

# IMPROVING OCCUPATIONAL HEALTHCARE DELIVERY TO SUPPORT WORKERS' COMPENSATION RETURN TO WORK:

Building on Evidence-Based Practice from  
Washington's Centers of Occupational  
Health & Education (COHE) Experience



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## PREFACE

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The Stay-at-Work/Return-to-Work (SAW/RTW) Policy Collaborative was established by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP) to support the development of policies, programs, and practices that encourage the continued employment of workers likely to leave the workforce due to injury, serious illness, or disability. The Collaborative consists of a Community of Practice to provide input and real-time feedback on specific policy topics related to SAW/RTW, and Policy Working Groups (PWGs), led by Subject Matter Experts (SMEs) and supported by IMPAQ International, who explore policies and practices that curtail long-term work disability and job loss due to injury and illness, provide policy recommendations to key stakeholders, and develop resources to support policy action. The 2017 PWGs focused on three topics: (1) Replicating and Adapting the State of Washington's Centers of Occupational Health and Education (COHE) Model; (2) Musculoskeletal Conditions and Pain Management; and (3) Transition Back to Work. This Policy Action Paper is a product of the Replicating and Adapting the COHE Model PWG, co-led by Dan Sung (SME Lead) and Kay Magill (IMPAQ Lead).

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## EXECUTIVE SUMMARY

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The Replicating and Adapting the COHE Model Policy Working Group (PWG) of the U.S. Department of Labor’s Office of Disability Employment Policy’s Stay-at-Work/Return-to-Work (SAW/RTW) Policy Collaborative explored the policy considerations of adopting or adapting the return-to-work (RTW) strategies of the Washington State Department of Labor & Industries’ (L&I’s) Centers of Occupational Health & Education (COHE). With the implementation of the COHE program, Washington has taken a systematic approach to supporting RTW by making ongoing improvements to its occupational healthcare system and involving all stakeholders— injured workers, medical providers, insurers, employers, and the state’s workers’ compensation system—in the effort. By coordinating care, training providers, coordinating communication among the different parties, and supporting the use of occupational health best practices, Washington has been successful in improving worker outcomes, reducing the risk of long-term disability and premature exit from the workforce, and promoting the workers’ RTW.

The PWG examined the COHE program as well as other state workers’ compensation programs that have replicated elements of the COHE model and/or adapted COHE-type strategies in their efforts to improve both health and RTW outcomes for workers with work-related injury or illness and reduce these workers’ long-term disability. The goal of this policy action paper is to address the opportunities and challenges in adopting policies at the state level that promote recovery and RTW within the workers’ compensation system.

The importance of a strong RTW focus and effective occupational healthcare delivery in workers’ compensation programs cannot be overstated. The policy goal must be to influence and modify the workers’ compensation system in way that will result both in better health outcomes and return to employment for workers in the system, preferably as soon as possible following the work-related injury or illness. The challenge for policymakers lies in identifying policies and initiatives that are of demonstrated value and are feasible, given the particular context in which they will be implemented. To do this requires that state policymakers take a systematic approach to developing policies that support workers’ compensation RTW programs. In doing so, they must ensure that they are inclusive of multiple stakeholder groups within their systems, including the injured worker, employer, insurer, medical provider, and the state itself.

The PWG provides the following recommendations for state agencies working toward improved occupational healthcare delivery and RTW policies to improve work outcomes in workers’ compensation systems of care:

1. **Take a systems change approach.** Improving workers’ compensation so that the injured worker’s healthcare *and* RTW outcomes are maximized requires having a vision of how the whole system does and should work.

2. **Consider replicating or adapting the COHE model.** COHE is not just for monopolistic states where all the power of the insurance marketplace lies with the state workers' compensation agency. Use the COHE model as the platform on which an effective system for delivering quality healthcare that promotes RTW can be built.
3. **Build on existing systems and initiatives.** Many states have existing laws, regulations, and policies on which to build.
4. **Start with a pilot program.** Begin comprehensive adoption/adaptation of COHE (or another model that has been chosen) on a small scale by implementing a pilot program.
5. **Begin with small steps that address key components.** In states where implementing the COHE model may not be immediately feasible, adopt a goal/vision that incorporates as many components of COHE as practical.
6. **Make strategic use of the state's workers' compensation regulatory apparatus.**
7. **Identify clinical champions in partner organizations, and recognize their central role in healthcare delivery and RTW.** The COHE model represents a paradigm shift in healthcare delivery. It is essential to identify passionate leaders who are willing to champion COHEs and manage the significant cultural change involved.
8. **Share information about the demonstrated benefits of a strong COHE-type program with businesses of all sizes, and use financial tools to incentivize their participation in the system.** Encourage businesses to participate in the system and invest in RTW for their employees through incentives such as subsidies that cover the costs of providing accommodations that can enhance the productivity of the injured worker.

## **1. INTRODUCTION AND BACKGROUND**

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The Replicating and Adapting the COHE Model Policy Working Group (PWG) of the U.S. Department of Labor's Office of Disability Employment Policy's Stay-at-Work/Return-to-Work (SAW/RTW) Policy Collaborative explored the policy considerations of adopting or adapting the RTW strategies of the Washington State Department of Labor & Industries' (L&I's) Centers of Occupational Health & Education (COHE). The PWG examined the COHE program as well as other state workers' compensation and healthcare programs that have replicated elements of the COHE model and/or adapted COHE-type strategies in their efforts to improve both health and RTW outcomes for workers with work-related injury or illness and reduce these workers' long-term disability. The goal of this policy action paper is to address the opportunities and challenges in adopting policies at the state level that promote recovery and RTW within the workers' compensation system.

The importance of a strong RTW focus and effective occupational healthcare delivery in workers' compensation programs cannot be overstated. The policy goal must be to influence and modify the workers' compensation system in way that will result both in better health outcomes and return to employment for workers in the system, preferably as soon as possible following the work-related injury or illness. The challenge for policymakers lies in identifying policies and initiatives that are of demonstrated value and are feasible, given the particular context in which they will be implemented. To do this requires that state policymakers take a systematic approach to developing policies that support workers' compensation RTW programs. In doing so, they must ensure that they are inclusive of multiple stakeholder groups within their systems, including the injured worker, employer, insurer, medical provider, and the state itself.

### **Washington State's Centers of Occupational Health & Education (COHE)**

Washington established the community-based COHEs in 2002 with the goals of (1) improving the quality of care for injured workers, (2) reducing work disability, (3) improving workers' health outcomes, (4) preventing chronic disability through provider education and support, and (5) increasing employer and worker satisfaction with the healthcare received. The key elements of the COHE model are:

1. Care coordination
2. Occupational health best practices
3. Regular provider training and performance feedback
4. Provider incentives
5. Advisors and COHE medical director
6. Community outreach

With the implementation of the COHE program, Washington has taken a systematic approach to supporting workers' return to work (RTW) by making ongoing improvements to its occupational healthcare system and involving all stakeholders—injured workers, medical providers, insurers, employers, and the state's workers' compensation system—in the effort. By coordinating care, training providers, coordinating communication among the different parties, and supporting the use of occupational health best practices, Washington has been successful in improving injured worker outcomes, reducing the risk of long-term disability and possible premature exit from the workforce, and promoting the workers' RTW.

## **Workers' Compensation in the United States**

In the early part of the twentieth century, work in America was dangerous. Records from the time indicate that a worker was killed every thirty seconds. As the human and economic costs of these injuries and fatalities rose, business and labor came together to develop solutions. Eight states, led by Wisconsin, passed the nation's first workers' compensation laws in 1911; by 1948, every state had developed some form of workers' compensation program.<sup>1</sup> Hailed as the grand bargain, workers' compensation offered protections for both employees and employers.

In workers' compensation, employees receive medical treatment and lost wages upon suffering a work-related injury or illness. In return, employees give up the right to sue their employers for negligence. Employers receive protection from negligence lawsuits (and potentially significant jury awards) and their claim exposure is limited to benefits defined by state law. In return, employers are responsible for all injuries "arising out of employment," regardless of fault. These principles are the foundation of workers' compensation in the United States today.

Workers' compensation is a social insurance program in which the premiums are paid by the employer. In most states, employers have two options for securing coverage: buy a workers' compensation policy through the competitive insurance market<sup>2</sup> or become qualified self-insurers.<sup>3</sup> North Dakota, Ohio, Washington, and Wyoming are monopolistic states, in which employers that do not self-insure are *required* to purchase coverage through the state-run insurer rather than on the competitive market.<sup>4</sup> Employer premiums are based on the industry

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<sup>1</sup> U.S. Department of Labor, Office of the Assistant Secretary for Policy (2016). *Does the Workers' Compensation System Fulfill Its Obligations to Injured Workers?* Report.

<sup>2</sup> The competitive insurance market consists of private insurance companies licensed to do business within a state. Nineteen states have a state insurance fund that operates in the competitive insurance market, competing with the private insurance companies.

<sup>3</sup> Generally, self-insurance is reserved for companies with the capital and financial stability to cover current and future claim liabilities. Each state has different qualifying requirements for self-insurance and most states require security (e.g., bond, letter of credit, surety) to pay liabilities in the event of company insolvency.

<sup>4</sup> Self-insurance is permitted only in Ohio and Washington; it is not allowed in North Dakota or Wyoming.



classification (e.g., clerical, carpentry, retail), state-defined benefits, the employer's previous loss experience, and any carrier-specific discounts.

Throughout the past century, workers' compensation programs have evolved to meet the changing needs and expectations of the American labor force and economy. One significant change was the move from voluntary coverage to compulsory coverage; Texas is now the only state that does not require workers' compensation, and employers in that state that do not secure coverage can be sued for negligence. Many of the earliest workers' compensation programs had monetary caps for medical treatment; today, those caps have disappeared. In place of caps for medical treatment, states have implemented various healthcare management strategies to constrain medical costs, including managed care, fee schedules, treatment guidelines, formulary, and utilization review, to name a few.

Another area of considerable change is the kinds of injuries and illnesses considered compensable claims. The first workers' compensation laws considered primarily traumatic injuries—spinal cord injuries, severe extremity fractures, amputations, or traumatic brain injuries. Over the past century, both statute and case law have evolved to recognize occupational disease (e.g., mesothelioma, silicosis, cancer) as well. In addition, many states have expanded coverage for mental health disorders. However, although these changes increased the categories of injuries and illnesses that could make a worker eligible for workers' compensation, reports published by the Occupational Safety and Health Administration (OSHA) in 2015<sup>5</sup> and the U.S. Department of Labor in 2016<sup>6</sup> noted the trend in some states of raising the causation standard to “major contributing cause,” making it more difficult for injured workers to qualify for workers' compensation benefits. Additionally, the system has grown in regulatory complexity, not to mention variability among state laws with regard to coverage, benefits, and so forth, making it difficult for workers to navigate the system without an attorney.

## **Workers' Compensation Programs in the States**

Although the core principles of workers' compensation are consistent across the United States, there are significant differences among the states in law, organization, administration, process, and dispute resolution. It is a commonly heard colloquialism that “if you've seen one state . . . you've seen one state” when talking about state workers' compensation programs. Although federal legislation has been enacted over the years to shore up state workers' compensation coverage, and federal programs have been developed for particular groups of workers or workplace exposures,<sup>7</sup> each state has its own workers' compensation law, and workers'

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<sup>5</sup> U.S. Department of Labor, Occupational Safety and Health Administration (2015). *Adding Inequality to Injury: The Costs of Failing to Protect Workers on the Job*. Report.

<sup>6</sup> U.S. Department of Labor, Office of the Assistant Secretary for Policy, op. cit.

<sup>7</sup> For example, the Federal Employees Compensation Act (FECA), passed in 1916.

compensation still exists as an entirely state-based system, with no oversight or regulation by the federal government.<sup>8</sup> Today, the only significant direct federal involvement in workers' compensation is through OSHA and Medicare Secondary Payer. Each state's workers' compensation system has evolved to meet the specific needs of its workforce, its employer groups, and its political goals. Changes in statutes, regulation, administration, and case law influence almost all parts of the system, including causation, benefit payments, medical treatment, dispute resolution, and rehabilitation.

The merits of the state-based system, with no federal oversight or mutually agreed-upon standards, have been debated since its earliest days. Some believe that the states' consistent focus on lowering the cost of workers' compensation has resulted in benefit declines to injured workers and has made it more difficult for them to access the system. Others argue that state systems, free from federal oversight, meet the local needs of employees and employers and allow for more flexibility and innovation. For example, several states have been leaders in adopting strategies to address inappropriate opioid use in workers' compensation through the adoption of treatment guidelines and a formulary, in an effort to improve medical treatment and RTW for injured workers in the state.

The four monopolistic states—North Dakota, Ohio, Washington, and Wyoming—are unique in that the state agency acts as the workers' compensation insurer and claims administrator, in what is essentially a single-payer system. In all other states, responsibility for insuring or managing workers' compensation claims rests with private insurers or self-insured employers and their claims administrators. Because they are responsible for all claim outcomes, the monopolistic states tend to have a great interest in developing policies and designing programs that improve claims administration, medical treatment, and other elements that affect worker outcomes, and they have great authority to act on that interest. It may be a challenge for states that are non-monopolistic to develop quality improvement or systems change initiatives similar to a model such as COHE because they do not have the same structure, resources, or authority as is found in monopolistic states. Challenges for non-monopolistic states may include:

- **Multiple responsible entities.** A state may have multiple agencies<sup>9</sup> that are involved in workers' compensation, with different agencies that are diverse in their scope, organization, priorities, and administrative responsibility for enforcing coverage requirements, developing medical management policies, monitoring compliance of benefit payments, and resolving disputed claims. In most states, state insurance

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<sup>8</sup> U.S. Department of Labor, Office of the Assistant Secretary for Policy, *op. cit.*

<sup>9</sup> In Minnesota, for example, multiple agencies are responsible for different functions: The Minnesota Department of Labor oversees administrative functions and the Division of Administrative Hearings resolves disputes. In contrast, Tennessee has a single agency, the Division of Workers' Compensation, that has broad oversight for the administration of the state's workers' compensation act.

departments have authority for regulation of workers' compensation insurance policies and rates. In addition, most states have either formal or informal advisory bodies (such as advisory boards or stakeholder groups) that inform administration and policy.

- **Limited medical policy leadership.** The share of medical cost as a percentage of total workers' compensation claim costs has increased steadily over the past decade, with medical care now representing an amount equal to cash benefit payments in the system.<sup>10</sup> This has necessitated greater engagement by state agencies in developing medical policy solutions. According to the Workers' Compensation Research Institute, all but six states have implemented medical fee schedules, 30 have adopted treatment guidelines, 21 have utilization review regulations, and most allow for managed care networks.<sup>11</sup> At the same time, most states have limited ongoing resources and expertise in medical policy. For example, only 16 states have state-level medical directors, and many of these are only part time.<sup>12</sup> This means that a state may have a limited focus on maintenance of and compliance with existing medical management policies, and may have limited resources or expertise to develop new quality improvement initiatives.
- **Difficulty in obtaining data.** As a practical matter, it is often difficult to obtain administrative data needed for decision-making regarding policy, program implementation, and evaluation if the data must be obtained from multiple insurers in the state. Not only are there multiple entities with which to deal, but private insurers are likely to have a considerable amount of proprietary data that will be unavailable to the state's policymakers.

Many close to the workers' compensation industry will say that Washington's L&I department was only able to successfully implement the COHE program because the state has a monopolistic workers' compensation system. The state's monopolistic nature clearly played a role in the development of COHE, but it is not the only reason for the program's success. L&I worked closely with medical providers, employers, and the community, building strong relationships with key stakeholder groups that bought into the COHE program. The value of these relationships to the continued growth of COHE cannot be overstated, and developing such relationships is something any state could accomplish. In addition, although being the only purchaser of workers' compensation healthcare services in the state was of obvious benefit to Washington, other

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<sup>10</sup> Baldwin, M. L. and McLaren, D. F. (2016). *Workers' Compensation: Benefits, Coverage, and Costs*. Report. National Academy of Social Insurance, p. 16.

<sup>11</sup>Tanabe, R. P. (2015). *Workers' Compensation Medical Cost Containment: A National Inventory, 2015*. *Workers Compensation Research Institute (WCRI)*. WC-15-27. This report is an excellent resource on the various policy solutions states have implemented.

<sup>12</sup> Paduda, J. (2016). *Where Are All the Medical Directors? IAIABC Perspectives*, 2, 20-21.

states, especially those with large state funds that they can leverage to foster support for a COHE-like program, have at least some power to influence change in their insurance markets.

### **State Workers' Compensation RTW Strategies**

Much of the work-related disability in today's workplace is avoidable. Disability is often created through failures in the system that is supposed to support the injured workers in their path to recovery. Following a work injury, the best way to reduce the chance of an injury turning into a disability is getting the worker timely and effective medical care, particularly when this medical care is coupled with prompt follow-up by the employer and insurer and a return to work as soon as it is medically appropriate. Avoiding disability can take significant pressure off workers' compensation systems, the Social Security disability system, medical providers, employers, and the injured workers themselves.

According to OSHA, four million nonfatal work-related injuries and illnesses occur annually,<sup>13</sup> meaning that the number of workers who leave the workforce—temporarily or permanently—each year due to a work-related injury or illness may be in the millions.<sup>14</sup> The impacts of such workers being disengaged from work can be felt not only by the worker but by society, the economy, and the worker's family. The importance of having both effective occupational healthcare service delivery and strong RTW programs supported by states cannot be overstated.

A number of states have put into practice a variety of RTW initiatives and strategies designed to help workers who have work-related injuries, illness, or disability to return to the workplace and keep their jobs. In Appendix A, we identified states with existing workers' compensation RTW programs and policies, and created a map and a set of links for each state so identified.<sup>15</sup> We believe that the presence of such initiatives may be indicate readiness and/or willingness to adopt workers' compensation care coordination strategies and occupational health best practices such as those that have been successfully employed by Washington's COHE program to improve RTW and reduce long-term disability. The map also indicates that most, but not all, of the states we identified with workers' compensation RTW strategies have a state-administered workers' compensation fund. Some states may be able to use this administrative role as a mechanism for implementing policy changes throughout the workers' compensation system.

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<sup>13</sup> U.S. Department of Labor, Occupational Safety and Health Administration (2012). *Injury and Illness Prevention Programs White Paper*.

<sup>14</sup> Bardos, M., Burak, H., and Ben-Shalom, Y. (2015). *Assessing the Costs and Benefits of Return-to-Work Programs*. Mathematica Policy Research. Final report submitted to the U.S. Department of Labor, Office of Disability Employment Policy.

<sup>15</sup> We excluded states with related programs for the employment of people with disabilities that were not directly focused on COHE-type RTW strategies, such as the vocational rehabilitation programs in Alabama and Arkansas.

States identified as having existing RTW policies and programs within their workers' compensation systems include, for example, Delaware, which has RTW coordinators and healthcare practice guidelines that include RTW, provider certification, and mandatory continuing education for providers. Georgia's Model Return to Work Program for state employees includes the same four occupational health best practices as does COHE.

Other states have a focus on employers, such as New York, which offers an RTW handbook with best practices and provides employers with a financial incentive to implement an approved RTW program through its Workplace Safety and Loss Prevention Incentive Program. Oregon's efforts to incentivize RTW include their Employer-at-Injury Program (EAIP), in which the state provides temporary partial disability payments, as well as employer subsidies for wages and accommodations to employers who re-employ injured workers. These payments lower the costs

**MONTANA'S APPROACH TO ENGAGING HEALTHCARE PROVIDERS IN RTW PROCESS**

The Montana Department of Labor & Industry (DL&I) strives to minimize avoidable disruption caused by work-related injury or illness and assists the worker to stay at or return to work by means of several key policy interventions (Montana DL&I, 2017a). In support of this goal, the Montana Code Annotated 39-71-1036 requires the treating provider to complete the Medical Status Form at each clinical office visit (State of Montana, 2015). The Medical Status Form is a tool used to safely facilitate an earlier return to work, highlighting the worker's capabilities rather than disabilities (Montana DL&I, 2017). The provider can also code for reimbursement for patient education involving SAW/RTW issues.

At times, treating providers may be hesitant to return injured workers to the workplace if they are uncertain about potential hazards. Recently, Montana added a special code to the fee schedule allowing the treating provider to request consultation with a Certified Rehabilitation Counselor (CRC) to establish the feasibility of an early return to work and assistance in identifying workplace restrictions. Reimbursement is available to the treating provider for obtaining the CRC consultation and engaging in a discussion of the findings with the worker. In these ways, the Montana DL&I continues to develop strategies for engagement at the provider-injured worker interface to support early and safe return to work.

to the employer that are associated with early RTW, thus encouraging the injured worker to return to his or her job as soon as medically appropriate. The Preferred Worker Program (PWP) in Oregon makes assistance available to employers who hire qualified workers with permanent disabilities sustained on the job who cannot return to their prior employment. Such assistance includes exempting the cost of workers compensation insurance premiums for the worker for three years, claim cost reimbursement, 50% wage subsidy for preferred workers, and reimbursement for employment costs for tuition, assistive tools and equipment, and worksite modification.

Montana has a policy that requires insurers to provide RTW services. The state also provides RTW assistance to employers through state workers' compensation or insurers. For example, the state provides up to \$2,000 to assist employers with modifications and accommodations. Like Washington, Montana has made an especially strong effort to engage healthcare providers in the RTW process, relying on several key policy interventions to require providers to focus on RTW, not just recovery (see sidebar).

Among other strategies and initiatives, state governments must take a systematic approach in supporting RTW programs that focus on coordinated medical care and on being inclusive of multiple stakeholder groups within their systems, including the injured workers, employers, insurers, medical providers, and the state itself. Developing programs like COHE can provide coordinated, timely, and appropriate care to reduce the risk of long-term disability and to decrease the corresponding risk of early and permanent exit from the labor force.

In the next section of this policy action paper we will provide additional detail on the COHE program itself as well as information about the State of Colorado's efforts to build on the COHE model as it develops a major quality initiative for the state's healthcare delivery system.

## 2. IMPROVING HEALTHCARE DELIVERY TO SUPPORT RTW IN WORKERS' COMPENSATION

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As discussed previously, the workers' compensation system in the United States is complex and varied. The evidence supports the contention that the current system is poorly designed to deliver occupational healthcare for injured workers, and that it will take system change to improve it more than a minimal amount. Moreover, there is little emphasis in the current system on providing workers with healthcare that will support or facilitate their RTW. The present policy action paper discusses some important considerations concerning efforts to improve healthcare delivery in the workers' compensation system, and makes recommendations regarding how to improve the elements of the system that affect the quality of occupational healthcare delivery and the injured worker's RTW. It should be noted that our goal is not to address the wide range of problems in the workers' compensation system. Our focus is limited to a discussion of changes needed to improve the quality of healthcare delivered through workers' compensation with the aim of reducing long-term disability and increasing the likelihood of RTW.

The PWG determined that it would be useful to examine the issue of the quality of occupational healthcare for injured workers through the lens of collaborative care. We have chosen to use as a framework the model developed by the staff at the MacColl Center for Healthcare Innovation at the Kaiser Permanente Washington Health Research Institute (formerly Group Health) in the mid-1990s. Based on an assessment of the available literature, input from a large panel of national experts, and analysis of expert-recommended strategies, the MacColl Chronic Care Model (CCM) identified six essential elements of a system to provide high-quality healthcare.<sup>16</sup> Refined in 2003 to account for advances reported in the literature and reflect the experience of numerous healthcare systems that had successfully implemented the model, the CCM incorporated additional themes into the six elements and made the concepts more specific. Although the CCM itself focused on chronic disease care, many aspects of the elements identified by the model are applicable to other types of healthcare delivery, including occupational healthcare provided through the workers' compensation system.

In the MacColl model, the essential elements of a quality system are:

1. The health system (which includes high-quality senior leadership; mechanisms for effective system change; and incentives for quality improvement, collaboration, and other best management practices)
2. A well-designed delivery system (which has well-defined roles; uses planned, evidence-based interactions; provides case management; and ensures regular follow-up)

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<sup>16</sup> MacColl Center for Health Care Innovation. *The Chronic Care Model*.

3. Support for decisions (which includes relying on scientific evidence; embedding Evidence Based Medicine [EBM] guidelines in practice; and attending to patient preference)
4. Clinical information systems (which includes having patient and population data available for timely, effective decisions and communication)
5. Self-management support (which includes effective strategies for problem solving, goal-setting, organizing resources, and the like)
6. The community (which involves including stakeholders and mobilizing community resources)

Different states have different visions for how to address the challenge of improving outcomes for injured workers and increasing workforce attachment. However, many take an approach to improving quality that is similar to that of the MacColl model, and can find aspects of other states' programs that are relevant to how they might develop their RTW policies and programs. In the next sections, we describe the COHE approach to improving the quality of occupational healthcare delivery, followed by the experience the state of Colorado has had with adapting and replicating this approach.

### **The Centers of Occupational Health & Education (COHE) Program**

The COHE program was established by the State of Washington's workers' compensation fund as a community-based healthcare strategy to improve outcomes for injured workers and reduce their long-term disability. The COHE model began as a pilot program in two sites in 2002 and expanded to four sites in 2008. Numerous evaluations were done of COHE's short-term (one-year) outcomes, and briefings and internal reports were provided to L&I, its advisory group, and other stakeholders.<sup>17</sup> These analyses showed that COHE was associated with a 20% reduction in the likelihood of being off work and on disability 12 months after injury. In addition, the total cost per claim (medical and disability costs combined) for patients treated through the COHE was \$510 less than the cost for non-COHE patients. The estimated return on investment (ROI) was 3:1. This led to the passage of a state law<sup>18</sup> in the spring of 2011 that expanded the four pilot sites statewide, and made the COHE delivery system a permanent fixture in the state workers' compensation system.

The law requires that “[b]y 2015, all injured workers in Washington must have access to occupational healthcare through COHEs.” Since passage of the law, COHEs have been established

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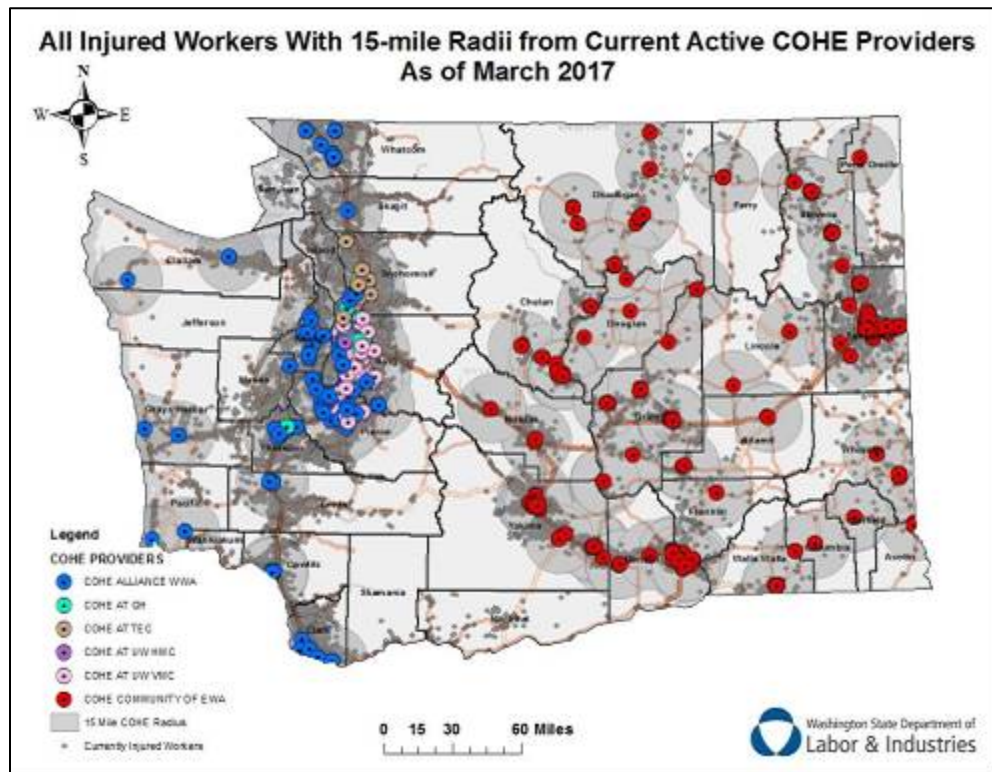
<sup>17</sup> Wickizer, T. M., Franklin, G., Fulton-Kehoe, D., Gluck, J., Mootz, R., Smith-Weller, T., and Plaeger-Brockway, R. (2011). Improving quality, preventing disability and reducing costs in workers' compensation healthcare: A population-based intervention study. *Medical Care*, 49(12), 1105–1011.

<sup>18</sup> *SB 5801, An Act Relating to Establishing Medical Provider Networks and Expanding COHEs in the Industrial Insurance System.*



in six sites, and more than 3,000 providers are engaged in approximately 52% of the treatment of all injured workers in the state through the COHEs.<sup>19</sup> As shown in Exhibit 1, by March 2017, 97% of injured workers lived within 15 miles of a COHE provider. All 39 counties in the state are now covered by a COHE; L&I no longer prepares a map showing the locations of all the COHEs because there is so much overlap in coverage (for example, there are five COHEs that now cover at least part of King County.)

**Exhibit 1. COHE Access Map**



As noted previously, L&I contracts with six healthcare organizations that each sponsor a COHE by (1) staffing and managing the program; (2) training providers in occupational health best practices; and (3) working with L&I to improve occupational health delivery in their medical community. These six COHEs are:

1. COHE at University of Washington Medicine Valley Medical Center of the Puget Sound
2. COHE Community of Eastern Washington
3. COHE at University of Washington Medicine Harborview Medical Center
4. COHE at the Everett Clinic

<sup>19</sup> The percentage of COHE claims for 2016 was 51.9%. As of July 10, 2017, the total enrollment for all the COHEs was 3,643. Source: Internal data run by COHE research staff.

5. COHE Alliance of Western Washington
6. COHE at Kaiser Permanente

The key elements of the COHE model are:

### 1. **Care Coordination**

An important feature of the COHE model is the Health Services Coordinator (HSC), who provides assistance, guidance, and support to the participants in the system. In Washington, most injured workers go to providers who treat few (<10 per year) workers' compensation cases. Treating injured workers and coordinating their care can be a daunting task for them. HSCs help them when they get the infrequent workers' compensation patient. HSCs are not state employees, but are hired by the COHE. They focus their services on the first 12 weeks of the claim. They are paid on a fee-for-service basis for their work. The HSC provides timely care coordination to ensure that the injured workers' care is not unnecessarily delayed. The HSC plays a central role in communicating with the medical providers, injured workers, employers, and claim managers to ensure that treatment and RTW goals are aligned and that everyone is on the same page with regard to what is being done for the injured worker. The work performed by the HSCs is documented in the L&I administrative data systems and is viewable by the claim manager and by other parties to the claim.

### 2. **Occupational health best practices**

Another critical element in the COHE model is the provision of help in implementing occupational health best practices that support the delivery of high-quality care to injured workers. The occupational health best practices used in the COHE are not clinical per se; rather, they are related to claim management, treatment planning, and communication. Providers receive training and support from the COHE staff; once a year they are required to have at least a half-hour of review of occupational health best practices and L&I policies and procedures.

L&I supports the use of occupational health best practices by the following means:

- Providing access to resources, including the HSC
- Creating billing codes to enable documentation of these practices
- Providing the data analysis capability to track activities and outcomes

There are currently four best practices, although others may be added in the future. These best practices are:

- Timeliness—submitting a complete initial Report of Accident (ROA) in two business days or less so that claims can be opened quickly

- Function—completing an Activity Prescription Form (APF), which is shared with the provider, the employer, the worker, and L&I, on the first office visit if there are restrictions, when patient restrictions change, or whenever the injured worker cannot go back to work at full duty
  - Connection with the employer—contacting the employer when a patient has work restrictions or will not be going back to work
  - Attention to disability risk—reviewing the file with the worker and with the HSC to identify the barriers that may be keeping that person from going back to work
3. **Regular provider training and performance feedback**  
As noted in above, the COHEs offer ongoing training and education to help providers implement occupational health best practices and comply with L&I policies. Training is also provided in practices such as the Progressive Goal Attainment Program (PGAP), an activity coaching/motivational intervention. L&I provides the COHEs with regular performance reports for providers that the COHEs then distribute. These reports inform the providers on the percentage of their claims that have met L&I targets. COHEs also receive a quarterly report on their performance.
4. **Provider incentives**  
Providers receive financial and non-financial incentives for participating in the COHE. (Participation is voluntary.) The biggest incentive is the assistance and support from the HSCs. Providers appreciate the training and feedback on best practices. Finally, providers receive a modest financial incentive of a 50% increase in payment for any timely ROA.
5. **Advisors and COHE medical director**  
Each COHE has a pool of advisors from various clinical specialties who act as a resource to other COHE providers, increasing knowledge and use of occupational health best practices. The COHE medical director is the lead for the advisors and provides the overall vision for the COHE. Early in the COHE pilot, advisors helped design the Activity Prescription form, which is now used statewide.
6. **Community outreach**  
The COHE success is in large part due to the involvement of business and labor, both at the local and state level. Business and labor representatives helped design the COHEs early on and have since served as advisors.

## **Effectiveness of COHE**

Researchers at the University of Washington conducted a detailed and comprehensive evaluation of the COHE program to learn as much as possible about its short-term and long-term effects on work disability and cost outcomes. Detailed information regarding the COHE's design features

and implementation was reported in two articles prepared by Wickizer, et al. and published in *Milbank Quarterly* in 2001 and 2004.<sup>20,21</sup> Short-term outcomes were reported in a subsequent paper published in *Medical Care* in 2011.<sup>22</sup>

In brief, the evaluation found that the COHE program was associated with a 21% reduction in the likelihood of being out of work and on disability one year after injury. COHE was associated with reduced disability payments of \$267 per claim and decreased medical costs of \$145 per claim. These outcomes pertained to all 105,000 claims analyzed for the evaluation, but many of these claims represented minor injuries, such as lacerations or contusions, that required little or no care coordination provided by COHE. When the evaluators limited the analysis to back sprain claims (n = 15,500), the effect of COHE was considerably greater in magnitude. For example, the likelihood of an injured worker with a back sprain treated by COHE being out of work and on disability at one year after injury was 37% less compared to the same injured worker treated by a non-COHE provider. Cost savings were also greater: Disability payments and medical costs were reduced by \$541 and \$191 per claim, respectively.

Not only did COHE have important short-term effects, but it also had significant long-term effects. The COHE evaluation team obtained follow-up data on disability measures and costs for an eight-year period after injury. Three disability measures were combined to capture the effects of (1) having a L&I pension; (2) remaining on workers' compensation disability for five or more years; or (3) qualifying for Social Security Disability Insurance (SSDI). The analysis showed that, compared with non-COHE patients, COHE patients were 26% less likely to have one or more of these disability outcomes. The COHE evaluation team also examined disability outcomes from a population perspective, which provides important information regarding the potential of the COHE to improve population health. Over the eight-year follow-up period, the population of injured workers treated through COHE experienced 231,500 fewer disability days per 10,000 workers compared with the population of injured workers treated by non-COHE providers. This translates into *634 years* of disability avoided per 10,000 injured workers. Viewed from a population perspective, one begins to understand the potential of well-organized systems of care to promote recovery and early RTW. Critical to success is organizing systems of care to provide timely and effective secondary prevention early in the claim.

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<sup>20</sup> Wickizer, T. M., Franklin, G., Plaeger-Brockway R., and Mootz, R. D. (2001). Improving the Quality of Workers' Compensation Health Care Delivery: The Washington State Occupation Health Services Project. *Milbank Quarterly*, pp. 5-33.

<sup>21</sup> Wickizer, T. M., Franklin, G. M., Mootz, R. D., Fulton-Kehoe, D., Plaeger-Brockway, D. R., Drylie, D., Turner, J. A., and Smith-Weller, T. (2004). A Community-Wide Intervention to Improve Outcomes and Reduce Disability among Injured Workers in Washington State. *Milbank Quarterly*, pp. 547-567.

<sup>22</sup> Wickizer, T. M., et al. (2011), op. cit.

## **COHE as a Model of Effective Healthcare Delivery That Supports RTW**

COHE is a good example of a model of occupational healthcare delivery and of collaborative care for that supports RTW in the workers' compensation system. In a crosswalk with the MacColl model, we can see that important components of COHE are closely aligned with MacColl's essential elements:

1. The health system: COHE requires an executive and clinical champion and quality improvement activities.
2. A well-designed delivery system: COHE requires the use of HSCs; defines patient population; and defines triggers for when interventions should take place.
3. Support for decisions: COHE defines four EBM best practices and is working toward adding others (e.g., opioids, guideline compliance).
4. Clinical information systems: COHE requires use of a shared IT system, the Occupational Health Management System (OHMS), by the HSC to manage the population of injured workers, communicate with others in the system, track key tasks, and provide feedback on performance measures.
5. Self-management support: COHE's best practices embed principles of self-management; COHE is developing functional recovery expectations.
6. The community: COHE requires engagement with business, labor, and L&I, as well as healthcare provider community support for the model.

## **Adapting the COHE Model in Colorado**

### **Colorado's Workers' Compensation Healthcare System: Guiding Principles**

The Workers' Compensation Act of Colorado was enacted "to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers without the necessity of any litigation, recognizing that the workers' compensation system in Colorado is based on a mutual renunciation of common law rights and defenses by employers and employees alike."<sup>23</sup> This legislative declaration emphasizes the importance of balancing the principles of "quick and efficient" medical care for injured workers versus the need to provide medical care at a "reasonable" cost to employers.

Colorado's workers' compensation healthcare system is composed of medical programs developed through a principle-based approach. Under this approach, policy and regulatory

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<sup>23</sup> See Colorado Revised Statutes, 8-40-102.

decisions are based on the application of **all** the principles outlined in Colorado’s Workers’ Compensation Act. Physician accreditation (Rule 13), medical utilization standards (Rule 16), medical treatment guidelines (Rule 17), and the medical fee schedule (Rule 18) are examples of Colorado medical programs that effectuate the principles of quick and efficient medical care at a reasonable cost.

The principle-based approach to policy and program development has been successful in Colorado because of the commitment to balance all the principles from its legislative mandate. In the spirit of continuous improvement, however, in 2016, the Colorado Division of Workers’ Compensation (CO DOWC) explored ways to incorporate the concept of “quality” into its healthcare system. Embedding quality into Colorado’s workers’ compensation healthcare system is appealing because it captures the principles enumerated in the legislative declaration of the Colorado’s Workers’ Compensation Act. On a deeper level, the idea of explicit adoption of the concept of quality is compelling because it draws on additional principles that are essential for a high-performance healthcare system. The Agency for Healthcare Research and Quality (AHRQ) defines quality healthcare as “doing the right thing, for the right patient, at the right time, in the right way to achieve the best possible results.” The Institute of Medicine (IOM) defines quality healthcare as being timely, efficient, safe, effective, patient-centered, and equitable. These definitions show that quality is more than just quick, efficient medical care delivered at a reasonable cost. Quality provides an improved paradigm to implement Colorado’s legislative mandate, one that can add considerable value to the healthcare system and provide greater benefits for employers, injured workers, and healthcare providers in the workers’ compensation system.

### **Colorado’s Strategy: Using the COHE Model as a Platform**

Colorado considered existing programs, such as its fee schedule and treatment guidelines program, as possible vehicles for rollout of its new quality-based vision of healthcare, as these programs (as they developed in Colorado) possessed all the essential elements of quality. But ultimately, CO DOWC chose to promote a new healthcare delivery system as the platform for its quality healthcare vision. Re-engineering a healthcare delivery system for Colorado’s workers’ compensation healthcare system under the umbrella of quality is an ambitious goal, but creating a new delivery system allows CO DOWC to more clearly signal to stakeholders the new direction and vision for its healthcare system.

Washington’s COHE program is an ideal model for Colorado to consider employing because it is an evidence-based healthcare delivery model, similar to the MacColl model,<sup>24</sup> that focuses on collaborative and coordinated care and incorporates all the elements of quality healthcare.

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<sup>24</sup> MacColl Center for Health Care Innovation, op. cit.

COHEs align with CO DOWC’s commitment to achieve **all** the principles of quality (as opposed to focusing on the narrower principles of quick, efficient, and cost-effective care).

The most important factor in successful implementation of Colorado’s COHE healthcare delivery system is creating a culture committed to quality healthcare. Change is difficult, and changing culture across an entire healthcare system is incredibly challenging. In fact, cultural change of this magnitude will happen only if strong leadership and change agents exist at all levels of the healthcare system. At the system level, CO DOWC is committed to serve as a champion of quality and the COHE delivery model. But CO DOWC recognizes that it is also essential to identify leaders and champions within all key stakeholder groups, and within specific organizations. It is unrealistic and impractical to assume that any one stakeholder group or organization could effectuate a system-wide shift to quality on its own.

Having identified COHE as the ideal platform for promoting quality healthcare, CO DOWC made the decision to implement the platform in a more controlled, low-risk way. Meetings with Washington’s L&I staff, as well as review of evidence-based research from organizations such as the MacColl Center for Health Care Innovation, recommended implementation and design of a complete healthcare delivery *system*. Because incorporation of additional elements of quality and promotion of a COHE delivery model represented a significant change in Colorado’s existing workers’ compensation healthcare system, CO DOWC promulgated a new regulation<sup>25</sup> that opened a pipeline for stakeholders to propose pilot programs on quality initiatives such as the COHE model.

There are numerous benefits in conducting pilot programs as opposed to system-wide, regulatory implementation of a new idea. First, new and untested concepts can be proven on a smaller scale. This minimizes the effects of unforeseen or undesirable consequences to stakeholders in the system. Second, pilot programs provide stakeholders (including the regulatory agency) greater flexibility in shaping important details of the idea to be tested. In Colorado’s case, the pilot program regulation provides the flexibility for CO DOWC to work with stakeholders to precisely define the parameters of any COHE delivery model proposal. CO DOWC has taken advantage of this benefit by steering stakeholders in the direction of developing “full-blown” COHE delivery models, versus testing “incomplete” COHE delivery models. Third, multiple pilot programs can be conducted to examine different aspects of an idea—pilots allow examination of “variations on a theme.” For example, one set of COHE pilots could compare different diagnoses covered under the COHE delivery model. Another set of COHE pilots could test the efficacy of payer-based health services coordinators versus provider-based health services coordinators. Fourth, pilot programs are better suited for process improvement—pilots

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<sup>25</sup> Rule 18-8(D), effective January 1, 2017. See Colorado Department of Workers’ Compensation (2017). Fee Schedule Rule 18-8(D), pp. 69-70.

are shorter in duration and easier to iterate than programs dictated by regulations. Finally, voluntary pilot programs identify stakeholders who are willing to champion and promote ideas like COHE, versus compelling stakeholders to “accept” and implement programs mandated by regulations. Pilot programs are a collaborative, voluntary approach for stakeholders to safely test an idea, which is arguably better than a compulsory, directive approach.

### **Elements of Colorado’s COHE Program**

It is generally recognized that a small group of injured workers account for a large majority of costs in workers’ compensation. Some of these expensive cases are injured workers with major injuries. However, there is also a subset of injured workers who do not achieve good outcomes even though their injuries and overall medical conditions suggest that they should do well.

Colorado created an opportunity for stakeholders to voluntarily submit healthcare quality proposals any time after January 1, 2017. Because this is a voluntary opportunity, however, and because quality is a paradigm shift for Colorado’s workers’ compensation healthcare system, CO DOWC anticipated challenges in filling the proposal pipeline. To address that challenge, CO DOWC has worked closely with carefully selected stakeholders to develop promising pilot proposals. CO DOWC has focused its efforts on filling the pipeline with COHE-type proposals that focus on coordinating communication among injured workers, medical providers, and employers, and coordination of care among healthcare providers. The goal of these proposals is to improve the quality of care delivered by focusing on early communication and coordination, functional outcomes, incorporation of the RTW principle, and reducing costs for the high-risk group of injured workers described previously.

Key elements of Colorado’s coordination of care delivery model are:

1. **Care coordination.** As with the Washington COHE model, the HSC position is the linchpin of the program. This position provides expertise, support, and guidance to key players (i.e., injured worker, employer, payer representatives, and the range of healthcare providers treating the injured worker on a claim) involved in workers’ compensation medical care. Because Colorado’s HSCs are integral in coordinating administrative matters and clinical care, the ideal HSC is a clinician (e.g., nurse, physical therapist) who has a strong background in navigating workers’ compensation healthcare systems. Colorado’s HSCs focus care coordination on serious and/or chronic workplace injuries and illnesses. The ideal candidate for this position is an unparalleled communicator who can effectively engage the diverse players involved in workers’ compensation medical care.
2. **Occupational health best practices.** The HSC is also the nexus between healthcare providers and occupational health best practices. In addition to coordinating care and providing support for primary care physicians, specialists, and other clinicians, the HSC



ensures that all healthcare providers in the continuum of care use Colorado's Medical Treatment Guidelines and correctly apply the concepts (e.g., focus on functional treatment and outcomes, biopsychosocial assessment, medical causation, RTW, maximum medical improvement, impairment ratings, attention to disability risk) covered in Colorado's Provider Accreditation program.

3. **HSC training and certification.** Given the importance of the HSC position, HSCs must be trained and must maintain certification with CO DOWC. The training and certification program for HSCs will be similar to Colorado's Provider Accreditation programs, which are mandated by statute. A robust training and certification program helps to ensure the quality and consistency of services delivered by HSCs.
4. **Financial reimbursement and incentives for HSCs.** HSCs will be reimbursed according to a separate fee schedule. Existing fee schedules (including Colorado's medical fee schedule) often undervalue or do not pay for coordination of care services. As a result, coordination of care is either poorly performed or not provided at all. The HSC fee schedule will cover the entire array of services provided by HSCs and reimbursement levels will incentivize the use of HSCs. Even though similar services will exist in Colorado's medical fee schedule, the HSC fee schedule will have higher reimbursement rates and be available only to CO DOWC trained and certified HSCs.
5. **Program metrics.** To track progress and to ultimately establish evidence of success for the program, it will be important to track a variety of metrics related to patient care processes and outcomes (clinical, social, work-related, and financial). Data will be collected initially to establish the patient's baseline metrics and then on an ongoing basis to document progress toward the patient's and the program's goals. The specific set of metrics will be established in cooperation with CO DOWC. Whenever possible, additional data will also be obtained to allow the creation of metrics to allow comparisons between injured workers who are engaged in the COHE program with patients receiving non-COHE care. HSCs will meet with the CO DOWC staff on a regular basis to review and improve ongoing data collection, analyses, and metric creation, and to formulate appropriate improvements to the program in response to this information.

Examples of possible program metrics include the following:

**Overall program metrics**

- Number of coordinators
- Volume of patients being managed

**Individual metrics**

- Diagnosis (ICD-10)
- Patient satisfaction
- Time to RTW
- Time to Maximum Medical Improvement (MMI)
- Medical costs
- Indemnity costs
- Progress on functional evaluation

**Other metrics**

- Employer satisfaction
- Provider satisfaction

### 3. RECOMMENDATIONS

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The importance of a strong RTW focus and effective occupational healthcare delivery in workers' compensation programs cannot be overstated. The policy goal must be to influence and modify the workers' compensation system in way that will result both in better health outcomes and return to employment for workers in the system, preferably as soon as possible following the work-related injury or illness. The challenge for policymakers lies in identifying policies and initiatives that are of demonstrated value and are feasible, given the particular context in which they will be implemented. To do this requires that state policymakers take a systematic approach to developing policies that support workers' compensation RTW programs. In doing so, they must ensure that they are inclusive of multiple stakeholder groups within their systems, including the injured worker, employer, insurer, healthcare provider, and the state itself.

The Replicating and Adapting the COHE Model PWG provides the following recommendations for state agencies working toward improved occupational healthcare delivery and RTW policies to improve work outcomes in workers' compensation systems of care:

1. **Take a systems change approach.** The workers compensation system in the United States that has been around for more than 100 years has many complicated interactions with other systems, including, in most states, multiple healthcare delivery systems and the competitive insurance market. Improving the workers' compensation system so that the injured worker's healthcare *and* RTW outcomes are maximized requires having a vision of how the whole system does and should work, as is taking place now in Colorado.
2. **Consider replicating or adapting the COHE model.** COHE is not just for monopolistic states where all the power of the insurance marketplace lies with the state workers' compensation agency. Some states may be able to leverage the purchasing power of their state insurance funds in the insurance marketplace in much the same way that Washington was able to use its monopolistic status to involve providers in pursuing the overall healthcare and employment goals of COHE. Nor does COHE need to look exactly the same in every state; its key components—care coordination; occupational health best practices; provider training, feedback, and incentives; medical and organizational leadership; community outreach and stakeholder involvement—can be implemented in many different contexts.
3. **Build on existing systems and initiatives.** Many states have existing laws, regulations, and policies to build on. For example, states that already have well-developed RTW programs for their state employees may find that it takes only a few small steps to engage with private insurers to expand such programs to all workers in the state.

4. **Start with a pilot program.** Begin comprehensive adoption/adaptation of COHE (or another model that has been chosen) on a small scale by implementing a pilot program similar to Colorado's pilot of COHE. Use pilot implementation as a way to begin serious dialogue with key stakeholders, test the feasibility of different implementation strategies, and gather compelling evidence of effectiveness within the state's own policy and service delivery context.
5. **Begin with small steps that address key components.** In states where implementing the COHE model may not be immediately feasible, adopt a goal/vision that incorporates as many components of COHE as practical. Ensure that this incremental approach is done thoughtfully with steps that gradually engage key stakeholders, such as the approach Montana is using, which is described in the previous sidebar.
6. **Make strategic use of the state's workers' compensation regulatory apparatus.** In Colorado, it was determined that implementation of a COHE delivery model represented a significant change in Colorado's workers' compensation healthcare system, so CO DOWC promulgated a new regulation that opened a pipeline for stakeholders to propose pilot programs on quality initiatives like the COHE model.
7. **Identify clinical champions in partner organizations, and recognize their central role in healthcare delivery and RTW.** In the COHE experience, the presence of strong medical and clinical leadership and connection is as important, if not more so, as the structure of the state's insurance market. The COHE model represents a paradigm shift in healthcare delivery. It is essential to identify passionate leaders who are willing to champion COHEs and manage the significant cultural change involved. Whether implementing the full COHE model or starting with small steps, it is important to recognize that leadership by medical and other healthcare providers is critical to initial and continued success for RTW initiatives and programs that work.
8. **Share information about the demonstrated benefits of a strong COHE-type program with businesses of all sizes, and use financial tools to incentivize their participation in the system.** Encourage businesses to invest in RTW for their employees through tools such as employment subsidies, which can incentivize companies to reintegrate injured workers quickly, despite the potential costs of early RTW. Similarly, accommodation subsidies can cover the costs of providing accommodations that can enhance the productivity of the injured worker.

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## GLOSSARY OF TERMS AND ACRONYMS

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Term	Definition
<b>Care coordination</b>	A component of the COHE model, care coordination is led by the Health Services Coordinator and involves coordination and communication among injured workers; employers; claim managers; and providers of medical, rehabilitative, and related services.
<b>Claim manager</b>	The individual who manages a workers' compensation claim. In the COHE program in Washington State, claim managers with L&I review and authorize occupational health services and process forms and information about claims.
<b>Centers of Occupational Health &amp; Education (COHE)</b>	A program established in Washington State in 2002 aimed at achieving the workers' compensation healthcare goals of improving quality of care, reducing work disability, improving health outcomes, preventing chronic disability through provider education and support, and increasing employer and worker satisfaction with care. COHEs work with medical providers, employers, and injured workers in a community-based program designed to ensure timely, effective, and coordinated services for injured workers.
<b>Community outreach and stakeholder involvement</b>	A component of the COHE model, community outreach and stakeholder involvement entail obtaining the buy-in of business and labor through inclusion of them in COHE development and ongoing management.
<b>Evidence-Based Medicine (EBM)</b>	The conscientious, explicit, judicious, and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information
<b>Evidence-Based Practice (EBP)</b>	The use of systematic decision-making processes or provision of services that have been shown, through available scientific evidence, to consistently improve measurable client outcomes. EBP relies on data collected through experimental research and accounts for individual client characteristics and clinician expertise.
<b>Health Services Coordinator (HSC)</b>	A professional within the COHE model who plays a crucial role in care coordination, one of the key elements of the COHE model. HSCs provide assistance, guidance, and support to participants in the COHE system—injured workers; employers; claim managers; and providers of medical, rehabilitative, and related services. HSCs are employees of the COHE, not of the state. They focus on the first 12 weeks of the claim and provide important services in the areas of timely care coordination and communication.
<b>Impairment</b>	An alteration of the individual's usual health status (i.e., some objective anatomic or pathological abnormality) that is evaluated in physical and medical terms to determine structural limitations.

Term	Definition
<b>MacColl Chronic Care Model</b>	An approach to caring for people with chronic disease in a primary care setting. The model creates practical, supportive, evidence-based interactions between an informed patient and a prepared, proactive practice team. The essential elements of quality care are a health system, a well-designed delivery system, support for decisions, clinical information systems, self-management support, and the community.
<b>Medical and organizational leadership</b>	A component of the COHE model, medical and organizational leadership includes the pool of advisors that each COHE has from a range of clinical specialties, who act as a resource to other COHE providers, increasing knowledge and use of occupational health best practices. The COHE medical director is the lead for the advisors and provides the overall vision for the COHE.
<b>Occupational health best practices</b>	A component of the COHE model, best practices in claims management, treatment planning, and communication that include: <ul style="list-style-type: none"> <li>• Timeliness (submitting an initial Report of Accident in two business days or sooner so that claims can be opened quickly)</li> <li>• Function (completion of an Activity Prescription Form, which is shared with the provider, the employer, the worker, and L&amp;I, on the first office visit if there are restrictions, when patient restrictions change, or whenever the injured worker cannot go back to work full duty)</li> <li>• Connection with the employer (contacting the employer when a patient has work restrictions or will not be going back to work)</li> <li>• Attention to disability risk (reviewing the file with the worker and with the HSC to identify the barriers that may be keeping that person from going back to work)</li> </ul>
<b>Occupational Health Management System (OHMS)</b>	A web-based computer system that will provide front-end case-management tools to help coordinate services for injured workers. Health services coordinators in COHE in Washington State use the OHMS to manage and track injured workers and key tasks, communicate with others using the system, and provide feedback on performance measures.
<b>Occupational healthcare</b>	The promotion and maintenance of the highest degree of physical, mental, and social well-being of workers in all occupations by preventing departures from health, controlling risks and the adaptation of work to people, and people to their jobs. Occupational healthcare comprises a wide variety of health services, such as surveillance of employee health and therapeutic care on or off business premises.
<b>Provider</b>	An individual or organization that provides healthcare services, including medical, pharmacological, physical, rehabilitative, and behavioral health services.



Term	Definition
<b>Provider incentives</b>	A component of the COHE model, provider incentives encompass both financial and other incentives for opting to participate in the COHE, such as a modest increase in payment for any timely report of accident, and access to assistance and support from the HSCs.
<b>Regular provider training and performance feedback</b>	A component of the COHE model. In Washington State, L&I provides COHEs with regular performance reports for providers, as well as quarterly performance reports for COHEs.
<b>Return to Work, RTW</b>	A focus on supporting workers who sustain injuries or develop health conditions in returning to the jobs they held before their injury or condition onset, or, if that is not possible, in returning to a modified version of their position or another position with the same employer, or, if not that, then a position with another employer through which they can reconnect to the workforce.
<b>Stay at Work, RTW</b>	A focus on supporting workers who sustain injuries or develop health conditions in remaining in the jobs they held and/or with their employers from before their injury or condition onset, or, if not that, then a position with another employer through which they can remain part of the labor force.
<b>SAW/RTW Policy Collaborative</b>	Established by DOL ODEP to support the development of policies, programs, and practices that encourage the continued employment of workers likely to leave the workforce due to injury, serious illness, or disability, the SAW/RTW Policy Collaborative consists of a Community of Practice to provide input and real-time feedback on specific policy topics related to SAW/RTW, and Policy Working Groups led by Subject Matter Experts who work together to explore effective SAW/RTW practices, inform policy recommendations to key stakeholders, and develop resources to support policy action.
<b>Social Security Disability Insurance (SSDI)</b>	A Social Security program that pays monthly benefits to citizens who become disabled before reaching retirement age and are unable to work.
<b>Work disability</b>	The inability to perform essential job tasks or maintain employment due to a health concern.
<b>Workers' Compensation</b>	State-based programs in which employees receive medical treatment and lost wages upon suffering a work-related injury or illness, and give up the right to sue their employer for negligence. Employers receive protection from negligence lawsuits, and their claim exposure is limited to benefits defined in state law. In return, employers are responsible for all injuries arising out of employment, regardless of fault. Workers' compensation is funded by employers, who generally either buy a workers' compensation policy through a private insurer or become a qualified self-insurer.

## Acronyms

Abbreviation	Term
<b>ACOEM</b>	American College of Occupational and Environmental Medicine
<b>AHRQ</b>	Agency for Healthcare Research and Quality
<b>APF</b>	Activity Prescription Form
<b>CO DOWC</b>	Colorado Division of Workers' Compensation
<b>COHE</b>	Centers of Occupational Health & Education
<b>CoP</b>	Community of Practice (of the Stay-at-Work/Return-to-Work Policy Collaborative of the U.S. Department of Labor's Office of Disability Employment Policy)
<b>DL&amp;I</b>	Montana Department of Labor & Industry
<b>DOL</b>	U.S. Department of Labor
<b>EAIP</b>	Employer-at-Injury Program (Oregon)
<b>EBM</b>	Evidence-based medicine
<b>EBP</b>	Evidence-based practice
<b>HSC</b>	Health Services Coordinator
<b>IAIABC</b>	International Association of Industrial Accident Boards and Commissions
<b>L&amp;I</b>	Washington State Department of Labor & Industries
<b>MMI</b>	Maximum Medical Improvement
<b>ODEP</b>	Office of Disability Employment Policy
<b>OHMS</b>	Occupational Health Management System
<b>PWG</b>	Policy Working Group
<b>PWP</b>	Preferred Worker Program (Oregon)
<b>ROA</b>	Report of Accident
<b>RTW</b>	Return to Work, Return-to-Work
<b>SAW</b>	Stay at Work, Stay-at-Work
<b>SME</b>	Subject Matter Expert
<b>SSDI</b>	Social Security Disability Insurance
<b>WCRI</b>	Workers Compensation Research Institute

**APPENDIX A**  
**WORKERS' COMPENSATION RETURN-TO-WORK STRATEGIES: A RESOURCE MAP**

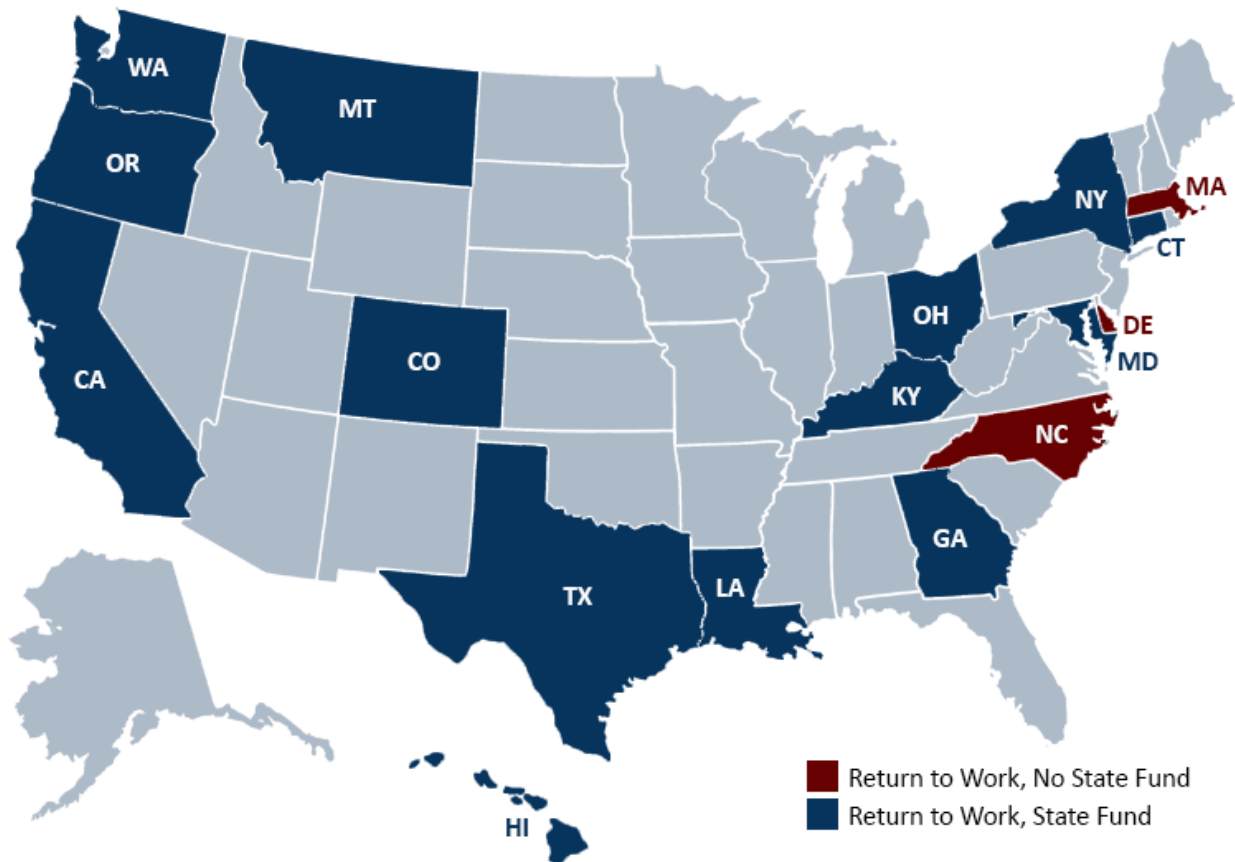
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## 1. WORKERS' COMPENSATION RTW STRATEGIES BY STATE

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A number of states have put into practice various initiatives and strategies designed to help workers who are injured or disabled on the job to return to work (RTW) and keep their jobs. The presence of certain such initiatives may be an indicator of readiness and/or willingness to adopt workers' compensation RTW care coordination strategies and occupational health best practices like those that have been successfully employed by the Washington State Department of Labor & Industries' (L&I's) Centers of Occupational Health & Education (COHE) program.

The map above shows the states where we identified existing workers' compensation programs and policies that could serve as a foundation for implementation of COHE's RTW strategies. (We excluded states with related programs for the employment of people with disabilities that were not directly focused on COHE-type RTW strategies, such as the vocational rehabilitation programs in Alabama and Arkansas.) The map also indicates that most, but not all, of the states we identified with workers' compensation RTW strategies have a state-administered workers' compensation fund. Some states may be able to use this administrative role as a mechanism for implementing policy changes throughout the workers' compensation system.

Below, we provide a brief description of the RTW strategies identified and located on the map as of March 9, 2017, along with links to key source documents for the map, which are further described in Chapter 4.

### **California**

California provides a [voucher](#) for education or training if a worker is unable to return to his or her prior occupation (supplemental job displacement benefit); [reimburses small employers](#) for workplace modifications; and requires (through the Fair Employment and Housing Act) an [interactive process](#) between employee and employer to determine whether reasonable accommodations can enable the employee to remain at work or to return to work.

### **Colorado**

Colorado has a [provider accreditation process as well as mandatory provider education](#), which includes an explanation of how an RTW philosophy leads to the best possible outcomes for injured workers. Colorado has nine [medical treatment guidelines](#) that incorporate the principle of RTW, and recommendations that facilitate RTW.

### **Connecticut**

Connecticut has [light-duty guidelines, as well as workers' compensation rehabilitation coordinators](#) who help with RTW services, including assisting with rehabilitation engineering and workplace modifications.

### **Delaware**

Delaware has RTW coordinators and healthcare practice guidelines that include RTW, [provider certification](#), and mandatory continuing education for providers.

### **Georgia**

Georgia's [Model Return to Work Program](#) for employers includes the same four occupational health best practices as COHE in Washington State. Also available are temporary partial disability payments for an employee returning to work and earning less than he or she did before an injury. A claimant worker must now show a good faith effort to work at an appropriate job for a 15-day trial period within physician-directed limitations. If he or she doesn't, the employer may suspend benefits.

### **Hawai'i**

Hawai'i provides [temporary partial disability](#) during transition back to work; requires [state and county employers to have RTW programs](#); entitles public employees to light-duty work; and requires public employees to participate in employer RTW plans before receiving vocational rehabilitation services.

### **Kentucky**

Per [statute](#), Kentucky requires [managed care plans](#) to (1) coordinate delivery of health services and RTW policies; (2) promote an appropriate, prompt return to the workplace; and (3) facilitate

communication between the employee, employer, and healthcare providers. Workers are entitled to up to one year of [vocational rehabilitation](#) if needed.

### **Louisiana**

Louisiana entitles injured employees to [up to 26 weeks of vocational rehabilitation](#) if they are unable to return to their previous jobs.

### **Maryland**

Maryland provides [temporary partial disability](#) when the worker can only perform limited or part-time duties and is earning less than he or she previously did. An employee is entitled to [up to 24 months of vocational rehabilitation](#) if unable to return to his or her previous job.

### **Massachusetts**

Massachusetts provides for a [28-day trial work period](#) when returning to work, to minimize risk of loss of benefits when attempting RTW. Private rehabilitation providers [must be approved](#) by the state.

### **Montana**

Montana requires insurers to provide [SAW and RTW services](#). The state provides SAW and RTW assistance through state workers' compensation or insurers. Montana provides up to \$2,000 to assist employers with modifications and accommodations.

### **New York**

New York provides employers a financial incentive to implement an approved RTW program through its [Workplace Safety and Loss Prevention Incentive Program](#), as well as an [RTW handbook](#) with best practices.

### **North Carolina**

North Carolina makes vocational rehabilitation available to anyone who has returned to work at less than 75% of his or her pre-injury average weekly wage. The state offers a [trial RTW period](#) for up to nine months to provide an incentive for employees to try returning to work while minimizing the risk of terminating benefits before an employee is fully ready.

### **Ohio**

Ohio provides [incentive payments](#) to employers who hire or retain injured workers who have completed a rehabilitation program. This includes [Transitional Work Grants](#) to help employers develop transitional work opportunities and the [Transitional Work Bonus](#) program which rewards employers who successfully provide transitional work. Ohio has also established a [workers' compensation managed care system](#).

### **Oregon**

Oregon provides [temporary partial disability payments](#), as well as employer subsidies for wages and accommodations to employers who retain or re-employ injured workers through the

[Employer-at-Injury Program \(EAIP\)](#), and to employers who hire injured workers through the [Preferred Worker Program \(PWP\)](#).

### **Texas**

Texas provides employers with [reimbursements for workplace modifications](#). The state adopted a closed workers' compensation formulary (non-recommended drugs are available only in cases of medical necessity with prior approval) that has proven [successful](#).

### **Washington**

In Washington, [COHEs](#) provide care coordination and occupational health best practices, including coordinated RTW planning. In addition, the state's [Stay at Work program](#) provides incentives to employers to retain injured employees for light-duty jobs; these incentives include reimbursement of up to 50% of the injured employee's base wages, as well as payment of training expenses.



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## 2. WORKERS' COMPENSATION RTW STRATEGIES BY STATE – MAP SOURCES

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In this chapter, we describe key source documents for mapping workers' compensation RTW strategies by state. Unless otherwise indicated, the information below is based on current information posted on state websites related to workers' compensation issues. The services/programs described here apply to all workers in a state.

### California

#### **Workers' Compensation Reform and Return to Work: The California Experience**

*The RAND Corporation* – Seth A. Seabury, Robert T. Reville, Stephanie Williamson, Christopher F. McLaren, Adam Gailey, Elizabeth Wilke, Frank W. Neuhauser

<http://130.154.3.8/pubs/monographs/MG1035.html>

[http://www.rand.org/content/dam/rand/pubs/monographs/2010/RAND\\_MG1035.pdf](http://www.rand.org/content/dam/rand/pubs/monographs/2010/RAND_MG1035.pdf)

In this 2011 monograph, the RAND Center for Health and Safety in the Workplace reports on research it conducted on behalf of the California Commission on Health and Safety and Workers' Compensation. The research team reviewed 10 years of policy changes with effects on workers' compensation in California to see how the changes affected RTW of injured and disabled workers in the state. They also looked at the effects of changes to the workers' compensation system on adequacy of benefits. The report provides details of their investigation and findings, as well as information about California's workers' compensation system, including education and training opportunities for workers unable to return to a previous occupation and employer reimbursements for workplace modifications.

### Colorado

#### **Workers' Compensation > Medical Providers > Provider Education**

*Colorado Department of Labor and Employment*

Online information

<https://www.colorado.gov/pacific/cdle/provider-education>

This part of the website of the Colorado Department of Labor and Employment describes the state's education program for medical and other healthcare practitioners who care for injured workers receiving workers' compensation. The program was developed and is run to meet Colorado statutory requirements. The state has different accreditation levels for practitioners who care for workers and those who provide worker impairment ratings (the latter group consists of medical doctors and doctors of osteopathy), as well as training for allied health practitioners (such as physician assistants, physical and occupational therapists, advanced practice nurses, and psychologists).

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#### **Workers' Compensation > Medical Providers > Medical Treatment Guidelines**

*Colorado Department of Labor and Employment*

Online information

<https://www.colorado.gov/pacific/cdle/medical-treatment-guidelines>

This part of the website of the Colorado Department of Labor and Employment links to the state's nine evidence-based medical treatment guidelines created by the Division of Workers'

Compensation. The guidelines address occupational injuries that occur most frequently or incur high costs of treatment. All nine medical treatment guidelines incorporate the principle of RTW and provide recommendations that facilitate RTW.

## **Connecticut**

### **Workers' Compensation Commission Information Packet**

*State of Connecticut*

Guidebook

<http://wcc.state.ct.us/download/acrobat/Info-Packet.pdf>

This approximately-40-page guide provides information about workers' compensation in Connecticut, beginning with an overview of the Workers' Compensation Act and the state's Workers' Compensation Commission and continuing with a flow chart which identifies tasks that employees, employers and insurers, and attending physicians should perform during each phase of a workers' compensation case. The following pages elaborate on details of the phases of a case, describe additional benefits under the Workers' Compensation Act, and provide city and town workers' compensation jurisdictions and contact information. Additionally, this resource includes guidelines for light-duty work and details of the role of workers' compensation rehabilitation coordinators, who work with employees to help coordinate vocational rehabilitation services.

## **Delaware**

### **Workers' Compensation: Provider Certification**

*State of Delaware, Department of Labor, Division of Industrial Affairs*

Online information

<https://dia.delawareworks.com/workers-comp/hcps/provider-certification.php>

Delaware's Division of Industrial Affairs describes the role that certified healthcare providers play in workers' compensation in the state and the requirements to attain certification. Links are provided to access relevant sections of statute, download the list of certified providers in the state, and take the continuing education course required for healthcare providers to become or remain certified.

## **Georgia**

### **State Board of Workers' Compensation Model Return to Work Program**

*State of Georgia*

Manual

<https://sbwc.georgia.gov/sites/sbwc.georgia.gov/files/imported/SBWC/Files/erwm.pdf>

Designed for employers, this manual provides guidance in establishing and running an RTW program. It explains the goals of an RTW program, describes how to establish an implementation team and develop policies and procedures, identifies key program components and suggests how to initiate and establish them, and includes resources such as a flow chart of the RTW process and job activity analysis and transitional employment plan templates. Key program components in the model program overlap with best practices in Washington State's COHE program model.

## **Hawai'i**

### **HRS Chapter 386: Hawai'i Workers' Compensation Law**

*University of Hawai'i, West O'ahu, Center for Labor Education & Research Law*

Online information

<http://www.hawaii.edu/uhowo/clear/home/HRS386-2.html>

This web page features Hawai'i's workers' compensation law as of July 2015. Workers' compensation law in the state includes provisions for vocational rehabilitation, treatment guidelines, requirements for healthcare providers, and permanent and temporary total disability and temporary partial disability benefits.

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### **Hawai'ian Government Correspondence Regarding HB1268 HD2 SD2 CD1 Act 168 (15) Relating to Workers' Compensation**

*State of Hawai'i*

Official correspondence and law

[http://www.capitol.hawaii.gov/session2015/bills/GM1269\\_.PDF](http://www.capitol.hawaii.gov/session2015/bills/GM1269_.PDF)

This file includes official correspondence from the governor of Hawai'i to the state legislature regarding a bill's being signed into law related to RTW provisions of workers' compensation law for public employees in the state. The law requires that public employees complete a RTW program to be eligible for vocational rehabilitation benefits.

## **Kentucky**

### **803 KAR 25:110. Workers' Compensation Managed Health Care Plans**

*State of Kentucky*

Law

<http://www.lrc.state.ky.us/kar/803/025/110.htm>

This regulation presents requirements and standards for certification of managed health care system plans to provide services as part of the workers' compensation system in Kentucky. It includes a requirement for "aggressive case management" as part of the managed health care system plan, which it describes as involving care coordination and RTW policies, promotion of a safe and expeditious RTW, and facilitation of communication between and among key parties (employee, employer, and health care providers).

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### **Medical Services and Cost Containment: Managed Care**

*State of Kentucky, Labor Cabinet, Department of Workers' Claims*

Online information

<http://www.labor.ky.gov/workersclaims/mscc/Pages/Managed-Care.aspx>

This web page describes the history of managed care as a cost containment measure within Kentucky's workers' compensation system. Managed care emphasizes controlling utilization through gatekeeper physicians, pre-certification of services, strong case management and coordination of medical treatment and return-to-work policies. Through managed care plans, employees choose doctors from within a provider network, and elements to control health care use and costs include case management, care coordination, and policies to expedite workers' return to work. Links to relevant laws are provided.

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## **342.710: Rehabilitation Rights, Duties, and Procedures—Acceleration of Benefits**

*State of Kentucky*

Statute

<http://www.lrc.ky.gov/statutes/statute.aspx?id=32541>

This section of Kentucky's workers' compensation statute (the full statute may be found in the chapter on Workers' Compensation (Chapter 342), within Title XXVII: Labor and Human Rights, <http://www.lrc.ky.gov/statutes/chapter.aspx?id=38914>) describes medical and vocational rehabilitation services available to people receiving workers' compensation. Workers who have sustained injuries that have made them unable to do work for which they have training and experience are eligible for vocational rehabilitation services, which are generally limited to one year.

## **Louisiana**

### **Frequently Asked Questions from Employees and Employers about Rights and Responsibilities in Workers' Compensation: What If I Cannot Return To My Old Job?**

*Louisiana Workforce Commission*

Frequently asked questions (FAQs), online information

[http://www.laworks.net/FAQs/FAQ\\_WorkComp\\_RightsAndResponsibilities.asp#answer\\_13](http://www.laworks.net/FAQs/FAQ_WorkComp_RightsAndResponsibilities.asp#answer_13)

This FAQ about workers' compensation in Louisiana describes vocational rehabilitation in the state. It explains that employees are eligible for vocational rehabilitation if they cannot earn wages equal to what they were earning before their work-related injury leading to their workers' compensation claim. It is also noted that employers are responsible for identifying a licensed professional vocational rehabilitation counselor to help their employee return to work. If eligible for services, employees can receive up to six-and-one-half months (26 weeks) of vocational rehabilitation.

## **Maryland**

### **Maryland Workers' Compensation Law: Available Benefits, Who Files the Claim? and the Commission Process; Temporary Partial Disability Benefits**

*State of Maryland, Workers' Compensation Commission*

Online information

[http://www.wcc.state.md.us/Gen\\_Info/WCC\\_Benefits.html#benefits](http://www.wcc.state.md.us/Gen_Info/WCC_Benefits.html#benefits)

This part of the Maryland Workers' Compensation Commission website describes temporary partial disability benefits available as part of Maryland's workers' compensation system. The employer or its insurer pays the covered employee compensation that equals 50% of the difference between the average weekly wage of the covered employee and the wage earning capacity of the covered employee in the same or other employment while temporarily partially disabled, subject to a maximum payment of 50% of the state average weekly wage.

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### **Maryland Workers' Compensation Law: Available Benefits, Who Files the Claim? and the Commission Process; Vocational Rehabilitation Benefits**

*State of Maryland, Workers' Compensation Commission*

Online information

[http://www.wcc.state.md.us/Gen\\_Info/WCC\\_Benefits.html#pmt\\_of\\_benefits](http://www.wcc.state.md.us/Gen_Info/WCC_Benefits.html#pmt_of_benefits)

On this part of its website, the Maryland Workers' Compensation Commission provides an overview of vocational rehabilitation benefits available to injured workers in the state. When a covered employee is disabled from performing work for which they were previously qualified as the result of an accidental injury or an occupational disease, the covered employee is entitled to vocational rehabilitation services. Training may last up to 24 months and other services may include coordination of medical services, vocational assessment, vocational evaluation, vocational counseling, vocational rehabilitation plan development, vocational rehabilitation plan monitoring, vocational rehabilitation training, job development, job placement.

## **Massachusetts**

### **Workers' Compensation Frequently Asked Questions: Returning to Work**

*Keches Law Group, P.C.*

Online information

<https://www.kecheslaw.com/returning-to-work.html>

This web page provides guidance for injured workers in Massachusetts who are interested in returning to work. It explains how the RTW process is structured in Massachusetts and what happens if the worker's injury or condition gets worse after he or she returns to work, how an employee can calculate what his or her compensation will be for partial RTW, and how vocational rehabilitation may figure into the RTW process.

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### **452 CMR 4.03: Qualifications and Standards of Providers**

*State of Massachusetts, Executive Office of Labor and Workforce Development*  
Law

<http://www.mass.gov/lwd/workers-compensation/related-links/452-cmr-1-00-8-00/452-cmr-4-00/403.html>

This part of the Code of Massachusetts Regulations (CMR) details requirements for vocational rehabilitation services providers, who must be approved by the state Office of Education and Vocational Rehabilitation (OEVR) to provide vocational rehabilitation services to injured workers. The code describes academic and professional experience required of rehabilitation counselors and notes that providers are required to obtain or renew approval on an annual basis.

## **Montana**

### **Stay at Work/Return to Work**

*Montana Department of Labor & Industry*

Online information

<http://erd.dli.mt.gov/work-comp-claims/claims-assistance/saw-rtw>

At this part of its website, the Montana Department of Labor & Industry describes SAW and RTW programming in the state. The department explains that injured workers who file workers' compensation claims are notified about SAW and RTW programs in the state via postcard, lists situations in which a worker would be ineligible for SAW and RTW programs, describes how assistance is requested and provided, notes that employers are eligible—through the department's SAW/RTW program—to receive up to \$2,000 in support of workplace

modifications for injured employees, and identifies insurer and department responsibilities. It is noted that if an insurer cannot be identified as liable for the injured employee's claim, the department will assign a rehabilitation counselor to the case. The work of the rehabilitation counselor overlaps with components of the Washington State COHE program (e.g., identification and resolution of barriers to staying at work or returning to work and coordination of communication between and among parties involved in the claim).

## **New York**

### **Part 60: Workplace Safety and Loss Prevention Incentive Program (Safety, Drug and Alcohol Prevention, and Return to Work Incentive Programs)**

*State of New York, Department of Labor*

Law/statute/regulation/rule

<https://labor.ny.gov/formsdocs/wp/CR60.pdf>

This 21-page .pdf document provides statutory language about workplace safety and loss prevention incentive programs, including return to work incentive programs. The document details Labor Law Regulation Part 60 Pursuant to Section 134 of the Workers' Compensation Law as amended by Chapter 6 of the laws of 2007.

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## **RTW Program**

*New York State Workers' Compensation Board*

Guidebook

[http://www.wcb.ny.gov/content/main/ReturnToWork/RTW\\_Handbook.pdf](http://www.wcb.ny.gov/content/main/ReturnToWork/RTW_Handbook.pdf)

This undated 31-page guidebook for employers describes the reasons to establish a Return to Work program, best practices, and steps to develop a return to work program. It also provides sample plans, sample policy statements, draft forms, and answers common questions.

## **North Carolina**

### **Proposed Revisions to Workers' Compensation Rules**

*North Carolina Industrial Commission*

Law/statute/regulation/rule

<http://www.ic.nc.gov/ncic/pages/r404a.htm>

This web page on the North Carolina Industrial Commission website provides statutory language of changes to Article IV. Disability, Compensation, Fees Rule 404A regarding Trial Return to Work. The statute details the timing of the submission of certain relevant forms as well as the timing of compensation payments.

## **Ohio**

### **4123-18-11: Incentive Payments to Employers Who Hire or Retain Injured Workers Who Have Completed a Rehabilitation Program**

*State of Ohio, Bureau of Workers' Compensation*

Law/statute/regulation/rule

<https://www.bwc.ohio.gov/downloads/blankpdf/OAC4123-18-11.pdf>

This single-page .pdf document describes Ohio statute 4123-18-11 (effective 2015), which provides the Ohio Bureau of Workers' Compensation the means to provide a financial incentive to employers to retain or hire injured workers who have completed rehabilitation.

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### **Transitional Work Grants**

*State of Ohio, Bureau of Workers' Compensation*

Online information

<https://www.bwc.ohio.gov/employer/programs/TransitionalWork/TWGrantsDescription.asp>

This page of the Ohio Bureau of Workers' Compensation website describes the Transitional Work Grants program, which is designed to help employers develop a customized transitional work program to help their injured workers remain at or return to work. Such programs can lower workers' compensation costs for participating companies. The program provides funds to help employers contract with an accredited transitional work developer to create their transitional work program. The grants are 3-to-1 matching grants with grant amounts ranging from \$2,900 - \$6,300 depending on the number of employees a company has. The page provides multiple links with more details on eligibility, grant reimbursement, fund details, etc., as well as links to accredited Transitional Work Program developers, grant application and other relevant forms.

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### **Transitional Work Bonus**

*State of Ohio, Bureau of Workers' Compensation*

Online information

<https://www.bwc.ohio.gov/employer/programs/TransitionalWork/TWBonusDescription.asp>

This page of the Ohio Bureau of Workers' Compensation website describes the employer Transitional Work Bonus program whereby employers may receive incentive bonuses for using an approved Transitional Work Plan to actively work toward the return to work of their injured employees. The cost benefits can include a 10% bonus, reduced compensation payments, and lowering claims reserves. The page further describes eligibility requirements and application instructions, and it provides multiple links to relevant information and forms.

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### **Managed Care Information**

*State of Ohio, Bureau of Workers' Compensation*

Online information

<https://www.bwc.ohio.gov/provider/brochureware/ManagedCare>

This page of the Ohio Bureau of Workers' Compensation website describes how the state's Health Partnership Program is working with managed care organizations (MCOs) to administer benefits to Ohio's injured workers. Among other things, the MCO is responsible for claims reporting, medical case management, dispute resolution, bill review, and educating and assisting employers about safety and RTW issues. The page details provider enrollment and certification requirements and provides online links to relevant information, directories and forms.

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## **Oregon**

### **2014 Report on the Oregon Workers' Compensation System, Twelfth Edition, January 2015**

*State of Oregon, Department of Consumer and Business Services*

Report

<https://www.oregon.gov/DCBS/reports/Documents/general/wc-system/14-2362.pdf>

This comprehensive, 122-page report on the Oregon Workers' Compensation in 2014 describes the state's workers' compensation system and the effects of recent legislative changes on the system. The report features chapters on Medical Care and Benefits, detailing new medical fee schedules, as well as results and data on Oregon's RTW programs such as the Preferred Worker Program (PWP) and the Employer-at-Injury program (described below).

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#### **Employer-at-Injury Program (EAIP)**

*State of Oregon, Workers' Compensation Division*

Online information

<http://wcd.oregon.gov/rtw/Pages/eaip.aspx>

This page on the Oregon.gov website describes the Employer-at-Injury Program (EAIP), which is part of the Workers' Compensation Division's RTW program. The EAIP program is a program which lowers the costs associated with early RTW, thus encouraging injured workers' early RTW. The page describes eligibility requirements for workers and employers, describes the nature of transitional work, details the benefits to employers of EAIP, and provides an online link to the Reimbursement Request form.

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#### **Preferred Worker Program (PWP)**

*State of Oregon, Workers' Compensation Division*

Online information

<http://wcd.oregon.gov/rtw/Pages/pwp.aspx>

This page on the Oregon.gov website describes the Preferred Worker Program (PWP) as part of the RTW Program in the Workers' Compensation Division. The page details the assistance available to employers who hire qualified Oregon workers with permanent disabilities sustained on the job who cannot return to their prior employment. Such assistance includes exempting the cost of workers compensation insurance premiums for the worker for three years, claim cost reimbursement, 50% wage subsidy for preferred workers, and reimbursement for employment costs for tuition, assistive tools and equipment, and worksite modification.



## Texas

### Return to Work Reimbursement Program for Employers

*State of Texas, Department of Insurance, Division of Workers' Compensation*  
Flyer

<http://www.tdi.texas.gov/wc/rtw/documents/smlemplyrpilot.pdf>

This 1-page flyer targets employers, providing information on the Return to Work Reimbursement Program, and how to submit an application for reimbursement. The flyer provides a link to the application form on the Texas Department of Insurance website and a phone number for direct assistance.

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### Closed Formulary Could Decrease Use of 'N' Drugs

*Risk & Insurance*

Article

<http://riskandinsurance.com/closed-formulary-decrease-use-n-drugs>

This 2014 article cites the results of a 2014 Workers Compensation Research Institute study titled, "Impact of a Texas-Like Formulary in Other States," which concludes that decreasing the use of 'N' drugs in a closed pharmacy formulary in Texas' workers' compensation system led to a decrease in the utilization of drugs designated as non-formulary drugs and in turn to substantial prescription cost savings. The article also explores how other states can replicate Texas' success, potentially reducing total prescription costs by 14-29%.

## Washington

### Centers of Occupational Health & Education (COHEs)

*Washington State Department of Labor & Industries (L&I)*

Online information

<http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OHS/default.asp>

This page of the Washington State L&I website describes the six Centers of Occupational Health & Education (COHE) in the state and how they work with injured workers, medical providers and employers together to coordinate cases with the ultimate goal of improving injured worker outcomes and reducing disability. The page includes an introductory presentation, links to videos describing what COHEs do and developing best practices. The page provides links to pages containing information specific to COHE providers, workers, employers, and the results of recent research on the COHE solution.

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### Setting up and Managing a COHE

*Washington State Department of Labor & Industries (L&I)*

Online information

<http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/OHS/SettingUp/default.asp>

This web page serves as an online toolkit to provide organizations that would like to sponsor a COHE with the information and materials they need to get started. It also provides information for organizations already sponsoring COHEs. Information and links cover topics including staffing, provider education and training, HSCs, and community outreach.

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## **Stay at Work**

*Washington State Department of Labor & Industries*

Online information

<http://www.lni.wa.gov/main/stayatwork>

This page of the Washington State Department of Labor & Industries' website describes Washington's Stay at Work program, a financial-incentive program whereby the state encourages employers to provide temporary, light-duty jobs to injured workers while they heal by providing reimbursement for some costs, including 50% of employee base wages for up to 66 days, and expense reimbursement for necessary training materials, tools and clothing. The site provides instruction for employers on taking advantage of Stay at Work benefits, as well as FAQs for employers, healthcare providers, and injured workers.

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## **COHE Program Report, April 2017**

*Washington State Department of Labor & Industries*

<http://www.lni.wa.gov/ClaimsIns/Files/Providers/ohs/COHEProgramReport.pdf>

Online information

This January 2017 PowerPoint illustrates the overall aggregated impact of the COHEs, based on measurement information supplied by L&I Research & Data Services and L&I Actuarial Services. The COHE Program Report is provided on a quarterly basis by the L&I to provide the COHEs with data to help them implement best practices successfully and deliver the best service to providers, employers, and workers.

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### 3. ADDITIONAL RESOURCES ON WORKERS' COMPENSATION RTW

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In this chapter, we summarize selected resources that informed our understanding of RTW strategies employed by the states' workers' compensation systems. Note: In some cases, the author(s)' abstract or document description is presented verbatim.

#### **Does the Workers' Compensation System Fulfill its Obligations to Injured Workers?**

*DOL Office of the Assistant Secretary for Policy (OASP)*

October 2016 Report

<https://www.dol.gov/asp/WorkersCompensationSystem/WorkersCompensationSystemReport.pdf>

State-based workers' compensation programs provide critical support to workers who are injured or made sick by their jobs. These programs are a key component of the country's social benefit structure and of occupational safety policy, and the only major component of the social safety net with no federal oversight or minimum national standards. This report provides an introduction to these programs, but it also sounds an alarm: working people are at great risk of falling into poverty as a result of workplace injuries and the failure of state workers' compensation systems to provide them with adequate benefits. (Abstract from OASP website.)

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#### **Workers' Compensation: Benefits, Coverage, and Costs**

*National Academy of Social Insurance: Marjorie L. Baldwin and Christopher F. McLaren*

October 2016 Report

<https://www.nasi.org/research/2016/workers-compensation-benefits-coverage-costs>

This report highlights the fact that workers' compensation benefits as a percentage of payroll had dropped to historic lows, although employers were shouldering increasingly high costs. The report reviews data from workers' compensation systems across the country and opens with national and state trends, as well as trends in workers' compensation. It then presents data on covered employment and wages, workers' compensation benefits paid, employer costs associated with workers' compensation, and workplace injury and claim estimates.

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#### **The Demise of the Grand Bargain: Compensation for Injured Workers in the 21<sup>st</sup> Century**

*An Academic Symposium Cosponsored by Pound Civil Justice Institute, Rutgers Center for Risk and Responsibility, Northeastern University School of Law*

September 2016

<http://poundinstitute.org/sites/default/files/docs/2016%20Symposium/Grand-Bargain-Symposium-agenda-5-30-16.pdf>

This conference re-examined The Grand Bargain in light of evolving legal doctrine, a changed labor market, and changing politics. How well is the workers' compensation system serving its original purposes of swift, sure, and efficient remedies? Does an employer-based insurance scheme for workplace injuries supplanting tort remedies remain desirable? How does the common law command of a remedy for every legal wrong affect the architecture of workers' compensation systems? What responsibilities should employers and employees bear in this system? What are the ramifications of a move towards universal health insurance? Responses to

these questions can inform debates occurring now in courts and legislatures across America. The conference included the following paper:

*Can State Constitutions Block the Workers' Compensation Race to the Bottom?*

Robert F. Williams

September 2016

<http://poundinstitute.org/sites/default/files/docs/2016%20Forum/williams-symposium-draft-11-9-16.pdf>

The enactment of workmen's compensation legislation occasioned one of the nation's great battles over judicial review of reform legislation. As we have seen, the enactment of nineteenth-century tort reform legislation led to relatively few cases striking down legislation. But the enactment beginning in 1910 of workmen's compensation legislation (as today's gender-neutral workers' compensation statutes were then known) led several of the nation's courts to strike down the new compensation programs. The result was a political crisis for some of the nation's leading state courts, the New York Court of Appeals chief among them. Presently the author believes most people in most states would recognize a moral duty for a state to provide some means by which a victim of workplace injury could be compensated. However, now, as in the past, competitive economic pressures may tempt employers to avoid the responsibility of compensating workers for injuries.

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**How Can States Help Workers Keep Their Jobs After Injury, Illness, or Disability?**

*Mathematica Policy Research* Policy Brief

September 2016

<https://www.mathematica-mpr.com/-/media/publications/pdfs/disability/2016>

States can take a number of steps to help workers keep their jobs and to garner the support of private-sector organizations and services in this effort. Policymakers, program directors, and other stakeholders should consider the merits of each step within the context of their state.

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**Return To Work: A Foundational Approach to Return to Function**

The International Association of Industrial Accident Boards and Commissions (IAIABC)

IAIABC Disability Management and Return to Work Committee

April 19, 2016

[https://www.iaiabc.org/images/iaiabc/Return-to-Work\\_Foundational-Approach-to-Return-to-Function\\_Final.pdf](https://www.iaiabc.org/images/iaiabc/Return-to-Work_Foundational-Approach-to-Return-to-Function_Final.pdf)

Return to work plays a significant role in the health and recovery of the individual, the reduction of disability, and the improvement of productivity and security. It also mitigates significant costs to employers, taxpayers, and society as a whole. When an individual remains connected to the workplace and continues to make a positive contribution to society, recovery rates and life expectancy improve. This paper explores some common misperceptions and realities that exist among key stakeholder groups—workers, employers, caregivers, insurance companies, regulators, and attorneys—when it comes to return to work efforts. Full reintegration of the injured person is not possible without all the key stakeholders committing to the restoration of health and function of the injured person.

## **Advocacy model for comp claims empowers workers, speeds return to work**

*Business Insurance*

Stephanie Goldberg

March 27, 2016

<http://www.businessinsurance.com/article/20160327/NEWS08/160329865/advocacy-model-for-workers-compensation-claims-improves-medical?tags=|92|304>

Using an advocacy-based model for workers compensation claims can reduce attorney involvement, improve medical outcomes and speed return to work. At its core, an advocacy-based claims model involves designated service providers assisting and empowering injured workers at any point during the claims process.

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## **Helping Workers Who Develop Medical Problems Stay Employed: Expanding Washington's COHE Program Beyond Workers' Compensation**

DOL ODEP SAW/RTW Policy Collaborative Paper

David Stapleton and Jennifer Christian

2016

[https://www.dol.gov/odep/topics/pdf/SAW-RTW\\_PAP\\_COHE.pdf](https://www.dol.gov/odep/topics/pdf/SAW-RTW_PAP_COHE.pdf)

This policy action paper was developed during the third year of the DOL ODEP SAW/RTW Policy Collaborative. It describes Washington's COHE program and examines the possibility of expanding the COHE model to workers with injuries or health conditions unrelated to their jobs who are not eligible for workers' compensation benefits, but who nevertheless could benefit from the care coordination and other services involved in COHEs. The paper explores the feasibility of such a concept and proposes a pilot test of such an expansion of COHE.

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## **Adding Inequality to Injury: The Costs of Failing to Protect Workers on the Job**

*OSHA Report*

May 2015

<https://www.dol.gov/osha/report/20150304-inequality.pdf>

Every year more than three million workers are seriously injured, and thousands more are killed on the job. The costs of workplace injuries are borne primarily by injured workers, their families, and taxpayer-supported components of the social safety net. Changes in state-based workers' compensation insurance programs have made it increasingly difficult for injured workers to receive the full benefits to which they are entitled. Employers now provide only a small percentage (about 20%) of the overall financial cost of workplace injuries and illnesses through workers' compensation. The most effective solution to the problem posed by this paper is to prevent workplace injuries and illnesses from occurring. At the same time, it is vitally important that state-based workers' compensation programs take steps to eliminate roadblocks that prevent workers with compensable injuries or illnesses from receiving the full compensation to which they are entitled.

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## **Promoting Retention or Reemployment of Workers after a Significant Injury or Illness**

*Mathematica Policy Research*

October 2015

[https://www.dol.gov/odep/topics/pdf/SAW-RTW\\_Retention\\_FINAL\\_2015-10.pdf](https://www.dol.gov/odep/topics/pdf/SAW-RTW_Retention_FINAL_2015-10.pdf)

Each year, millions of workers in the United States lose their jobs or leave the workforce because of a medical condition. Keeping these workers in the labor force could help them stay productive, maintain their standard of living, and avoid dependency on government programs. In this paper, the authors suggest policies and practices that would encourage employers to retain or hire these workers, and we include specific recommendations for incorporating these policies in federal efforts.

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## **The “Toxic Dose” of System Problems: Why Some Injured Workers Don’t Return to Work as Expected**

*Journal of Occupational Rehabilitation:*

MacEachen, E., Kosny, A., Ferrier, S. et al.

September 2010

<http://link.springer.com/article/10.1007/s10926-010-9229-5>

Problems with RTW and extended workers’ compensation claims in dysfunctions in organizational dynamics across RTW systems including the workplace, healthcare, vocational rehabilitation and workers’ compensation. These system problems are difficult to identify because they appear as relatively mundane and bureaucratic. These appeared to have damaging effects on workers in the form of a ‘toxic dose’ affecting the worker beyond the initial injury. ... Worker’s problems with extended claims were linked to RTW policies that did not easily accommodate conflict or power imbalances among RTW parties and by social relations and processes that impeded communication about RTW situations and problems. Avenues for intervention are located in a shift to a critical lens to RTW process that addresses differences of knowledge, resources, and interests among different parties.

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## **Employer-Initiated Disability Management: A New Opportunity for Workers Compensation Insurance**

*Milt Wright & Associates*

Richard Pimental

(no date)

<http://www.miltwright.com/articles/EmployerInitiatedDisabilityMgmt.pdf>

This article examines workers’ compensation RTW strategies and the trend of letting employers make RTW decisions, which presents challenges to insurance companies, including having to re-evaluate the traditional claims control process that is focused on cost savings and does little to enhance the RTW process. The article describes an employer-initiated model that creates direct links between the employer, the injured worker, and the medical care provider to the treating physician at the time of injury, and how that model establishes a competitive edge for insurance providers.

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## **A Communitywide Intervention to Improve Outcomes and Reduce Disability among Injured Workers in Washington State**

*Milbank Quarterly*

Thomas M. Wickizer, Gary M. Franklin, Robert D. Mootz, Deborah Fulton-Kehoe, Roy Plaeger-Brockway, Diana Drylie, Judith A. Turner, and Terri Smith-Weller

September 2004

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690225>

In this article, authors report on implementation of COHEs in the project's pilot phase and evaluation of preliminary data from that phase. They present the problem of deficiencies in the quality of health care in the United States, review past interventions in the workers' compensation healthcare delivery system, identify quality indicators in the pilot, describe how COHEs are organized, and offer data from the evaluation of the project in its pilot phase.

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## **Improving the Quality of Workers' Compensation Health Care Delivery: The Washington State Occupational Health Services Project**

*Milbank Quarterly*

Thomas M. Wickizer, Gary Franklin, Roy Plaeger-Brockway, Robert D. Mootz

March 2001

[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2751183/pdf/milq\\_194.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2751183/pdf/milq_194.pdf)

Researchers and health policy analysts in Washington State set out to determine the extent to which administrative process changes and delivery system interventions within workers' compensation affect quality and health outcomes for injured workers. This research included a pilot project to study the effects of providing occupationally focused health care through managed care arrangements on health outcomes, worker and employer satisfaction, and medical and disability costs. Based on the results, a new initiative was developed to incorporate several key delivery system components. The Washington State experience in developing a quality improvement initiative may have relevance for health care clinicians, administrators, policymakers, and researchers engaged in similar pursuits within the general medical care arena.