition, the senior management team in seven of eight plans provided strong leadership and sponsorship for OH/WC care. Six of eight plans had established a strong physician-management partnership, and five of eight plans included internal services for physical/occupational therapy and orthopedics—key services for providing a positive return on investment.

Current Kaiser Works Program Installations

Kaiser Works is installing OH/WC programs in two HMOs. Implementation highlights include:

- Installation of a OH/WC program that can become fully functioning within 12 months;
- Implementation of clinical guidelines for OH/WC care within three months. Common OH/WC guidelines—useful for both work- and non-work-related conditions—address musculoskeletal and eye injury, effects of exposure to hazardous substances, as well as screening and treatment of psychiatric conditions. Using guideline templates and existing local guidelines, a multidisciplinary review committee has been organized to generate interdepartmental work agreements and implement guidelines;
- Implementation of a comprehensive Quality Management Program for OH/WC care can be effected in two months by using templates and an on-site Quality Management Committee. The implementation process emphasizes peer review, quality indicators, and high-priority, focused studies;
- Physician training that uses a self-study module, presentations, and ongoing case and process monitoring during program installation;
- Mentoring for project teams during the implementation phase.

Discussion

In the context of high employer and insurer interest in managed OH/WC care, integrated HMOs can effectively influence medical and administrative practices and deliver better WC outcomes. These abilities provide KP a unique market opportunity, especially given that other health care providers are currently struggling to provide WC care. This area of clinical competency can help differentiate Permanente Medical Groups from other providers.

The evidence is still preliminary, but Kaiser Works has been effective in quickly transferring Best Practices among OH/WC Programs. This work is essential because purchasers perceive a continuing gap in service delivery. Improved policies and procedures, clinical guidelines, Quality Management protocols, and claims billing systems have been shared among KP Divisions as a result of Kaiser Works' efforts. Perhaps the keys to this successful transfer include 1) the close relationship between Kaiser Works and Kaiser-on-the-Job (and other OH/WC programs), and 2) the ability to create useful templates that are based on effective clinical practice.

Client satisfaction with Kaiser Works is very high (96% have reported being "very satisfied"). Among plans that have begun to implement recommendations, collection of WC revenue has been targeted to increase by 75% in the next three years. Early trends suggest that those goals will be reached.

Kaiser Works will continue to push forward in three areas: developing agreements on uniform quality measures across participating plans to allow for benchmarking; tracking rates of WC case identification, pre- and post-installation billing and collection, and contribution to margin; understanding the effect of OH care on stimulating new member and group enrollment.

The goal of having a national OH/WC product has not yet been achieved, but we believe it can be achieved with much continued hard work and with continued organizational support. The challenge to Kaiser Works will be to assist KP in overcoming the political, financial, and geographic barriers to maximize the opportunities available to our Program. ❖

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