

Commission on Health and Safety and Workers' Compensation

MINUTES OF MEETING August 25, 2005 Elihu M. Harris State Building Oakland, California

In Attendance:

Chair John Wilson

Commissioners Allen Davenport, Kristen Schwenkmeyer, Alfonso Salazar, Robert B. Steinberg,
and Darrel "Shorty" Thacker

Executive Officer Christine Baker

Not in Attendance

Commissioners Leonard C. McLeod and Angie Wei.

Call to Order

Chair John Wilson called the meeting to order at 10:00 a.m. Chair Wilson announced a change in the order of presentations on the Agenda, moving the spinal surgery second-opinion process presentation toward the end of the meeting.

Minutes from the April 28, 2005, Meeting

Chair Wilson asked for a vote regarding the Minutes of the April 28, 2005, meeting.

CHSWC Vote

Commissioner Davenport moved to approve the Minutes of the April 28, 2005, meeting, and Commissioner Salazar seconded. The motion passed unanimously.

Chair Wilson commended CHSWC staff for work on the Minutes.

Update on the Permanent Disability Study

Christopher R. Brigham, MD, CIME, FAADEP, FACOEM, Brigham &
Associates, Inc.

Frank Neuhauser, Project Director, UC DATA, UC Berkeley

Christine Baker, Executive Officer, CHSWC

Lachlan Taylor, Staff Judge, CHSWC

Christine Baker provided an update on the status of the Permanent Disability Study requested on June 14 and July 14 by Senate President pro Tem Don Perata and Assembly Speaker Fabian Nuñez. Ms. Baker stated that CHSWC staff has been studying the effects of the new 2005 permanent disability (PD) schedule. She stated that initially, the focus was on efforts to estimate the cost impacts of Senate Bill (SB) 899 in cooperation with the Workers' Compensation Insurance Rating Bureau (WCIRB). More recently, the efforts have been focused on meeting legislative requests to compare average ratings under the old and new schedules and to recommend how to modify the new schedule to achieve the percentage of PD ratings that were

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nearly equal to a percentage of long-term earnings loss as found by the RAND PD study. Ms. Baker stated that CHSWC staff had hoped to present the study today but it would have been incomplete; more experience and more data under the new schedule are needed. Therefore, the Speaker's office has suggested that CHSWC defer the report until adequate data are obtained from the Disability Evaluation Unit (DEU). Therefore, today, Ms. Baker stated, there will be a progress report on the studies that have been done to date.

Ms. Baker stated that an accurate PD rating is one which quantifies the average percentage loss of future earning capacity (FEC) for the persons who receive that rating. The accuracy of a rating is distinct from the adequacy of the compensation paid for that rating. Ms. Baker commented that the RAND PD study found that the old schedule was fairly accurate on the average. The average percentage disability rating was about 1.09 times the average percentage of long-term earnings loss. Although the average was mostly accurate, it was less accurate for some types of injuries than for others. Some injuries were rated about 1.8 times the average percentage of earnings losses, while some were rated about .05 the average percentage of earnings losses. Senate Bill (SB) 899 allows the Division of Workers Compensation (DWC) to obtain more accurate ratings by using both the American Medical Association (AMA) Guides and wage loss data. The challenge is to apply that wage loss data at the same time that the starting point for ratings has been changed by the adoption of the AMA Guides.

Ms. Baker further stated that the Administrative Director (AD) of the DWC promulgated the 2005 Permanent Disability Rating Schedule (PDRS) as an emergency regulation effective January 1, 2005. In the 2005 PDRS, the AMA impairment percentage is multiplied by an FEC factor. The product of that multiplication is used in the calculation of the PD rating where a standard disability rating is used in the 2005 schedule. Ms. Baker stated that the FEC factor serves two purposes: it scales up the AMA impairment percentages in an effort to ameliorate the reductions otherwise prevalent in the AMA ratings; and it assigns different multipliers to different types of injuries in an effort to apply RAND findings.

The FEC factors have been controversial, Ms. Baker further stated. The difficulty is that the initial RAND study was conducted using the PDRS in use at the time prior to SB 899. The RAND findings could have been used to make the new schedule more equitable for different types of disabilities, but the same questions could not be directed to apply to each AMA impairment type for three reasons: (1) the AMA impairment ratings for the same injury are often very different from the former PDRS rating on which the RAND study data are based; (2) the AMA comparative ratings for one type of injury in proportion to another may be significantly different from the proportions of the former PDRS ratings; and (3) the ratings of the AMA Guides may on the average be much lower than ratings under the old schedule, so on average, the close relationship between average rating and average earnings losses will no longer hold. It is possible, Ms. Baker stated, to seek FEC factors that when applied to the AMA impairment percentages produce ratings that are on average at least as close to the 1:1 ratio as the ratings were under the pre-2005 PDRS.

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Ms. Baker explained that a crosswalk for conversions is required before the RAND-based earnings loss information can be applied to the AMA-based PDRS as required by SB 899. Ms. Baker commented that there are three studies that suggest the way that conversion should occur, and another study is in progress that will provide the information necessary to determine the conversion empirical. Two of the studies were dual-rating studies: one was conducted by Dr. Chris Brigham, funded by the Workers' Compensation Insurance Rating Bureau (WCIRB) and with assistance by CHSWC staff; the other dual-rating study was conducted by Professor Paul Leigh, at the request of the California Applicants Attorneys Association (CAAA). Ms. Baker stated that the results of the two studies are quite similar in some ways.

Another approach, Ms. Baker stated, was a model that compares the AMA ratings to the old ratings schedule by looking at the maximum possible rating for each type of injury under the two schedules. This model is useful in finding relative scale among various types of injuries but less useful in predicting the overall differences in scale between the two rating systems.

Ms. Baker stated that the three studies show that the schedule needs further adjustments. The last of the studies is still in progress. Data from the Disability Evaluation Unit (DEU) is entered into a database to indicate how the distribution of ratings under the old schedule that RAND studied compares to the distribution under the 2005 schedule. This will provide the most empirical evidence of what the adjustments to the schedule ought to be so that the schedule can most accurately reflect the average percentage of long-term earnings losses. Frank Neuhauser will present the preliminary results of that study.

Ms. Baker introduced Dr. Brigham. Dr. Brigham stated that he would share insights on the impact of some of the data on changing to the use of the AMA Guides. Dr. Brigham stated that he has been involved with the AMA Guides for approximately 20 years, including work as editor of the Guides Casebook and Newsletter, and that most of his work focuses on use of the Guides on a national basis. He stated that he has done a comparative study of cases under the old PDRS and cases under the AMA Guides, as well as a similar study for the state of Colorado. The purpose of the current study is to provide an understanding of what the impact would be from using the AMA Guides, which represents a paradigm shift in terms of the approach that the Guides use to assess impairment. Mr. Brigham stated that the study was undertaken with assistance from the Commission on Health and Safety and Workers' Compensation (CHSWC), the DEU, the WCIRB, Frank Neuhauser and others. A more detailed discussion of the study appears in the Guides Newsletter.

Mr. Brigham said that the study looked at 250 cases from 1997-2002, where there were ratings based on reports from a treating physician, a Qualified Medical Evaluator (QME) or an Agreed Medical Evaluator (AME). In the Guides, there is a process where data that needs to be obtained by a physician is applied to certain criteria and then by using specific conversions, the process comes up with a number that leads to a percentage that is called Whole Person Impairment or the Impairment Standard. With adequate information, the rating can then be calculated. In this case, the Impairment Standard number based on the AMA Guides was adjusted for the FEC factor, occupational variant, and age, and then, as appropriate, multiple disabilities were combined.

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One of the concerns of the study, Dr. Brigham explained, was whether there would be sufficient information for the study. However, only seventeen cases were rejected due to inadequate information to arrive at 250 cases. There may have been other information that may not be in the report that, if included, could have resulted in a ratable impairment. The study found that 97 of the 250 cases, or 39 percent, had no evidence of ratable impairment according to the AMA Guides. Dr. Brigham stated that this may be due to the fact that in the prior schedule, there were certain subjective factors, including observations, the concept of prophylactic work restrictions, and factors such as grip strength, that are not used in the Guides. The basis of the Guides is to have something more objective and verifiable in rating impairment so that the rating is more consistent and so that different physicians seeing the same patient would come up with the same rating. It was therefore not surprising, Dr. Brigham stated, that some of the cases had no ratable impairment, although it was surprising that the percentage of those cases was as high as 39 percent.

The next question, Dr. Brigham commented, is what the relative value in number is between what we saw before and what we have now. Analysis of the 250 cases revealed that the average PD rating was 22 percent in the past and 6.4 percent with the AMA Guides, a decrease of 71 percent. Looking at only those cases that have ratable impairment, it was observed that the previous rating was 25 percent PD and that decreased to 10.5 percent PD. Dr. Brigham also commented that there are differences in regions that have been observed. This is not surprising. Dr. Brigham defined the difference between the concept of impairment, which is a medical determination that comes up with a number that represents a loss of or loss of use of a body part or function, and disability, which is a gap between what we can do and what we need to do.

Looking at regional differences, Mr. Brigham stated, revealed that some areas had significant impact, including shoulders and arms. In the past, a percentage of cases were based upon decreased strength or grasp; however, that is a functional method that is not consistent or reproducible and therefore is not used in the Guides. For the same reason, significant differences are found with the spine and lower extremities. Therefore, most areas, other than that of the fingers, had significant differences.

Dr. Brigham stated that the results were not surprising; in fact, he expected to see ratings that would be substantially less than previously, and that questions and concerns would be about how much the reduction would be. The Guides are complex and challenging to use. Key variables affecting ratings would be the doctor's finding, how reliably the Guides are used -- and if the Guides are not used correctly, whether any errors are identified -- and how losses of wages would be determined. What the study expected to find is that someone new to using the Guides might have ratings that are slightly higher than should be and slightly higher than those of someone who is experienced using the Guides.

The key question, stated Dr. Brigham, was whether the amount of reduction in PD under the AMA Guides would be the same as the amount predicted before. He stated that there would be a significant decrease but not as predicted. This is because of an issue called the treating physician effect. The treating physician tends to be a patient advocate, so it is likely that this type of

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relationship will result in higher ratings. Other biases are that physicians are not skilled in the use of the Guides and so are more likely to use criteria inappropriately and therefore have ratings that are higher than should be. Other issues with erroneous ratings involve such factors as how the spine is rated or using factors, such as grip strength, that are not supposed to be used in the Guides. Dr. Brigham stated that in addition, there are some difficulties with issues of pain. The chapter in the Guides on pain, which is rarely used elsewhere in the country, is used in California.

Dr. Brigham stated that he reviewed new data on 241 cases with California impairment ratings and found a 74 percent error rate. This has improved from the end January 2005 when there were no accurate ratings. In January and February 2005, the error rate was 90 percent. The average rating overall was 12.4 percent, whole person. After review, when the data was applied to the Guides, it was substantially less, about 4.9 percent. Experience applying the Guides, Dr. Brigham stated, reveals that ratings based on objective criteria in the AMA Guides will result in lower ratings than in the prior PDRS. This therefore indicates that most ratings will be become reproducible once physicians become skilled in using the AMA Guides; until then, it is likely that most ratings will be erroneous.

Chair Wilson asked for questions. Commissioner Steinberg asked a series of questions regarding the old and the new schedule and the ratings under the new schedule. He also questioned whether the new DEU data included an FEC factor. Dr. Brigham replied that that was incorporated, that they took data from the previous schedule and the impairment standard and then ran that through the formula with the FEC factor adjustment and occupational and age adjustment.

Commissioner Steinberg asked what was meant by the ratings are erroneous. Dr. Brigham replied that these are ratings done by physicians. When the report is reviewed, analysis is done to determine which data the physicians had and how they applied the criteria. Sometimes when the process is new, the ratings are lower.

Commissioner Davenport asked what is to differentiate between a difference of opinion and a difference of expertise. Dr. Brigham replied that although there are a lot of areas in medicine that are gray areas, this is much more a case of a difference of expertise. Most of the cases reviewed were black and white cases, where you can see how the physician came up with the rating, so it was not so much a judgment issue.

Commissioner Steinberg asked how long it was expected that there would be errors. Dr. Brigham replied that over the next year, there should be improvement.

Commissioner Steinberg next questioned the grip strength loss in the AMA Guides. Dr. Brigham stated that the issue of grip strength lost is rarely used in the AMA Guides. There are other factors for assessing range of motion.

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Commissioner Steinberg asked about why grip strength is not a factor when using the AMA Guides. Dr. Brigham replied that grip strength is rated by other methods in the Guide which represent an anatomical, not a functional, approach.

Dave Schwartz, President of the California Applicants Attorneys Association (CAAA), asked Dr. Brigham if he is aware that most of the ratings in California are done by a QME, not by the treating physician. Dr. Brigham replied that does not make a difference in the errors. The current cases, whether with a Permanent and Stationary Report or an AME or QME report, do not reveal any differences in the error rates. He does see issues that appear to be issues in bias from both defense and applicant sides.

Mark Gerlach, Consultant for CAAA, stated that the error rate nationwide is 70 percent. Dr. Brigham replied that what they are seeing nationally is 20 percent, not 70 percent, and that he expects to get down to a range of 20 percent. The goal of the Guides is to gain consistency. Dr. Bingham's experience in California with longshore and harbor workers' cases is that there may be some differences between ratings, but they are nowhere as profound as what he has seen in workers' compensation in California.

Mr. Gerlach asked about clarification about the 4.9 percent expert review whole person rating. Dr. Brigham responded that that would be the mean impairment standard of all ratings without adjustments.

Commissioner Davenport asked whether 20 percent of the ratings would be wrong no matter what the system would be. Some of this may be due to the systems that treating physicians are using. If physicians do not use the Guides frequently, they will not be able to become proficient with ratings. You want a physician who does those procedures enough times to become proficient.

Chair Wilson asked if the error rate is consistent with California's old PD system or other systems in other countries. Dr. Brigham replied that you do not see literature about different rating systems, but that is consistent.

A member of the audience asked if there are plans to train QMEs. Chair Wilson stated that this question is outside Dr. Brigham's experience.

Tara Paillet from Voters Injured at Work asked about doctor bias. Dr. Brigham replied that the bias of the treating physician is a key element. The treating physician has an advocacy role with the patient and may increase a rating that he or she believes is too low.

Ms. Paillet asked why the study focused on cases from 1997-2002. Dr. Brigham replied that this was a data sample of cases that were closed or no longer actively involved, so that there was a final rating.

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Ms. Paillet then asked if the cases were all from California. Dr. Brigham replied that this study involved only California cases.

Ms. Baker stated that CAAA sponsored a study conducted by Dr. Paul Leigh, Ph.D., and Steven McCurdy, MD, from the University of California, Davis. They also took a sample of 250 cases in which medical evaluations had been written under the pre-2005 criteria, and they re-rated those cases using the 2005 criteria and the pre-2005 PDRS. Ms. Baker stated that although this study was done independently and the study design was different from the Brigham study, they are both dual-rating studies and they share similar strengths and weaknesses. For example, the Brigham study found a 58 percent reduction in ratings in cases that have ratable impairment, and the Leigh study indicates a 59 percent reduction in the average rating of cases that have ratable impairment. In addition, the Brigham study found that 39 percent of the 250 cases that were rated under the pre-2005 schedule would no longer have a ratable impairment according to the AMA Guides criteria and therefore would have a zero rating under the 2005 PDRS. These cases, often called the zeros, represented approximately 30 percent of the benefit dollars payable under the pre-2005 PDRS. The Leigh study found that approximately 10 percent of the sampled cases became zeros. Ms. Baker then stated that a key difference between the studies was that the Brigham sample was drawn from the DEU cases which tend to be similar cases, while the Leigh study has been drawn from reports of AMEs in attorney-represented cases, which tend to be more serious and complicated cases. Because of the different sampling effects, the actual percentage of cases that will become zeroes probably falls between 10 percent and 39 percent. Savings from the zeros would not be affected by revised FEC factors.

Ms. Baker commented that Dr. Leigh's study and Dr. Brigham's study are both limited by the fact that the medical reports were not written to AMA criteria. Although these studies show that revision of the old schedule to the new schedule is probably necessary, they are too limited to serve as a basis for making that revision. An accurate revision of the PD schedule requires more detail on how the system is actually performing under the current schedule.

Ms. Baker commented that Frank Neuhauser would describe preliminary results of the ongoing PDRS study. Mr. Neuhauser stated that he would present some results of his study of the DEU ratings under the new schedule, which is partially funded by the WCIRB and partially by the Commission. The DEU provided an extensive amount of data, and Commission staff played a key role in helping obtain the data. Mr. Neuhauser said that he would briefly discuss preliminary results, as well as talk about the data sources, how comparisons are made to past ratings, what the overall results are, particularly when broken down for some of the different disability groups, and directions for future work with these data.

Mr. Neuhauser stated that the DEU collects data on all the ratings performed by the unit, whether they are on represented or unrepresented cases. All of these ratings are from 1991 forward, about one and one-half million ratings. A database which was created earlier was the basis for the RAND study analyzing the effect of the adequacy of ratings in targeting benefits. That earlier database has been extended to include the most recent evaluations. Mr. Neuhauser stated that the new ratings done under the system have less maturity, cover different types of disabilities, and

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have several other different characteristics; therefore, comparison groups were established.. These tend to be younger cases than most of the cases coming to the DEU. They are controlled for seven different body categories and for the existence of multiple disabilities and for rating type.

Mr. Neuhauser further stated that there were two rating groups: summary ratings, which include panel QME ratings and treating physician reports and are for unrepresented workers; and consult ratings, which include walk-ins and mail-ins and are typically for represented workers. For unrepresented workers for summary ratings, the pool of applicants is pretty much identical between the old system and the new system; however, for represented workers, or summary ratings, that pool has changed a great deal. In the past, many represented workers, who were a significant fraction of the cases, did not go through the DEU system because those ratings were handled outside the process. Mr. Neuhauser stated that the new law, SB 899, requires that these processes be handled differently, and we have not yet seen how these processes work out. Represented workers are required to agree on an AME, or if no agreement between the parties can be reached, they are given a panel QME list. Each of the parties can discard one of the panel QMEs and the third is chosen. Because there may be a very different pool of represented cases under the new schedule, these cases are separated from the unrepresented cases and dealt with separately. Mr. Neuhauser stated that summary ratings are the best comparison between the old and new schedules. Regarding zero ratings, Mr. Neuhauser stated that they are working with the DEU to establish the percentage of claims that get zero ratings under each schedule. The comparison, like Dr. Brigham's data, is of those claims that get rated under both schedules with a positive rating.

Mr. Neuhauser stated that up until August 17, 2005, the DEU evaluated 1500 medical cases. About half of those were summary ratings, which fall under the 2005 PDRS, and the other half were consult ratings where there may be some dissimilarities. Mr. Neuhauser commented that this is a very low sample and that the sample could change over time. He further stated that in line with the Brigham study, the average rating for summary ratings under the 2005 PDRS, which was 11.1 percent, compared to 18.3 percent in the pre-2005 PDRS; this represents a 39 percent decline in average rating for summary ratings and it compared to a 38 percent decline for consult ratings, which had a 17.45 percent rating in the 2005 PDRS and about a 28 percent in the pre-2005 PDRS. That is still a 38 percent reduction.

Mr. Neuhauser also stated that there were significant differences in pre-2005 and 2005 rating schedules of different body parts and psychiatric cases for both summary ratings and consult ratings. There is about a 40 percent decline in average ratings for body parts such as wrist/hand; arm/elbow/shoulder; lower extremity; backs, but a 43.4 percent increase for psychiatric cases. Psychiatric cases are not rated according to AMA Guides, so California has developed a review process based on the Global Assessment Functioning (GAF) scale. Mr. Neuhauser stated that this is an area to focus on in the future. In consult ratings, there is more discrimination in the ratings. There are larger declines for wrists and hands than other body parts, such as spine.

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Mr. Neuhauser commented again that the sample size is small and that the results could change over time. Ongoing research will be conducted, with monthly updates being received from the DEU, and analysis will be conducted with the updates each month. The target is to get fairly precise estimates under the new schedule for each of the 22 categories for which there are estimates of wage loss in the RAND study. There is about a 50 percent increase month-to-month in the number of ratings from the DEU. Four thousand more ratings are expected by mid-November, and that should provide a chance to do fairly accurate estimates of the differences between the two schedules in ratings, and probably at the level of many of 22 body parts.

Commissioner Steinberg asked if the analysis included FEC factors. Mr. Neuhauser replied that it did for those cases rated under the 2005 schedule but not before.

Commissioner Steinberg asked what the average increase of the FEC is. Mr. Neuhauser replied that the FEC is responsible for about a 25 percent increase in the average rating.

Mr. Schwartz from CAAA asked how determinations on psychiatric claims can be made when there is a small number of claims in each category. Mr. Neuhauser replied that there are about 57 psychiatric claims across two sets of data, but this is only early data and disaggregated to individual impairment category, so it is important to be cautious. Individual categories figures might vary as more data is available. The overall declines of about 35 to 40 percent, however, are probably going to be pretty stable over the long term.

A representative of CAAA asked why additional research will be needed on psychiatric claims. Mr. Neuhauser replied that no one else has based their psychiatric schedules on the GAF, but that the GAF is an appropriate schedule. Psychiatric cases were the least well compensated under the prior schedule. The wage loss associated with psychiatric cases, as well as the quality of the match between ratings and psychiatric cases, was very poor and warrants additional research. Finally, the increase in psychiatric cases is 30 or 40 percent for every case, but there is a much wider deviation that warrants additional research because the cases are severe and the ratings are not consistent between the two schedules.

A member of the audience asked for clarification on severity of psychiatric ratings. Mr. Neuhauser replied that what was meant by severe psychiatric cases was that the wage loss associated with psychiatric injury in the RAND study was the most extreme of the cases.

Chair Wilson asked if the doctors are receiving training on the AMA Guides. Ms. Baker replied that CHSWC has partnered with the AMA to present trainings statewide in order to increase the expertise of doctors in the use of the AMA Guides. She stated that Dr. Brigham is participating in forums training doctors on the Guides and he will make that information available.

Commissioner Davenport asked when the analysis of the DEU ratings will be available. Ms. Baker replied that the analysis will be available in the spring of 2006 or before, and these reports will provide the basis for which the schedule may be revised.

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Peggy Sugarman with Voters Injured at Work.org stated that her organization has put together some informational packets with actual cases of injured workers. She stated that she hoped CHSWC would be receptive to hearing from injured workers.

Proposal for International Standards Organization (ISO) 9000 Certifications of Quality Systems and ISO 14000 Certification of Environment Management Systems and the Effects on Injury Rates, Injury Severity and Workers' Compensation Costs in California

Professor David I. Levine, University of California, Berkeley

Professor Mike Toffel, University of California, Berkeley

Ms. Baker introduced Professor David Levine from UC Berkeley. Professor Levine stated that his presentation would explore the effect of quality standards on worker health and safety. Professor Levine first stated that job loss in California has been significant, as in the rest of the country. There is a hypothesis that quality management will help save jobs. There are a vast number of programs that might affect occupational health and safety, including: US OSHA -- the Voluntary Protection Program (VPP) and the Strategic Partnership Program (OSPP); the US EPA – Audit Policy; ISO 9000 Quality Management Standard, the most widely known certification program, and ISO 14000 the Environmental Management Standards. Dr. Levine stated that few studies have identified whether these programs actually improve health and safety. This study could be the first of what could be a series of evaluations.

Dr. Levine further stated that the ISO 9000 standard for quality management presents standards for operations. Thousands of California workplaces are certified in ISO 9000, which means that products coming out of these workplaces use standard procedures that are certified to meet ISO 9000 standards. There have been some evaluations of how ISO 9000 affects companies and customers but very little evaluation of how this standard affects workers.

Dr. Levine stated that there are several ways ISO 9000 might improve health and safety. For example, ISO 9000 can ensure the documenting of procedures and the use of standardized procedures, which, in turn, can help eliminate potentially hazardous practices. ISO 9000 can also require corrective action, which facilitates root cause analysis of quality problems and of accidents and “near-misses.” However, Professor Levine also pointed out that standardization can lead to repetition which can lead to cumulative trauma disorders, such as carpal tunnel syndrome. Some studies have shown that total quality and just in time (JIT) programs lead to more repetitive motion injuries.

Dr. Toffel stated that the proposed study will be the first to evaluate the effect of ISO 9000 on occupational health and safety. The key challenge with this type of study will be the choice of an appropriate comparison group of non-adopters. The study proposes that each non-adopter that will be compared to the adopter will be from same industry, with the same geographic region, same size, and same distribution in employee occupations, as well as same prior health and safety record. Data that will come from the QSU Publishing and Dun & Bradstreet will include areas such as revenue, industry, employment, and ISO adoption date. Data from the WCIRB

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will include health and safety outcomes including annual injury claims, annual serious claims (e.g., \$2000 or permanent disability), annual total workers' compensation costs, and other data to be determined, as well as worker characteristics. Analysis in California will be of single-plant firms and will focus on plant-level and firm-level data.

Professor Levine reviewed the potential policy implications that could result from ISO adoption resulting in the lowering of injury rates or workers' compensation costs. Policy makers could reduce the cost for marginal adopters by providing incentives; insurers could consider ISO adoption when determining workers' compensation insurance rates; and the health and safety community could be more aware of what tools are helpful for improving health and safety. If the research shows that ISO adoption increases injury rates or workers' compensation costs, then policy makers, insurers and the health and safety community could adopt practices accordingly.

Chair Wilson asked if the study will make any recommendations for ISO adoption. Professor Levine replied that if the results of the study are strongly positive, it would be a strong indication that the ISO standard should be adopted.

Daniel Ashley, a member of the audience, spoke about the impact on his employer, a very large municipality in California, of adopting the California VPP program. Mr. Ashley stated that the program has been absolutely astronomically important in reducing workers' compensation costs from the \$1 million level to the \$100,000 to \$200,000 level. At the point of adoption, workers' compensation cases and management issues increased; however, following that initial increase, which was expected due to the change, there has been significant decrease. Professor Levine replied that for a year after adoption, companies are working through problems. The study therefore will look at adopters before 2003 in order to look at companies who have been using the standard for longer than a couple of years, and the study will not focus on the year before and the year after adoption.

Ms. Paillet asked if the study will use data from the University of California Berkeley Suitcase Clinic. Professor Levine replied that they will be using WCIRB data.

Chair Wilson asked Christine Baker to summarize the issues around the proposal. Ms. Baker stated that this study meets the goals of the safety focus of CHSWC. She further stated that CHSWC has the budget to do the study and that Commission staff has reviewed the study.

CHSWC Vote

Commissioner Davenport moved that CHSWC approve the proposal, and Commissioner Thacker seconded. The motion passed, five to one, with Commissioner Steinberg casting the opposing vote.

Commissioner Salazar suggested that one segment of the study should focus on small business. Professor Levine responded that they will divide the sample by region, industry and size and will look at subclasses to the extent possible.

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Proposal for "Quality of Care in California Workers' Compensation: The Carpal Tunnel Demonstration Project"

Teryl Nuckols-Scott, MD, MSHS, Assistant Professor, David Geffen
School of Medicine at UCLA

Steven Asch, MD, MPH, Associate Professor, David Geffen School of
Medicine at UCLA

Ms. Baker introduced Dr. Teryl Nuckols-Scott and Dr. Steven Asch who are developing a proposal for exploratory feasibility work in the area of quality of care and explained that this project has developed from the larger medical study being done by RAND. Dr. Nuckols-Scott stated that she would explain a plan to develop a proposal for a demonstration process and then would suggest that CHSWC consider investing in the proposal development process. The objectives of the demonstration project would be to show that the quality of medical care provided to injured workers can be systematically evaluated, to evaluate the quality of care provided for one or two common work-related injuries, and to show how information about quality can be reported to inform decisions by policy makers and payors.

Dr. Nuckols-Scott then stated that overall, adults in the United States receive about half of the recommended care for medical conditions. Medical care for back and joint injuries is not much better. Dr. Nuckols-Scott further stated that quality-of-care problems probably also exist in the California workers' compensation system. Quality problems include providing either too much medical care or too little medical care. Too much care, or overuse, involves providing care that is more likely to harm than benefit the patient and affects 11 percent of patients. Too little care, or underuse, involves failing to provide care that conveys substantial benefit and affects 46 percent of patients. In workers' compensation, overuse and underuse both affect whether payors receive value for their money. Value is defined as a ratio between improvement in health and costs to payors. Overuse represents poor value because workers' health is unlikely to improve and medical costs are unnecessary. Underuse also represents poor value because workers' health is unlikely to improve and costs to payors can increase if this lack of improvement delays return to work, leads to permanent disability, or creates a need for more medical care later on.

Dr. Nuckols-Scott also commented that overuse and underuse affect California workers' compensation. Recent workers' compensation reforms were a response to overuse. Underuse might also contribute to high medical and disability costs. A small percentage of claims have surprisingly poor outcomes due to poor care. In other states, policies promoting care that enhances and speeds recovery have reduced disability costs. Dr. Nuckols-Scott stated that underuse in California has not been studied to date.

Dr. Nuckols-Scott next stated that policy makers and payors can monitor quality of care and encourage improvement. They can assess care by individual providers and identify outliers for investigation. A study of the Texas workers' compensation system, Dr. Nuckols-Scott commented, revealed that unnecessary care was consistently delivered by 800 providers; however, the Texas study did not identify underuse. Dr. Nuckols-Scott then stated that policy

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makers and payors can also look at provider networks or groups to analyze overuse and underuse, which, in turn, will make the network responsible for practices within the network and adopt strategies for discouraging overuse and underuse. One strategy is value-based purchasing, where payors choose to contract with those providing higher quality. Another strategy is pay-for-performance incentives, where payors give monetary rewards to those providing higher quality of care. A system-wide analysis can enable policy makers to develop a system to identify emerging issues or problems and track responses to policies.

Policy makers and payors need report cards to describe quality of care. Report cards on medical networks would help assess how well each network performs overall and how well it addresses important tests and therapies. An annual system report card, which would be useful for policy makers, would help assess how the new policies are affecting quality, whether overuse and under use are changing over time, and which important tests and therapies are most overused or underused.

Dr. Nuckols-Scott next discussed the rationale for the demonstration project, stating that quality-of-care problems probably exist in the California workers' compensation system. Both workers and payors would benefit from better quality, as workers have improved health outcomes and payors get better value for their money and possibly reduced medical and disability costs. Dr. Nuckols-Scott further stated that it is feasible to monitor quality of care for the California workers' compensation system. Policy makers and payors could use this information to make informed contracting decisions and to create incentives for improving quality.

The first step in the demonstration project, Dr. Nuckols-Scott commented, would be to develop quality-of-care indicators for two common work-related injuries, carpal tunnel and lower-back injuries. The project would then develop process-of-care and outcome indicators. In addition, the project could obtain data addressing the care of workers with the selected injuries. Data would include administrative data and medical records or charts. The project would also evaluate quality of care using the indicators by applying the indicators to administrative data and charts and analyzing and interpreting the findings. Finally, the project would generate user-friendly report cards on quality of care within medical networks and across the state as a whole. The results of the project would be shared with stakeholders.

Dr. Nuckols-Scott reviewed the objectives of the proposal development process: conducting background research by identifying existing quality indicators; quality monitoring systems in other states and important therapies for the selected industries; communicating with California stakeholders to identify perceptions of quality issues and priorities and to provide information of the greatest interest to users; and designing and preparing for the project by identifying organizations that might provide data and drafting a sample report card.

Dr. Nuckols-Scott then reviewed the rationale for the proposal-development process, which includes identifying a substantial body of existing work that is potentially applicable to the demonstration; identifying organizations that would share data but need more data that have already been identified; identifying pitfalls to quality monitoring which would enhance the

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success of the demonstration and any ongoing monitoring; and obtaining user input which is needed to design report cards that provide useful, accessible information.

Next, Dr. Nuckols-Scott reviewed the steps in the approach to the proposal development process which include: communicate with stakeholders about project objectives; identify potential collaborators and examine data sources; conduct preliminary literature searches; recruit a technical advisory panel; develop methods for recruiting clinical panelists; draft a sample report card; write the proposal; and communicate again with stakeholders about the proposal.

An investment by CHSWC, according to Dr. Nuckols-Scott, would enable the project team to communicate with stakeholders from the inception of the project, prepare a polished proposal for a rigorously designed project, and create a consortium of public and private funding sources for the work as a whole.

Commissioner Davenport asked if there are major healthcare systems like Kaiser where they do similar studies. Dr. Nuckols-Scott replied that there are.

Chair Wilson asked Ms. Baker to summarize issues with the proposal. Ms. Baker stated that an inter-agency agreement would UCLA would be developed for the feasibility study that would involve initial proposal exploration, and the cost would be about \$30,000.

Peggy Sugarman asked if the study would distinguish between what doctors would like to provide as a recommendation versus what they are authorized to provide. Dr. Nuckols-Scott replied that this was an interesting question, but that this study was only going to look at what was provided. Ms. Sugarman commented that she believed doctors are not being allowed to provide what they think is necessary, which is partly due to misunderstanding of the ACOEM Guidelines and partly due to limitations on certain therapies in the workers' compensation system. She stated that she does not see how the study would reconcile what is being provided with what is needed.

Dr. Asch replied that a review of the charts and the recommended treatment could be evaluated.

Ms. Baker stated that Commission staff strongly recommends the study, particularly since the issue of appropriate treatment is of concern.

Commissioner Steinberg asked if this study was just exploratory. Ms. Baker replied that it is totally exploratory at this time to see how the proposal should be developed. Efforts will be made to look for other funders to do the study.

CHSWC Vote

Commissioner Thacker moved that CHSWC approve the proposal, and Commissioner Schwenkmeyer seconded. The motion passed unanimously.

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Update on Spinal Surgery Second-Opinion Study Requested by Senate President pro Tem Don Perata and Assembly Speaker Fabian Nuñez

Frank Neuhauser, Project Director, UC DATA, UC Berkeley

Ms. Baker introduced Frank Neuhauser and stated that CHSWC is being presented with a draft of the update on the spinal surgery second-opinion process (SSSOP) study, which has not gone out to the public yet. Mr. Neuhauser stated that this process allows employers or insurers to request a second opinion when spinal surgery is recommended. There has been significant concern in the workers' compensation community that spinal surgery has been increasing. Mr. Neuhauser stated that it is true that hospital costs are increasing; however, it is outpatient hospital costs that are increasing, and those costs are not associated with spinal surgery costs, while other costs are staying steady.

Mr. Neuhauser then presented some of the findings of the study and summarized the conclusions of the study. The findings included that there has been the spinal surgery is much more heavily utilized in California workers' compensation system than other compensation systems in the nation and in group health; that complex and invasive spinal surgeries are increasing rapidly; that ACOEM guidelines and utilization review are helpful, but there are gaps in the guidelines for spinal surgery; that at least in the medium-term, SSSOP is a well-targeted approach to appropriate review. Mr. Neuhauser further commented that some workers face potentially substantial burdens in complying with SSSOP that may be due to limited access so that expansion of the panel of second-opinion evaluators is essential. Evaluation of the burdens on workers and the impact on treatment should continue. Evaluation of outcomes of foregone surgeries is also critical.

Future work, Mr. Neuhauser stated, should include a survey of workers affected by SSSOP. A mail survey with telephone follow-up could determine if workers completed the process and if not, why not; if workers obtained surgery at their own cost; and what the outcomes are for workers: are they employed? what is their health status? what were overall claim costs? and what is their level of satisfaction? This would be a fairly straightforward study and would not take a lot of time or money.

Ms. Baker asked CHSWC to approve additional work to meet the legislative request for a study to be completed by 2006. She stated that Mr. Neuhauser has laid out the issues and approval by CHSWC would allow the additional work to be completed.

Chair Wilson asked what the next steps would be. Ms. Baker replied that at this point, it would be appropriate to form an Advisory Committee and to send the paper out for comment.

Commissioner Steinberg suggested that the study be completed before the 2006 deadline. Ms. Baker added that injured workers will be contacted to determine if there are barriers to access.

CHSWC Vote

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Commissioner Steinberg moved to approve for circulation and feedback the draft paper on the Spinal Surgery Second-Opinion Study, and Commissioners Davenport and Thacker seconded. The motion passed unanimously.

Ms. Baker then recommended that the presentation on the CHSWC report "Understanding the Effect of SB 899 (State 2004, Chap. 34) on the Law of Apportionment" be tabled for the next CHSWC meeting, as data is still being collected. The data and the legal discussion will be presented at that time.

Chair Wilson then asked Ms. Baker to report on CHSWC staff activities.

Executive Officer Report

Christine Baker, Executive Officer

Ms. Baker presented the Executive Officer Report with a streamlined update on projects since the last CHSWC meeting. First, she stated that CHSWC co-sponsored a very successful Forum on terrorism and is preparing a draft issue paper on terrorism. The forum, the "National Symposium on the Future of Terrorism Risk Insurance," was held at the University of Southern California on June 20, 2005, and included participants from RAND, the Wharton School, University of Pennsylvania, and the Center for Risk and Economic Analysis of Terrorism Events (CREATE) at University of Southern California.

Topics for the forum included:

- The terrorism threat: insuring for the future.
- The economics of terrorism insurance.
- Trends in terrorism and the architecture of TRIA (Terrorism Risk Insurance Act).
- Can insurance cover weapons of mass destruction?
- Insurance response: how we will prepare for the threat.
- Insurance and the catastrophic loss of human life: workers' compensation, life insurance, and victim compensation.
- The future of terrorism insurance.

The background issue paper will summarize the findings of the forum and will inform the public about existing terrorism coverage in the workers' compensation system.

As discussed, work on the paper in response to the Senate Pro-tem request and the Assembly Speaker regarding PD is proceeding. This was a difficult request given the unavailability of data until now.

Ms. Baker then stated that CHSWC's work with RAND on the medical study has been very fruitful. The study on repackaged drugs, as well as work currently being done on this issue, has

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served to inform the legislature on this issue. She stated that CHSWC does get calls from the legislature and refers members of the legislator to Commission studies. The medical study will inform CHSWC on monitoring of the system and provide us with a framework for doing so. The final RAND study report briefing is expected in October.

CHSWC has also been working on getting several projects started. A request for proposal (RFP) for a return-to-work study is in process. RAND was the only bidder. This is a complex study, which will entail matching records between EDD and workers' compensation data. This requires a lot of confidentiality and a lot of linking of data sets. RAND has done this kind of work before for CHSWC; it is the only reliable method of measuring return to work.

Ms. Baker then stated that CHSWC has proceeded to contract for a study of firefighters, police officers and other safety personnel on safety and disability retirement. This study was at the request of Assembly Member Vargas and Assembly Member Rick Keene. Joint funding will be through the National Institute of Occupational Safety and Health (NIOSH) which is very interested in safety for firefighters. The final approval should be forthcoming from the Department of General Services.

CHSWC's Worker Occupational Safety and Health Education and Training Program (WOSHTEP) is off the ground and continuing to grow. Among other accomplishments, printed materials for a small business resources program are now available, and more details on WOSHTEP projects will be presented at a later meeting.

A WOSHTEP Strategic Planning meeting with UC Berkeley and UCLA is planned for September 22 and 23 in Oakland. The objectives of the meeting will be to develop a five-year Strategic Plan for WOSHTEP, specifying goals, objectives and priorities. Invited speakers will provide new data and perspectives on trends, and efforts will be made to determine where we should be focusing efforts and how to better serve WOSHTEP target audiences, including employers, small businesses, young workers, and underserved populations. A draft of the Strategic Plan will be presented to the Advisory Board at the October 27th meeting and then submitted to CHSWC.

Mr. Baker stated that she has kept the Commissioners informed via email regarding her work on the idea of WOSHTEP participating in an evaluation/demonstration project and getting funding from the NIOSH for that purpose. The idea would be an intervention and evaluation project combining the CHSWC's occupational health and safety program and information with training on health promotion. CHSWC is exploring the feasibility of partnering with the Department of Corrections and NIOSH on development of a health-promotion module, as well as on an evaluation of the WOSHTEP Specialist Curriculum. CHSWC has entered into an agreement with the Department of Corrections to offer the Specialist course to all the Department's facilities statewide.

Ms. Baker stated that there has been a request to evaluate the impact of repackaged drugs and the impact of those costs on the workers' compensation system. CHSWC has set up a study working

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with data from the California Workers' Compensation Institute (CWCI) and with Barbara Wynn from RAND and Frank Neuhauser from UC Berkeley.

Judge Lachlan Taylor reported that Senate Bill (SB) 929 (Speier) was not heard in committee today. He stated that it is disappointing not to be able to obtain those savings for employers that this bill would provide. Initial research by CHSWC shows that the portion of medications dispensed through physicians is much larger than initially expected. Employers pay an average of about four-and-a-half times as much for exactly the same drugs when the drugs are dispensed by physicians as when the employees pick them up at pharmacies. Judge Taylor stated that efforts will continue to be made to make this system serve the interests of employees and employers.

Public Comment

Chair Wilson opened the meeting for public comment.

Peggy Sugarman from Voters Injured at Work asked CHSWC to take quick action and to shorten the delay for injured workers to receive benefits.

Dave Schwartz, President of the California Applicants Attorneys Association, stated that he is glad that CHSWC recognizes the need for a change in the PDRS. He further stated that injured workers are reporting more than a 40 percent reduction in benefits, and that there are 10,000 injured workers who are rated every month. He stated that there are serious problems with the AMA Guides, especially with cases with zero ratings and with a lack of objectivity.

Roy Otis, member of California Applicants Attorneys (CAAA), stated that he is not speaking for CAAA but from his own experience as an applicants attorney and that he supports the comments made by Peggy Sugarman and Dave Schwartz. He asked why CHSWC could not recommend a 30-40 percent increase in workers' compensation benefits on a temporary or emergency basis in order to help injured workers receive adequate benefits.

Adjournment

The meeting was adjourned at 12:30 p.m. The next CHSWC meeting is scheduled for Thursday, October 6, in Oakland.

Approved:

John C. Wilson, Chair

Date

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Respectfully submitted:

Christine Baker, Executive Officer

Date