SUMMARY: VHA WORKERS COMPENSATION PLAN

1. In 1997, VHA formulated a strategic plan for the elimination of work-related illnesses and injuries that relied on developing top-management commitment, building an in-house set of tools, developing training programs, and responding to field requests for problem solving. That was associated with a decrease in the lost time claims rate (**Figure 1: lost time claims rate slide – All VA**). Since 1992, although VHA's costs have increased, much of that increase represents cost of living increases and not an increased number of claims until 2002 (**Figure 2: WC Costs with COLA**). In response to an OIG investigation and concerns from the DASHO about under-reporting of injuries, VHA changed the performance monitor from decreasing lost time cases to increasing the ratio of reported lost time injuries to total reported injuries.

2. Between 1999 and 2002, VHA evaluated several strategies towards the elimination of injuries and illnesses, and the associated reduction in workers compensation costs, including with an OIG audit of cases, a review of workers compensation case records and WC-MIS coding, and scrutiny of ASISTS data.

    a. VHA evaluated records adequacy. At present data in WC-MIS often appear misleading. VHA reviewed amputations, one of OSHA's "three-by-five" strategy outcomes. 45% of injuries coded as amputations were actually something else (**Figure 3: amputations**).
    b. The OIG review identified that the majority of cases could not be evaluated because either DOL records were unavailable or because they contained inadequate information to decide how better to manage them (**Figure 4: OIG case review**). In response, several facilities and one VISN are piloting placing a nurse in the DOL District office on a regular basis to help with claims management
    c. A Case Management Technical Advisory Committee was convened in 2000. A draft document was assembled, that served as the basis for the VISN 11 project, was developed and a WC program checklist was developed (attached), recently incorporated into VHA's Annual Workplace Evaluation (AWE). A similar document has been developed for occupational health.
    d. VHA evaluated injury distributions based on ASISTS to determine a strategic plan. (Only 40% of the injuries reported in ASISTS are actually reported in WC-MIS). Figure (**Figure 5: ASISTS injury distribution**) shows the cause of injury as defined in ASISTS. About 30% were either not coded (6%) or represented small percentages that were deemed not worth documenting individually. Striking is that 12% of reported injuries were patient transfer injuries. Along with these, slips, trips, and falls; "struck by"; material handling; and violence represented our priority injuries. These appear important not just because of frequency but because they are also defined as important issues for our employees (see for example, ANA survey and proposed bargaining agreement). Specific initiatives were developed for each.
        i. Patient transfer injuries: A program was developed that serves as the joint VA/DoD model program. A VISN-8/SEC-co-funded proposal is currently

under way in VISN 8 to evaluate the true costs of and best implementation strategies for a broad-based patient transfer injury. VISN 8 has demonstrated a substantial decrease in workers compensation costs based on that initiative. An annual course is held in Florida.

ii. Slips, trips, and falls: VHA is a participant in a Liberty-Mutual/National Institute for Occupational Safety and Health three-part program to reduce slips trips and falls.

iii. VHA has initiated a broad-based program to address violence in health care, using the performance monitors system.

iv. A program for bloodborne pathogens injury-related devices and device standardization with NAC

e. VHA evaluated its WC program infrastructure. First, although VHA funds WC-MIS ($450,000 / year), the data system does not address all of VHA's needs. Most "old" injury costs could not be explained using WC-MIS, and the categories did not support the development of strategic plans (**Figure 6: old type code cost).** On the other hand, new claims according to WC-MIS had as a cause "over-exerted", with repetitive strains and acute injuries as a common trigger (**Figure 7: new type code cost**). Major cost drivers, such as continuation of pay, which properly belong in the WC-MIS system, have not been incorporated despite several conversations to that point over the years. Some VISNs were recognized to have innovative programs that led to cost savings, earlier return to work, and other benefits. In addition, VHA identified five problems.

i. WC specialists at the facility level have a very high turnover rate. This is due to job dissatisfaction, the generally negative tenor of the field, and the lack of social support.

ii. WC specialists often do not adequately coordinate their work and strategies with safety and employee health programs at the facility level.

iii. For some years, the course previously given by the DASHO at the Little Rock EES center (occupational health and safety training center) has not been held.

iv. VHA does not have a strategic alliance with DOL/ESA in the way it has a functional partnership with OSHA, so that goals, strategies, and plans are not aligned. This leads to very different costs and periodic roll case distributions by DOL district (**Figure 8**). VHA's partnership with OSHA has led to the recognition of VHA as a leader in the Federal government in health and safety **(http://vaww.ceosh.med.va.gov/SpecialReports/OSHA_Eval.pdf).** This represents an important model for successful performance improvement.

v. DOL Districts may not manage cases uniformly well. Many VHA employees who are treated in the private sector receive substandard care, and DOL has been unwilling to use the quality improvement approaches pursued by VHA in clinical matters. DOL staff are inadequately trained in the use of clinical practice guidelines and other cognitive aids.

3. The implications for cost savings and employee morale improvement were presented last year at the Screening and Evaluation Committee, to All VISNs in the national All Employee Survey briefings, and to the Under Secretary for Health's Office. The SEC funded a position for a VHA national WC program manager, as DASHO had suggested in the past. When that position was filled, VHA developed a plan. The plan elements were derived from program elements in VISNs that had successfully reduced program costs (**Figure 9: Costs by VISN**). That plan includes

    a. Development of a field-training guide based on the previous DASHO course by incorporating several newer issues. Clinical case management has become an important adjunct to case management. Data coding improvement is necessary, based on the high frequency of errors (target date: March 1, 2003).
    b. Conduct of a satellite broadcast series to disseminate its use. Although face to face training is preferable, such as was conducted in Little Rock in prior years, under the current budget constraints facilities are unlikely to fund travel, and VHA recently lost 16% of its field travel budget (program slots available through EES throughout Spring 2003)
    c. Dissemination of successful program elements including: stationing staff in the DOL District office, conducting reviews of periodic rolls cases, and specific case management guidance (April – July).
    d. A combined quality improvement program based on audit elements for workers compensation and employee health programs (forms under revision).
    e. A structured approach to site visits and local support using the developed tools (depending on field travel funds availability in the current budget)
    f. The development of a formal partnership with DOL on workers compensation, to address training needs for DOL claims examiners and quality improvement approaches (DASHO responsibility)
    g. Collaboration at the facility and VISN level between safety, workers compensation, and occupational health clinicians (national meeting of VISN-level coordinators in planning,)

4. VHA developed a model VISN roll-out plan for joint WC, safety, and employee health programs in VISN 8, using among others the tools piloted in VISN 11. That is currently being evaluated for lessons learned in roll-out, including the utility of quantitative evaluation measures.

5. VHA staff visited the DASHO WC manager to discuss these priorities and lay out a plan. We are under the impression that we agreed to the following joint activities
    a. Development of a systematic review system for DOL case support, starting with psychiatric and stress claims
    b. Revitalization of the basic workers compensation course
    c. Systematic development of DOL relationships at the district level, to be complemented by DASHO's approach to DOL at the national level.

Figure 1: VHA Lost Time Claims Rate by Year

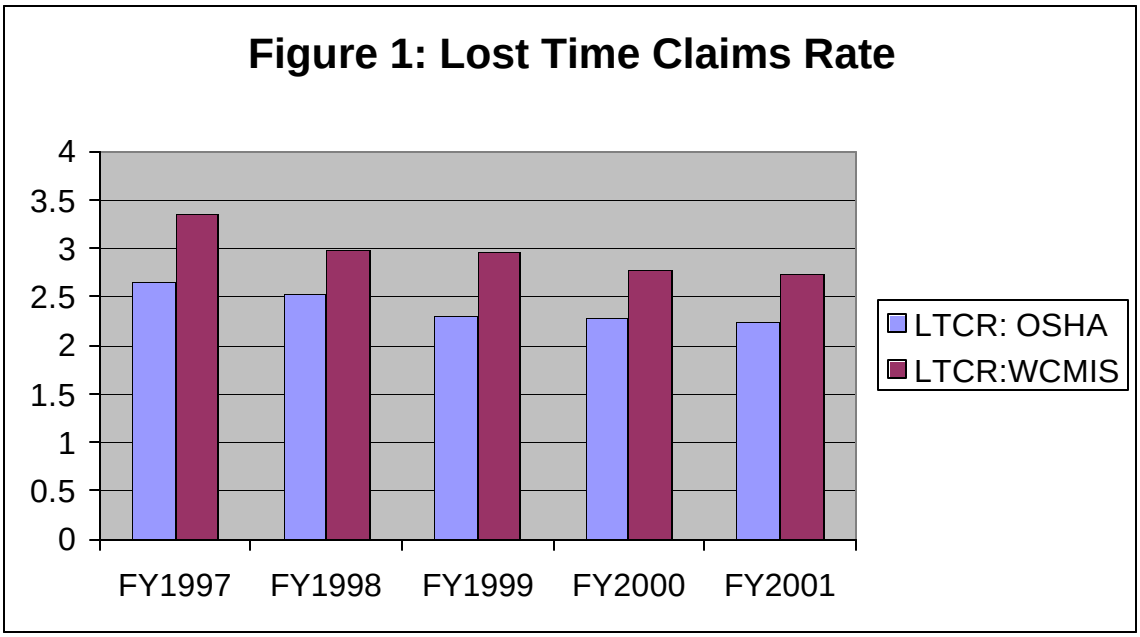


Figure 2: VHA National Compensation Costs with COLA

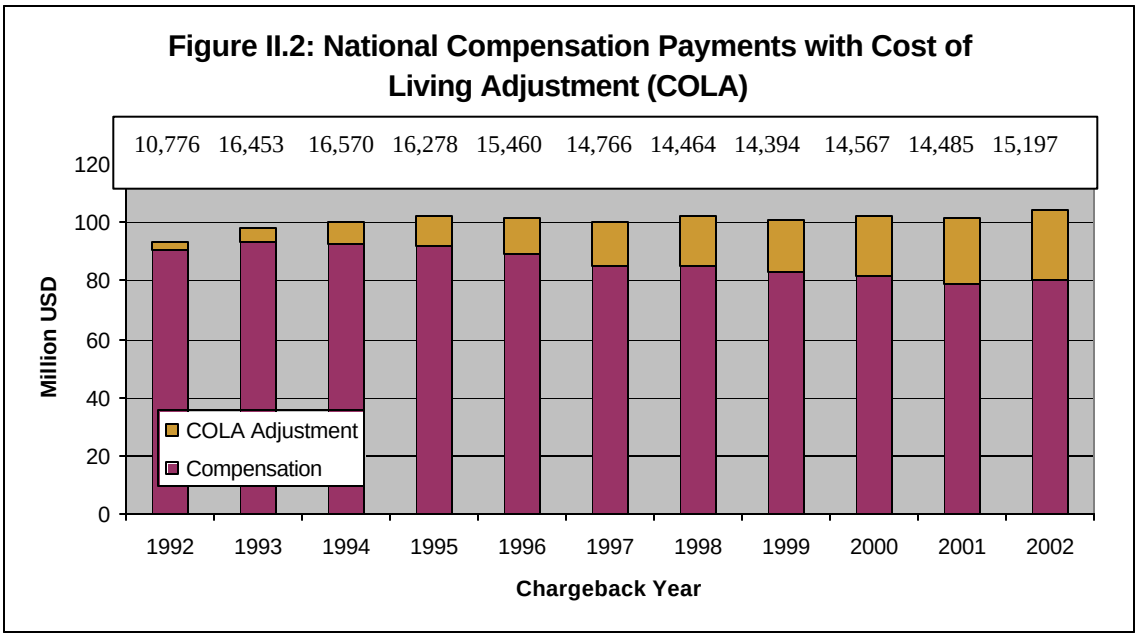


Figure 3: Coding of Amputations in WC-MIS

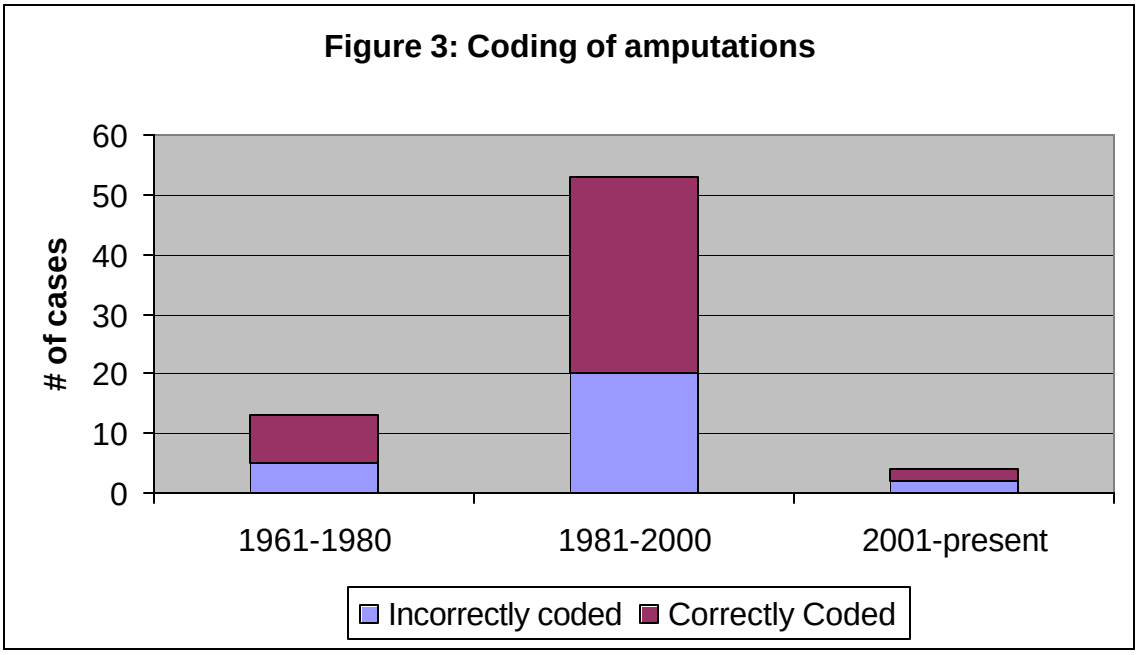


Figure 4: VA-OIG Case Review Panel Results

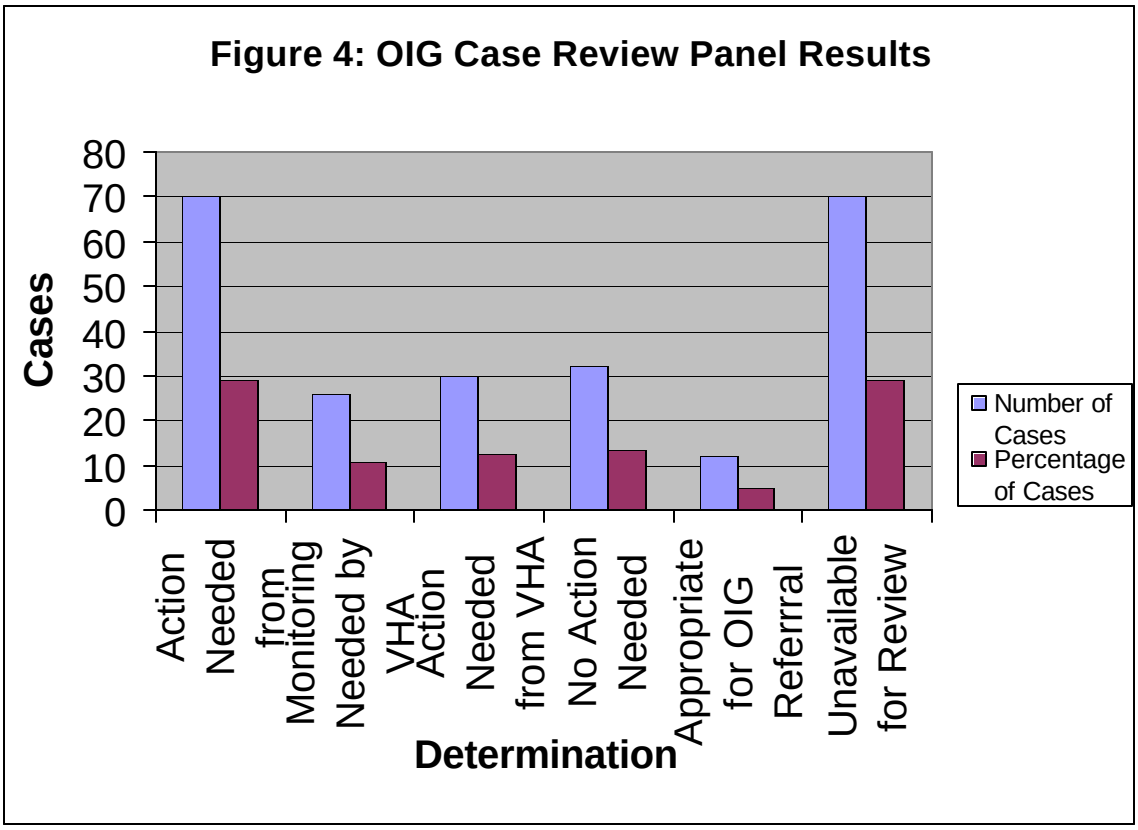


Figure 5: ASISTS Injury Distribution

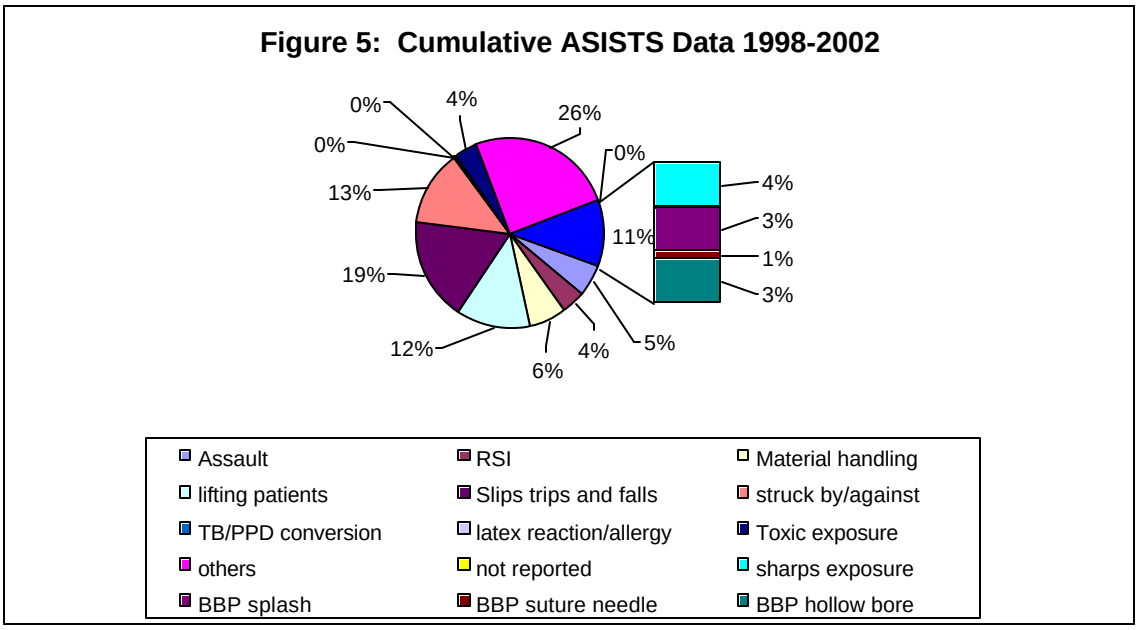


Figure 6: VHA National Compensation Cost of Old Claims by Injury Type Category

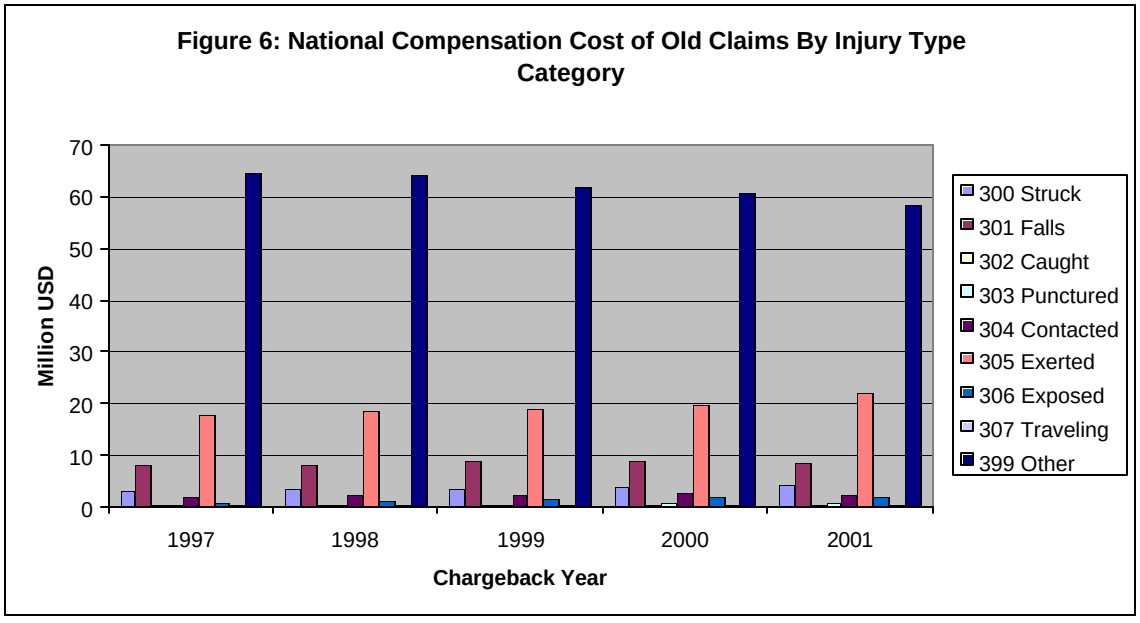


Figure 7: VHA National Compensation Cost of New Claims by Injury Type Category

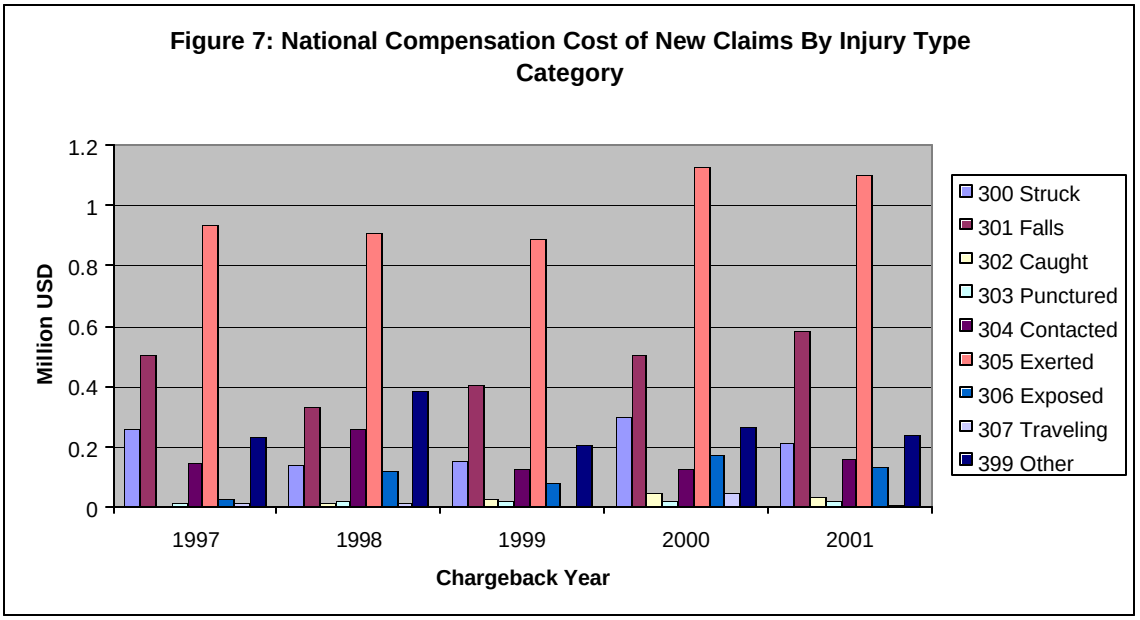


Figure 8: VHA Average Compensation Cost Per Claim By DOL District

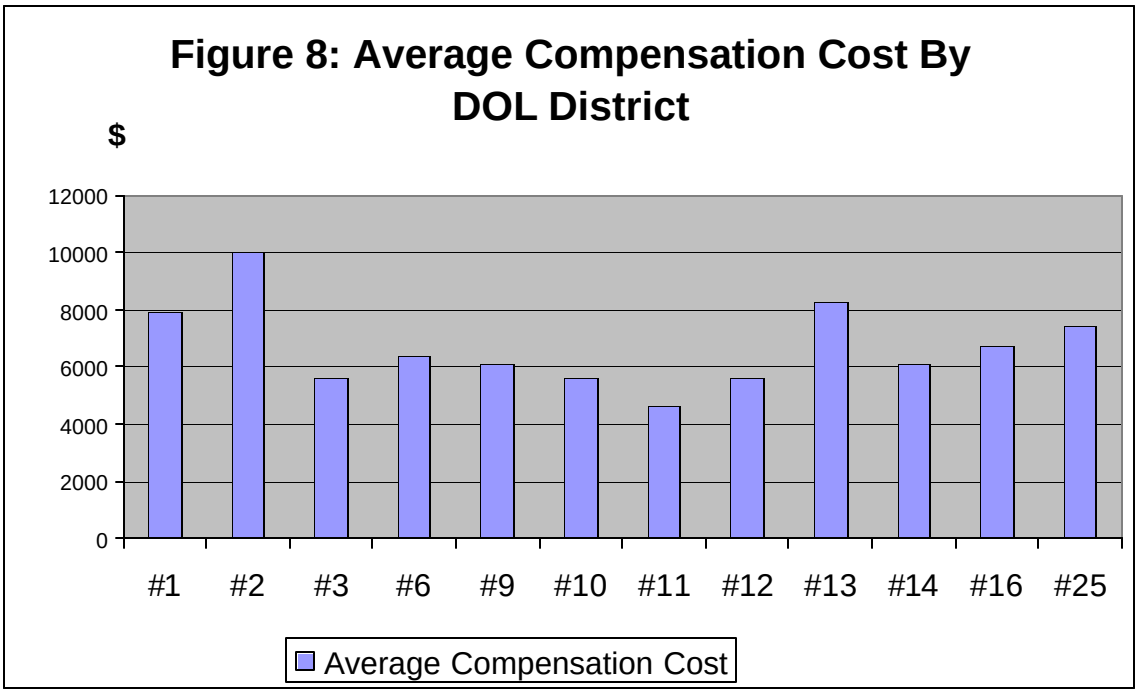
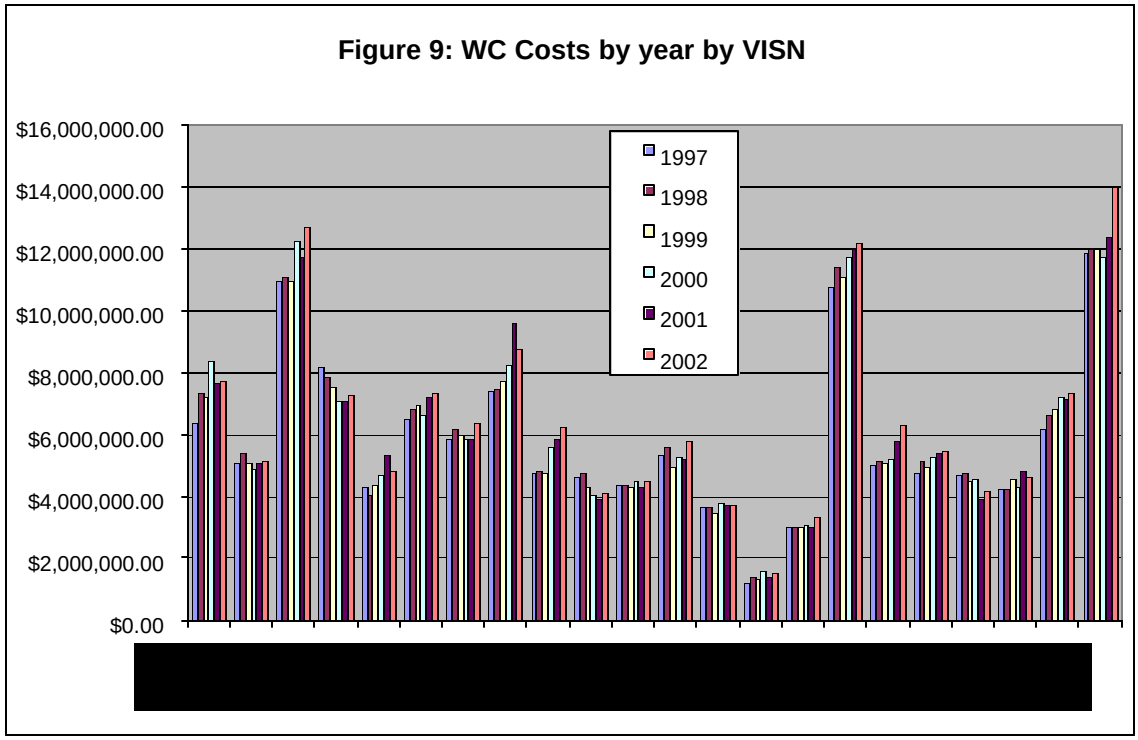


Figure 9: VHA Workers' Compensation Costs by Year by VISN



Workers Compensation Best Practices Checklist

OWCP BEST PRACTICES.doc