Chapter 6: Opportunities for Improvement

INTRODUCTION

In this chapter we summarize our observations and strategies to address areas that could be made more efficient, effective and produce better outcomes for Washington workers and employers. Note that many of these are inter-related and are touched on in several places. For example, we address prompt 3-point contact in connection with improving claims management performance; however, this issue also concerns more effective performance management practices, which is addressed separately.

We organize this discussion in three general headings containing many interrelated elements:

1. Claims are open too long, which impacts workers and employers
2. CMs and Units are not being effectively measured, specifically in alignment with claim outcomes
3. Other inefficiencies, which are provided to support L&I efforts at overall administrative improvements

Changes to address some of these conditions are simpler to implement than others. Additionally, some involve statutory changes, thus adding to implementation complexity. Importantly, the order of presentation does not follow that presented in the report, i.e., it does not start with Chapter 1 observed opportunities, followed by Chapter 2 observed opportunities, etc. However, references to the relevant chapter, where the particular content was discussed, are provided.

1 ADDRESS ROOT CAUSES OF PROLONGED DISABILITY

As outlined in several of the preceding chapters, and discussed in detail in Chapter 5, the extremely long durations of TL in Washington and related problem of very high rates of pensions are so unusual and are so closely connected to the overall performance of the Washington workers' compensation system that significant changes are needed. Our discussion in this regard address the entire span of the claims process, but the biggest disconnects between Washington and other jurisdictions seems to be in the handling of claims in which the worker has not returned to the workforce within a few months of injury (discussed in Chapter 2). Washington's legal standards for terminating TL and requirements for administering vocational services are much different than other state systems. The fraction of injured workers that are deemed "unemployable" is both unusual and contrary to the best interests of the workers and employers.

Washington's average duration of temporary disability is over twice the national average (NCCI data), and the rate of permanent total disability is 31 times the countrywide average rate and 3.9 times the next highest state (NCCI data). We observed several contributing causes: 1) CM

performance issues involved in delivering claims management services; 2) administrative and structural issues involving claims management services; and 3) statutory implementation challenges to effective claims management practices.

A. CM Performance Opportunities

1. Prioritize phone contact and deliver prompt calls to workers and employers

As discussed in detail in Chapter 1 and 2, our observations from file reviews is that actual voice contact with workers and employers by a CM within the first few days of claim receipt occurs in a minority of TL claims: 32% of reviewed files (2010-13) showed actual voice contact by CM with worker w/in 30 days. The standard tracked by L&I is actual or attempted voice contact with stakeholders within the month of receipt. Direct contact with parties, starting with the injured worker and the employer, followed by the provider as needed, is the ideal approach to initiating claim management—day one of the claim if possible. This is crucial for several reasons. First and foremost because concrete case management plans should ensue from such contacts. There is a wide acceptance in the insurance industry of the standard practice of making actual (as opposed to simply attempted) voice first contact with an employer and injured worker within one business day of the assignment of an accident report for claims identified as involving any lost time, including kept-on-salary claims, and 3 business days for medical only claims. Additionally, beyond contacting the worker and employer, a plan for contacting the provider, as needed, should be documented; in many claims early contact with the provider may not be required.

This is a pivotal aspect of effective claims management. Early contact with the worker and employer promotes better case investigation; insight into claim risks and issues; relationship building; improved communications; and sets expectations regarding RTW. In short, early contact is the foundation for effective claim management planning.

There may be techniques to balance best practices against the practical difficulty experienced by L&I in making immediate 3-point contact. Intermediate strategies, which L&I seems to be working toward, would segregate the claims that seem to be easily and swiftly resolved for one level of contact, and those that are at-risk of longer disability and complications for more proactive contact. For example, contacting the employer immediately may not be necessary if the accident report indicates immediate return to work and contact with the worker offers a realistic indication of early return to work. In principle, some claims can be auto-adjudicated (strictly by computer), but auto-adjudication rules need to be closely monitored to ensure that few of these “simple” claims morph into long-term disability. Personal contacts with physicians or their offices might be reserved for instances in which the doctor’s reports are late, incomplete, or offer dubious opinions or conclusions. In every TL case, however, the injured worker should be contacted by either a CM or Claims Assistant or Processor within a day or two of the injury receipt.

2. Prioritize claim management planning

In connection with the voice-contact observations outlined above, improved case planning, together with application of appropriate early RTW interventions, should become standardized practices. Our file reviews showed few files that documented effective case planning and application of interventions tailored to the needs presented in a particular claim. The immediate result of voice contact should be an explicit plan for returning an injured worker to work, which recognizes obstacles to RTW detected from the voice contact. The plan should be in place

promptly, following shortly after completion of contacts, claim investigation; in general, the plan should be in place within a few days of the accident.

The plan would include documentation of contacts, actions taken and needed, treatment expectations, risks, options, planned interventions, consults, and potential interventions to minimize lost time. Inputs to the plan should be provided by all staff making various stakeholder contacts, including ERTW staff contacting employers, vocational specialists consulted by the CM, and ONCs offering medical advice (discussed in Chapter 2). Importantly, overall management of these activities rests with the CM, and this management should result in a documented plan to effectively manage the claim to optimal outcomes. The plan should be communicated to the worker and employer, by voice if there are complex issues involved. The parties should be informed on next steps in the process and the target time for revisited the plan. Metrics around the timing and effectiveness of this planning should be used to monitor plans and their effectiveness.

For injured workers at risk for long-term disability, intervention must come very early in the life of the claim, before barriers to returning to work harden. Thus, tools should be available to alert the CM when a particular claim is deviating from expected norms, or at-risk for future deviation. Predictive analytics (discussed further below) should assist this activity, but CM insight into and management of the process is important. A multidisciplinary team should be used to address conditions identified by analytical models. It is well known that return to work is complicated by such factors as obesity and other co-morbidities, substance abuse, and cognitive deficits. L&I has already quantified some risk factors, e.g., showing that even a short duration of opioid use contributes significantly to claim duration. Principles of disability management recognize the need for a team of experts to manage such risk factors. For example, experts in addictive behavior or post-traumatic stress might be needed to work with the treating physician and vocational experts. The specific interventions needed are likely to be beyond the expertise and time available to CMs. But the CM should be at the center of managing this interdisciplinary team, and involving the employer and injured worker.

3. Connect RTW training with performance management

The training program for CMs on communication and RTW management skills (Return-to-Work Toolkit training) recently implemented appears to be well designed to foster activities that will lead to better claim outcomes. This training should become more standardized across the claims units and follow up training be conducted, in accordance with a strategic plan for continuous improvement related to claims management training. Included in this training should be appreciation for the usual concerns of the parties to the claim, and good listening and communication skills (discussed in Chapter 2). Methods for identifying CMs who appear to have poor early RTW success should be developed and lead to coaching to improve communication skills in this area. The techniques should become institutionalized for all new CMs and reinforced from time to time for experienced ones. The training should incorporate outcome-oriented practices: e.g., role-play training on making calls, and “team triage” on selected claims. Finally, the training should be connected with performance measurement, data systems and analytics, and remediation training and coaching.

The GEMBA-walk practice used by L&I is a model that can be developed to accomplish this enhanced collaboration and coaching. This practice is currently used in certain cases to more promptly and effectively deliver vocational rehabilitation services, and is triggered by the timing of AWA plans. Additional triggers, for example certain physician practices or treatments and complex medical conditions, could be used to highlight claims for analysis in a GEMBA walk. We recognize that claims units currently engage in collaboration on a wide variety of issues, including complex medical cases. Our discussion concerns increased, regular training and a more defined workflow in which medical management practices are better integrated with regular, timely review of CM actions and plans in targeted cases.

4. Standardize claim file documentation

As mentioned above, in file reviews we observed minimal evidence of file documentation that demonstrated effective claim management planning. The claim file should more clearly and fully document steps taken to manage the course of the claim. In our file review we saw many instances of incomplete descriptions of actions and plans. Cryptic or formulaic notations were common, e.g., "opioids?" or "PPD?". More consistent and complete file documentation of such plans and actions is needed to assist CMs with monitoring needed actions, supervisors with review CM performance, and L&I with measuring success regarding such actions. L&I has recently introduced a new claim review template, which is designed to facilitate more straightforward creation of claim file reviews. Not all claims involve completion of such templates, however, only those selected for review. Such documentation, perhaps in more streamlined format for "everyday" use, should be implemented in all TL claims involved more than minimal time loss; there should be a clear expectation on items to be documented and this activity tied to performance measurement and coaching.

B. Administrative Opportunities

1. Integrate predictive analytics into claims management processes

Effectively addressing the observations highlighted in this Chapter hinge on continued utilization of claims management analytics. Such analytics would apply to two areas: "At-risk" claim identification, i.e., claims that are statistically at risk of prolonged duration; and statistical identification of "interventions that matter." L&I is actively working to isolate those claims most in need of particular interventions, as well as those factors involved in claims management that are most associated with preferred outcomes. We saw ample evidence that L&I management is aware of the need to restructure the timing and delivery of vocational services. What seems to be lacking are practical and well understood rules for interventions in cases at risk of becoming extremely costly both to the State Fund and the lifetime earnings of the injured worker. One way to achieve this is modeling the claims process to find statistically robust early warning indicators of problems and trigger points for particular vocational services. This will require state of the art decision models that might require expert assistance outside of L&I to accomplish.

Such utilization of claims management analytics should be continued and expanded. Tools should be available to alert the CM when a particular claim is deviating from expected norms, or at-risk for future deviation. Additionally, analytics should be used to establish success rates for particular interventions, in order to better inform CMs which interventions are most likely to lead to preferred outcomes. We recognize that L&I is aware of the factors that contribute to long-term disability, but this insight should be integral to daily CM claims management activities.

2. Clarify claim file confidentiality practices

In connection with the performance issues outlined above, a related issue concerns the lack of clarity about whether certain internal notes, including documentation of communications among the CM, supervisors, and medical and vocational advisors as well as strategies to address identified risks and issues, can be privately recorded in a zone of the claim file that is not available for viewing by the parties to the claim. The lack of confidentiality forces the CM to use vague, stylized, and neutral statements in the file plan and actions. Uninhibited communication by the CM, e.g., regarding sensitive medical or psychological issues that impact effective claims management, should be documented for supervisors and other internal parties with a role in the claim. The case reserves should also be restricted to the protected zone. There are some aspects of current practice where notes are considered to be made in confidence, but it is not clear among management, unit supervision, and CM staff how these protocols are designed and enforced, and what is confidential, and what is not. Additionally, this data is "unstructured" and difficult to be used in creating actionable reports. This should be investigated and clearly defined, with a goal of creating the confidential "zone" while maintaining appropriate stakeholder access to all file information currently available. Statutory changes may be required to enable this change.

3. Implement RTW standard practices

Employing vocational services to achieve RTW as quickly and safely as possible and avoiding retraining except as the last resort in the disability management process are principles that L&I clearly understands. In particular, the traditional AWA process is not designed to help workers on disability with RTW. Rather it is an adjudicatory process to test for "employability," and can be seen as moving the claim along a particular path that can often be met with resistance. L&I's recent "Early AWA" initiative seeks to tailor delivery of vocational assessment early in the claim, in an effort to discern the appropriate level and timing of additional services. Results of the Early AWA initiative to date are promising. Such innovations should continue, including the development of even new service types and methods, but ultimately a model for service delivery should be developed and spread across the entire "claim floor" along with development of related metrics to measure success or the need for modification. In addition to developing and deploying new vocational protocols it would be beneficial to capture good data on performance and incorporate this data into performance metrics and analytical models to inform CM decisions as well as help identify high performing vocational service providers.

Additionally, the selection criteria for re-training plans should be more focused, applying only to those cases where re-training is most appropriate. Formal retraining should be reserved for candidates that have a good chance of succeeding in a formal academic setting. L&I should to apply additional focus on OTJ training and develop suitable RTW interventions for those found unsuitable for formal retraining. We believe that at the completion of early assessments, for example between 1 and 3 months of TL and no significant medical complications, a vocational rehabilitation counselor should recommend either on-the-job training (OJT) or a formal retraining referral for plan development based on the injured worker's age, training, likely physical abilities and aptitude for formal training versus OJT. Such factors would need to be identified using developed analytical models, as well as professional experience of both CMs and VRCs. If retraining appears appropriate, the VRC could then concentrate on developing a client specific, highly tailored retraining plan. The VIP statutory language provides heavy emphasis on the timing and delivery of retraining plans. While such emphasis on measurement and accountability is crucial to success, this places an outsized focus on retraining plans. Formal

retraining provides meager returns. Recent data shows that about 45% of Option 1 retraining plans fail to complete and between 34% and 43% of workers completing retraining plans returned to work within two years following claim closure (2009 to 2011). If objective indications and the subjective judgment of the VRC and CM suggests that retraining is unlikely to be completed successfully, other options should be developed. We recognize that L&I has attempted to promote OJT; new financial incentives or other assistance appear to be needed to motivate employers to work with VRCs to develop OJT opportunities.

4. Improved information system

L&I recently pursued modernization of its claims management system, submitting a budget request ($9.8 million) for replacement of its LINIIS claims management system. At first glance this would appear to be a significant investment. However, this is a modest sum to accomplish major redevelopment, e.g., Pennsylvania recently replaced its workers' compensation claim system at reported costs of over $45 million; costs for a California replacement system were over $60 million.[1] Regardless of the sufficiency of the requested budget, L&I should pursue replacement of its core information system used for claims with an integrated, more "user friendly" system. At best, working in the current information-system environment is complex, requiring highly specialized knowledge. At worst, information is going overlooked because of the requirement to "query" the system to find routine information, as opposed to it being presented to the user in an automated way. The many upgrades over the years have helped, but the system lacks the functionality needed by CMs. The need to utilize both ORION and an outdated LINIIS system, in addition to other information systems and resources, takes a significant amount of time away from CMs, time that could be better utilized in file review, action plan development, and developing timely RTW strategies – all of which affect the duration of disability and claim costs.

A related imperative is to design this technology around key case activities, integrating the claims management process with analytics and tools, such as: actions that have been identified to lead to better case outcomes; the tasks connected with those actions; and dates and performance of those tasks. Dashboards and alerts could be utilized to monitor expected outcomes, using predictive modeling. Thus, for example, claims with greater than "X" months of lost time, for certain categories of injury, could be highlighted for the CM to update planning and suggest possible interventions. Planning would require identification of specific actions to be taken and associated dates; and progress against such actions would be shown to CMs and supervisors to better identify at-risk claims and those actions being taken to manage them.

C. EMPLOYABILITY STANDARD IS SUBJECTIVE

The employability standard is difficult to apply. The standard is atypical among workers' compensation systems, and results in a relatively high number of workers being considered unemployable. Also, application of the standard is challenging and causes delays to claim resolution. Finally, CMs utilize vocational service specialists to undertake these assessments, and these services are expensive and result in high vocational service costs for the Washington system.

[1] See http://www.lenardcohen.com/news/lenard-cohen-discusses-the-new-wcais-system.

The employability standard should be clarified and more easily-applied criteria established. In connection with this undertaking, however, L&I would benefit from re-examining the causes of the high rate of pensions in Washington to determine why the Washington pension rate remains so high. Several contributing factors identified by the Upjohn study are discussed in Chapter 5 and Appendix 2. The principle factors identified by Upjohn should have been resolved by now, and the improving job market should be reducing the causes of pensions—lack of gainful employment opportunities. Yet, the pension rate relative to lost time injuries remains high relative to the pre-1990 experience in Washington, and in comparison to other states. In addition, the relatively stable and lower rate of pensions for self-insured employers relative to State Fund claims ought to be studied. Considering the huge cost of pensions, it would be worthwhile to revisit, as in the Upjohn study of the contributing causes to pensions, and identify legal and administrative reforms, in addition to providing more objectivity to the employability standard, in order to bring the pension rate relative to lost time claims down to the levels prior to the 1990s.

2 PERFORMANCE MEASUREMENT

A. UNIT AND CM-LEVEL PERFORMANCE INDICATORS

There is a need for outcome-based measurements tied to regular CM performance evaluation. CMs should be aware of factors, actions, and interventions, and how their management of such services, lead to better outcomes. This should also be tied to overall unit and departmental performance.

The reports given to claim supervisors regarding CM and unit performance be more focused on essential performance indicators. These should be used for reviewing the individual CM's claim files and action plans so that effective training and corrective actions for CMs can be developed to promote appropriate claims management. Any significant differences in the performance among the claim units should be traced to their causes. We note that L&I has recently begun piloting an initiative, in connection with its "First 100 days" analysis, that seeks to improve and speed up CM reviews of their files through creation of a new file review template. This assumes that the CM has provided the required action-plan and other updates to the file that could be reviewed by both the CM and their supervisor as required to address needed issues, and also assumes that the CM performs the review of each file, before there would be true benefit from this initiative. Web enablement of the CBOB+ report, which has recently been started, is a good step. Such tools, however, should not be simply expanded, but should be refined. Better, as opposed to more, metrics should be identified and developed with staff input and engrained into supervisors in each claim unit.

The most important outcome measurements to use in measuring performance include percentage of cases returning to work with the employer of injury, percentage of cases returning to work with any employer within certain timeframes, the average duration of TL, the percentage of cases meeting RTW targets, and the frequency rate of justified protests and appeals. More discussion on performance metrics is presented in Chapter 5.

B. PUBLISH ANNUAL PERFORMANCE REPORT

Any important initiatives by L&I should be accompanied by published and rigorously developed measurements of progress and success in meeting objectives (as modelled in the recent "Dashboard" reports to WCAC). Such a report would include performance highlights, e.g., key performance indicators, and report on trends in such indicators, as well as report on strategic initiatives.

Currently, there is no comprehensive set of consistently published performance metrics. Such a report should have the character of an annual corporate report to shareholders, or stakeholders for non-investor owned organizations. For public organization like L&I, such a report should include non-economic indicators of the wellbeing of injured workers, such as the degree of permanent injury, RTW including income recovery and persistence of employment. It would be desirable to make a hierarchy of measures, beginning with sub-unit indicators that roll up logically into larger unit and programmatic performance numbers. The lower level measures are useful for training and supervision; the highest-level numbers should be reported to system stakeholders. For evaluating performance against other similar systems, it would be useful to include many of those reported by the Association of WC Boards of Canada as "Key Performance Measures."[2]

For example, in the 2014 – 2020 strategic plan,[3] a number of useful measures were linked to the 5 top-level strategic goals for the Department. An important component for reporting on progress towards goals is an annual or other periodic report focused on system issues, management and legislative initiatives, and performance indicators. This report should be an in-depth review of L&I's strengths and weakness, along with identifying system threats and opportunities. Establishing reasonably attainable goals along with the measures would help provide insight for readers of progress towards reaching the desired goals.

Also useful in a periodic published report would be discussion of the degree to which the identified measures were changing outcomes and impacting the goals. Specifically, identification of actions that are taken in applying the measures of success to reach the goals, along with links of the actions to targeted outcomes, would help in developing precision in reaching goals and changing outcomes. For example, the 2014 – 2020 strategic plan identifies "% of new claims receiving vocational services by 90 days" as a measure used in the RTW goals. This is a topic discussed in detail in this report. A critical aspect of meeting this goal would be to determine which vocational services help change outcomes, both positively and negatively. Tracking and reporting by service delivery, as well as the linked outcome, would help with correcting service deficits and with greater investment in the positives. We recognize that the strategic plan is just a snapshot of a much more detailed set of plans. Establishing and publishing such plans, however, in a consistent repeatable format, would help serve to track progress, define actions being taken, and ultimately reveal if the actions (and measures) were changing outcomes.

[2] Customized "Key Statistical Measures" reports can be created at the AWCBC website (http://awcbc.org), in the "statistics" section, available at http://awcbc.org/?page_id=14#KSM.
[3] http://www.lni.wa.gov/IPUB/101-171-000.pdf.

3 ADDITIONAL AREAS FOR SERVICE AND EFFICIENCY GAINS

A. NEED BETTER ADHERENCE TO PRACTICE STANDARDS FOR OCCUPATIONAL MEDICINE, VOCATIONAL SERVICES

We observed in file reviews instances where medical providers gave vague treatment notes and out-of-work notices, such as "No work 1 week." Vague, open-ended duty restrictions do not allow CMs to make effective evaluations of RTW, particularly whether the provider will engage in a partnership to assist with appropriate RTW options. COHEs have made excellent progress in developing a model for occupational medicine practice. Standard practices like those involved in COHEs should be advanced, and issues of poor performing providers rigorously addressed.

Additionally, there are issues regarding delivery of vocational service, including VRCs being late with developing AWA reports and, in certain cases, plans being sent back for re-work or improvement. Certainly some aspects of such issues are outside the control of VRCs, but some are the result of non-standard practice. This is an area where L&I is currently actively engaged in developing improved practices; an example is the development of "standard practice" used by VRCs to improve timing of developing AWA reports. Yet, the standards are not being routinely met. After additional standardization of the vocational service delivery process, providers should be held to more rigorous standards of compliance with plan development rules and procedures. L&I is striving to make performance-based referrals for vocational services. More enforcement of standards by sanctions may be necessary, e.g., warning a provider that they may lose their right to be on the preferred provider list if vocational reports are not promptly reviewed. The use of sanctions must be carried out with great care so as to avoid unintended consequences, such as service providers altering their practices solely to meet standards without regard to outcomes. By holding service providers to higher standards the level of worker satisfaction ought to improve.

B. EXPANDED OMBUDS ROLE (COULD REQUIRE STATUTORY CHANGE)

The Self-Insured Ombuds program is limited to workers of self-insured employers. Project Help is available to both State Fund and self-insured workers and employers, but it does not have the more formal structure of the Ombuds program. We believe that expanding into a unified Ombuds Program that covers both State Fund and self-insured claims would provide for more consistent support of workers and employers and help obviate the need for pursuing some protests and appeals. Expert information from a trusted, independent source can be very valuable for workers with concerns about workers' compensation. The Ombuds function in Washington has proven effective over its 6-year existence, and could be extended to offer service to all workers. This model is successfully used in Ohio, Oregon, Alabama, Kansas and other states. Extending service for all workers' compensation problems system-wide would provide a comparative source of insight into how the system functions for self-insured versus state fund workers.

If not feasible to have a single ombuds that would cover both State Fund and self-insured issues, it would still be beneficial to create an independent State-Fund Ombuds Program patterned after the self-insured Ombuds Program. The methodical approach and performance metric of the Self-Insured Ombuds program are worth imitating for State Fund interventions. Also, creating a clear feedback loop, as in the self-insured Ombuds Program, whereby

recommendations for improvement and change can be made to the Department, would help ensure that observed issues are addressed and needed changes take place.

C. Relaxed L&I role in certain SI decisions (likely statutory change)

We observed that in some orders, e.g., issuing an allowance order, concerning decisions that are made initially by self-insurers, it appears that L&I adds little value in the decision making process of self-insurers. Moreover, L&I's role in this process and may give an incorrect perception that L&I has reviewed and endorsed the decision of the employer. In file reviews, it was clear that in the allowance order process, L&I did not perform an independent review of the supporting information, which makes sense because the self-insurer is agreeing to accept the claim. In other decisions we expect that a structure can be established to ensure appropriate action by self-insurers without the added time required to receive formal approval by L&I. In our review of denied claims, L&I approved almost all self-insurer requests (98%). This indicates either that L&I is not independently reviewing denial recommendations, or that self-insurers are presenting very clear and convincing evidence supporting their positions (our observations were that supporting evidence was not ample in such cases, however). Either way, claim processing functions such as compensability adjudication are done autonomously by self-insurers in all other jurisdictions. It is highly likely that these could also be done effectively by Washington self-insurers and their TPAs, with proper audit oversight and interventions by the Ombuds. At a minimum, L&I should clearly communicate the extent of its review of self-insurer decisions when delivering case orders.

Some L&I staff resources currently devoted to processing functions could be re-purposed into enhanced audits to more efficiently identify the problem self-insurers. These could take the form of increased sample sizes, or reviewing more claim processing areas such as timely and accurate first payments.

Note that adopting this delegation of authority to self-insured employers likely would require a statutory change. RCW 51.14.140 requires that a self-insurer "request allowance or denial of a claim" and establishes a time limit for such requests.

D. Increased use of FileFast (could impact staffing)

We observed that most accident reports are filed by providers, and not by employers, who have first-hand knowledge of the injury. This is causing delays in claim reporting. The FileFast process is an effective measure to speed accident reporting, as well as to obtain more thorough accident and injury information. Employers should be encouraged to submit first reports of accident and physicians encouraged to submit medical reports through FileFast. Achieving a higher share of claims coming through FileFast may require marketing research, further financial incentives, and would certainly involve a major outreach to groups with the greatest identified potential for using this technology. Possible areas for consideration of expanded usage would include smaller, less sophisticated employers and promoting to them the benefits and cost savings from potential use of this system. Increased usage by both physicians and employers would speed the flow of essential information to the CM, without diminishing the role of the treating physician. These early reports would be particularly useful for uncontested traumatic injuries with lost time potential.

E. More protest review by Claim Consultants (could impact staffing)

The Washington dispute process is complex and the dispute resolution path that is taken depends on a somewhat arbitrary decision, namely whether the party first filed an appeal to the BIIA or a protest to L&I. The standard protest process involves the CM who made the decision reviewing the file, which is a good design for catching simple errors. But when the protest involves a fact dispute, presumably the CM did not make an arbitrary decision and the parties simply disagree, and allowing the CM to "re-make" the same decision doesn't seem to add much value. If the decision were arbitrary, then allowing another reviewer, the Claims Consultant (CC), with distance from the case, to perform the initial review of the decision would seem to provide a more bona fide review. We believe that limiting CM review to only simple errors and missing information, and expanding CC or senior unit CM review to disputes of a more substantive nature, would make the process more unified and consistent.

We recognize that sending all protests directly to Claims Consultants, by-passing CMs, would add significant workload to Claims Consultants. There may be an alternative approach, however, which would eliminate unnecessary re-assumption processing times and also provide a more independent review of CM decisions regarding issues that are truly in dispute, as opposed to errors or missing information. Such an alternative would involve the CM collecting file documentation of the basis for any reversal of their decision (such as the cases where information was received after the first decision) and proceed with timely resolution of that issue. However, if the CM believes their decision is correct and no known missing information is impacting the decision, the file should be sent to either the WCA4 in the unit, the unit supervisor, or possibly a Claims Consultant to request an affirmation order. This would allow a more independent review before a CM simply decides they were "right in the first place." This would also largely eliminate the need for the re-assumption review, because such review already has occurred by the CC, except in those cases that are directly appealed without protesting to the department first.

If as a result the need for review on re-assumption is reduced, then this alternative should decrease overall protest times and result in more independent decisions, made by more experienced reviewers, and thus would be "better" decisions. If an appeal were the first formal dispute raised, then L&I would always re-assume jurisdiction and handle it as a protest, according to this same process.

We suspect that a fair number of protests arise out of decisions that are made with inadequate or missing information. It may be that the decision itself forces the issue and gets the information delivered, e.g., worker fails to supply a report so payment stops and worker then supplies the report. In such instances, the current protest process would seem to provide the simplest, most direct approach to resolving the issue. But this involves using the protest process to correct case management problems. The protest process should correct bad decisions. We recognize that this might seem simplistic; for example, if a provider does not offer an opinion on causation, despite repeated requests, and only does so after a formal denial order is issued, then perhaps the order/protest process served a valid purpose, namely to force the issue and get the needed information. In such situations, however, the CM could provide data as to why the protest process was effectively used for "case management" purposes, and this could serve to improve the overall process, and avoid such unnecessary protests.

F. Shift to employer reporting (mandate or incentives; could require regulatory change)

The primary mechanism for accident reporting is by providers, which is not a common feature of most systems, which utilize employer accident reporting as the primary mechanism. Employers are more familiar than providers with the nature of the job at time of injury and other circumstance of the accident. Thus getting their input early in the claim would assist with claim validation. Moreover, this would provide an excellent opportunity to gain insight into employer engagement with RTW. Reporting accidents is not equivalent to filing claims; the former is important to triggering the insurer's response, and should be made as expeditious as possible. The latter involves formally lodging a claim within a workers' compensation system. What we are discussing is prompt accident reporting, not claim filing.

The claim reporting process should be re-structured such that the primary mechanism for accident reporting is from employers, and to move away from provider responsibility for initiating the accident report. Providers cannot as easily be mandated as employers to make prompt accident reports to L&I. This would help speed up reporting to L&I, which in turn would improve timing performance of subsequent decisions. This should not serve to eliminate provider reporting to L&I; on the contrary, it is essential to effective claim management to receive prompt provider input regarding the claim and associated treatment. Such input should not delay, however, the employers' accident reporting process.

G. Online provider communications

We observed that physicians and medical providers were not frequent users of online communication tools. L&I should aggressively undertake to increase acceptance and usage of online communications tools by physicians. Medical offices are increasingly equipped to use electronic records, electronic billing, and email communications with patients. COHE providers have demonstrated the ease and utility of using online tools. Increasing electronic reporting of the Activity Prescription Form would pay dividends in improving early return to work and speeding first payment of indemnity. Secure messages between the CM and the providers' offices would help resolve misunderstandings or clarify expectations. We suggest that L&I consider further financial incentives for timely and complete medical communications through My Secure L&I. This should be coupled to an educational and outreach program aimed at clinic office staff, and perhaps hospital staff who deal with emergency room billing. These staff should learn the tools and functionality (e.g., setting up a personalized dashboard) that will attract them to use online communication. Moreover, in designing the LINIIS replacement system, L&I should incorporate provider input to ensure that online communications are easy to use and the preferred communications mechanism.

H. Establish standard dispute response times (CM and CC)

We observed that there are not consistently applied standards in communicating with stakeholders about what timelines to expect in resolving protests. The Department should adopt a policy, applicable to both CMs and CCs, of setting achievable standards for a substantive, clear response to a protest and a decision on re-assumption of appeals. The average protest resolution is 55 days, and this particular timeline may be acceptable. Regardless, the need for clarity in "the next steps" of the claim process was demonstrated in a 2013 L&I survey of injured workers. 27% of respondents gave L&I a poor grade in terms of "letting the worker know what

would happen next," and 30% gave L&I a poor rating in "involving the worker in the process." A 30-day target for closure on protests seems like a reasonable expectation unless it is clear at the time the protest was received that an IME or other external supporting documentation was needed. If the selected target date cannot be met, the parties should be kept apprised of the revised target.

Although there is obviously risk that a particular case might take more time than anticipated, leading to further frustration, we suggest that in a large portion of cases the expectation will be met or exceeded, and would likely lead to overall better satisfaction with the process and ultimately the results. We suggest that when a protest supplies all necessary information for processing, as described in the L&I information supplied to the parties with the order, that a targeted internal resolution time, e.g., 30 days, be established and that performance be monitored as to meeting this target. Compliance with such internal standards should be measured and be given management attention if the standard is routinely breached. Additionally, early personal contact with the parties to a claim, discussed in Chapter 2 of this report, would very likely eliminate some disputes and appeals, cut the number of requests for assistance from ombuds or Project HELP, cut back appeals to BIIA, and reduce attorney involvement.