

Access, Quality, and Outcomes of Health Care in the California Workers' Compensation System, 2008

A Report to the California Department of Industrial Relations, Division of
Workers' Compensation, Mandated by Labor Code Section 5307.2

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The School of Public Health's logo (Soul Catcher) is a Northwest Coast Indian symbol of physical and mental well-being. It was designed by artist Marvin Oliver and is a registered trademark of the School.

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We are very appreciative of the efforts of the seven claims administrators (identities unknown to us) who contributed greatly to the Back Disability Worker Survey by providing the 6-month follow-up data on compensated time loss, which allowed us to better describe and understand the relationship between access barriers and work disability. Most importantly, we gratefully acknowledge the contributions of the injured workers and health care providers who elected to participate in these surveys, without whom this study could not have been conducted.

EXECUTIVE SUMMARY

This study, commissioned by the California Department of Industrial Relations, Division of Workers' Compensation (DWC) and conducted by researchers at the University of Washington (UW) School of Public Health, was designed to evaluate the adequacy of access to quality health care delivered to injured workers through the workers' compensation (WC) system in California. Like the 2006 study conducted by the Center for Health Policy Research at UCLA, this study was mandated by Labor Code (LC) section 5307.2, as added by SB 228, and included statewide surveys of injured workers and providers in 2008. We begin by highlighting our conclusions, then briefly describe the 3 surveys we conducted, present results of each survey and comparisons to the 2006 UCLA study, and end with our recommendations.

CONCLUSIONS

- There does not appear to have been much change from 2006 to 2008 in the level of access to quality care.
- Most (4 out of 5) injured workers were satisfied with their health care and rated their overall quality of health care good or better. In addition, between 84% and 89% of workers reported that their main provider performed each of 4 occupational health best practices.
- Over half (52%) of providers indicated that their WC patient volume had decreased in the past 2 years, and one-third (32%) reported that they intended to decrease WC volume or quit treating WC patients altogether. Administrative burden, UR-related delays and denials, restrictiveness of treatment guidelines, and issues related to payment and reimbursement, among other factors, were found to be predictive of provider intent to decrease or quit treating WC patients.
- There were important access barriers that appeared to increase work disability and costs; almost half (47%) of injured workers reported experiencing one or more access barriers at some point during their treatment. We conclude that access to quality care is not adequate and that there is both great need and great potential for improvement.
- On a population level, the excess work disability and costs related to access barriers are substantial – on the order of millions of lost work days and hundreds of millions of dollars in direct economic costs.
- We believe the aim of WC quality improvement can best be advanced by the prompt initiation of action steps to mitigate the access barriers that lead to potentially avoidable work disability and by the development of a research and policy agenda to further assess approaches to best accomplish this aim.

STUDY AIMS AND APPROACH

This study had 3 primary aims: (1) to evaluate the adequacy of access to quality health care for injured workers in 2008, (2) to assess changes in access to quality health care since the 2006 UCLA study, and (3) to determine the effect of access barriers on work disability. To accomplish these aims, three surveys were conducted: (1) the All-Injury Worker Survey, which assessed access to quality health care among the general population of injured workers, (2) the Back Disability Worker Survey, which examined the effect of access barriers on work disability among workers with back sprains/strains and at least some compensated time loss, and (3) the Provider Survey, which gathered information regarding the practice, experiences, and opinions of providers who participate in California's WC system. Taken together, these 3 surveys provide a detailed assessment of the state of access to health care for injured workers in California in 2008 and the effect of access barriers on work disability.

1. All-Injury Worker Survey

- Random sample of injured workers, similar to the 2006 UCLA worker survey
- Interviews conducted 10 to 13 months after June 2007 injury (11 months on average)
- 508 completed phone interviews from May 2008 to July 2008
- 28.3% adjusted response rate

2. Back Disability Worker Survey

- Injured workers with back sprains/strains who had some compensated time loss
- Injuries occurred between December 1, 2007 and April 30, 2008
- Interviews conducted 2 to 6 months after injury (90% within 2 to 4 months of injury)
- 493 completed phone interviews from May 2008 to July 2008
- 39.2% adjusted response rate
- Survey responses were linked to administrative data on compensated time loss covering 6 months after the date of injury

3. Provider Survey

- Licensed providers who treated WC patients between 2004 and 2008
- Eligible provider types: doctors of medicine and osteopathy, chiropractors, acupuncturists, podiatrists, clinical psychologists
- 809 completed mail/web surveys; contacted between April 2008 and December 2008
- 28.2% adjusted response rate

SUMMARY OF RESULTS

All-Injury Worker Survey

Fifty-eight percent of the respondents were male, 45% were Latino and 42% were white. The most common injury category was sprain/strain/joint/disc injuries (48%). Over 80% received their care through a Medical Provider Network (MPN).

Access

The All-Injury Worker Survey assessed a number of access indicators pertaining to travel distance, waiting time for appointments, delays or denials of care, language barriers, and other problems in obtaining health care, specifically including physical or occupational therapy (PT/OT), specialty care and/or prescription medications. Key findings of the 2008 survey include:

- 9 out of 10 injured workers (89%) obtained initial care for their injury within 3 days of advising their employer about their injury
- 83% to 86% did not travel further to appointments than the MPN travel distance standard (15 miles or less to initial and main provider and 30 miles or less to specialist)
- 10% of respondents reported barriers obtaining prescription medication, 21% reported problems accessing PT/OT, and 27% reported problems accessing specialist care (percentages are based on those respondents needing the health care service in question)
- 10% of respondents experienced delays or denials of care often or more frequently
- Almost half (47%) of injured workers reported experiencing one or more access barriers at some point during their treatment

Satisfaction, Quality, Recovery and Other Outcomes

We found workers' assessments of quality and satisfaction to be positive: 4 out of 5 respondents (80%) indicated they were satisfied or very satisfied with the care they received and a similar percentage (79%) believed the quality of that care was good to excellent. The care provided to injured workers conformed in some measure with occupational health best practices in a great proportion of cases (over 80% of the time, when applicable).

Less encouraging was the assessment of injured workers in regard to their recovery. At approximately 10 to 12 months after injury, over half (54%) of injured workers had failed to fully recover, and 1 out of 10 workers (12%) reported no improvement. Further, 1 out of 5 workers (21%) reported that their injury was still having a "big effect" on their life. Approximately one quarter of respondents (24%) reported missing more than 30 days of work,

but the great majority (91%) were able to return to work at least temporarily. Of concern, 39% of workers who returned to work at least temporarily and needed job accommodations reported that necessary job accommodations were not made.

Back Disability Worker Survey

Respondents participating in this survey were similar in most respects to respondents in the All-Injury Worker Survey. Sixty-seven percent of the respondents were male, 47% were Latino, and 39% were white. Three out of four injured workers (76%) saw a PT or OT, and 39% saw a specialist. Like injured workers in the All-Injury Worker Survey, the great majority of workers with back sprains/strains (more than 85%) received their health care through a MPN.

Access

The profile of access measures reported by respondents was similar to that reported by respondents in the All-Injury Worker Survey:

- 9 out of 10 injured workers (90%) obtained initial care for their injury within 3 days of advising their employer about their injury
- 82% to 86% did not travel further to appointments than the MPN travel distance standard (15 miles or less to initial and main provider and 30 miles or less to specialist)
- 11% to 29% reported encountering some problem accessing PT/OT care, specialist care or obtaining prescription medication (these percentages are based only on those respondents needing the health care service in question)
- 53% of respondents encountered at least one access barrier

Effect of access on work disability

Workers who experienced one or more access barriers had, on average, approximately 17 more days of compensated time loss 6 months after injury, compared to workers who did not encounter these access barriers. On a relative basis, access barriers increased the duration of compensated time loss by approximately 60%, from 26 days to 43 days. To quantify the impact of access barriers on a population level, we estimated that approximately 3.8 million potentially avoidable days of compensated time loss, representing a cost of \$349 million, may be incurred by California workers encountering access barriers during the first year after their injury.

Provider Survey

There were 743 providers who were participating in the WC system at the time of interview. The majority (54%) of providers overall were in solo practice. The great majority of providers indicated that, at least 75% of the time, they understood the physical and mental health demands

of workers' jobs (74%) and discussed work status or return to work (71%), but only 44% reported that they contacted the employer about modified work at least 75% of the time (when applicable). Overall, 45% of providers agreed that injured workers had adequate access to quality health care. Almost all (96%) providers who reported that their WC patients experienced delays or denials of care sometimes or more often felt that these delays or denials interfered with their patients' recovery at least sometimes.

Providers consistently rated delays and denials resulting from UR and administrative burden/paperwork related to UR as the most important barriers interfering with WC health care delivery. Other factors rated important included restrictiveness of ACOEM guidelines and the Medical Treatment Utilization Schedule (MTUS) and administrative burden/paperwork related to reporting requirements.

Ensuring that injured workers have adequate access to quality health care depends critically on the availability of providers and their willingness to treat injured workers. At the time of interview, 66 of the providers surveyed were no longer treating injured workers. The leading reasons they gave were: (1) administrative burden-reporting requirements, (2) payment denials, and (3) denial of treatment due to utilization review. Over half (52%) of the 743 current providers indicated that their WC patient volume had decreased in the past 2 years, and one-third (32%) reported that they intended to decrease WC volume or quit treating WC patients altogether. Of great concern is the fact that 51% of orthopedic surgeons, a key provider group in the WC system, reported that they intended to decrease or quit treating WC patients.

COMPARISONS TO 2006 UCLA STUDY FINDINGS

All-Injury Worker Survey

Similar methodologies enabled comparison of the findings of the 2006 UCLA worker survey with those of the 2008 All-Injury Worker Survey. Findings were quite comparable in terms of worker sociodemographics and degree of recovery. We observed no marked differences from 2006 to 2008 in access to quality care or worker satisfaction, for example:

- 88% of 2006 survey respondents received initial care within 3 days, compared with 89% of 2008 survey respondents.
- Initial care was within 15 miles for 86% of workers in both survey years, and main providers were within 15 miles for 82% of 2006 survey respondents and 83% of 2008 survey respondents.
- 78% of 2006 survey respondents were satisfied or very satisfied with their overall care, as compared with 80% of 2008 survey respondents.

Provider Survey

We compared 2008 to 2006 findings on (1) provider perceptions of the adequacy of access to quality care for injured workers, (2) a decrease in patient volume in the past 2 years, and (3) intent to decrease WC patient volume or quit treating WC patients. The comparisons showed no marked changes in these key measures for all providers as a group. More than half of the surveyed providers continued to perceive access to quality care for injured workers as inadequate. In both surveys, 52% of providers reported a decrease in their WC patient volume in the past 2 years, and approximately one-third of the provider respondents reported intent to decrease WC volume or quit treating WC patients.

Primary care MDs/DOs were the only provider type with a meaningful difference in intent to decrease or quit treating WC patients. Whereas 35% of primary care MDs/DOs reported intent to decrease or quit treating WC patients in 2006, 24% did so in 2008. There were some differences in questions and particularly in sampling procedures from 2006 to 2008, which limits the conclusions that can be drawn from the comparisons presented above.

RECOMMENDATIONS

Based upon the results of our surveys and analyses, we outline several recommendations (not in order of importance) for improving the performance of the California WC system.

Employer Offer of Job Accommodations: The ability and willingness of employers to offer job accommodations to facilitate timely return to work is a critical factor in limiting work disability, promoting improved productivity and health outcomes for injured workers, and reducing employer WC costs. DWC has already initiated public relations efforts to educate employers, especially small employers, about the importance of return to work. In addition, DWC could develop incentives for employers, especially small employers, to develop job accommodation programs. This could involve the creation of a funding pool to provide premium discounts for employers who develop and use job accommodation programs.

Functioning of Utilization Review: Both the earlier 2006 UCLA provider survey and our 2008 worker and provider surveys indicate a need to improve administrative processes related to the functioning of UR programs within the California WC system. Two key problems meriting attention are (1) delays arising from UR and (2) administrative burden associated with UR. We offer two suggestions for reducing delays and improving UR functioning. First, there is an obvious need for better and more detailed information regarding the functioning of UR, the efficiency of the UR review process, and the frequency and timing of UR appeals by the attending provider. This information could possibly be obtained through analysis of

administrative data and/or qualitative data collection, including focus groups. Second, the efficiency of UR may be enhanced by using a “provider targeted” approach to UR. In this form of UR, providers having few UR denials in a specified baseline period are given a waiver for prospective UR review but remain subject to retrospective audit to ensure that the volume of their requests has not increased and that there is no compromise in meeting specified UR criteria for appropriateness. DWC does not have the authority to implement this recommendation, but it could initiate discussions with claim administrators, UR organizations, and physician groups to consider the idea. Ultimately, it would be up to claim administrators to make such a change in UR procedures.

Provider Administrative Burden: Much of the provider discontent captured by our survey relates to UR, but there also appears to be broader dissatisfaction with the general level of administrative burden imposed on providers. Physicians function under an intolerable paperwork burden, largely imposed by payers. To the extent the WC system adds to this burden, it is not surprising that physicians and other providers would give voice to their frustration via our survey. We recommend that DWC establish a task force comprised of appropriate stakeholder groups to identify acceptable approaches for reducing the administrative burden imposed on providers participating in the WC system.

Language Barriers: More than a quarter of workers who did not speak English well reported difficulty understanding their main provider, and language barriers were associated with excess disability burden. Workers who must see an MPN-based provider with whom they cannot communicate should have access to language assistance services. Efforts should be made to close any regulatory gaps that have the effect of a higher prevalence and systemic tolerance of language barriers for workers treated via MPNs (the vast majority). New legislation could mandate that language assistance services be offered through MPNs as a condition of their participation in WC. Employers could be encouraged (or required) to inform injured workers of their rights to appropriate translation services (as a paid benefit of the WC system in particular circumstances), and to consider the language capabilities of providers in conjunction with the languages spoken by their employees when setting up MPNs. We recommend that DWC add translated information about injured workers’ rights to interpreters to their website and make links to translated materials more visible. More information should be available in languages common among California workers (in addition to Spanish). All multilingual services provided by DWC should be publicized in a way that is accessible to those injured workers most in need of them. We also recommend that future surveys more specifically address language barriers in order to gain insight into the extent of this problem and its consequences.

Quality Improvement within MPNs: Though MPNs currently may offer only limited formal organization for WC health care delivery, they may have the potential to serve as an organizational locus for improving both quality and injury prevention in the WC system. This

would require at a minimum organized WC quality improvement and assurance programs that do not currently exist. MPNs would seem to be a natural focal point to begin considering how to advance this goal, but doing so would require the strong commitment and leadership of claim administrators, perhaps along with appropriate legislation. MPNs could also play a role in fostering injury prevention, by tailoring patient education and communication about occupational health and injury prevention to address preventable threats to health and safety in the workplace.

DWC-to-Provider Communication: Data gathered by our provider survey indicate that many providers do not rely primarily on the DWC website for communication about WC issues or announcements. Given the choice, more providers stated they would prefer information be mailed or e-mailed to them instead. At a minimum, it would seem desirable to identify approaches to enhancing the utility of the DWC website as a mode of communication with providers. The DWC website could also serve an educational and training function for providers.

Quality Improvement Research and Policy Agenda: Finally, we suggest that DWC develop a quality improvement agenda, building on the findings presented in this report. This will require a clear identification of priorities and goals for improving the future performance of the WC system, along with the development of an integrated research and policy agenda to assess approaches to best accomplish this aim. Ample resources should be directed toward maintaining and fully utilizing DWC's highly valuable Workers' Compensation Information System (WCIS), in order to optimize the extraction of information relevant to such a policy agenda. Experience suggests that such an investment pays important dividends in terms of improving the basis for sound health policy, enabling crucial program evaluation, and developing and continually improving effective programs that meet the health needs of injured workers.

The recommendations made in this report are intended to encourage policy and programmatic discussion, further investigation, and development of action steps that could mitigate access barriers and improve the performance of California's workers' compensation system for injured workers, employers, health care providers and other system stakeholders. It would be appropriate for the Commission on Health and Safety and Workers' Compensation (responsible to evaluate and recommend improvements to the WC system) to provide resources for and play a leading role in this work, in partnership with the California Division of Workers' Compensation.