Prepared for the
Commission on Health and Safety and Workers' Compensation

by the Institute of Industrial Relations
University of California at Berkeley

Return-to-Work in California: Listening to Stakeholders' Voices

by Juliann Sum, J.D., M.S.
and John Frank, M.D., M.Sc.

in consultation with:
Julia Faucett, R.N., Ph.D., F.A.A.N.
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CONTENTS

I. EXECUTIVE SUMMARY

For many injured workers with permanent disabilities, workers' compensation benefits alone are insufficient to replace lost wages. Returning to work in sustained employment, therefore, is probably the best way for injured workers to avoid significant financial losses. In addition, scientific evidence shows that returning to medically suitable modified-duty work aids healing and recovery. Many obstacles, however, hinder successful and sustained return-to-work, including communication problems and financial disincentives of important stakeholders in the workers' compensation system.

This study examines perspectives and insights from five interest groups and strategies suggested by the study participants to overcome problems that hinder return-to-work in California. Focus groups of injured workers, claims administrators, union representatives, management representatives, and health care providers were conducted to discuss
medical practices, employer programs and policies, and workers' compensation claims programs that can help injured workers return to long-term, sustained employment. The participants also discussed problems that make it difficult for injured workers to return to work and possible methods to overcome those problems.

FINDINGS:

The focus group findings revealed widespread distrust of others' motives and blaming of others for injured workers not being able to return to long-term, sustained employment. These feelings and beliefs appear to pervade the workers' compensation community.

Participants in the focus groups identified "best practices" of treating physicians, employers, and claims administrators that they believed help injured workers return to sustained employment. Participants in three of the groups said that it is important that treating physicians know how to write useful medical reports and formulate clear and specific work restrictions. However, no other specific practice? of treating physicians, employers, or claims administrators? was identified as beneficial by participants in most or all of the groups. Participants either disagreed about some practices, or they did not have a chance to comment on practices identified by participants in the other groups.

Participants also expressed views about overall problems in the workers' compensation system that hinder return-to-work, and they offered ideas on strategies to overcome some of the problems. Education? for workers, employers, treating physicians, and unions? was one approach that was suggested by participants in all of the focus groups. Cultural, attitudinal, economic, and legal problems were also discussed, but no commonly favored strategy emerged for dealing with those kinds of problems.

RECOMMENDATIONS:

The project team recommends that the Commission consider undertaking further discussions in the workers' compensation community and further applied research to follow up on this study. These recommended activities are listed below and discussed more fully later in this report.

A. Information About Roles and Responsibilities

To help ameliorate some of the blame and distrust in the system and to improve our understanding of what can be expected of persons who provide important services to injured workers and employers, it is recommended that informational materials about these providers of services be developed. The materials would describe the providers' roles and responsibilities, their training, how they are paid, and how they are regulated. The Commission could establish a cooperative, multipartite task force to assist in developing these materials.

B. Respectful Attitudes Towards Injured Workers

Previous research has documented the serious losses experienced by many injured workers and the disrespectful treatment they face in trying to navigate the workers' compensation system. This study also shows that injured workers often face suspicion and negative stereotyping, which can hinder recovery. It is recommended that the Commission develop methods and plan activities to promote respectful treatment of injured workers. This could be accomplished in consultation with the task force described above.

C. Model Practices of Treating Physicians, Employers, and Claims Administrators

It is recommended that the Commission develop a set of model practices of treating physicians, employers, and claims administrators that are based on ethical "codes of conduct" and, where possible, evidence-based standards of care. As a starting point, the Commission could consider some of the "best practices" that were identified by participants in the focus groups. The Commission could develop the model programs in consultation with the task force described above. In addition, the Commission could establish and consult with an academic advisory body possessing expertise in the relevant fields of business, health, and law.

D. Strategies To Overcome Problems in the System

The focus group participants and members of the Project Advisory Committee have begun to identify possible strategies to overcome system-wide problems that prevent injured workers from returning to long-term, sustained employment. Education was one approach that was suggested by participants in all of the focus groups. In addition, some of the participants made recommendations to reduce delays in medical treatment and create incentives for employers to accommodate injured employees. It is recommended that the Commission hold follow-up meetings to evaluate the participants' suggestions, identify feasible and desirable strategies, and plan specific activities to improve methods for helping injured workers return to sustained employment. Discussions could be held with

the task force described above.

II. INTRODUCTION

Getting back to work may be the best way for injured workers to avoid financial losses, because for many workers, the benefits in the California workers' compensation system are insufficient to replace lost wages. Workers with permanent partial disabilities experience losses exceeding 30% of the after-tax income that they would have earned over a five-year period if uninjured. This is true for workers from both insured and self-insured companies. For many, losses are expected to continue beyond five years after injury.[1]

The greatest losses occur when the disabled worker loses his or her job and cannot find work that pays as much as the worker was paid previously, or cannot find any work at all. For example, the RAND Institute has found that two-and-a-half years after injury, unemployment among permanently partially disabled workers who were injured at insured companies in 1993 was 16.9% greater than if they had not been injured, and it was 13.6% greater among those who were injured at self-insured companies. After five years, unemployment was 8.9% and 14.4% greater for permanently partially disabled workers from insured and self-insured companies, respectively.[2]

These losses might be preventable. There is some research evidence and much practical experience to indicate that if workers can participate in early return-to-work programs that offer transitional jobs medically suited to their injuries, these workers will recover faster and more completely and have a better chance of keeping their jobs than if they stay home while recovering. In addition, where injuries occurred as a result of inherently unsafe conditions, permanent modifications may be necessary to ensure that workers are not reinjured. Employer programs that accommodate and support injured employees increase the likelihood that the employees will return to work.[3]

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[1]Five years after injury, workers' compensation benefits replaced 69% of after-tax earnings for permanently partially disabled claimants who were injured in 1993 at insured firms and 64% of after-tax earnings for those who were injured in 1993 at self-insured firms. Reville, Robert, et al., RAND Institute for Civil Justice, "Permanent Disability at Private, Self-Insured Firms: A Study of Earnings Loss, Replacement, and Return to Work for Workers' Compensation Claimants," prepared for the Commission on Health and Safety and Workers' Compensation, 2000, pages xviii-xix.

[2]See Reville, Robert, et al., page 43.

[3]Krause, Niklas, et al., "Does Modified Work Facilitate Return to Work for Temporarily or Permanently Disabled Workers?," a review of the literature prepared for the Commission on Health and Safety and Workers' Compensation and the Industrial Medical Council, 1997.

Numerous obstacles, however, hinder successful and sustained return-to-work. These may include communication problems and financial disincentives. For example, employers, claims administrators, and treating physicians are not required to take proactive steps to return a newly-injured worker to suitable transitional work. As a result:

? Treating physicians are often not informed about the injured worker's job or different jobs that could be assigned or offered to the worker while recovering.

? Employers are often not informed about specific changes that could or should be made in the workplace to accommodate the injured worker and prevent reinjury.

? Injured workers are often not informed about steps, if any, that can or will be taken to help the worker return to work.

Instead, there may be tendencies either: (1) to keep an injured worker entirely off work while recovering to avoid the possibility of aggravating the injury and help the employer avoid the cost of temporary accommodations; (2) to immediately release an injured worker to full duty to help the employer avoid the cost of temporary disability indemnity payments; or (3) to terminate the injured worker's employment.

It is not until an injured worker has been off work on temporary total disability benefits for 90 days that the employer, the claims administrator, and the treating physician are required to take specific steps designed to return the worker to work, either through placement with the same employer or through vocational rehabilitation services.[4] Many researchers believe that efforts must be taken much earlier than 90 days, by both the employer and the health care provider, in order to prevent long-term disability.[5]

[4]See Labor Code ?4636, 4637, 4638.

[5]See, for example, Frank, John, et al., "Preventing Disability from Work-Related Low-Back Pain," Canadian Medical Association Journal, 156(12), June 16, 1998, pages 1625-31; Loisel, P., et al., "Management of Occupational Back Pain: The Sherbrooke Model, Results of a Pilot Feasibility Study," Journal of Occupational Medicine, 51 (1994), pages 597-602.

A. Objectives

Because of the serious physical, financial, and personal problems confronting workers with permanent disability, the Commission on Health and Safety and Workers' Compensation has recommended continuing efforts by the workers' compensation community to promote injured workers' prompt return to work in sustained employment.[6] This project was designed to assist the Commission and the workers' compensation community in achieving this goal. In addition, this project was designed to complement the quantitative studies on return-to-work being conducted for the Commission by the RAND Institute.

The primary objective of this project was to collect in-depth, qualitative data about experiences and insights regarding three major areas of activity that can help injured workers return to long-term, sustained employment:

- ? Medical practices
- ? Employer policies
- ? Workers' compensation claims programs

The data were collected through a series of five focus groups. During the original design of this project, it was anticipated that most of the information and insights would revolve around events occurring soon after an occupational injury, including efforts to ensure prompt return-to-work. Therefore, this project focused explicitly on collecting perspectives and insights from the five interest groups who are involved in the earliest stages of a claim: (a) injured workers, (b) claims administrators, (c) union representatives, (d) management representatives, and (e) health care providers.

Other objectives of the project were to analyze how existing laws and regulations governing workers' compensation vocational rehabilitation benefits may affect return-to-work outcomes (to the extent uncovered in the focus group sessions), formulate practical messages that could be included in educational materials to promote positive return-to-work outcomes, and help identify further types of research needed to attain the Commission's goal of helping injured workers return to sustained employment.

[6]See "Annual Report of the California Commission on Health and Safety and Workers' Compensation, 1999-2000," page 35.

B. Project Team

The members of the project team were as follows:

1. John Frank, M.D., M.Sc., investigator. Dr. Frank is a family physician and an epidemiologist. While managing the project, Dr. Frank was an adjunct professor at UC Berkeley's School of Public Health and a professor of public health sciences at the University of Toronto. In addition, he co-founded the Institute for Work & Health in Toronto, Canada.

2. Juliann Sum, J.D., M.S., investigator and project coordinator. Ms. Sum is an attorney and an industrial hygienist. Since 1994, Ms. Sum has coordinated Commission-sponsored research and educational projects based at the Institute of Industrial Relations and the Labor Occupational Health Program, UC Berkeley. In previous positions, Ms. Sum worked for a labor union to create and administer an occupational health program and represented insurers in complex insurance coverage litigation.

3. Julia Faucett, R.N., Ph.D., F.A.A.N., project consultant. Dr. Faucett is a nurse and an associate professor, and the director of the Occupational and Environmental Health Nursing Program at the School of Nursing, UC San Francisco.

4. Laura Stock, M.P.H., project consultant. Ms. Stock is a health educator and an associate director of the Labor Occupational Health Program, UC Berkeley's School of Public Health.

C. Planning Activities

Prior to the start of this project, the project team helped plan and conduct a meeting with the Commission's Construction Industry Task Force on February 16, 2000. At this meeting, representatives from labor and management discussed return-to-work problems and issues that are of particular concern in the construction industry in California. The participants then brainstormed on potential solutions. During the meeting, ideas were organized into the following categories: (1) informational and educational solutions, (2) cultural and attitudinal solutions, and (3) economic and legal solutions.

An advisory committee was formed to enable the project team to obtain advisory input from organizations and persons with practical experience in workers' compensation and return-to-work issues. To form this committee, the team assisted the Commission in selecting and inviting members of the workers' compensation community.

The first meeting of the advisory committee was held on March 31, 2000. Twenty-three persons attended, including representatives from the claims industry, employers, labor, community legal services, applicants' attorneys, injured workers, the Department of Industrial Relations, the Division of Workers' Compensation, and the Industrial Medical Council. At this meeting, the participants reviewed the overall scope and activities of the project. They also reviewed the ideas discussed by the Construction Industry Task Force and further discussed and elaborated on problems and solutions that might be applicable in a broad range of industries. Finally, the participants were invited to advise on methods to recruit participants for the focus group sessions.

Ideas generated in the meetings of the Construction Industry Task Force and the Project Advisory Committee were used in the data collection, as described in the next section of this report.

III. RESEARCH ACTIVITIES

This project was designed as an exploratory study, to obtain preliminary information on important issues and concerns regarding injured workers' prospects for future, long-term employment, as viewed by some of the main participants in the California workers' compensation system.

The project team convened five focus groups of study participants. The participants were grouped with other persons who had similar roles in the workers' compensation system to encourage freer expression of opinions and ideas. Each group discussed their experiences, perspectives, insights, and opinions regarding different efforts? both successful and unsuccessful? for returning injured workers to sustained employment. They also discussed major barriers they have observed in trying to return, or trying to help injured workers return, to sustained employment. Finally, they discussed possible solutions to overcome those barriers.

A. Qualitative Research Methodology

This study used focus groups to obtain data on experiences, insights, and barriers to long-term, sustained employment for injured workers. Focus group research is used to collect in-depth qualitative data that closely reflect the perceptions, feelings, and manner of thinking of the participants. This contrasts with written questionnaires that often seek limited answers to closed-ended questions to generate data that can be analyzed quantitatively. Focus group data are subjected to rigorous review

and analysis following specific guidelines and accepted research procedures.[7]

Focus groups are an important research method used in applied social research, especially in the health field. Researchers have used focus groups, for example, to learn about attitudes, beliefs, and practices related to birth control use in economically developing countries, declines in fertility following modernization, parents' educational preferences for young boys and young girls, and support of aging parents by adult children.[8] Public agencies and nonprofit organizations have used focus groups to increase the effectiveness of their programs.[9] In California, for example, a focus group study was recently conducted to understand parents' views toward state programs that offer health coverage for children in low- and moderate-income families.[10]

In a focus group, the interactions in the group increase the participants' candor, probe the thinking behind participants' opinions, and uncover concerns below the surface that were not apparent to researchers beforehand. In other words, focus groups generate data that would be much less accessible without the interaction of the group. Therefore, rather than merely providing data on whether a person is satisfied with a particular program, focus groups also provide specific information on why the person is satisfied or dissatisfied and how the program could be improved.

The moderator of a focus group facilitates interaction between the participants by presenting questions in a neutral manner and by refocusing the discussion when irrelevant topics are introduced. The key to obtaining data effectively lies in the interaction of the group members with each other. The moderator uses questions that are open-ended to allow flexibility in the group discussion. The questions and discussion guide, however, are planned carefully in advance to achieve a proper balance between open discourse and focusing on relevant topics.

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[7]Pope, Catherine, and Nicholas Mays (eds.), Qualitative Research in Health Care, 2nd Edition, BMJ Books, London (2000), pp. 20-29, 75-88.

[8]Morgan, David L., The Focus Group Guidebook, Focus Group Kit, Volume 1, Sage Publications, Thousand Oaks, CA (1998), p. 41.

[9]Morgan (1998), pp. 41-42.

[10]Michael Perry, Lake Snell Perry & Associates, "Medi-Cal and Healthy Families: Focus Groups with California Parents to Evaluate the Medi-Cal and Healthy Families Programs," prepared for the Kaiser Family Foundation, January 2001 (available at www.kff.org).

B. Recruitment and Enrollment

Prior to undertaking any activities to recruit focus group participants, the project team obtained approval from the UC Berkeley Committee for the Protection of Human Subjects, as required by federal law, on detailed procedures for identifying and recruiting participants, obtaining informed consent, and protecting participants' identities. Participants gave written consent for the use of data that they provided and were promised that their participation and individual data would be kept confidential within the extent of law.

1. Injured Workers

Injured workers were recruited through state Division of Workers' Compensation Information & Assistance offices, labor unions, law firms that represent injured workers, and injured-worker support groups. Flyers were prepared to recruit injured worker volunteers to participate in a group discussion on working after a job injury and be paid a $50.00 stipend. Each of the organizations made the flyers available to interested persons. Individuals who called us were enrolled on a first-come, first-served basis.

The final group who participated included 11 injured workers. The workers had been employed in the following industries at the time of injury: (a) six had worked in business, health, educational, social, or engineering services industries; (b) three had worked in public administration; (c) one had worked in the transportation industry; and (d) one had worked in the insurance industry. Their injuries included repetitive stress injuries of the arm or hand, back and neck injuries, knee injuries, and head injuries.

2. Claims Administrators

Claims administrators were initially recruited by Commission staff. Letters were sent to 12 claims administrators who had expressed interest in participating in Commission projects, inviting them to participate in the focus group session. Eight of these claims administrators either were able to participate, or referred us to another person who could participate. The final group who participated included eight claims administrators: (a) four from insurance companies; (b) two from self-insured, self-administered employers; (c) one from a third-party administrator for self-insured employers; and (d) one from a joint powers authority.

3. Union Representatives

Union representatives were initially recruited by Commission staff. Letters were sent to 10 union representatives who were either members of the project advisory committee or members of a labor advisory board for UC Berkeley's Labor Occupational Health Program, inviting them to participate in the focus group session. Five of these union representatives either were able to participate, or referred us to another person who could participate. The project team then recruited

additional union representatives who were either recommended by the California Labor Federation, AFL-CIO, or had previously worked on projects with UC Berkeley's Labor Occupational Health Program. Of these additional persons, four were able to participate, or referred us to another person who could participate.

The final group who participated included nine union representatives: (a) four from unions representing workers in hotel, recreational, health, educational and other service industries, including some in the public sector; (b) two from unions representing workers in food and transportation equipment manufacturing industries; (c) one from a union representing workers in the construction industry; (d) one from a union representing workers in the transportation industry; and (e) one from a union representing workers in the communications industry.

4. Management Representatives

Commission staff sent letters to 13 employer representatives who had expressed interest in participating in Commission projects, asking for their assistance in recruiting persons in management who are in a position to offer or assign work that an occupationally injured employee can do safely, and who supervise the work. Seven of these representatives either were themselves able to participate, or referred us to another person or persons who could participate.

The final group who participated included eight management representatives: (a) five from food, computer equipment, and other manufacturing industries; and (b) three from hotel, health, or educational services industries. We had hoped to recruit managers from small, medium, and large employers. However, except for one participant who was from a multi-employer organization, small employers were not represented in the group.

5. Health Care Providers

The focus group of health care providers was conducted last. In the four previous sessions, focus group participants believed that the performance and effectiveness of the treating physician depends on whether the physician was selected by the worker or the worker's attorney, on the one hand, or by the employer or employer's claims administrator, on the other. In addition, for purposes of selecting the focus group participants, project advisors and members of the project team believed that nurse practitioners and physical therapists, who cannot be designated as treating physicians in the workers' compensation system, play an important role in return-to-work efforts.

Quantitative data were not available showing either the proportions of different professions and specialties that are involved in providing health care in workers' compensation in California, or the proportions of treating physicians who are selected by workers, their attorneys, employers, or claims administrators. Therefore, the project team sought to recruit approximately equal numbers of health care providers commonly selected by workers or applicants' attorneys on the one hand, and those commonly selected by employers or claims administrators on the other. We also set aside two slots for nurses or nurse practitioners and one for a physical therapist.

Based on the above criteria, Commission staff sent letters to organizations representing injured workers, applicants' attorneys, employers, and claims administrators, asking them to recommend health care providers who are "treating physicians" in the California workers' compensation system, as defined in the workers' compensation system. (The statutory definition of "physician" in workers' compensation includes medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractors.[11]) Commission staff sent letters to statewide organizations representing occupational health nurses and physical therapists, asking for their assistance in recruiting those types of health care providers. In addition, the project team requested names of physical therapists from a physical therapist member of our Academic Advisory Panel.

As a result of these efforts, more than 70 health care providers were recommended to us. We sent letters to those providers inviting them to enroll in the focus group session. The providers who called us were enrolled on a first-come, first-served basis, within the categories previously established for the composition of the group. The final group who participated comprised seven health care providers: (a) four "treating physicians" recommended by injured workers or applicants' attorneys (a psychologist, a chiropractor, a medical doctor specializing in physical medicine and rehabilitation, and a psychiatrist); (b) one "treating physician" recommended by employers or claims administrators (an orthopedic surgeon); (c) one family nurse practitioner who works at an occupational health clinic under contract with employers; and (d) one physical therapist who treats injured workers through consultation or referral from physicians.[12]

C. Invitation and Informed Consent

Approximately two to four weeks prior to each focus group session, the project team mailed a letter to each participant confirming enrollment and explaining the purpose and nature of the session, a consent form that had been approved by UC Berkeley's Committee for the Protection of Human Subjects, driving directions, and a map. Follow-up telephone calls were also made to confirm attendance and answer any questions the participants might have.

D. Design of the Discussion Guides

Each session was designed to last two hours. To maximize the focus, relevance, and usefulness of the discussions, for each session a five- to six-page guide was prepared that contained introductory information about the project, basic ground rules regarding the confidential and voluntary nature of the discussions, introductory questions to help the participants and the members of the project team

[11]See California Labor Code ?3209.3.

[12]Unlike the previous groups, a substantial number of health care providers enrolled but did not attend: two medical doctors recommended by employers or claims administrators, one medical doctor recommended by applicants' attorneys or injured workers, and one nurse practitioner who works on-site for an employer.

become acquainted with each other and better understand each others' comments, and "key" questions to guide the discussions into the main subject areas of this project. The biggest challenge was to balance the need to obtain information regarded as relevant to this project (by making the questions sufficiently specific) against the need to discover what issues were the most relevant to the participants in the particular session (by making the questions sufficiently open-ended).

The key questions were prepared based on the primary objective that had been established in the original design of this project. Background information and definitions were then prepared for each key question, to enable the moderator to explain the scope, meaning, and direction of the questions. Additional questions called "probes" were also prepared, to enable the moderator to stimulate responses or to steer discussions that might be too general or that stray from the questions. Some of the probes were based on ideas and knowledge gained in the advisory meetings that were held in the planning phases (described above). In addition, outlines and other information to guide the discussions were prepared and displayed on flip chart paper and given out as handouts during the sessions.

The questions, explanations, probes, and other materials were designed and modified for each session, depending on the roles and experiences of the participants in the particular session and on information obtained in preceding focus group sessions. Thus, each guide was carefully drafted, revised, and redrafted by the members of the project team. The key questions asked in each of the five sessions are given in the Appendix.

E. Facilitation and Observation of the Sessions

Each session lasted two hours, and the sessions were audiotaped. The project coordinator (Juliann Sum) moderated the sessions, using the discussion guides and accompanying information presented on flip charts and in handouts. Other researchers on the project team took notes and asked pertinent questions during the sessions. Project assistants collected signed consent forms, operated the recording equipment, and helped with setting up equipment and materials for the sessions.

F. Transcription and Analysis

The audiotapes of the five sessions were transcribed. Originally, the project team had planned to conduct only abridged transcriptions of the sessions. However, after early results showed major differences in perspectives and unexpected nuances between the different groups on many important issues, the team decided to fully transcribe all of the sessions to allow more precise analysis of both differences and commonalities.

The project team reviewed the content of the sessions to gain an understanding of the full range of themes, issues, and concerns that were uncovered in the sessions. Based on the initial review, subject-matter codes were developed to organize the data.

The transcripts were then coded (indexed and cross-indexed) by the project coordinator according to the subject-matter codes and rearranged physically for further analysis and organization of the data. The analysis relied on both review of the rearranged transcript data and review of the team members' notes and recollections regarding the content of the discussions and the intensity of emotions of the participants.

IV. FINDINGS

This study has examined perspectives, insights, and opinions about medical practices, employer policies and programs, and workers' compensation claims programs that can help injured workers return to long-term, sustained employment. The focus group findings are organized into three categories:

A. "Recurring Themes" covers issues and concerns that were common in all five focus groups.

B. "Views Regarding Practices and Programs of Treating Physicians, Employers, and Claims Administrators" describes participants' perspectives on specific aspects of those practices and programs.

C. "Strategies Suggested by Participants To Overcome Problems in the System" summarizes participants' overall views on problems and their underlying causes, along with their ideas about how to tackle some of those problems.

In this section of the report, quotes are provided to illustrate each of the themes in the

participants' own words. This report does not show all of the comments that were made.

A. Recurring Themes

This subsection of the report gives an overview of the major themes that emerged in the five focus groups: (1) blame and distrust of others' motives; (2) the imbalance of power against the injured worker; and (3) complexities, conflicts, and disputes. Later subsections describe the participant' experiences and perspectives on particular practices, policies, and programs and their suggested strategies to tackle problems in the system.

1. Blame and Distrust of Others' Motives

One theme that pervaded the sessions was distrust of other persons' and organizations' motives. Participants felt that financial incentives drive the actions of others, as opposed to a concern for the long-term employability of injured workers. As might be expected, many of these views differed sharply across the five focus groups.

Most of the participants also felt that others' selfish motives resulted in actions that prevent injured workers from returning to sustained employment, by either worsening the workers' injuries (e.g., requiring the worker to return to work prematurely), hindering recovery (e.g., refusing necessary treatment), or not allowing the workers to return to work while recovering. The participants did not identify practices, policies, or programs of their own organizations that hindered injured workers returning to work or to sustained employment.

Examples of the participants' varied and conflicting views are given below.

a. Injured Workers' Motives and Actions

Claims administrator and management representative participants believed that some injured workers seek to have more work restrictions specified than necessary, or try to stay off work entirely:[13]

> *" . . . it really depends on that employee. If that employee does not want to be at work, they can maneuver themselves out."* ? management

[13]In contrast, other participants felt that injured workers want to return to full, productive work:

> *"I'm in a fairly low-wage industry, but not many of the workers that I know are okay with the workers' compensation part of it. They want to go back to work, because they're getting less than their full salary, and they and their families depend on their full salary."* ? union representative

> *"Everyone wants to be contributing when they're working, and not just sitting there. . . ."* ? claims administrator

representative

"The [employees] know that the more they . . . lie that they can't do something, the more they know they're going to get [in permanent disability benefits]." ? management representative

b. Employers' Motives and Actions

Injured worker and union representative participants believed that some employers try to bring back injured employees as soon as possible in order to avoid paying for temporary disability benefits, and that some refuse to bring back injured employees in order to avoid paying for necessary accommodations:

" . . . if an employee is hurt, and they need a week off . . . the employer is going to face a full charge for the workers' comp claim. So that's the motivation. The motivation is not to get the employee back to work." ? union representative

" . . . twice my doctor has asked for accommodations for me and twice . . . I mean I have letters from my boss, and she said, `No, we're not going to provide it because we don't have to,' . . . Absolutely no regard for me." ? injured worker

c. Unions' Motives and Actions

One injured worker participant expressed distrust of unions' motives and their seeming lack of interest in helping members who are injured:[14]

"My experience with the union, and with all unions actually, is that interest in the individual is very small. . . . in my experience, unions are always interested in sharp raises, even when workers express that that is not their major concern. Those kind of issues that make the unions stronger are the main interests, and really, when I was a shop steward, I had very little support in helping individuals." ? injured worker

One management representative participant felt that the union representing their employees

[14]In contrast, another injured worker participant felt that his union sought to help him stay employed after an injury:

"I'm a member of a workers' union, and I actually worked with the union to try to settle on some of the important accommodation issues. . . . They were very open to actually trying to work to keep me up. . . . " ? injured worker

actively prevents injured employees from returning to work:[15]

> *" . . . our union wouldn't let any modified worker out on the floor. . . . our union's kind of ugly. So they feel that when a person is injured at work, they feel that it is solely the responsibility of [company] and [parent company] to make sure that that person is well taken care of . . . the union feels that, because it was our fault they're injured, we need to take them under our wing, and then that job that they're bidder-holder to needs to be divvied up amongst other people and given the overtime, or another person brought in, that could possibly be on layoff. . . . "* ? management representative

d. Claims Administrators' Motives and Actions

Injured worker, health care provider, and union representative participants believed that claims administrators delay and deny claims and withhold payment for necessary medical treatment in order to save money:

> *"The insurance companies?their main job is to spend as little as they can. . . . "* ? injured worker

> *" . . . we're not going to get away from the fact that insurance companies want to keep the money no matter what. . . . as many people as I do consultations for, the same insurance companies when I'm treating a patient will deny my care or put it on delay. . . . `If you know I'm telling you the truth. . . . ' they'll say, `We're sorry, at this point in time the exposure is too great, so we're going to try?hopefully it will go away.'"* ? health care provider

> *" . . . They are denying things that are so plain and straightforward, medically sensible, that it makes me believe that there is a defense strategy, having to do with starving out workers and making proper care more difficult."* ? health care provider

> *"I've heard . . . that the insurance companies are actually rewarded for*

[15]In contrast, other management representative participants felt that unions can be helpful in return-to-work efforts:

> *"We actually sat down with our union. We developed our modified return-to-work policy, we sat down with the head of the union. . . . "* ? management representative

> *"Slowly but surely organized labor is realizing that return-to-work is good for the employees, their own organization. Slowly but surely you're seeing a change."* ? management representative

denying or delaying. . . . they . . . get a bonus for how much money is not spent on injured workers." ? injured worker

e. Applicants' Attorneys' Motives and Actions

Claims administrator and management representative participants believed that applicants' attorneys select treating physicians who will keep their clients off work, and that they do this to maximize their own fees (which are based on their clients' award or settlement of permanent disability benefits):[16]

" . . . once an employee gets an attorney, then it changes the whole goal for the outcome of the claim. The goal is no longer return the person to work, meaningful employment anywhere. . . . The applicant's attorney will guide that claim in such a manner that they get the largest PD, which means the most money that they put in their pockets." ? management representative

" . . . the adversarial role has come from the attorney, who is holding the person back. . . . in order to get the greater reward, [the worker must] stay away from the job. . . . " ? management representative

" . . . the longer the TTD you have, the more likely you're going to escalate the amount of PD. And to look at some of these really bad cases, we absolutely see trends like this, where it seems like a straightforward injury, an attorney gets involved and refers to the usual doctor for that attorney. And then you have symptom migration to different body parts, you have exotic diagnosis of RSD, of psychiatric components. . . . I am more angry at the attorney as to what it does to the injured worker, because it takes over that person's life. Their life then becomes the claim, and all they get at the end of the day is the PD, and we all know that while it's expensive for us, in a person's life, that? s not much money. And then the attorney is escalating his fee because he gets that larger chunk of PD money from the injured worker. . . . All they care about is getting a higher award at the end of the day. . . . I'm not saying all attorneys are this way, I'm just saying that there are a lot of them who are. They have an understanding that once the employee is back in the workplace with his co-workers, he's got

[16]In contrast, one participant felt that commonly-heard criticisms of applicants' attorneys are unjustified:

" . . . you get claims adjustors who tell you . . . `Well . . . you know what the attorneys are doing is they're trying to drive up the costs so they can get a bigger settlement.' In a lot of cases that's not true. What they're trying to do is get the employee or the injured worker the most they can get. Because they're not going to get it from the employer." ? union representative

to be getting better and it? s less likely that he going to be that disabled. And if he has no disability, guess what? He gets no payment." ? claims administrator

Management representative participants believed that applicants' attorneys, by their actions, prevent injured workers from returning to sustained employment:

" . . . the [employee] that obtains an attorney, the ulterior motive there to drag out the TTD as long as possible? six, seven years?till push comes to shove, to vocational rehab, interruption of voc rehab three to four different times. And that person . . . (A) does not come back to the original employer, (B) very rarely ever does get a real, normal job again." ? management representative

f. Treating Physicians' Motives and Actions

Claims administrator and management representative participants believed that worker-selected treating physicians try to please workers who want to stay off work in order keep the worker coming back as a patient:

" . . . family practice doctors. . . . they have a different relationship to the injured worker, and some of them, how do I say this, don?t often have backbone. If the injured worker wants to be off for a couple of weeks for other reasons, they are going to accommodate that. And they will kind of sign off on what the injured worker wants versus talking about return-to-work. . . . It? s a relationship-based issue and how the doctor works with his patients." ? claims administrator

Claims administrator and management representative participants believed that attorney-selected treating physicians try to please the attorney in order to get more referrals from the attorney:[17]

[17]Claims administrator and management representative participants felt that although the financial motivation of physicians selected by injured workers or attorneys is inappropriate, financial incentives for employer-selected physicians are appropriate:

". . . I'd say those doctors that really feel that they have a vested interest in trying to help get this person back to work . . . are the ones that are probably going to facilitate . . . this person being back and being on the job for a longer period of time. . . . " ? claims administrator

"The employer is really the client of the occupational health clinic. . . . So they might have a contract and say, `We'll negotiate a special rate.' And then if . . . the clinic was having everyone off work, then [employer will] say, `You need to change. I'm not going to renew my contract, because you keep all my employees off work.'" ? claims administrator

" . . . if you are referred by the applicant's attorney to . . . be the treating physician or treating provider, you know what to write. You're in it for the money." ? management representative

" . . . sometimes a case will fall into litigation and the change in treating physician has another angle and that angle might be more geared towards the ultimate outcome of permanent disability. . . . Those docs typically are not very focused on return-to-work. . . . It's often the opposite." ? claims administrator

" . . . this little social circle of attorneys and physicians will get this employee coming back to this doctor. . . . the doctor and attorney are, I don't want to say in collusion, but in reality that's what it is. They can milk the system forever. The employee, in many cases, is basically innocent. Once they're into that system, the attorneys and doctors play them back and forth, and that person will be out there for five, six, seven years. . . . Meanwhile everyone else is getting rich." ? management representative

In contrast, union representative participants believed that employer-selected treating physicians try to please employers who want to avoid paying for temporary disability benefits while the worker is recovering:

" . . . that's the name of the game. Is that the employer's doctor? It's not the employee's doctor, it's the employer's doctor, and their goal is, regardless of how badly they're injured, if they can walk out of that doctor's office, they can go back to work and perform some duty, no matter how demeaning it may be. . . . " ? union representative

"There are employer doctors who'll send somebody back with a crutch to climb a ladder. I have seen it. I can give you any number of examples of folks being sent back to work too early."
? union representative

One union representative participant felt that employer-selected physicians, by their actions, cause workers' injuries to worsen:

"Nothing is worse than sending a worker back to work when they're not fully healed, fully cleared. Invariably there's going to be a reinjury. I've just seen that repeatedly. . . . I've seen it too often."
? union representative

Health care provider participants believed that a particular health maintenance organization is only concerned about pleasing the employers that it contracts with for treatment of nonoccupational injuries and illnesses, and is not very concerned about the wellbeing of occupationally injured workers:

"[HMO] is obscene [in] workers' comp. . . . as a health provider.

[HMO]?who do they contract with? Their money doesn't come from their patients. . . . They are abusive to people that come in with psychological workers' comp injuries. . . . It's incredible. . . . I see the people?the occ med guy won't give them any time off work. And they will never give them any mental health treatment. And it's very clear who they are concerned about." ? health care provider

g. Rehabilitation Counselors' Motives and Actions

Injured worker participants believed that rehabilitation counselors try to please the claims administrators who select them, rather than really help the injured worker:

" . . . voc rehab counselors [could advocate for us] if they were not allowed to get their clients from the insurance companies."
? injured worker

"The voc rehab . . . they seem like they didn't want to help me too much, and so it was like, okay, they're going to get a large sum of my money. . . . I had seen how much that they didn't do, and I still had to pay for it, I was like, `I got taken in!'" ? injured worker

2. The Imbalance of Power Against the Injured Worker

Injured worker, union representative, and health care provider participants felt that the system as a whole is unfair to injured workers:

> *"Everybody gets a little chunk of the pie except us. . . . we have a little mafia here. It's all connected, and the only person who is alone is the worker."* ? injured worker

> *" . . . if the power balance was more equal. . . . the power balance is not? the injured worker goes into this company system and just gets swallowed up."* ? union representative

> *" . . . the system . . . it's entrenched and defended with big guns."* ? health care provider

> *"I think there's a process . . . that actually impedes healing and return to work. . . . There's kind of a victimization process . . . and it's just a matter of who's encouraging the process. You can have a workers' comp attorney who will encourage you to be a victim. Your employer, by pushing too hard, is encouraging you to feel victimized. . . . there needs to be a balance of power. . . . when you're the sick person, and `All these people are coming at me and I don't know what the process is and no one is trying to help me,' you're making the person more ill. You're impeding the return-to-work process by doing this."*
> ? union representative

Injured worker, union representative, and health care provider participants felt that some employers do not respect or care about their injured employees and that they have the power to get rid of these employees rather than accommodate them:[18]

> *"Their attitude is, `Everything for management. Death to workers.' . . . Basically, their attitude is that we don't have to do anything?make us."*
> ? injured worker

> *"The only thing that causes them to accommodate is respect and concern. There's no profit in that."* ? injured worker

> *"I have so many workers that come to me and say, `I've worked for 30*

[18]In contrast, one participant felt that most employers want to retain their injured employees:

> *"I do find that most employers are not there to hurt their employees, that they really want to have an employee come back to work. I've never known an employer who says, `I'm going to hurt this person on purpose.' But they try really hard to bring them back to work. . . ."* ? claims administrator

years for this [employer]. I'm injured. I can no longer go back and do my job.' And I have to say, `And they don't owe you a goddamn thing.' . . . There's something?and I agree with the workers?there's something wrong with that. You have no responsibility as an employer. . . . I really empathize with workers. . . . it's just not fair."
? union representative

"Some employers' paradigm is that any injured worker is a liability . . . `We don't want them back.'" ? health care provider

3. Complexities, Conflicts, and Disputes

Claims administrator participants felt that complexities in the system foster distrust and hostility, which hinder return-to-work efforts:

"No one's trusting anyone, because it has become a very complicated, litigious system, and therefore, the injured worker hires an attorney because he thinks he has to. Well, the attorney never really has time to talk to him, so he never really gets an understanding of what's going on. Then, he starts getting all these benefit notices that sound very legalistic, and scare him half to death, and he's getting one a day practically. He doesn't know what that's about. So, he starts getting angry. He gets angry at the claims administrator, he starts getting angry at his employer, . . . so it's a very complicated, complex system." ? claims administrator

Management representative participants felt that because of the complexity of the system, return-to-work gets forgotten by everyone:

" . . . it's become too complicated, all this grandfathering in: `Well, if the injury occurred in '92 or before, and if it's '93, then in '96 we go this way. . . . " "I think it gets so complex that return-to-work gets forgotten." "It gets forgotten by everyone."
? management representatives

Management representative participants felt that methods for rating permanent disabilities contribute to disputes, which hinder return-to-work efforts:

" . . . My estimate says that we think this claim is worth $8,000 or $9,000 dollars, using the rotten system that we got, I believe that it's worth $8,000 or $9,000. And you can get that and we? re back to work and we're going down the road. And you get an attorney who now, because we have a system that is so badly flawed that they can say, `Oh no, we can get you $45,000.' The difference between $8,000 and $45,000?no system, no injury should be that far apart in rate. No injury." ? management representative

A health care provider participant felt that when a claim becomes adversarial, the relationship between employer and employee is cut off:

> *" . . . once it's an adversarial relationship . . . It becomes a match between the applicants' attorney and the defense attorney to line up the doctors' reports. . . . it cuts off relationships between the employer and patient, because the employer is told, `You don't contact the employee once he's got an attorney, you contact the attorney.' The employee says, `They don't care about me anymore.'"* ? health care provider

B. Views Regarding Practices and Programs of Treating Physicians, Employers, and Claims Administrators

In the focus groups, the injured worker, claims administrator, union representative, and management representative participants were asked to describe actions of treating physicians, employers, and claims administrators that they believe affect whether an injured worker will return to sustained employment. The term "treating physician" was defined as the doctor who was either designated by the injured worker prior to injury or selected by the employer, the claims administrator, the injured worker, or the worker's attorney after injury. The term "employer" was defined as the person or persons in management who are in a position to offer or assign work that an injured worker can do safely, and who supervise the work. The term "claims administrator" was defined as persons who handle workers' compensation claims for employers, either in-house, through an insurance company, through a third-party administrator, or through a joint powers authority.

The health care provider participants were asked to describe important factors that they believe affect whether an injured worker will return to sustained employment. They were also asked to describe what information and other input they find to be relevant and useful in determining: (1) when a worker can or should return to work; and (2) appropriate work restrictions.

1. Treating Physicians' Practices

Many of the participants believed that to be able to help injured workers return to sustained employment, treating physicians need to understand the workers' compensation system.

In addition, participants in all five groups believed that it is important for treating physicians to truly listen and communicate, but views differed widely as to whom the physician should work with or believe? the injured worker on the one hand, or the employer or claims administrator on the other:

? Injured worker and health care provider participants felt that correct diagnosis and proper treatment are essential to helping injured workers return to sustained employment, and some of these participants said that the treating physician must listen to the injured worker and believe the worker's reports of pain in order to arrive at a

correct diagnosis. Injured worker participants therefore felt that the physicians whom they or their attorneys selected were more effective in treating the workers' injuries than the physicians selected by their employer or claims administrator. In contrast, management representative participants felt that treating physicians should not always believe injured workers' reports of pain.

? Claims administrator and management representative participants felt that treating physicians should actively work with the employer or claims administrator to return the injured worker to work as soon as medically possible. In contrast, union representatives felt that when treating physicians allow themselves to be influenced the employer, the injured worker loses trust in the physician.

a. Understanding the Workers' Compensation System

Claims administrator, union representative, and management representative participants felt that it is important that treating physicians have an in-depth understanding of the workers' compensation system to be able to write useful medical reports and formulate clear and specific work restrictions:

> *" . . . I think many times the physician impedes the employee's progress and income and a whole lot of other things, because they don't know. . . . in many cases . . . our third party administrator?they have a terrible time getting the reports out of them, because they don't understand what's required."* ? management representative

> *"It's clearly going to depend upon the treating physician, and how educated they are in workers' comp and return-to-work issues. . . . as educated as the physicians are, sometimes they forget that if they are treating [in] occupational medicine, they need some kind of training . . . that teaches them when you're speaking to . . . a claims administrator or insurance carrier, that you're very specific as to what the work restrictions are."* ? claims administrator

b. Communicating with the Injured Worker

Injured worker, union representative, and health care provider participants discussed the importance of the treating physician listening to the injured worker to arrive at a proper diagnosis, establishing rapport and trust with the injured worker, and educating the worker about his or her injury and aspects of returning to work. Participants in the five groups differed, however, as to whether the treating physician should believe the worker's reports of pain and consider the worker's concerns or preferences about staying off work.

(1) Listening to the Injured Worker

Health care provider participants emphasized that is important for the treating physician to listen to the injured worker, both to establish trust and to determine how to treat the worker's injury:

> *" . . . be a doctor first, and examine the patient. Try and listen to what the patient is saying and find a reason for their problem. . . . "* ? health care provider

> *" . . . you listen with your ears and your body language, if you stay out of people's way, they have a huge amount of information relative to all the things that we need to know about them. Often when I'm working with the residents, and physicians, they're trained to obtain histories by asking pointed questions where they get . . . trapped into asking pointed questions early, and absolutely block the information that would flow to them naturally if they had just shut up. So, first visit, to establish trust and a relationship wanting to be a partner in this individual's recovery. I find that the best way, to shut up and listen to them, and a lot of stuff will come out of them. They'll tell you what they need, what they want, what they are afraid of."* ? health care provider

One health care provider participant observed that physicians' failure to listen to injured workers frequently generates dissatisfaction with medical treatment:

> *"I see a lot of people who have seen five doctors prior, and most prominent, single complaint that they voice about their prior medical treatment is `They didn't listen to me. They didn't listen to my complaints.'"* ? health care provider

Injured worker participants felt that it was important that their treating physicians believed their reports of pain and other experiences with their injuries:

> *" . . . the best thing my treating physician has done, and he was appointed by my attorney, was primarily that he believed me and takes my injury seriously. . . . "* ? injured worker

In contrast, management representative participants felt that treating physicians should not

always believe what injured workers say about the pain they are experiencing:

> *"I've spoken with . . . a lot of good treating physicians. . . . They trust that . . . on a scale of one-to-ten, when the patient says nine-and-a-half, that they're really in that much pain. Even though, from objective standards, they couldn't possibly be at a nine-and-a-half, because they'd be passed out."* ? management representative

> *" . . . a treating physician . . . is more prone to accept . . . whatever you say you are, `I hurt, my back hurts,' you know. They don't worry too much about trying to determine objectively whether that's true or not. They will simply write down, `Back hurts.'"*
> ? management representative

Injured worker and health care provider participants felt that it is important for the treating physician to be responsive to injured workers' needs and preferences in understanding their injuries and seeking alternative treatments:

> *"I will ask people, `What is it that you need done or need to know to feel settled about your injury?' And it's amazing how many times . . . [other physicians] haven't done the right test. They haven't done the one test that the patient is still concerned about. . . . it is going back to listening to the patient very carefully. Not going into doctor mode, or, `With this injury, I do that.'"* ? health care provider

> *"I went to a self-selected doctor, and the most important thing he did was he allowed me to seek out therapy that I felt was beneficial, which really improved my physical state and . . . allowed me to get to the point where I could start to even think about returning to work. . . . It also made me more proactive in terms of finding my own cures, because there was someone I would go to who would listen to me and prescribe whatever I said was working."* ? injured worker

Injured worker, union representative, and health care provider participants felt that it is important for the treating physician to respect injured workers' concerns and preferences about staying off work, returning to modified-duty work, or finding another job:

> *" . . . he decided to send me back four hours a day . . . and I think that was really important because I really had no idea what I could or could not do at that point, and he was very receptive to my feedback. . . . He was very open."* ? injured worker

> *" . . . the decision to return to work is a medical decision. But the employee has a say in it, you know. It's between you and your doctor. Do not let your employer make or influence that decision."*
> ? union representative

" . . . the information relative to return-to-work is very, very straightforward, and that is, I ask, `Do you want to return to this job?' That's what I ask people, early on, and most especially if progress seems to be slow. . . . And when the answer comes back, `No, I really don't,' then I don't bother anymore attempting to liaison with the employer or whatever. I say, `Listen, let's get you into voc rehab, and be done with this,' and we don't go into a repeated return-to-work, fail, return-to-work, fail cycle."
? health care provider

In contrast, a claims administrator participant felt that the treating physician should not always accommodate an injured worker's preference to stay off work:

" . . . family practice doctors . . . If the injured worker wants to be off for a couple of weeks for other reasons, they are going to accommodate that. And they will kind of sign off on what the injured worker wants versus talking about return-to-work." ? claims administrator

(2) Informing and Educating the Injured Worker

An injured worker participant felt that the most important thing her treating physician did that will help her return to work was to educate her about her injury:

" . . . the doctor I got from my attorney . . . the most important thing he did was really educate me about my injury, and gave me a lot of information that all turned out to be true. . . . I have a good understanding of what's going on and how easy it is to get reinjured, and I am able to think of some realistic ideas for the future."
? injured worker

A claims administrator participant emphasized that physicians should educate patients as to when it is safe to return to work, even while still experiencing some pain:

"I think the physician needs to have discussions with the patient . . . letting them know that they may experience some pain, but it's nothing to be concerned about. That they can still continue to do the modified duties. . . . Years ago, I had a patient that had continuously tried to go back to work. . . . until he changed physicians, and the physician sat down him and actually had a discussion with him about certain pain that he might be experiencing that didn't mean it was going to be injuring himself, [so] he remained at work. All of the fear of . . . feeling pain was because he felt that he was causing further injury and he really wasn't." ? claims administrator

Claims administrator, management representative, and health care provider participants felt that it is important that treating physicians educate injured workers about the return-to-work process and the advantages of returning to work:

" . . . he has a very good bedside manner, and he doesn't kind of feed into that `poor me' kind of thing with the patient. He tells them . . . you know, gives them a little kind of a pep talk about trying to encourage them back to work. . . ." ? claim administrator

" . . . I do education, information. . . . I talk to my patients. `You're not going to get a better job than this." ? health care provider

" . . . the doctors I have seen successful are the ones who are . . . communicating to those injured employees that they want to help them use the workplace as part of the treatment. . . . really working with the thought that using your work duties as part of your medical treatment and explaining that to the employee." ? claims administrator

(3) Establishing Trust with the Injured Worker

Union representative participants emphasized that trust between the injured worker and treating physician is essential for successful treatment, recovery, and return-to-work:

" . . . I always ask . . . `How do you feel about your relationship?' . . . I think that's more important than if they were the best doctor in the world and you just felt terrible every time you went in there."
? union representative

" . . . if you feel like your treating physician is a traitor, you don't want to practice the treatment that he advises you, because you have lost confidence in that person, and you don't really want to go see them."
? union representative

c. Communicating with the Employer and the Claims Administrator

Management representative and claims administrator participants discussed the importance of the treating physician working closely with employers and claims administrators to ensure that injured workers return to work as soon as medically possible, because this enables the physician to formulate specific and realistic work restrictions based on available jobs. In contrast, union representatives objected strongly to treating physicians allowing themselves to be influenced by employers or claims administrators in determining when an injured worker can return to work.

(1) Learning About the Workplace

Claims administrator, union representative, and management representative participants felt that to be able to write specific and realistic work restrictions, the treating physician must understand the physical requirements of the injured worker's regular job and other available jobs. To acquire this knowledge, some treating physicians visit the work environment or review job descriptions,

photographs, or videotapes of jobs being performed. Management representative participants also felt that the treating physician must understand employers' policies on return-to-work and programs to prevent further injury or disability, and must be willing to meet and communicate with the employer about methods to help injured workers return to work:

> *" . . . treating doctors who are successful [with return-to-work] . . . understand the workplace the injured worker is coming back to. And some of the most successful programs are programs where the employers and the treating doctors, ahead of time, know each other and work together, and the doctors will often go into the workplace and observe the work being done so that they understand the jobs there, the physical requirements of the job. . . . There are ways of getting it done other than having the doctor physically traveling to the workplace. A lot of employers videotape their jobs, so they can show a videotape and a detailed job description to the doctor. Hopefully the doctor can then take time to sit down and look at that tape and go over it and study it."*
> ? claims administrator

> *" . . . when I pick these physicians, it's a requirement that they come to the facility, that they see each of these jobs. I also give them job descriptions. . . . so he knows what is involved with these positions. And so that helps him to give a very realistic set of restrictions. . . . And also too at the occ med clinic, the physical therapist . . . comes over once a quarter, and she'll take a series of digital photographs of the different jobs and the facilities as people are going through their motions. So she also has a really good idea of what the person does and what that person's limitations are. So we don't have to follow this long laundry list of restrictions like, `limited to no more lifting than one pound,' you know."* ? management representative

> *"[It is essential] that they will talk with us, that they'll communicate with . . . our case managers, that we can communicate with them . . . [and] get them on the phone. We talk about our return-to-work policy. We show them the environment. We talk about our preventative programs. We have a pretty aggressive ergonomics program we show them. We talk about what the process is, what the employees have available. So we really try to get them to understand how we approach*

it always, so that even when we're calling to question, they understand why we're doing it." ? management representative

(2) Determining When an Injured Worker Can Return to Work

Claims administrator participants felt that it is important that treating physicians be willing to speak with them or with their case managers about individual cases and be open to considering methods to shorten an injured worker's time off work:

"Some doctors are very accommodating or work very well with [our nurse case managers]. . . . I think once . . . the communication is established, reasonable people can work out the issues."
? claims administrator

" . . . our nurse case managers or return-to-work coordinators . . . have a pretty good . . . success rate . . . getting the doctor to say, `You know, maybe this person should do that job.'" ? claims administrator

In contrast, union representative participants felt that treating physicians should not allow themselves to be influenced by employers or claims administrators in their medical determinations of when an injured worker can return to work:

" . . . something I would like to see more often, and that's the physician holding up to their original position under employer inquiry. And what I mean by that is the treating physician will say . . . the person is not able to return to work for six weeks. And then the company will call and question the physician in minute detail, `Can they sit? Can they stand? Can they raise their arms? Can they . . . ?' . . . until it comes out that, `Yes, the employee can go back to work because they can do these things.' . . . they cower under that, for whatever reason."
? union representative

" . . . the decision to return to work is a medical decision. But the employee has a say in it, you know. It's between you and your doctor. Do not let your employer make or influence that decision. That is a medical decision. No one else can make it." ? union representative

" . . . it compromises the employee's health and healing to sabotage their relationship with the doctor. So if that has happened, if the treating physician has said, `You'll be out for six weeks,' and the employee left the doctor with that understanding, the employer in the meantime contacts the treating physician and reverses that position. . . . You poison that relationship, and it is then appropriate for the employee to have a new physician, because how are they going to have trust in how they're being treated when that goes on?" ? union representative

A health care provider participant who is a treating physician in workers' compensation said that he would like to work with employers to help injured workers return to work as soon as medically possible:

> *"I would love to hear from the employer. . . . I think I could do some education there and facilitate a return-to-work if I could tell the relevant supervisor what the situation is. . . . "* ? health care provider

2. Employers' Policies and Programs

Claims administrator and management representative participants described employers' policies and programs that they believed to be effective in helping injured workers return to work. However, often these policies and programs are not implemented, according to many participants in the five focus groups. Some claims administrator and management representative participants described methods that have been used to overcome certain problems.

a. Policies and Programs Regarded As Desirable

Management representative and claims administrator participants identified features of programs that they regarded as successful. Almost all of the management representative participants were from large companies or governmental entities, and one of the participants pointed out that the others in the group were from the "Cadillacs" of return-to-work programs. Claims administrator and management representative participants acknowledged that the policies and programs that were described in their sessions would be difficult for smaller employers to implement.

(1) Design of Programs To Help Ensure Transitional or Permanent Return-to-Work

Claims administrator participants favored proactive return-to-work programs with clear, written policies stating that injured employees are expected to return to work as early as medically possible:

> *". . . we suggest to our employers that they include return-to-work as a policy in their employee-benefits package, so that the employee knows before they ever sustain an industrial injury, this is a benefit that you're going to get from this employer, and at this place of employment. That if they should sustain a work injury, that employer is going to make every effort to bring them back to work, so they enjoy the benefits of being in the workplace."* ? claims administrator

" . . . if the employer has a written policy, so that all the employees know ahead of time that there is that expectation that they will be coming back. . . . Part of the supervisor's written responsibility is to sit down with the employee. It's the employee's responsibility to come back from the doctor, either in person or by phone, so they can sit down and talk about what's going to happen from there."
? claims administrator

Management representative participants felt that successful return-to-work programs require careful selection and ongoing education of treating physicians:

"We're constantly re-evaluating [treating physicians], and trying to look for more. . . . We talk about our return-to-work policy. We show them the environment. We talk about our preventative programs. We have a pretty aggressive ergonomics program we show them. We talk about what the process is, what the employees have available. . . . "
? management representative

"We've started having with our physicians and physical therapy do what we call a `grand round.' And we sit down quarterly with the doctors, we pick specific cases, no names. I get up . . . and give a scenario. And then the doctor says, `Here's what we would do under this given scenario.' And the PT comes in and says, `This is what we would do under that same scenario' . . . It gives us a better idea of what the doc is thinking. It also gives us an idea what physical therapy is thinking. And they find out what we are thinking and what we need, to provide the injured worker to go back to work." ? management representative

Management representative participants felt that successful return-to-work programs also require careful selection of claims administrators:

" . . . during our contract negotiations. The insurance carrier has to understand that our philosophy is that we will take care of our employees." ? management representative

"Really, viewing your third-party administrators or your insurance partners as partners and working, really trying to help them understand what your approach is and working as a team. And I'm sure it's much easier if you're self-insured than if you're buying the insurance policy. . . . And we actually have had some forums where we brought our TPA onto the site . . . and talked about our return-to-work program and so forth, so that, again, it created that partnership instead of that adversarial, `It's that stupid insurance company bugging me, or not doing this, or doing that' . . . So again, just keep trying to get everybody with the same goal."
? management representative

A claims administrator participant from a self-insured, self-administered employer described an

in-house rehabilitation program and a preferential-placement program that offer permanent, alternate work to employees with permanent disabilities:

> *" . . . The other program that we do have is that we have a rehabilitation program. So we are assisting and trying to guide and actually coordinate the human resources and the department, just bringing people back to permanent, alternate work. . . . And then the last one, which we haven't had use of that much recently . . . it's like a preferential placement. . . . Employee of the company . . . can't be employed by their own department, but it looks like they had a good record, so we have a preferential placement program where we kind of do a search within the entire company. . . . [for] someone who can't go back to their regular line of work. And so we're looking for some other suitable, alternate, permanent employment."* ? claims administrator

(2) Coordination and Communication in Individual Cases

Claims administrator and management representative participants felt that it is important for employers to communicate with injured employees promptly, frequently, and respectfully in order to maintain the employment relationship and encourage the employees to return to work.

> *"Communicate, listen, and follow up. . . . with everyone involved. And that's where a lot of times is that the employer talks to the doctor, the employer talks to the insurance company, and they forget to talk to the most important person, and that's the injured worker."*
> ? claims administrator

> *"I think it helps too to explain to the employee immediately. Because they're hurt, and they don't know what's going to happen to their income or to their job or whatever. So I think if you've got that good relationship going with the employee, and you let them know, `This is how this works. So, we'll contact you, and you don't need to worry about your pay, because we're going to pay you for the end of the day, the day of the injury. And then within ten days you're going to get a check from [workers' compensation insurer]. This is how much they're going to pay you per day.' Just kind of take away some of the other worries that they have, and so that you're their friend. . . . It's no longer the animosity of the big bad employer and `You're the slug because you got hurt and you're probably faking it' kind of mentality. They understand that you do think they're credible and you're working with the doctor and you have some trust in the doctor, obviously. And that you're going to work with them, and that you miss them, you want them to come back to work. We have the supervisor call them at home and just check on them, see how they? re doing, say, `Hey, your buddies here miss you. How are you feeling?' Our workers' comp coordinator calls and says, `Are you getting everything you need? Have you received your first check? How did you feel about the*

doctor? Do you feel like this one is going to work for you? Do you need to see someone else?' We really try to be there for them, so that they want to come back to work early." ? management representative

" . . . communication is very important. You have to sit down with the employee and explain why this is good for him, why the employer is doing it for his benefit, what the expectation is, how long it is going to last, that we are going to be checking every week to see how you're doing, and if you see things that you can do within your restrictions, and you have ideas, share those with us, we'll work with you. You know, it's all that relationship thing." ? claims administrator

A management representative participant described activities of on-site coordinators who are responsible for handling all safety, medical treatment, and workers' compensation claims management issues for employees who are injured:

" . . . we have [the employees] present to the coordinator as soon as they're injured. She or he will refer them out to occupational medicine. They come back to that coordinator. The coordinator walks them through everything, does an investigation right on the scene with the supervisor, tries to find out if something has hurt them that we can fix, make sure that they are put in contact with our third-party administrator, and then tags when each appointment is so they have a diary system, follows when that appointment is, finds out why the doctor hasn't referred, or if they have referred, why it's taking four or five weeks to get out to a doctor. . . . this person is responsible for working with the claims management, as well as the employee. They work with safety. In fact, they're a part of the safety committee. They actually go out and do investigations in the department. They're required to have training classes and teach managers and supervisors how to handle injured workers." ? management representative

Management representative and claims administrator participants felt that it is important that employers give job descriptions to treating physicians (including videotapes and photographs in some cases) and work closely with the physicians to identify jobs that the injured worker can do:

" . . . In our organization. . . . there's information that we automatically send to the treating physician. Our goal is to send it before they're actually seen for the first time, explaining what types of alternative work or light duty we have available, what the time frames, what the hours are, and what the actual physical abilities of this modified job is, directly to doctor before the patient is even seen."
? management representative

"We . . . are doing a representative job analysis for each position, based on each facility, so that when there is an injured worker, we can send that to the treating physician."
? management representative

"One of the things that I've seen employers do . . . is that if someone is injured on the job, the supervisor actually drives them to the occupational clinic. That way they can have a face-to-face discussion right then with the doc about what's going on with this guy medically, what kind of duties they might be able to do right away, so that there is never lost time. . . . Another way to handle it . . . is a relationship with the clinic that the employer has, so instead of person-to-person, they can do it by phone, or by fax, or the other ways of communicating.
. . . " ? claims administrator

"I . . . have clients who have occupational health clinics in-house, that stay on top of the physicians. . . . to write down restrictions. And they even call the physician, if they don't quite understand the restrictions, they will call the physician to find out . . . the specifics about it." ? claims administrator

Management representative participants felt that it is important for employers to actively oversee the handling of workers' compensation claims by claims administrators, to ensure appropriate medical treatment and return-to-work.

"We have quarterly claims reviews. . . . And the claims review people . . . will come and we sit in a big room, and we bring in the department head from production who has those employees. So they understand what restrictions they've had. . . . So you get information going two ways, between the supervisors and the administrators. But then we also get to hear information about what they've done, what is this doctor saying, what's the next step. `Is this person going to have back surgery?' Or, `How are they healing from that surgery?' Or, `What steps have been taken? What kind of PT are they going through?' But we actually discuss in detail those claims and we come up with a strategy . . . `What are we going to do about this one? Can they do that kind of work?'. . . And we can say, `Why haven't you sent them a check?' Or, `Why are they still with this doctor, when obviously it isn't doing any good?' Why don't you refer them to a specialist?' And so we can kind of force the issue, because the insurance company obviously wants to save money. . . . " ? management representative

b. Problems and Challenges

Participants in the five focus groups identified problems and challenges in implementing programs in the workplace to help injured workers return to work. These included refusal by some employers to provide necessary accommodations and lack of knowledge about how to deal with work injuries.

(1) Lack of Necessary Accommodations While Recovering

Injured worker, claims administrator, and health care provider participants said that often employers will not provide necessary accommodations because they do not want the injured employee to return to work until the employee is fully healed:

> *"I was told they had a policy of light-duty return-to-work as soon as possible. But my superintendent refused to abide by that, so I could not go back to work until I was 100 percent capable of doing the job."* ? injured worker

> *"The employers in our area are for the most part unwilling to provide the limited or modified work environment for injured workers. They would much rather have them return to full duty at a much later period than to modify duty at a variable period. Unfortunately, as everyone knows, the longer a worker stays out of work, the lower the chance of his returning to work becomes, and so from my point of view, it is the unavailability, virtually complete unavailability of real, modified work."* ? health care provider

> *"I have patients who have been working with me for two years. . . . They are now 80 percent relieved of their pain . . . if they could work in some capacity that would allow them to continue to progress . . . but the system doesn't allow that, because the system says you either come back because you're normal, or you can't come back. . . . "*
> ? health care provider

Injured worker and health care provider participants said that sometimes supervisors require injured workers to work while recovering, but without the accommodations needed to prevent further injury:

> *" . . . there are policies in place to try to prevent injuries as far as making workstations ergonomic . . . but . . . in my department I was ordered to return to work. No accommodations were made for me. . . . I was offered two months and then ordered to return to work against my doctor's wishes. . . . "* ? injured worker

" . . . The belief of the employer may not go all the way down to the supervisor. The employer might want them back, and the supervisor wants them to do their old job, and . . . depending on the power of the employee, sometimes they are bullied into doing their old job and their injury actually advances rather than improves." ? health care provider

" . . . In the once-in-a-while situation, where I can get an employer to return a worker to a modified job, half the time it turns out to be the original job in disguise. Which is to say, there is modified work, but go back and do all the things you did before." ? health care provider

Injured worker and health care provider participants said that refusal to provide necessary accommodations was sometimes caused by the employer's inflexible view of either company rules or workers' compensation laws.

" . . . on paper, said that they were willing to accommodate me and abide by the doctor's orders, but in reality, they didn't. . . . I had seniority to transfer to those positions. So I asked for a transfer, but was not transferred. They said to me, `This is the only thing we have for you. You either make it, or you don't.'" ? injured worker

"A voice-activated system was recommended for me . . . even by the company doctors that I was sent to. It was actually 12 months before I heard anything from my supervisor. . . . I kept asking and she finally said, `Well, I've got an answer from management. They say it's too expensive.' I said . . . I would buy it. And it took about another three months to finally get an answer and say, `Well, maybe we're willing to consider you as a pilot project.' They thought, without even researching it, they thought it was too expensive. And their fear was that, according to my supervisor, `If we do it for you, we're going to have to do it for other injured [employees].'" ? injured worker

"I had a [patient] . . . who had [medical condition] which made it clearly painful for this lady to carry a shoulder bag. You know, shoulder bags can be full . . . and weigh quite a bit. . . . So I made a modest suggestion that . . . they give her one of these little carts, okay? `Absolutely no,' the employer said. `That's not the way we do it here.' Okay, you know what? She was out a year-and-a-half. That lady could have been back to work literally within a month or so with a cart, but, `No, we can't do that.'" ? health care provider

"It may take months to get an employer simply to modify the workstation or even to allow the employee to modify the workstation. There is a lot rigidity in the workplace with regard to anyone who requires . . . just a reasonable accommodation, just ordinary courtesy in terms of making their job something that they can continue to do. This I run into all the time. . . ." ? health care provider

Injured worker, claims administrator, and union representative participants said that in some cases, refusal to provide necessary accommodations seemed to be caused by a lack of financial or legal incentives.

> *" . . . [employer] has treated me as disposable, partially because my time off hasn't come out of their budget, it comes out of their insurance company's budget. . . . Though they promised to talk about the voice-activated software that he had prescribed . . . their official word was that they're not going to buy it for me until I'm permanent & stationary, which means if I reach eight hours without needing it, they won't feel a need to buy it. After I re-injured myself, then they didn't have to buy it either."* ? injured worker

> *" . . . with [employer] . . . workers' comp comes out of one pot of money, and money to say, buy the ergonomic equipment to prevent ergonomic injuries comes out of another pot. . . . financial incentives to basically ignore early problems."* ? union representative

> *" . . . when the market became so competitive, and the rates fell so far . . . it was like they were almost getting insurance for free . . . and it was much more challenging to get . . . upper management to put financial resources in return-to-work, because it wasn't costing them very much money for insurance. . . . They were just transferring it to the carriers. . . . "* ? claims administrator

> *"I . . . bought [voice-activated software] . . . but they're not letting me use it. . . . they don't believe they're legally required to, and that is the end of the story for now."* ? injured worker

One injured worker participant said that work flow was not coordinated at her company, causing her to be assigned too much work, in conflict with work restrictions for her injury:

> *" . . . I went back to work . . . four hours a day, three times a week. . . . each project is handled by multiple project managers, so at any given time you have the equivalent of five bosses, and so they say, `Oh, we have deadline to make. Can you do this? . . . We need this out tomorrow. Can you stay for 10 hours?' . . . you just can't schedule it because . . . you're following five people's different schedules and they change all the time."* ? injured worker

One union representative participant said that the human resources department of a particular company will promise to provide the accommodations that are needed to allow an injured worker to return to work, but that this promise will not be carried out in the workplace:

> *" . . . one thing I've seen happen a lot is that promises made in the return-to-work negotiation are not kept. . . . the promises are being made by a group of people who have absolutely no impact to what happens in the workplace. . . . the HR department is completely separate from the workplace. . . . saying to the doctor and the employee that certain things, you know, will happen when they return to work, and those things do not happen. . . . there has been no agreement in the return-to-work group that that would happen."* ? union representative

(2) Lack of Permanent, Alternate Work

Claims administrator and union representative participants said that often employers will provide accommodations temporarily but not on a permanent basis, apparently because of concern about liability under the federal Americans With Disabilities Act:

> *" . . . with the advent of ADA, if you keep [an injured employee] too long, employers are stuck with that employee. So oftentimes . . . they can accommodate on a temporary basis. . . . if they keep them there for a year and then they say they can't accommodate any longer . . . then the employees turn it around and sue them under ADA." "That's why . . . we're encouraging [our employers] to put it into the policies. . . . that . . . transitional work will last 30 to 60 days, with review every 30 days, no more than 90, and then the idea of looking from that point at permanent accommodation."* ? claims administrators

> *" . . . in [employer], they started drafting very specific light-duty or return-to-work policies that. . . . don't provide any permanent solution. They're all limited. . . . the employer was sort of forced into a situation where they had to adopt a policy which I think was a defense to, `If you accommodate therefore you're obligated further to accommodate.'"*
> ? union representative

(3) Employer Not Contacting the Treating Physician

One health care provider participant who is a treating physician in workers' compensation, and who is usually selected by applicants' attorneys, said that he would like to work with employers to help injured workers return to work, but that employers never contact him:

> *" . . . I never hear from the employer. And the relevant person in the employer's organization is the person who has decision-making authority with regard to that patient's job. Now, that may be the immediate supervisor, or the division manager, or whomever, but I never hear from*

them. . . . I don't even know most of the time who it is. . . . " ? health care provider

(4) Workers Being Discouraged from Reporting Injuries

Injured worker, union representative, and health care provider participants described problems with workers being discouraged from reporting their injuries. These workers then sustain more serious injuries than if they had received prompt medical treatment, thus causing greater difficulties in returning to work:

" . . . [manager] went on to say that he didn't feel we needed to report all our work injuries. . . . he was like, `You can go home. You take care of yourself.'" ? injured worker

" . . . when I talk to workers, especially ones that have the more serious injuries. . . . we ask them . . . `Well, could you have gone to medical earlier?' . . . And a lot of them will tell you the same thing?that it's management pressures to not go to medical. . . . "
? union representative

" . . . people are returning to work with low-grade symptomology that's never a big blip on the radar screen. And the injured worker tends to just say, `Well, I'll just tough it out.' The employer doesn't know about it, doesn't want to know about it, because it means more accommodation, and that stuff builds up, and in these high-tech workers, after two or three years of this?boom! They're injured again. And their prospects after that, after their second or third injury are much less favorable." ? health care provider

(5) Discrimination in Employment

Injured worker and union representative participants described experiences with discriminatory treatment or termination of a worker's job after the worker was injured:

" . . . a lot of construction employers . . . will do really everything from just laying the person off as soon as they get injured, right there on the spot. Sometimes they refuse to provide them with the forms, claim they don't have any to give them to fill out, or tell them to come back and fill it out later and they don't allow them to. They . . . immediately

question the validity of the injury. . . . just incredible abuse."
? union representative

(6) Conflictual Relationships Between Employer and Employee

Health care provider participants discussed how conflictual relationships, either before or after a job injury, reduce the likelihood that an injured worker will return to the same place of employment:

" . . . a lot of times there are just interpersonal conflicts that are so awful that people can't go back to work where they were. That's just impossible. And, for example, someone successfully harassed somebody and they are never going to be able to work under that person again. And commonly there lacks a mechanism within the job to be sure that a person has been given a fair chance to succeed. And . . . I think that oftentimes there is a fuzzy system of generating written performance evaluations leading to termination, but it leads to a kind of interpersonal conflict that gets so intense, that between that person A and that person B, it's never going to be fixed. And that is related to physical things too. Like you see a guy who was physically injured in a situation where he told the supervisor five times about a dangerous piece of equipment, then he's never going to work at that place again, comfortably. And I see that a lot of times, and that's not addressed. And a lot of the people that continue to have ongoing muscular tension and pain that should have gone away because the orthopedic injury seemingly should have resolved, it's that stuff that exists, and until that's addressed, they're not going back." ? health care provider

(7) Influence Over Types of Medical Treatment

A union representative participant felt that a particular employer exerted excessive, inappropriate influence over the particular types of medical treatment given to injured employees:

"There's all kinds of natural healing, acupuncture, and so forth. And I don't see those acknowledged as a form of treatment. . . . With our HR department. . . . They pressure workers? you have to be receiving treatment for this injury, and . . . they have a very limited view of what they consider treatment. . . . If I go out on disability, it's up to the company if they're going to pay me their portion or not. . . . depending on how they deem, you know? `Have I been good? Am I good? Am I having surgery? Do I have an appropriate illness that they recognize? Did they see blood?'" ? union representative

(8) Lack of Knowledge About How To Deal with Work Injuries

Injured worker and management representative participants felt that employers often do not know how to deal with work injuries. Some felt that smaller employers face difficulties in learning about their obligations and about basic steps to take when an employee is injured:

> *"When . . . I was reinjured on the job, they didn't even have ice bags, and I was in pain laying there, and they didn't know what to do, and then when I went to the emergency office . . . they didn't call a cab, they didn't call paramedics, they had me walk there. My thing is with that company is that they're not educated people, in that area of workers' comp, and so they don't know anything about it."*
> ? injured worker

> *" . . . companies of our size can do these kinds of things and get that feedback, but if you've only got 25 employees?first of all, you've probably never met the person from the insurance carrier. . . . Don't even know what part of town the doctor lives in, or where his office is. That person is . . . just totally lost to the employer. And the employer probably doesn't get enough information back to even know whether you could bring him back to work or not. They don't know. It's zero information between the employer and either the employee, the doctor, or the insurance carrier. The little guys don't know. The information he gets is maybe a quarterly report from the carrier that says how many injuries he had."*
> ? management representative

> *" . . . a medium-sized employer, where the person is the HR, the safety and health, the finance guy?he's everything. . . . you've got to bring this program down to a level, where Joe Q Employer can utilize it."*
> ? management representative

(9) Finding Meaningful Work for Injured Workers

Claims administrator and union representative participants felt that work assigned to injured workers while recovering should be meaningful, but that this is not always possible:

> *" . . . not provide someone a task that is going to be embarrassing. In that situation in the sheet metal shop where this worker was used to lifting 150 pounds, or 100 pounds, and all of the sudden, he has a back injury, and he was unable to perform that activity, yet they're having him sweeping the floor. And his co-workers would come around and point the finger and giggling. . . . You can't do this. You can't demean someone like this. . . . they're a sheet metal worker, so maybe you can find him something in the inventory."* ? claims administrator

> *"The key is to try to provide meaningful work when they do come back to*

work . . . so it's substantive for that employee. The one thing that I do want to say is that sometimes there are restrictions, you may define what is meaningful, but the employee, may, because of his or her limited education, because of whatever their work history has been, it's like they're fish out of water, and so that's a factor that may influence whether that person is going to stay in their job or not, because he or she is no longer happy." ? claims administrator

In contrast, other participants pointed out that some employers try to assign transitional work that is not too comfortable, to avoid the employee wanting to keep the job permanently:

" . . . the attitude is still there, that yes, they're going to bring some people back that they don't want them to get too comfortable at. So, they're not going to sit there and think about whether what they're providing is demeaning or not. It's just that, you know, they're going to provide them with job duties that are expecting only to last for a short time, for a few days, and that should be the employee's expectation. And sometimes if they have a man who is used to working outside, and they bring him inside, well, the idea of that is well, if you bring him inside he doesn't want to be there, so he'll get back." ? claims administrator

(10) Co-Workers' Attitudes

Injured worker and claims administrator participants mentioned problems and concerns with resentment by co-workers when an injured worker returns to a modified-duty job:

" . . . I got injured. . . . I faced some problems with some other staff members in my unit. First of all, because . . . they don't know that the employer has to accommodate by law, and secondly, because they're not aware of repetitive strain injuries." ? injured worker

" . . . old-school thought process. . . . `If I bring this person back and they're only doing light-duty, all my other people over here who are working so hard, they're going to feel like he's getting preferential treatment, then they're going to get ticked off, and we're going to have some real problems.' That's a big issue." ? claims administrator

c. Methods Used To Overcome Problems

Several participants discussed their experiences with methods that they have used, or have seen used, to overcome some of the problems in implementing programs to help injured workers return to work.

(1) Education About the Return-To-Work Process

A claims administrator participant described educational approaches to overcome employers' reluctance to allowing an injured employee to return to work while recovering:

> *"We've seen it where the employers are concerned that the individual is going to come back and reinjure themselves. And so, pretty much it's just a lot of educating on our part, educate the employers that it is really in their best interest and their employees' best interest that this happen, but there's a big fear out there. And we've had some employers that have said we can't take them back unless they are 100 percent. . . . and that's pretty much when we jump into the loop and start having group gatherings. You know, sit-downs. The individual will sit down with the supervisor, and we'll just kind of talk about it, and it truly is just an education."* ? claims administrator

Another claims administrator participant described educational programs to avoid resentment by co-workers when an injured employee returns to a modified-duty job:

> *" . . . there's the element of when you do bring a person back to work . . . you are not just educating, in my case, the supervisor, and in your case the employer, you're also trying to educate the other employees. And that's something that we try to do so that they can understand what's going on. . . . We try to set up some strategy, maybe with the supervisor from the group, and try to make sure that they understand. Not necessarily that specific employee situation, but understand what the program is within the company."* ? claims administrator

(2) Financial Incentives To Reduce Time Off Work

Claims administrator participants described "charge back" mechanisms that motivate individual departments in a company to reduce temporary disability indemnity costs by reducing injured employees' time off work:

> *" . . . all the workers' compensation costs were not attributable to each department, so the company started to charge back to each department what the workers' compensation costs. They're self-insured, and the departments quickly started taking them back, and they would take them back. And actually, not only would they take them back, but their overall loss ratio decreased, because they did improvements to prevent injuries."*

? claims administrator

A management representative participant and a claims administrator participant from a self-insured, self-administered employer described how the workers' compensation departments of their companies pay the wages of injured workers who are assigned modified-duty jobs, to motivate the other departments to assign modified-duty work to injured employees:

> *" . . . all the cost of labor is attributable to that . . . product. . . . So the supervisor does not want half a person, because they're paying for a full person and only getting half-a-person. . . . So one of the things I did to overcome that is I now pay all the wages for all the people that are on modified work. . . . My budget. . . . the cost of the modified work is no longer attributed to the product that is going out. . . . So now they get a free half-a-person. And it's amazing how many modified-work positions suddenly became available."* ? management representative

A claims administrator participant described a system where individual supervisors are paid directly for reducing injured employees' time off work:

> *" . . . there is an incentive on the part of supervisor, to actually, to bring back an injured worker as soon as possible . . . [under a company program that allows them] to pad their pocket a little bit. . . . "* ? claims administrator

(3) Elimination of Incentives To Not Report Injuries

One union representative described a labor-management agreement to eliminate incentives for not reporting injuries:

> *" . . . we demanded . . . language that says there can be no incentives that revolve around not reporting legitimate injuries. And that's in our contract."* ? union representative

D. Claims Administrators' Programs

Claims administrator participants described features of their programs that they believed to be effective in helping injured workers return to work. However, participants in the other groups did not describe any particular programs of claims administrators that they regarded as beneficial. Injured worker and health care provider participants described

problems they have experienced with claims administrators delaying or denying authorization for necessary medical treatment.

a. Programs Regarded As Desirable

Claims administrator participants described programs and activities to educate employers and help them select treating physicians. They also described case management programs to handle certain kinds of claims.

(1) Educating and Guiding the Employer

Claims administrator participants described efforts to educate employers about the advantages of injured employees returning to work while recovering:

> *"We try to influence and basically from a business standpoint, that [early return-to-work] is in their best interest, and of all concerned. . . . that there is a business need and then there's the other human need in terms of being concerned for that employee."* ? claims administrator

Claims administrator participants also described efforts to guide employers to work with occupational medicine clinics and unions to facilitate early return-to-work:

> *" . . . Part of my role is educating the employers and establishing that relationship with the clinic. Either going to visit the clinic themselves, which I find helps with some of our smaller employers, and/or getting . . . the doctor out to see the site."* ? claims administrator

> *" . . . We've got to educate. . . . What we encourage our employers to do when they come up against a union contract renewal, try to insert something about return-to-work into the union contract. . . . If you can . . . show . . . all the benefits to their union employees, sometimes it will be more successful."* ? claims administrator

One claims administrator participant described efforts to guide employers on how to communicate with injured employees who will be working in modified-duty positions:

> *" . . . what we encourage the employer to do is . . . [sit] down with the injured worker, and sometimes if appropriate, even with the doctor there, or the nurse involved. . . . go over what the work restrictions are so that everyone's clear on what the limits are, and then go over the job duties or job tasks and how they are going to be applied, and then have a check-back system so, `How long are you going to be doing this before I'm going to check back to see how you're doing, see if you are improving or if there are any problems?' Be sure that there is a system in place if there are any problems . . . and immediately bringing those to light."* ? claims

administrator

Claims administrator participants described efforts to educate employers that workers' compensation should not be used to address personnel issues:

> *"Sometimes it's educating the employer to not use the workers' comp system to address their other personnel issues. . . . "*
> ? claims administrator

(2) Identifying Preferred Health Care Providers

Claims administrator participants described how carriers find and recommend effective health care providers and offer financial incentives to encourage employers to use those providers:

> *" . . . we work closely with [health maintenance organization], and we have preferred-provider clinics that end up signing a contract with [insurer] who meet certain criteria. . . . The employers get a 10 percent discount by bringing to use one of these clinics as their occupational clinic, and also, they have to provide a written return-to-work policy."* ? claims administrator

> *"We allow our customers to choose. . . . I think most carriers have a similar program, where they have choices and it's up to the employer to chose who they post. . . . so most carriers have contracts with different PPOs, and typically they encourage their customers to use those contracts because they get a better price."* ? claims administrator

(3) Managing Cases

Claims administrator participants described different case management programs in each of their companies. The different programs varied somewhat in their objectives and methods.

A claims administrator participant described one objective of case management to get the injured worker back to work immediately:

> *"We assign a disability management nurse to every lost-time case, and that nurse is making the calls on the first day. . . . trying to get the person back to work immediately . . . that's the goal. `What's the treatment plan if they can't go back to work, and how can we work towards that goal? Can we get them back today?' Start asking right away . . . `What are the restrictions today?' Even though they are actively treating and they just got hurt, we still can accommodate some transitional duty."* ? claims administrator

Other claims administrator participants described objectives of case management to control cases "that have the potential to explode at some point in time" or have the potential for delayed

recovery. It appeared that these types of cases do not necessarily consist of all lost-time cases, nor are they necessarily limited to lost-time cases:

> *" . . . the adjustors now are . . . being trained to apply what we call 28 different `red flag' modifiers. . . . based on modifiers, certain tasks, adjustors are being asked to make referrals. . . . The idea of the program is to identify early on cases that . . . have the potential for delayed recovery."* ? claims administrator

> *" . . . it all lies in what we call the quarterback of the claim, and that is the claims rep or claims examiner, who is really monitoring all this activity, and looking out for when it is appropriate for a field case nurse to go out in the field and meet with the doctor and the injured worker. So, we're constantly looking at those . . . to the point where we have been developing medical-only claims representatives, which is just looking at medical-only claims, and this way, this person can focus in on 200 claims or whatever the amount of volume it is . . . they need attention, because they are the ones that have the potential to explode at some point in time."* ? claims administrator

Claims administrator participants said that at the beginning of a claim, they make "three-point contact" with the injured worker, employer, and treating physician:

> *" . . . When that case first comes in . . . doing the 3-point contact, asking certain questions about the employee and the employer. . . . "* ? claims administrator

Claims administrator participants described efforts to help employers describe an injured worker's job to the treating physician and find other suitable work for the worker:

> *" . . . you can always send the [job description form RU-91] early, and just get everyone to nail down their job. . . . That's what I find works."* ? claims administrator

> *" . . . going out and meeting with the injured employee and the supervisor, and looking at how they are going the job. We are making suggestions on-site of either helping that person get back to work if they're not already there. If they are already doing modified, looking at the modified, and their regular job. The physical therapist is making recommendations then to the employee and the supervisor, after she's done the physical task analysis. . . . And we put together a report with pictures of the job and the recommendations that we're sending to the supervisor, the treating doctor, and the treating physical therapist."* ? claims administrator

> *"We encourage [getting feedback and ideas from the worker about the work]. Usually the worker has the best concept of what they can do, and what's in the workplace that they can do. So that's something we suggest.*

. . . " ? claims administrator

" . . . especially the small employers . . . they're racking their brains trying to come up with something, they can't think of anything. Well, one of the first questions I throw back to them would be . . . `Think of all the things that you've wanted to do for a long time and you just can't get to?what is your wish list?' . . . And a transitional job, especially in the small employer, might just be a list of tasks, and they may not be a meaningful, long-term job, but that really isn't what transitional work should be about. It should be transitioning back into their regular job." ? claims administrator

Claims administrator participants described efforts? either by claims assistants, claims administrators, in-house medical staff, or outside contractors with health care backgrounds? to discuss diagnosis, treatment, and return-to-work determinations with the treating physician:

"We outsource it to [a] staff of nurses . . . trained in occupational medicine. . . . they . . . have a conversation with the doctor's office, and that is, `Okay, what's your treatment? What's your prognosis? What's your diagnosis?'" ? claims administrator

" . . . the management care company that provides that service. . . . if there is a dispute on appropriateness of treatment plan or return-to-work issues, then we can escalate up to that physician advisor, and that doctor will make doctor-to-doctor contact. And yes, sometimes that is the key, because the doctor doesn't feel that the nurse or the adjustor is on an equal footing, and won't discuss those issues with others. . . . " ? claims administrator

" . . . we use [nurse case managers] selectively. . . . sometimes it's a situation where the doctor wants a way out, and it gives them a way out. . . . we have claims assistants on staff, so we bug the doctor's office every week, you know, trying to look at movement, what the status is, that type of stuff. And, if for no other reason, sometimes they just get tired of hearing from us and saying, `This person is ready to go,' or, `He'll be ready within a certain period of time.'"
? claims administrator

b. Problems

Injured workers and health care provider participants described problems with claims administrators delaying or denying authorization for medical treatment. The participants felt that these problems hinder an injured worker's recovery.

(1) Delays in Accepting a Claim

Injured worker and health care provider participants described experiences with claims administrators delaying for months the initial acceptance of a claim:

> *" . . . well, [claims administrator] seems to have been mocking the 90-day deadline. After 80 days they asked for my medical records and scheduled an appointment with their doctor, so it's 30 days past 90 days before the paper gets processed, and then they claim to have forgotten about it for another few weeks, and then they sit on it."* ? injured worker

> *" . . . this new thing of delay and deny, which has almost become commonplace for an insurance company to delay the case for 90 days . . . and during that time, if there is not secondary insurance, there's no medical care."* ? health care provider

> *" . . . I see so many cases where there is clearly no reason and no reason is ever given to me, why they should put a 90-delay on. . . . I've seen many of them that go on beyond 5 or 6 months beyond the 90 days, where they still deny, they're still denying. They say, `We haven't finished our investigation.'"* ? health care provider

> *" . . . They're worried about setting aside that huge chunk of money in their reserves, which they'd rather keep in the bank and make interest on, instead of in a non-interest account. So, that causes them to delay recognizing a case or accepting a case."* ? health care provider

(2) Delays in Sending Records or Communicating with the Treating Physician

A health care provider participant who is a treating physician in workers' compensation said that insurers do not send relevant medical records to him:

> *" . . . I don't get any information on the initial visit unless it comes from the applicant's attorney. The insurance company, the employer, never, and I mean never, send me any information on the initial evaluation. The initial evaluation is where I get 90 percent of my information. . . . Now, the records eventually come and it may be months later that the insurance company sends me the relevant information. . . . They don't even send me the report of the QME, or the orthopedic or neurologic consultant that they sent the patient to. They never send me the information, I never get*

those reports, unless I bang on the table, and I usually get them from the applicant's attorney because they have the copies." ? health care provider

Another health care provider participant who is a treating physician in workers' compensation said that claims administrators do not return telephone calls that he makes requesting authorization for treatment:

"I'd like to have a mandatory response time from the insurance adjustor to my phone calls." ? health care provider

(3) Refusal To Authorize Necessary Treatment

Injured worker participants described experiences with claims administrators refusing to authorize treatment recommended by the treating physician (one participant called it "practicing medicine without a license"):

" . . . most of the things that the treating physician doctor requested were denied by [claims administrator], which is the self-insured insurance company for [employer]. I had to get a lawyer to get any treatment at all. . . . Workers' comp insurance denied the claim that there was a head injury, even though their own doctors said that there was. . . . I didn't get an attorney because I wanted a lawsuit, only got an attorney because I wanted medical care." ? injured worker

" . . . they just essentially denied paying for anything. . . . I forked out $4,000 of my own money for my treatments, and testing for my injury. And to date, they still haven't paid for anything." ? injured worker

"My insurance company?half of my settlement was in penalties [for delay] . . . . They never really returned calls from my attorney, asking for medical benefits that their doctor said I should have."
? injured worker

Likewise, health care provider participants described experiences with claims administrators denying treatment that they had recommended:

" . . . the insurance companies are sending people for medical examinations and then using that information to decide on patient care. . . . They deny my recommendations and prevent me from getting them MRIs or physical therapy on the basis of the opinion of Dr. X. . . . In other words, there's a second track going on here, whereby they are painting paintings and making diagnoses and ascertaining treatment outside of the primary physician's mode." ? health care provider

" . . . The claims adjustor uses that data to instantly cut off treatment. Later you'll usually win. . . . presumption of compensability is what you're

talking about, but they ignore that." ? health care provider

One health care provider participant said that claims administrators routinely deny treatment for depression that results from a work injury:

> *"In terms of what insurance companies are denying that I think is fully unreasonable, is treatment for depression. . . . whether it be psychological counseling or medications. . . . I am getting recurrent denials of even potentially suicidal workers. . . . They say, `Oh no. That's something else. That's pre-injury, or their own problem.' But in fact, that's a real barrier, because seriously depressed people will not do therapy, they don't take their medications . . . but I can't get them treated for depression because the insurance company says, `No, that's not part of the work injury.' [But] it's a consequence of the work injury."* ? health care provider

(4) Lack of Familiarity with the Medical Issues in a Case

Injured worker and health care provider participants described experiences with claims administrators not being informed about medical issues. In some cases, this appeared to be caused by high turnover of individual adjustors:

> *" . . . Insurance companies will invariably, after 60-90 days change the claims examiner to another case, so the new person has to start over again, and they're knowing nothing about what's going on, also delaying the provider's pay, because they don't know if your bills are appropriate or not. . . . That's insurance games."*
> ? health care provider

> *"They change claims adjustors very frequently. They don't notify the treating physician. We have had instances where we have sent records for six months to the person we thought was the claims adjustor. It turns out it's somebody else. And then they tell us they threw the records away. `Can't find the records.'"* ? health care provider

E. Strategies Suggested by Participants To Overcome Problems in the System

The participants in the five focus groups were asked to describe major barriers to injured workers returning to work or to sustained employment and possible solutions for overcoming those barriers. As described earlier in this report, participants commented on specific actions of treating physicians, employers, and claims administrators that they believed create barriers to injured workers returning to work or to sustained employment. In addition, participants expressed views on a number of broader problems and their underlying causes, and they offered ideas about how to overcome some (but not all) of the problems.

This subsection of the report summarizes the participants' overall views on problems and their ideas on possible solutions. Their ideas and suggestions are part of the data collected in this study. NOTE: The project team does not necessarily agree with or endorse any particular idea or suggestion described below.

Participants in all five groups recommended education as one approach for overcoming problems that stem from lack of knowledge. They suggested educational topics and methods for educating workers, employers, treating physicians, and unions.

Cultural, attitudinal, economic, and legal problems were also discussed, along with some suggested strategies for dealing with those problems. However, no clear themes emerged in these areas. Most of these problems were discussed by only one or two groups. For other problems, participants in different groups expressed directly opposing views as to the nature of the problem or possible solutions for overcoming the problem.

1. Educational Needs

a. Workers' Educational Needs

Union representative and management representative participants discussed challenges in communicating with workers who speak languages other than English, particularly in explaining legal concepts in workers' compensation. One of the management representative participants said that 32 different languages were spoken in their company.

Educational topics suggested by injured worker, union representative, management representative, and health care provider participants included the following:

- ? Preventing injuries
- ? Importance of reporting injuries as soon as possible, to receive treatment and prevent permanent disability
- ? Anatomy, physiology, and extent that it is possible to move around and work while recovering

- ? Return-to-work programs, including workplace accommodations
- ? Difficulty in finding another well-paying job, compared to staying in one's current job
- ? Rights and procedures in workers' compensation, including the right to predesignate one's personal physician, benefit amounts, and how to determine what types of benefits are being paid with each check
- ? Rights under the Americans With Disabilities Act

Educational methods suggested by union representative participants included the following:

- ? Distributing educational factsheets to new hires
- ? Distributing educational videotapes to newly injured workers
- ? Unions educating their members

b. Employers' Educational Needs

Injured worker participants described experiences with employer not knowing how to work with, accommodate, and retain injured employees. Management representative participants said that small employers have great difficulty knowing how to work with claims administrators and treating physicians, to manage claims and bring injured employees back to work.

Educational topics suggested by claims administrator and union representative participants included the following:

- ? Return-to-work programs, including workplace accommodations
- ? Rights under the Americans With Disabilities Act
- ? Advantages of allowing injured employees to work while recovering, instead of waiting until the employee is fully healed

Educational methods suggested by management representative and injured worker participants included the following:

- ? Insurers educating their policyholders about workers' compensation laws and how to administer a return-to-work program (particularly needed by small employers)

? Ensuring that employers' official policies are communicated to individual managers

c. Treating Physicians' Educational Needs

Educational topics suggested by claims administrator, management representative, and health care provider participants included the following:

? Effects of the workers' compensation claims process on injured workers' earning power

? Specifying and explaining work restrictions to claims administrators

? Treating occupational injuries and make appropriate referrals

? Determining whether a musculoskeletal injury has underlying neurogenic drivers

? Treating the psychological aspects of an occupational injury, including making appropriate referrals

d. Unions' Educational Needs

Union representative participants said that it is difficult for some unions, depending on the size of the membership, to contact and advise all injured members. Educational topics suggested by union representative participants included the following:

? Advising injured members on how to protect their rights

? Disadvantages of allowing employers to require that arbitration replace litigation of claims filed under the Americans With Disabilities Act

2. Cultural, Attitudinal, and Organizational Issues

a. Employer's Responsibility to Injured Employee

Differing and opposing views were expressed regarding the employer's responsibility to an injured employee. Union representative participants criticized employers' lack of a sense of moral responsibility to take care of and retain their injured employees, particularly long-term employees. In contrast, management representative participants felt that employers should not be held solely responsible for their injured employees, and that the employees should take on some ownership of their own injuries and what happens afterwards, because often injuries are caused by both work and non-work factors.

No specific strategies were offered to address these attitudinal differences.

b. Goal of Returning to Same Employer

Different views were expressed as to whether injured workers should return to the same employer, rather than receive vocational rehabilitation services and try to find employment elsewhere.

Claims administrator, union representative, and management representative participants felt that efforts should be made to help ensure that workers return to the same (pre-injury) employer. Claims administrator and management representative participants felt, therefore, that injured workers should return to work as soon as possible in order to maintain contact with co-workers and a feeling of connection to the employer.

Health care provider participants felt, however, that an injured worker should not necessarily be returned to the same employer, contrary to a common assumption that the treating physician should always return the injured worker to the same job with the same employer. This is because in some cases, the job is no longer appropriate for the worker, or interpersonal conflicts at that particular worksite make it difficult or impossible to return. Therefore, early return-to-work was not viewed as desirable in cases where returning to the same employer would be unrealistic.

No specific strategies were offered to address these differences in viewpoint.

c. Quality of Jobs Offered to Injured Workers

Differing views were expressed regarding the quality of jobs that should be offered to injured workers. Claims administrator and union representative participants felt that work assigned to injured workers while recovering (and on a long-term basis) should be meaningful and rewarding. Claims administrator participants pointed out that some employers, however, deliberately assign transitional work that is not too comfortable, to avoid the employee wanting to keep the job permanently.

No specific strategies were offered to address these attitudinal differences.

d. Employment Relationships

Claims administrator and health care provider participants discussed how legal disputes in workers' compensation cases cut off relationships between employers and employees.

A claims administrator participant recommended that the role of state Information &

Assistance officers be enhanced, to help foster communications between employers and their injured employees.

e. Negative Attitudes Towards Injured Workers

Injured worker and union representative participants said that there are negative attitudes in our culture about injured workers (that an injured worker is "a liar, lazy and worthless"), especially if the worker has a repetitive stress injury or other "invisible injury," and that there is an assumption that most injured workers requesting workers' compensation benefits are committing fraud. The participants felt that these negative attitudes and assumptions impede healing.

Injured worker participants recommended that a public campaign be instituted to change attitudes, like campaigns that have deglamorized smoking, and that sanctions for fraud be enforced against insurers, not just against workers.

3. Economic Factors

a. Injured Workers' Disincentives To Report Injuries

Injured worker, union representative, and health care provider participants described how employers discourage workers from reporting injuries (either directly, through their managers, or indirectly, through peer pressure created by incentives offered to workers as a group to not have job injuries), and how workers are often reluctant to report injuries for fear of losing their jobs. This causes injuries to worsen in the absence of medical treatment and workplace accommodations.

A union representative participant recommended that labor-management contracts include language prohibiting incentives not to report injuries.

b. Inadequate Incentives for Employers To Accommodate Injured Workers

Injured worker, claims administrator, and union representative participants felt that employers have little or no incentive to accommodate injured workers, because it costs money and injured employees are less productive that noninjured employees.

A union representative participant recommended that the employer department that pays for workers' compensation (after an employee has been injured) be the same department that pays for ergonomic equipment (to accommodate injured workers and prevent further disability). A claims administrator participant recommended that the State of California

provide financial incentives to employers to bring injured employees back to work, like a particular program administered by the State of Oregon.

c. Injured Workers' Difficulties in Changing Occupations

Union representative, management representative, and health care provider participants described how it is often difficult for an injured worker to change occupations and find comparable employment. One participant said that this particularly true for highly skilled, highly paid workers who do not want to leave their areas of expertise. Other participants said that this is particularly true for lower skilled workers who have few technical, marketable skills.

Union representative and health care provider participants recommended that vocational rehabilitation benefits be increased to encourage injured workers who will not be able to return to their previous occupation to start vocational rehabilitation soon after injury, which would enhance recovery.

4. Legal Systems

a. Imbalance of Power

Injured worker, union representative, and health care provider participants felt that the workers' compensation system as a whole is unfair to injured workers.

Injured worker and union representative participants recommended that a "true advocate" position be created for injured workers, to make the power balance more equal. A health care provider participant recommended that case managers be assigned to oversee the care and progress of all injured workers, including injured workers whose cases are pending.

b. Complexity and Confusion

Claims administrator participants said that bureaucracy, complexity, and confusion in the workers' compensation system drive injured workers to litigation, which lead to anger towards the employer and claims administrator. Management representative participants said that because of the complexity of the laws, return-to-work gets forgotten by everybody.

Claims administrator participants offered the following recommendations to simplify the system:

- ? Revise job description form RU-91 to include jobs that involve repetitive strain injuries.
- ? Create one, simplified form for vocational rehabilitation plans that can be used for all dates of injury.

c. Role of the Treating Physician

Differing and opposing views were expressed about the proper role of the treating physician. In the California workers' compensation system, a treating physician's medical-legal findings are generally required to be presumed correct. Management representative participants felt that most treating physicians are poor evaluators of medical-legal and return-to-work issues because they tend to accept the injured worker's reports of pain, and that they should not be presumed to be correct.

Management representative participants therefore recommended that treating physicians not be allowed to determine medical-legal and return-to-work issues, and that realistic time frames be developed to limit duration of treatment. Claims administrator participants recommended that injured workers' right to switch to treating physicians of their choice be eliminated, that injured workers be required to required to request a QME (qualified medical evaluator) panel when the claims administrator objects to a report of the treating physician, and that subjective complaints be eliminated as a factor in determining work restrictions.

In contrast, health care provider participants said that claims administrators improperly disregard treating physicians' medical opinions and that they obtain medical evaluations only to decrease liability, not to ascertain the truth about the worker's condition. An injured worker participant recommended that claims administrators not be allowed to deny treatment prescribed by the treating physician.

d. Delays in Medical Treatment

Health care provider participants described frequent and lengthy delays in medical treatment causing "devastating" physical and emotional problems for the injured worker. Injured worker and health care provider participants described experiences with claims administrators delaying acceptance of new claims while investigating the claim for many months. An injured worker participant said that many doctors will not treat injured workers whose claims are pending.

Health care provider participants offered the following recommendations to reduce delays in medical treatment:

- ? Allow treating physicians to conduct medical tests that are standard and clearly indicated, without opposition by the claims administrator.
- ? Institute a rapid mechanism for adjudicating disputes where the claims administrator has denied the treating physician's recommendations.
- ? Encourage or require claims administrators to immediately authorize ergonomic evaluations and medical treatment.
- ? Require claims administrators to respond within one working day to requests for authorization from the treating physician.
- ? Institute straightforward legal standards as to what constitutes reasonable cause for delay in accepting a new claim.
- ? Allow claims administrators to pay for medical care while a claim is pending, without having to set aside money in their reserves for the value of the entire claim.

Injured worker participants offered the following recommendations:

? Do not allow employers and insurers to decide on medical care for injured workers.

? Require the Workers' Compensation Appeals Board to immediately issue awards to injured workers, instead of allowing employers and insurers to determine benefits.

e. Applicants' Attorneys Fees

Claims administrator and management representative participants felt that applicants' attorneys are motivated to select physicians who will keep injured workers off work, in order to maximize permanent disability benefits.

Claims administrator and management representative participants recommended that applicants' attorneys be paid more, or that they be paid based on their efforts to get the injured worker back to work.

f. Permanent Disability (PD) Benefits

Management representative participants felt that the unpredictability of PD benefits creates incentives to have more work restrictions be specified by the treating physician, because more restrictions will increase the worker's disability rating and the amount of PD benefits paid to the worker, and that qualified medical evaluators (QMEs), whose reports influence ratings of disability, write reports that are biased and not "truly evaluative."

Claims administrator and management representative participants recommended that for permanently disabled workers whose employers bring them back to work, PD benefits be decreased, which would create a financial incentive for employers to accommodate their permanently disabled employees, and that subjective complaints be disregarded as a factor in rating disabilities.

g. Temporary Disability (TD) Benefits

Claims administrator participants felt that injured, low-wage workers are motivated to stay off work, because temporary total disability (TTD) benefits, which are not subject to income tax, pay more than their regular wages.

No specific strategies were offered in this area.

h. Nondiscrimination Law in Workers' Compensation

Management representative participants discussed how the law against discrimination in workers' compensation prohibits employers from terminating occupationally injured employees who are off work, sometimes for two or three years, therefore causing employers to increase workloads for noninjured employees because they cannot replace the injured employee, and that this increases the risk of injury for the employees who have heavier workloads.

A management representative participant recommended that determinations be made as to whether an injured worker will be able to return at a reasonable point in time.

i. Medical Confidentiality Statute

Management representative participants said that recent legislation limiting the medical information that claims administrators may release to employers, Assembly Bill 435, discourages employers from bringing back injured employees, because the employers feel that without knowing all of the medical information, bringing the worker back might risk re-injury.

No specific strategies were offered in this area.

j. Multiple Legal Systems

Union representative participants discussed how difficult it is to understand and help injured workers with the different laws that could apply, including workers' compensation, the Americans With Disabilities Act (ADA), and the Family and Medical Leave Act (FMLA). In addition, an attorney may handle one area of law, but not all the areas that a worker may need to pursue.

A union representative participant recommended that unions not allow employers to require that arbitration replace the right to litigate ADA claims.

k. State and Federal Disability Laws

Claims administrator and union representative participants discussed how the Americans With Disabilities Act seems to motivate employers to limit the length of time that they will provide accommodations to injured workers while recovering, to avoid workers expecting permanent accommodations. A management representative participant felt that new legislation that expands the rights of disabled workers to alternative work, Assembly Bill 2222, motivates injured workers to have so many work restrictions specified by the treating physician that the employer will be required to find and offer alternative work.

No specific strategies were offered in this area.

V. ADVISORY REVIEW

A. Academic Advisory Panel

A panel of University of California researchers was formed to enable the project team to obtain academic advisory input in this project. The panel included the following:

- Robin Baker, M.P.H., Director, Labor Occupational Health Program, School of Public Health, UC Berkeley
- Henry Brady, Ph.D., Professor, Department of Political Science and Goldman School of Public Policy, and Director, Survey Research Center, UC Berkeley
- Lorraine Midanik, Ph.D., Associate Dean and Professor, School of Social Welfare, UC Berkeley
- Frank Neuhauser, M.P.P., Project Director, UCDATA Survey Research Center, UC Berkeley
- Patricia Sinnott, P.T., M.P.H., Doctoral Candidate, School of Public Health, UC Berkeley, and Member, California Industrial Medical Council

The panel met with the project team on April 27, 2001, to review the objectives and design of this project, the methods used to collect and analyze the data, and some of the results of the focus group sessions. We asked the panel members to advise us on possible methods for analyzing and reporting on the results of the focus group sessions, given the unanticipated complexity and diversity of themes emerging from the data. The panel members suggested ways to summarize major themes that were common in all of the focus groups and major themes that differed between the different groups, for purposes of obtaining advisory input at the final meeting of the Project Advisory Committee (described

below). In June 2001, the panel members commented on a draft version of this report.

B. Project Advisory Committee

The second meeting of the Project Advisory Committee was held on May 10, 2001. Additional persons were included who had expressed interest since the time of the first meeting. Forty-two members attended: nine representatives from labor, six from employers, six from the claims industry, six from applicants' attorneys, five from health care providers, three from injured worker support groups, one from rehabilitation counseling, three from the Division of Workers' Compensation, one from the Industrial Medical Council, one from RAND, and one from the Survey Research Center.

At this meeting, the advisory committee members reviewed activities to date, including methods that were used to recruit focus group participants, plan and facilitate the focus group sessions, analyze the data, and obtain advisory input from University researchers and from the workers' compensation community.

1. Comments on Some of the Themes from the Focus Groups

The advisory committee members reviewed an outline of some of the major themes that had begun to emerge from an initial review and analysis of the five focus group sessions. These included some themes that were common in most or all of the focus groups regarding practices, policies, and programs that promote return to sustained employment, as well as contrasting themes? that is, themes that differed between the groups. The contrasting themes highlighted blame and distrust that seem to pervade the workers' compensation system. The advisory committee members were asked whether they were surprised by any of the themes and whether they had any other comments.

Three health care providers responded that it is essential that treatment of emotional problems be included in the care given to injured workers. They said, however, that this is often fought by claims administrators, even when the injured worker has attempted suicide.

One applicants' attorney expressed shock at the suggestion, in the list of themes, that applicants' attorneys keep injured workers off work in order to get more money for themselves. He said that applicants' attorneys truly desire to help people, that he listens carefully to what the injured worker wants and counsels them that it is in their best interest to return to work, and that most injured workers want to return to work. He also said that he has seen a wide range of employer practices in helping or not helping injured workers return to work, and that many claims are filed against employers for violating Labor Code section 132a (the nondiscrimination statute in workers' compensation).

One injured worker said that attorneys are often retained because insurance companies terminate workers' compensation benefits. However, attorneys cannot take many kinds of cases. Therefore, injured workers often seek help outside the workers' compensation system. He also said that injured workers want to return to work, and that worker-selected physicians having no backbone (one of the themes in the outline) is a fallacy.

2. Comments on Some of the Strategies Suggested by Focus Group Participants

In the second half of the meeting, the advisory committee members were divided into three smaller groups to explore practical strategies to overcome problems in the system. They were given outlines of some of the suggestions from the five focus groups and asked to consider how those ideas could be implemented. Summarized below are ideas from the small groups of advisory committee members and additional comments that were made when the entire committee reconvened.

a. Informational and Educational Strategies

One group considered several ideas for programs to inform and educate workers, employers, and treating physicians:

(1) Educating Employers

The most popular suggestion was for employers to be fully educated on rights, responsibilities, and procedures when an employee is hurt on the job, and on how and what to communicate to the employee's physician right after the injury. This would include education of front-line supervisors and owners of small businesses.

When the entire committee reconvened, some members discussed problems involving small employers. One person suggested that small employers have problems in knowing how to help injured workers return to work. Another person said that many large employers are not knowledgeable either. A third person suggested that education be required when a new business is started.

(2) Simplifying Benefit Notices to Injured Workers

Two persons in the small group recommended that benefit notices, which are required to be sent to injured workers, be simplified and reduced. Currently, these notices are often delayed, missing, or inaccurate.

(3) Other Ideas

Other ideas offered by individual members of the small group were as follows: (a) educate injured workers on rights, obligations, and procedures at the time of injury; (b) require payment for delayed claims; (c) mandate return-to-work programs, and educate workers on those programs; (d) educate physicians; (e) get all participants in the system to adopt a mission to respect injured workers; and (f) reduce caseloads of claims adjustors and require that their communications be respectful.

b. Cultural, Attitudinal, and Organizational Strategies

The second group considered some ideas for improving public attitudes towards injured workers, improving the quality of jobs for injured workers, and improving employment relationships:

(1) Improving Attitudes Towards Injured Workers

There was support in the group for a public information campaign to change attitudes and increase respect for injured workers. The content would include the following: (a) the personal experiences of injured workers; (b) the costs of job injuries to society, employers, and workers; and (c) unbiased, reliable statistics about fraud committed by employers, claims administrators, and workers. Members of this small group further commented:

- Messages should be honest about the political and adversarial nature of the workers' compensation system.

- Messages should be tailored to different audiences according to their roles in the system and their ethnicities, literacy levels, and spoken languages.

- Focus groups could be used to design messages.

Members of this group also commented that workers should have access to helpful websites and other sources of information, referring agencies should explain exactly what types of information can be obtained where, and children in elementary and secondary school should be taught about job injuries and illnesses and systems for protection and advocacy.

(2) Ensuring High Quality of Modified-Duty Jobs

To ensure that jobs for injured workers are rewarding and fulfilling, the following recommendations were made to improve workplace accommodations and modified-duty positions: (a) increase information and resources for employers and employees about these positions and how to design them; (b) include the injured worker in the negotiations; (c) develop written job descriptions that include worker input; (d) allow enough time for discussion, interaction, and negotiation (as is required in Assembly Bill 2222); (e) develop methods for following up on individual plans and avenues of recourse if a plan is not followed; and (f) create a position for a "worker advocate" (possibly a nurse or nurse practitioner case manager), who would have early involvement in the case.

(3) Maintaining Employment Relationships

To encourage open and respectful communications between employer and employee and to avoid cases entering into a medical-legal dispute process prematurely, recommendations were made that state Division of Workers' Compensation offices be staffed and administered in a way that ensures that workers can reach Information & Assistance officers by telephone directly, rather than just hearing recorded messages. This would involve adequate training and support for I&A officers.

c. Legal and Economic Strategies

The third group considered several ideas for reducing delays in medical treatment, improving the permanent disability system, increasing advocacy for injured workers, and facilitating return-to-work. Most of the ideas discussed in this group were aimed at reducing delays in medical treatment, and some ideas were aimed at directly facilitating return-to-work:

(1) Reducing Delays in Medical Treatment

One person suggested that medical treatment algorithms be developed that would allow pre-approval of treatment for particular diagnoses. Several other persons supported this idea. It would help avoid delays in health care providers seeking authorization for each step in treatment, which would in turn help avoid deterioration in the worker's medical condition. Members of the group said that health care providers and claims administrators both need this information. Similarly, recommendations were made that guidelines be developed as to when injured workers should be referred to specialists, and that studies be conducted to determine which health care providers have poor outcomes for their patients.

Different members of the group suggested additional ways to avoid delays in medical treatment: (a) in employer programs that offer incentives to groups of workers to not have injuries, make it clear that once an injury occurs, it should be reported; (b) require, in state-mandated injury and illness prevention programs, that workers be involved in developing health and safety programs, which would foster a culture of health and safety in the workplace and help encourage workers to report injuries; and (c) in employer programs that offer incentives to workers to reduce absenteeism, do not include absences due to job injuries. When the entire committee reconvened, one person emphasized that we should focus more on efforts to prevent injuries and illnesses, and that this would improve overall

retention and employability of workers.

(2) Facilitating Return-to-Work

To facilitate return-to-work, some members of the small group supported the idea of creating financial incentives for employers to offer modified-duty jobs for their injured employees and new jobs for workers with permanent disabilities. This could be through a new fund (possibly created by the state, as is done in Oregon), rebates of insurance premiums, or insurers paying directly for the costs of creating modified positions. It was noted that small employers face significant hurdles in trying to create modified positions.

3. Comments About the Project

Two representatives of the California Applicants' Attorneys Association questioned whether the project team should be generating a report that describes some beliefs and opinions that one of the representatives viewed as inaccurate, strange, or ridiculous. They also questioned why knowledge of recently enacted legislation, Assembly Bill 2222, was not tested in the focus group sessions. The project team responded that this is a social science research project designed to observe and describe how people perceive problems in the system; those perceptions drive a person's behavior, which in turn affects what happens with claims. Although some of the beliefs expressed in the focus group sessions were probably not grounded in science or fact, investigating the validity of those beliefs would be a separate, scientific study. The project team also explained that this project was not designed to impart new information to the focus group participants or test people on their knowledge of that information. Furthermore, at the time that most of the sessions were held, Assembly Bill 2222 had not been enacted.[19]

At least six other members of the Advisory Committee said that the emotional tensions, distrust, interpersonal clashes, differing points of view, and differing realities are important causes of problems in the workers' compensation system. They felt that the workers' compensation community needs to acknowledge those factors in order to improve the system, and that this project will help in these efforts.

Towards the end of the meeting, some of the advisory committee members commented on the overall direction of this project and of future work: (1) perceptions in the system described in this project could be further examined through quantitative studies and reviews of the scientific literature; (2) both workers and employers face difficulties in understanding the reality of workers' compensation; (3) the permanent disability system may be irrelevant to whether injured workers return to work; and (4) all participants in the system, including injured workers, claims administrators, doctors, employers, and attorneys, need to improve coordination and reduce hostility.

[19] Assembly Bill 2222, which amended California's Fair Employment and Housing Act, became law on January 1, 2001.

VI. DISCUSSION

A. Applicability of the Findings

The results of the focus group sessions are useful for understanding a wide range of experiences, beliefs, perspectives, insights, and opinions in the California workers' compensation community regarding efforts to help injured workers return to long-term, sustained employment. Because of the planned focus of the discussions, the homogeneity of the groups, and the social interactions between the participants in each of the sessions, problems and concerns were brought to light that are usually difficult to uncover in more formal settings with mixed groups.

Thus, rather than merely expressing general opinions about undesirable features of our current system, the participants were able to explain more specifically *how* particular actions, behaviors, practices, policies, or programs appear to affect the likelihood that an injured worker will return to sustained employment. Also, this project has begun to explore some of the underlying assumptions, attitudes, and values that fuel many of the diverse, conflicting views about problems in our system.

This project does not aim to describe the fullest possible range of perspectives and opinions on these issues. Due to the small size of this project, we were not able to convene more than one group each from the five different categories of persons selected to be interviewed. The focus group participants who were interested and willing to commit the time and resources to participate in this project (and their organizations, for some participants) were not necessarily "representative" of their interest groups. For example, in the focus group of injured workers, there were no workers who had returned to work with few or no problems (and for whom the workers' compensation system was helpful). In addition, we were not able to convene persons from other important interest groups who probably also have valuable information and insights to offer.

This project also does not aim to directly measure or evaluate the *actual* effectiveness of different efforts to return injured workers to sustained employment. Those efforts are being undertaken by other researchers, including the RAND Institute. However, the results from this project can be used to help identify major areas of concern that require further attention.

B. Basic Model of Return-To-Work

Efforts to help injured workers return to sustained employment include the following steps:

1. ***Injured Worker's Signs and Symptoms:*** The injured worker describes his or her experience with the injury, including subjective symptoms such as pain, and sometimes shows objective signs of injury.

2. ***Treating Physician's Diagnosis, Treatment Plan, and Work Restrictions:*** The treating physician interviews and examines the injured worker, makes a diagnosis, determines necessary treatment, and specifies work restrictions.

3. ***Employer's Efforts To Correct Hazards and Accommodate Injured Workers:*** The employer encourages reporting of injuries, corrects safety problems, and provides accommodations to allow the injured worker to work safely while recovering and to work with accommodations permanently if necessary.

4. ***Claims Administrator Paying for Necessary Health Care Services:*** The claims administrator promptly authorizes and pays for necessary health care and medical evaluation services.

C. Serious Concerns, Problems, and Disagreements

Perceptions, beliefs, and opinions from the five focus groups reveal serious concerns, problems, and disagreements at each step, including the following:

1. Some participants believed that injured workers lie about subjective symptoms in order to stay off work and receive more benefits. Other participants felt that widespread suspicion of injured workers and an assumption that all injured workers are lying is unwarranted and unfair, and that suspicion impedes healing because of the emotional stress it places on the worker. Widespread suspicion also encourages indiscriminate denial of claims.

2. Participants disagreed, on the one hand, as to whether the treating physician should consider the injured worker's concerns and subjective complaints in diagnosing and treating the injury and specifying work restrictions. On the other hand, participants also disagreed as to whether the treating physician should be influenced by the employer or claims administrator in determining when an injured worker can return to work and necessary work restrictions. It appeared that often employers, claims administrators, or injured workers lose trust in the treating physician and therefore disregard or dispute (sometimes for financial reasons) the physician's findings and recommendations. Participants also disagreed as to whether treating physicians should try to release injured workers to return to work as soon as medically feasible, while still recovering.

3. Some participants said that employers often discourage reporting of injuries and cannot or will not accommodate injured workers, and that many employers, especially small

employers, do not generally know how to deal with work injuries or the workers' compensation system.

4. Some participants said that claims administrators often delay or deny payment for medical care unreasonably (presumably for financial reasons or due to suspicion of fraud), and that this impedes healing and leads to deterioration of the injured worker's condition.

From these sharply differing perceptions, beliefs, and opinions emerged the recurring themes of this study, described earlier in this report: (1) blame and distrust of others' motives; (2) anger, frustration, and demoralization because of the imbalance of power against the injured worker; and (3) frustration with complexities, conflicts, and disputes in the workers' compensation system. These wide-ranging concerns, problems, and disagreements are very likely resulting in prolonged, unnecessary time away from work and poor health outcomes for significant numbers of occupationally injured workers in California.

VII. RECOMMENDATIONS

When this project was originally conceived, it was hoped that we would find some areas of common ground and that concrete recommendations could be formulated to improve return-to-work outcomes for California workers. Instead, we found gridlock. The focus group findings revealed widespread blame and distrust between the players in the system and many differing or conflicting views about why injured workers experience difficulties in returning to long-term, sustained employment. As a result, two of the original objectives of this project? analyzing how vocational rehabilitation laws may affect return-to-work and formulating practical educational messages? could not be met within the time and resources that were available.

To keep moving forward on the findings from this project, we recommend that the Commission consider undertaking further discussions with the workers' compensation community and further applied research, as described below. Members of the Project Advisory Committee have said that to improve the system, the community needs to acknowledge and understand the distrust, interpersonal clashes, differing points of view, and differing realities that cause many of the problems in the system.

The first two sets of activities recommended below (items A and B) are intended to help ameliorate some of the blame, distrust, and hostility that pervade the workers' compensation community. The second two sets of activities (items C and D) could begin to resolve some of the specific concerns and problems reported by participants in this study.

A. Information About Roles and Responsibilities

This study has documented many of the perceptions, beliefs, and disagreements that drive adversarial conduct between stakeholders in the workers' compensation system. Participants voiced strong criticisms about each others' motives and actions.

To help dispel misunderstandings about each others' motives and actions, and to improve our understanding of what can be expected of persons who provide important services to injured workers and employers in the workers' compensation system, we recommend that informational materials about these providers of services be developed and disseminated. The materials would describe the providers' roles and responsibilities, their training, how they are paid, and how they are regulated. This would prompt people to consider their own roles and help injured workers and policymakers understand gaps and overlaps in responsibilities.

The persons described in the materials could include, for example:

1. Claims administrators who work for insurance companies, third-party administrators, self-insured, self-administered employers, and joint powers authorities.

2. Treating physicians and other health care providers who treat injured workers and who are selected by employers, claims administrators, injured workers, or workers' attorneys.

3. Qualified medical evaluators, agreed medical evaluators, and other persons who render opinions on medical-legal issues.

4. Applicants' attorneys and defense attorneys.

5. Rehabilitation counselors who help injured workers develop vocational rehabilitation plans.

6. Case managers who work for, or under contract with, claims administrators, employers, and health care providers.

The materials could be developed in consultation with a cooperative, multipartite task force. The members of the task force should probably be carefully selected by the Commission to avoid unnecessary conflicts and disagreements. Members of the panel could include persons who represent the professional groups to be described in the materials, as well as representatives of injured workers and employers.

B. Respectful Attitudes Towards Injured Workers

Injured workers in California must navigate a system that is fraught with complicated rules and procedures, and they are often treated disrespectfully by others.[20] Those with permanent disabilities sustain significant financial losses even after receiving workers' compensation benefits, and many are unable to find jobs that pay well.[21] This study shows that injured workers also face suspicion regarding the symptoms they describe and their needs or preferences about staying off work. This suspicion and negative stereotyping of injured workers can hinder recovery.

In response to suggestions from focus group participants for improving attitudes towards injured workers, members of the Project Advisory Committee supported the concept of a public information campaign to increase respect for injured workers. They also made specific suggestions regarding the content and design of messages in such a campaign (see page 68, above.)

To help dispel negative attitudes towards injured workers and thus promote healing, we recommend that the Commission develop methods and plan activities to promote respectful treatment of injured workers. This could be accomplished in consultation with the task force described in Recommendation A. Methods could include, for example:

1. Issuing an advisory bulletin explaining why negative stereotyping is unfair and harmful to injured workers and giving guidance on how to stop negative stereotyping.

2. Developing and disseminating evidence-based informational and educational materials describing the difficulties faced by injured workers in California, including reduction in health and functioning, fear of loss of employability, and? for workers who lose their jobs and cannot find new jobs? financial troubles and loss of social structure, social identity, and a sense of belonging.

[20]Sum, Juliann, et al., "Navigating the California Workers' Compensation System: The Injured Worker's Experience," prepared for the Commission on Health and Safety and Workers' Compensation by the Labor Occupational Health Program, UC Berkeley, 1996.

[21]Biddle, Jeffrey, et al., "Permanent Partial Disability from Occupational Injuries: Earnings Losses and Replacement in Three States," in Budetti, Burkhauser, et al. (eds.), Ensuring Health and Income Security for an Aging Workforce, W.E. Upjohn Institute for Employment Research, Kalamazoo, MI, 2001; Reville, Robert, et al., RAND Institute for Civil Justice, "Permanent Disability at Private, Self-Insured Firms: A Study of Earnings Loss, Replacement, and Return to Work for Workers' Compensation Claimants," prepared for the Commission on Health and Safety and Workers' Compensation, 2000.

C. Model Practices of Treating Physicians, Employers, and Claims Administrators

Participants in the focus groups identified "best practices" of treating physicians, employers, and claims administrators that they believed help injured workers return to sustained employment.

In three of the groups, participants said that it is important that treating physicians know how to write useful medical reports and formulate clear and specific work restrictions. However, no other specific practice? of treating physicians, employers, or claims administrators? was identified as beneficial by participants in most or all of the focus groups. With respect to treating physicians' practices, focus group participants expressed opposing views as to whom the physician should work with or believe. With respect to practices of employers and claims administrators, the focus group participants did not have an opportunity to comment on the desirability of "best practices" described by participants in the other groups.

We recommend that the Commission develop a set of model practices of treating physicians, employers, and claims administrators that are based on ethical "codes of conduct" and, where possible, evidence-based standards of care. The model practices could build upon some of the information developed in implementing Recommendation A.

To ensure that the model practices take into account the educational needs and practical concerns of all persons involved, the model practices could be developed in consultation with the task force described in Recommendation A. In addition, to ensure that the model practices take into account scientific and professional knowledge about successful return-to-work efforts and that they comply with all applicable laws, the Commission could establish and consult with an advisory body consisting of persons with expertise in disability management, epidemiology, health economics, health policy, health services research, workers' compensation law, occupational safety and health law, and employment law.

As a starting point, the Commission could review and elaborate upon some of the "best practices" that were described by participants in the focus groups and collect descriptions of additional practices that also seem to help or enable injured workers to return to work in sustained employment. Possible examples of "best practices" from the focus groups are as follows:

1. Treating physicians formulating and communicating clear and specific work restrictions (see pages 26, 31-32, above).

2. Employers communicating promptly, openly, and respectfully with injured employees regarding the return-to-work process and methods to find appropriate alternative work (see pages 35-36, above).

3. Claims administrators facilitating non-adversarial communication between the injured worker, employer, and treating physician to achieve medically appropriate return-to-work (see pages 48-49, above).

To achieve some common understanding of treating physicians' "best practices" in communicating with others, the Commission could explore the assumptions that underlie opposing views, expressed in the focus groups, as to whom the physician should work with or believe. It may well be, for example, that opposing views as to whether treating physicians should work with employers to achieve medically appropriate return-to-work are based on different assumptions (and lack of information) about the nature of a treating physician's communication with an employer, and that opposing views as to whether treating physicians should consider injured workers' reports of subjective symptoms are based on misunderstandings regarding the extent that medical conditions such as soft tissue injury can be measured objectively.

D. Strategies To Overcome Problems in the System

The focus group participants expressed views about system-wide problems that hinder return-to-work and underlying causes of these problems. They also offered ideas on possible solutions for overcoming some of the problems.

Education? for workers, employers, treating physicians, and unions? was one approach that was suggested by participants in all of the focus groups to overcome problems arising from lack of knowledge. This approach was endorsed by members of the Project Advisory Committee. The participants also offered suggestions to address cultural, attitudinal, economic, and legal problems. However, no commonly favored strategy emerged for dealing with those kinds of problems, in part because the participants did not have an opportunity to comment on ideas given by participants in the other groups.

We recommend that the Commission conduct follow-up discussions to evaluate the participants' suggestions, identify feasible and desirable strategies, and plan specific activities to improve methods for helping injured workers return to sustained employment. Discussions could be held with the task force described in Recommendation A.

Because education was one approach that was suggested and accepted by participants in all of the focus groups and endorsed by members of the Project Advisory Committee, we recommend that further discussions be held to expand and elaborate upon the educational messages that need to be disseminated and to design programs to implement these educational ideas. The focus group participants' educational ideas are summarized on pages 55-57, and the ideas from members of the Project Advisory Committee are summarized on pages 67-68 of this report.

Although no commonly favored strategy emerged for dealing with cultural, attitudinal, economic, and legal problems, several suggested strategies warrant further evaluation. One set of these strategies, improving attitudes towards injured workers, is discussed in Recommendation B. Two other sets of possible strategies that show promise are as follows:

1. Reducing Delays in Medical Treatment and Recovery

Some of the focus group participants and Project Advisory Committee members hoped to eliminate a requirement that treating physicians obtain authorization from claims administrators when tests or treatment are clearly indicated (see pages 61, 69, above). Committee members supported a suggestion that evidence-based-care algorithms be developed that allow pre-approval of treatment for particular diagnoses (see page 69, above).

Some of the focus group participants also felt that initial delays while a new claim is pending can cause serious health problems for the injured worker (see page 52, above). One participant recommended that claims administrators' financial disincentives to pay for medical care while a case is pending be reduced or eliminated (by not requiring them to set aside money in their reserves for the value of the entire claim; see page 62, above).

2. Creating Incentives for Employers To Accommodate Injured Workers

Some of the focus group participants and Project Advisory Committee members supported the concept of creating financial incentives for employers to offer modified-duty jobs for their injured employees and new jobs for workers with permanent disabilities (see pages 59-60, 70, above). This would be particularly important for small employers. The incentives could be paid from a fund created by the State of California, as is done in Oregon.

We therefore recommend that further discussions be held with the task force described above, to evaluate whether suggested strategies to reduce delays in medical treatment and to create incentives for employers to accommodate injured workers can move forward. Follow-up discussions could be held with groups that have special concerns, such as the Construction Industry Task Force or a group representing small and medium-sized employers.

APPENDIX A
Key Questions Asked in the Focus Group Sessions

1. Injured Workers Session

In the first session, held with injured workers in June 2000, the moderator asked the following questions to focus the participants on the issues relevant to the primary objective of this project:

Q. Describe the most important thing your treating physician has done that has made it easyXor difficultXfor you to return to work.

Q. Describe the most important thing your employer has done that has made it easyXor difficultXfor you to return to work.

Q. Describe the most important thing your insurance claims administrator has done that has made it easyXor difficultXfor you to return to work.

Q. Do you have any possible solutions to offer or recommend, to allow, encourage, or help injured workers return to sustained, long-term employment?

2. Claims Administrators Session

In the second session, held with claims administrators in October 2000, the moderator asked the following questions:

Q. Describe the most important thing you have seen a treating physician do, that helped an injured worker return to sustained employment.

Q. Describe the most important thing you have seen a manager or supervisor do, that helped an injured worker return to sustained employment.

Q. Describe the most important thing you have seen a claims administrator do, that helped an injured worker return to sustained employment.

Q. What is the biggest barrier you face in helping injured workers return to sustained employment?

Q. Based on today's discussion, do you have any possible solutions to

offer or recommend, to allow, encourage, or help injured workers return to sustained employment?

3. Union Representatives Session

Based on our experience with the previous two sessions, the questions for the third session, held union representatives in November 2000, were reorganized to encourage the participants to spend more time on barriers and solutions, and to link their proposed solutions to the particular barriers. The moderator therefore asked the following questions:

Q. Describe the most important things that you have seen treating physicians, employers, and claims administrators do, that helped injured workers return to sustained employment.

Q. What do you think is the biggest barrier to injured workers returning, or trying to return, to sustained employment? And do you have any possible solutions to recommend, to help, encourage, allow, or enable injured workers to return to sustained employment?

4. Management Representatives Session

In the fourth session, held with management representatives in November 2000, the moderator asked the following questions:

Q. Describe the most important things that you have seen treating physicians, employers, and claims administrators do, that helped injured workers return to sustained employment.

Q. In your opinion, what is the biggest barrier faced by employers in helping injured workers return to sustained employment? And to you have any possible solutions to recommend, to overcome that barrier?

5. Health Care Providers Session

Many of the participants in the four previous sessions identified practices of treating physicians that they believed either promote or hinder injured workers' return to work or to sustained employment. They also expressed beliefs and opinions about the types of information that treating physicians should or should not consider in making return-to-work determinations. Many of these views were in conflict. Therefore, some of the questions for the fifth session, held with health care providers in April 2001,

were rewritten to focus on some of the major concerns of the previous participants:

Q. In your experience as a health care provider for injured workers, what do you think are the most important factors that affect whether an injured worker will return to sustained employment?

Q. What information and inputXfrom the injured worker, the worker's attorney, the worker's employer, and the insurance claims adjustorXdo you find to be relevant and useful in determining: (i) when a worker can or should return to work and (ii) appropriate work restrictions?

Q. In your opinion, what is the biggest barrier faced by treating physicians in helping injured workers return to sustained employment? And do you have any solutions to recommend, to overcome that barrier?