

RAND Response to "Issues of concern regarding the Rand Study for PTSD- Commissioners Shelley Kessler, Christy Bouma and Nicholas Roxborough"

We thank the commissioners for raising these issues. The document below reprints the commissioners' comments and includes responses from the RAND study team following each comment.

Commissioner Shelley Kessler's Comments and RAND's Responses

Comment #1:

Since it was noted that Assemblymember Daly requested answers to 12 research questions, it would assist us and the public to present the questions for review. They give context for the study and the results.

Response to Comment #1:

These 12 questions are listed in full in Chapter 1 (pages 2-3) of the report to provide context and help readers understand the scope of the study. Appendix A of the report (pages 158-160) consists of a table that provides concise question-by-question answers to each of these twelve research questions. These concise answers are also presented in the chapters of the report where each question is addressed, in the form of a text box located in the concluding "Summary of Findings" section of each chapter. For reference, these questions (as we numbered them in the report) are as follows:

- RQ1: Do firefighters and peace officers have a higher incidence of traumatic stress injuries than non-public employees which pose similar exposure to traumatic stress, such as emergency room personnel, security guards, or private ambulance service employees?
- RQ2: Do firefighters and peace officers experience a significantly higher incidence of suicide, attempted suicide or other serious mental health conditions than other employees generally?
- RQ3: Are claims by firefighters and peace officers for mental health conditions denied under circumstances where the condition appears to be job-related but the employee has/d difficulty proving that fact, and is/was the rate of denial statistically different from other claims by firefighters (or peace officers) that are subject to presumptions of compensability? NOTE: As part of the response to this question, the contractor should analyze the denial rates of claims subject to presumptions of compensability, whether denial rates are different based upon the entity adjusting the claims (third-party administered [TPA], self-administered, or insured) and describe the ultimate disposition of denied claims, either upheld or reversed.
- RQ4: Do firefighters and peace officers file claims for mental health conditions at a rate statistically different from other employees?
- RQ5: Are claims by firefighters and peace officers for mental health conditions denied under circumstances where the condition appears to be job-related, but the employee has difficulty proving that fact, and is the rate of denial statistically significantly different from other claims and from other types of employees?
- RQ6: In addition to quantifying data requested in number 4, above, please consult with the professional mental health community to determine the feasibility of proving or disproving the job-relatedness of these mental health conditions.
- RQ7: To the extent that claims for mental health conditions filed by firefighters (or peace officers) are being denied by employers, is this occurring following prior treatment that was covered by employer-sponsored or other health care coverage, where the treating provider(s) concluded the condition was job-related, or in cases where there was no prior treatment or diagnosis?
- RQ8: Of the claims that involve mental health conditions, what percentage of these claims were primarily for mental health issues, and what percentage of these claims involved a mental health claim as a compensable consequence to a claim for physical injuries?

- RQ9: To what extent are mental health claims filed by public safety officers post-separation/termination claims, as opposed to claims for which the employer had notice during the term of employment?
- RQ10: In the case of denied workers' compensation claims by firefighters and peace officers for mental health conditions, is there evidence that the claimant later sought and obtained care through employer-sponsored or other health care coverage?
- RQ11: What might the costs to state and local governments be for each of the next five years now that SB 542 is in effect? Please separate out firefighter and peace officer estimated costs.
- RQ12: What would the costs to state and local governments be that are associated with the retroactive application of the rules set forth in SB 542? Please separate out firefighter and peace officer estimated costs.

Comment #2:

A total of only 13 firefighters and police officers were interviewed. Not only is this a tiny sample of the impacted individuals (with 30,000 firefighters in CA, for example) but the breadth and depth of what is considered to be First Responders is far more varied than the study acknowledges. Continuing the firefighter example: There are vast differences in exposure to traumatic events based on the types and volume of calls that firefighters respond to between rural and urban departments; in serving as firefighters versus firefighter-paramedics; in working on fire department ambulances as compared to engine and ladder companies; and from the experiences that accumulate over many years of service versus those of newly hired firefighters. The firefighter category alone is not sufficient to understand how these different situations affect PTSD.

Response to Comment #2:

We agree that there is a need for more research on how traumatic exposures and resulting mental health impacts vary between firefighters with different job duties, with different working conditions, in different departments, or in different communities. However, the qualitative work in this study was not designed to fully catalog the diversity of these experiences in terms of the diversity of traumatic exposures, how different traumatic exposures affect mental health, or how other factors may modify the relationship between workplace traumatic exposure and mental health. A rigorous study to address these types of questions systematically across the first responder population in California would have required a different design. But such a research study also is now much better situated after our in-depth exploratory study that focused on uncovering context and departmental characteristics of filing mental health claims within specific types of departments across California.

To address the breadth of the research questions laid out in CHSWC's request for proposal (which mirrored the questions posed by Assemblymember Daly), it was necessary to gather in-depth perspectives from a variety of different stakeholders linked to specific first responder departments in addition to analyzing and understanding the trends and outcomes of the WC claims filed for mental health conditions by first responders in California. To accomplish this, we conducted a mixed-methods study combining quantitative analyses with qualitative research. To understand how PTSD and other mental health claims are handled in California's workers' compensation system, we analyzed administrative data from the Workers' Compensation Information System (WCIS), a comprehensive database of workers' compensation claims managed by the state. We analyzed data in 12 years (2008–2019) of injury claims filed before SB 542 took effect, to establish some basic facts about the pre-SB 542 status quo in California. The goal of the qualitative research in this study was to systematically gain information from first responders and other stakeholders that was needed to address the research questions, but that could not be obtained from

quantitative analysis of existing (secondary) data sources. We did this by conducting over 50 semistructured interviews with a sample of relevant stakeholders from across California, and by convening a Technical Advisory Group containing various stakeholders and experts to gather input on study design (in October 2020) and on preliminary results (in May 2021).

We chose to conduct a study that aimed at understanding the phenomena of claim filing for mental health conditions and illnesses for first responders with a focus on understanding and comparing the specific context of their departments. We included case study departments by type (i.e., fire or police), the rate of mental health claim denials (i.e., high or low), the region (i.e., urban or nonurban), and the location in California (i.e., Northern or Southern). We established our stakeholder samples (applicants' attorneys, departments) and employed a nested department-based recruitment strategy, using quota-based, purposive sampling techniques, to engage interview respondents. Described in the report in detail on pages 10-13. We gained in-depth views and experiences from a range of stakeholders across a diverse set of departments, so that we could highlight the differences and similarities found by department and stakeholder characteristics (such as a department's type [fire or police] urbanicity or claim denial rate). A brief overview of our research activities is given in the Summary (page vi), and the study design is presented in detail in Chapter 2.

We pursued a nested department-based recruitment strategy to enable us to address the full scope of research questions about the functioning of the workers' compensation system. Figure 2.1 (p. 11) shows the nested department-based recruitment strategy, which provided the experience of the first responder and the stakeholders included to provide context surrounding their experience. To address our research questions required not only the experiences of first responders who have used or tried to use the workers' compensation system for treatment of job-related mental health injuries and conditions across California, but also perspectives from stakeholders about the context influencing mental health treatment, claims administration, and department mental health resources. The interviews in our study were not designed to capture a large, statistically representative sample of first responders; instead, we designed our recruitment strategy to achieve diversity along a limited number of important dimensions. Briefly, we used WCIS claims data to identify fire departments and peace officer organizations with varying volumes and denial rates for among mental health claims in the workers' compensation system. Using this data, we sought to include departments with high volumes of mental health claims (relative to their total workers' compensation claim volume) and either high or low denial rates for mental health claims. Departments were recruited to ensure the inclusion of departments with high and low denial rates for mental health claims, of departments from both rural and urban areas, and of departments from both Northern and Southern California. Table 4.2 (p. 58) describes the diversity of our interview sample of departments on these dimensions and a detailed description of our methods for defining an interview sampling frame is presented in Chapter 2 (p. 10).

Also, our qualitative research also incorporated stakeholder perspectives from the Technical Advisory Group (TAG). Individuals recruited for the TAG were meant to balance perspectives of different stakeholder groups, and included mental health professionals; managers and employers, including police and fire chiefs; workers' compensation attorneys; claims professionals from insurers or third-party administrators who work with large and small departments across the state; and stakeholders with experience with first responder's use of the workers' compensation system. Details on the TAG are on page 9 of the report.

We acknowledge that we did not conduct a survey meant to produce estimates that would be statistically representative of the population of first responders in California. However, our findings have identified some important department characteristics that could be utilized in the design of a sampling strategy and

development of a survey in a study that includes a first responder survey in California. The findings of our study support the next steps for important future research in this area for California.

Lastly, the diversity of experiences and potential exposures to traumatic events that exists among California's firefighting workforce is an important point to acknowledge. Chapter 3 discusses the evidence on posttraumatic stress and suicide among first responders, including references specific to firefighters (pages 30-35). From our interviews specifically, mental health professionals indicated that if clients are first responders, then they expect these first responders to have been exposed to lots of trauma; more so if they are in an urban department. They explained that first responders are exposed to traumas daily, including both single incidents and cumulative trauma exposure, both of which, according to mental health professionals, can and do cause mental distress, injury, and PTSD (Page 95). Additionally, we describe what we learned in our discussions with first responders, applicants' attorneys, mental health providers, and other key stakeholders that work within and support fire and police departments (i.e., chiefs and claims administrators), we heard about traumatic stress exposure, traumatic stress injuries, suicide, and other serious mental health issues and symptoms (pages 35-39).

Comment #3:

In addition, no mention of the union leadership for any of the studied work groups were included in the list of those contacted. The people who represent these workers should have been contacted to not only share their experiences, but to allow contact within their ranks for the various types of scenarios their members sought to deal with their PTSD. The union leadership would likely have given RAND access to a much larger group of workers to interview. This would have made the results more credible.

Response to Comment #3:

We did not seek out union representatives specifically. However we did include statewide first responder professional organization representatives on the TAG. This is detailed on page 9 of the report.

We chose to recruit first responders through mental health providers. This strategy has been used successfully by one of the study members (Meredith) to recruit military veterans with PTSD for research. The details are in the report on page 11-12 and in Appendix B. See Meredith et al., 2011.

Work Cited:

Meredith, L. S., R. B. Branstrom, F. Azocar, R. Fikes, and S. L. Ettner, "A Collaborative Approach to Identifying Effective Incentives for Mental Health Clinicians to Improve Depression Care in a Large Managed Behavioral Healthcare Organization," *Administration and Policy in Mental Health*, Vol. 38, No. 3, May 2011, pp. 193–202. As of June 25, 2021:
<https://www.ncbi.nlm.nih.gov/pubmed/20957427>

Comment #4:

Given that the study acknowledges that there is a lack of trust and confidence in EAP options, there is no citing of other concrete possibilities that might have been explored, except that those impacted likely paid for their own access to counseling of some sort. Again, this could have been captured by talking with worker representatives who assist their members as they navigate the EAP system for assistance and who might also have been able to find individuals within their ranks willing to share experiences.

Response to Comment #4:

The report describes the mental health resources provided by the departments (pages 100-103 of the Report) including EAP but also the other types of resources, followed by a section that describes the

culture within the departments (pages 103-108) and a section that delineates the type of mental health treatment the first responders reported (pages 108-109).

We also indicated that all of the departments that participated in the study provided a basic set of supports and avenues for mental health, such as an active EAP program, peer-support programs, and 4850 pay for workers who were off the job due to work-related injuries. Other departments also had wellness programs, mental health training, and PTSD support available for workers and a few of the departments also made available several additional mental health- and PTSD-related resources, such as providing first responders with funds and time to attend PTSD retreats and providing a confidential app through which workers and their families could access mental health services and support anonymously. We also pointed out that first responders are typically limited to the resources available through their department or through their medical provider network's (MPN's) mental health provider list.

We agree that the identification of best practices or alternative models for providing mental health care to first responders is an important topic for future study. While it was not in the scope of our study to explore these questions in depth, we hope that our study findings I some light on the challenges that first responders face in obtaining needed mental health care and might provide a foundation for future research identifying solutions.

Comment #5:

We don't know how many of the other people listed were contacted from each category. If the numbers are either larger or smaller than those of the impacted workers, that may distort the results and therefore it would be important to know those numbers as well.

- a. These are the people listed for whom we don't have specific numbers: – Applicants' attorneys, Department chiefs, Claim administrators, and Mental health providers
- b. Note no contact to union or organizational representatives for the fire and police members.

Response to Comment #5:

This information can be found on page 13 of the report. It states that for applicant attorney interviews, we completed nine (out of ten) (i.e., having one soft refusal), yielding a 90-percent response rate. We also reported that we recruited a total of 11 departments (with 11 soft refusals and two hard refusals; and eight departments were never contacted), yielding a 46-percent response rate (11/24). The Departments are equivalent to Department Chiefs (as each Department has one Chief). For eight of the departments, we completed the full set of interviews (chief, claims administrator, mental health provider, first responder). For the remaining three departments, we did not complete either a mental health provider interview or a claims administrator interview. Response #2 above addresses the inclusion of the union representatives for fire and police, as they were included in the TAG.

Comment #6:

Though acknowledged, the "hero stigma" that people in the first responder category face undermines their overt willingness to file claims for mental distress. Using the data that is not only dated and less comprehensive does not help us understand what kinds of experiences trigger distress post-incident among state's firefighters, firefighter/paramedics and police officers. Citing that as a possibility, but not actually investigating this basic cultural issue among first responders, makes for a less than convincing study. But at least the study noted the difficulty.

Response to Comment #6:

The goal of the study was not to understand what kinds of experiences are more or less likely to lead to PTSD or other mental health conditions among first responders. That said, we heard about a variety of

specific traumatic exposures in our interviews with first responders, and we discuss examples of these types of exposures in Chapter 3 (pages 36-39).

The scope of the study also did not explicitly call for an in-depth investigation of the phenomenon of mental health stigma or its impacts on workers' access to care or interactions with the workers' compensation system. Regardless, our qualitative and quantitative findings did touch on the impact of stigma in a number of places. We report that all the first responders whom we interviewed cited mental health stigma as a barrier to receiving mental health care (pages 99-100) and briefly discuss how stigma influenced their decisions to seek help. While the sample sizes were very small, we also were able to analyze data from the 2013-2019 California Health Interview Survey (CHIS) on the reason why workers had an unmet need for mental health care. 83 percent of peace officers with unmet needs for mental health care cited stigma as a reason for not receiving care. These estimates are in Table 6.1 (p. 110). Differing perspectives about the extent to which SB 542 might succeed in addressing mental health stigma are also discussed in Chapter 8 (pages 144-148).

An inherent limitation of workers' compensation claims data is that it cannot tell us directly about the occurrence of workplace injury (including PTSD) among workers who do not file workers' compensation claims—including those who are experiencing PTSD but do not seek help or file claims due to stigma. For this reason, we did not rely on workers' compensation claims data to characterize the prevalence of mental health conditions, but instead drew on a review of the literature and analysis of confidential household survey data: these analyses are discussed in Chapter 3.

We also recommend collection of more detailed survey data on PTSD prevalence and mental health stigma to support future research on this important topic. This is discussed in the Summary (p. xiv) of the Summary.

Comment #7:

There is acknowledgement that historically claims have been denied. Doesn't that also speak to why fewer claims are filed? If there is no trust in the system, it is far less likely that first responders would go through the effort to file and therefore they seek other alternative options. Speaking with more than 13 individuals would have helped deepen the study and would likely have raised other issues or concerns worth noting.

Response to Comment #7:

We agree that claim denials and other barriers to filing a successful workers' compensation claim are likely to deter workers from seeking compensation. This fact is acknowledged on page 7 of the report: "While direct evidence showing how claim filing and access to care are affected by legal presumptions does not currently exist, the basic premise of SB 542 (that reducing barriers to claiming will increase access to benefits) is valid: Previous research indicates that workers' compensation disputes and claim denials are highly stigmatizing to workers and that such barriers to compensation and medical care serve as a deterrent to claim filing (Strunin and Boden, 2004)."

Work Cited:

Strunin, L., and L. I. Boden, "The Workers' Compensation System: Worker Friend or Foe?," *American Journal of Industrial Medicine*, Vol. 45, No. 4, April 2004, pages 338–345. As of June 30, 2021: <https://www.ncbi.nlm.nih.gov/pubmed/15029565>

Comment #8:

Really significant is the statement made by Rand that "Impacts of SB 542 not yet observable in data used for study." Clearly this states the obvious that more study is needed. But certainly, whoever does the study

MUST speak to a greater number of directly impacted individuals and seek a deeper understanding of the diversity of experiences across the first responder category. The narrowly defined interview pool for such a significant issue must be expanded if relevant data is to be collected.

Response to Comment #8:

We agree that it would be valuable to conduct a more extensive set of interviews or, as discussed above, to collect new survey data based on a representative California sample, to address the remaining, unanswered research questions. As we discuss in Chapter 9 of the report, it will also be informative to revisit the claims data once the presumption has been in effect for several years.

Comment #9:

In the study's own words about important but unanswered matters: "Many Important Questions Could Not Be Addressed and Call for Further Research • Data on PTSD prevalence, incidence unavailable – Add questions to CHIS (PTSD Checklist) – Analyze restricted data files from federal surveys • Productivity, job retention benefits of mental health treatment for first responders is unknown – Quantify costs of productivity loss and turnover – Quantify benefits of earlier, more effective treatment • Ex post evidence on effects of SB 542 – Impacts on claim volumes, denials, and reversals – Actual costs to state and local government" These are fundamental questions that must be answered to understand the questions Rand was charged with investigating. Why weren't these questions pursued more vigorously by Rand? What was in the RFP that either prevented or could have allowed seeking answers to these issues?

Response to Comment #9:

Some of these research activities, such as ex post evaluation of claim outcomes and costs with SB 542 in place, will become feasible only after the presumption has been in place for several years. Others would have required substantial primary data collection (or, in the case of accessing restricted-use federal surveys, time-consuming data access procedures) that could not realistically be completed in a rigorous way within the time and budget available for this study while also addressing the other research aims identified by CHSWC. While it's always possible to do more research with more time and money, we hope that our study has advanced the state of knowledge on questions of interest to policymakers despite its limitations.

Comment #10:

In their summary, Rand stated that they also "Identified Challenges That May Call for Policy Solutions Beyond SB 542" which included, but is not limited to, "Direct care provision used by some departments to address these issues, but we don't know if this is cost effective or succeeds in helping first responders." So how would those issues be addressed or studied?

Response to Comment #10:

In Chapter 6 of our report, which characterized first responders' use of mental health care for PTSD from workers' compensation and other sources, we discussed a number of shortcomings of the mental health care delivery system that were identified by first responders whom we interviewed (pages 119-129). We discuss policy implications of these findings in the Conclusion (pages 150-151).

As noted in the comment, our interview subjects described a system of direct care provision that had been adopted in some departments as a response to the access problems that exist in the standard mental health care delivery system. A useful first step in evaluating whether this is a model that should be adopted more widely would be to survey departments to determine how many across California are sidestepping workers' compensation by directly providing mental health care. For those departments identified using this model of direct care provision, in-depth case studies could be conducted that include interviews with department chiefs, city and union leadership, and mental health providers. In addition, an anonymous survey of first

responders within such departments could be conducted with an additional set of interviews with a sampling of first responders within those departments to understand the provision of mental health care under this model. For participating departments, data on the cost of the program, utilization, and patient outcomes could be collected. By partnering with departments and unions, such a study would ideally combine workers' compensation claims data with other benefits and personnel data to provide a comprehensive evaluation of medical and disability leave costs in departments where such a system is in place. Data from other departments that do not use direct care provision would also be ideal to provide a comparison group.

More broadly, policymakers, departments, labor unions, and providers should be consulted to identify and evaluate various avenues for improving the access to, and timeliness of, mental health treatment for first responders (such as contractual agreements with unions, departments, and cities). Another issue worth considering, is whether workers' compensation carve-out arrangements—which are common in California's public safety agencies—in conjunction with more serious attention to the composition of mental health provider networks in group health, could help reduce the fragmentation of payers that was so deleterious to first responders with PTSD. Our interview subjects did not mention carve-outs in the context of their strategy for providing mental health care to first responders.

Comment #11:

“Trauma-exposed occupations not covered by SB 542 may have worse mental health than first responders EMT/Ambulance, Security Guards, Corrections Officers”. Odd that Rand doesn't know that EMT/Ambulance and paramedic ambulance workers are also under the Firefighter classification in many regions across California. Or that Security Officers and Correction Officers can also be included in the Peace Officer designation. To consider that these workers may have “worse mental health” than first responders is failing to see that these workers are, in fact, all first responders and in essence it pits these classifications against each other instead of seeing them all within the purposes of this study. Finally, missing these important facts about the work and experiences of first responders means that the study findings have incomplete relevance to the actual experience of our state's firefighters and police officers. For these reasons, I am very reluctant to accept the study findings, which could have large implications for California's first responders.

Response to Comment #11:

The focus of the study was on the presumptions created by SB 542. These apply to

- “(1) Active firefighting members, whether volunteers, partly paid, or fully paid, of all of the following fire departments: ...” LC 3212.15(a)(1)
- “Peace officers, as defined in Section 830.1, subdivisions (a), (b), and (c) of Section 830.2, Section 830.32, subdivisions (a) and (b) of Section 830.37, and Sections 830.5 and 830.55 of the Penal Code, who are primarily engaged in active law enforcement activities.” LC 3212.15(a)(4)

Chapter 2 of the report discusses our approach to occupation coding and to defining comparison groups (pages 24-27). Our analysis of the CHIS and NHIS data relied on Census Occupation Codes, which are derived from Standard Occupational Classification (SOC) codes to group workers. In the WCIS, we used the NIOCCS auto-coding algorithm to impute SOC codes based on the occupation description field and the industry code reported on the First Report of Industry. Because the WCIS data also include WC class codes, we used these to recode any EMTs with class codes for firefighting (7706 or 7707). This change resulted in identification of an additional 509 firefighter WC claims, out of a total of 82,651 firefighter records with occupation codes available, or about 0.6% of all firefighter claims identified in the WCIS.

We acknowledge that firefighters are typically certified as EMTs and are frequently trained as paramedics. The occupation codes that we used to define occupation groups in our quantitative analyses are designed to distinguish between firefighters (who are probably EMTs and may or may not be paramedics) and EMTs or paramedics who are not firefighters.

To confirm that our use of Standard Occupational Classification (SOC) codes to identify firefighters was not excluding firefighter EMTs and Paramedics, we reviewed the SOC coding manual used by the U.S. Bureau of Labor Statistics (BLS). The description of the firefighting profession used by BLS coders recognizes, correctly, that EMT and paramedic work is an important part of firefighting, and so the firefighting occupation as defined in our data should include those who do EMT or paramedic work as an important part of their duties. We also note that the SOC manual indicates that the EMT occupation, as defined by BLS, excludes firefighters. (See p. 110 of the 2018 SOC manual, [available from the BLS website](#).)

We also acknowledge that many correctional officers and other employees of correctional facilities or state hospitals are peace officers under Penal Code sections 830.5 and 830.55. As we discuss on page 26 of the report, we were not able to obtain clear guidance on whether correctional officers will be covered by the PTSD presumption, or if they might be excluded in some circumstances by the requirement that peace officers be "primarily engaged in active law enforcement activities." We assumed that they would not typically be covered, but our understanding is that this question might have to be litigated.

If readers are interested in calculating statistics on workers' compensation claims for a definition of peace officers that includes correctional officers, they can do so by taking a weighted average of estimates for peace officers and correctional officers using the claim volumes in the last row of Table 4.3 (p. 63) as the number of claims filed by workers in each occupational group, and then using the estimates in Table 4.4 (p. 64) to derive the number of claims involving PTSD (or other health conditions) within each occupational group.

Finally, we should clarify that the SOC code for Security Guards, which we used to define the comparison group in this study, explicitly excludes police officers and other law enforcement occupations. (See p. 121 of the 2018 SOC manual, [available from the BLS website](#).)

Commissioner Christy Bouma's Comments and RAND's Responses

Comment #1:

Regarding item #9 in the comments – in addition to PTSD not being measured, suicide completion is not measured. The study also inferred but did not expressly identify how the “hero stigma” influences a first responder’s admission of suicidal ideation, but rather simply concludes that the incidence of such ideation is not significant as measured against other groups. The concept is present but could be more prominently stated.

Response to Comment #1:

We acknowledge that it was not feasible for us to conduct an original analysis of suicide mortality by occupation within California within the time and funding available for this study while also addressing other research aims. In Chapter 3, we discuss published evidence on suicide rates by occupation (pages 32-35), including (p. 33-34) the most recently available estimates from the Centers for Disease Control and Prevention (CDC).

We also acknowledge that survey measurement of suicidal ideation by occupation could be subject to bias if mental health stigma has a larger impact on survey responses in first responder occupations than in the comparison occupations examined here (see discussion of Limitations in Chapter 2, on p. 48). If California policymakers are interested in studying how suicidality and mental health vary across occupations, they may want to consider supporting the inclusion of additional survey items in future waves of the CHIS, as we discuss in the Summary (p. xiv).

Comment #2:

The study identifies frequent denials and frequent reversals, but equally suggests that the data is not reliable to measure the scope of the problem and detail. How long is a first responder languishing in a denied status and how is that impacting cost to employers and additional trauma for the first responder? The failure of our data systems to capture detailed public sector data remains a barrier to analysis of the system failures for California first responders.

Response to Comment #2:

Our study did provide information that indirectly reflects the frequency with which claim denials are reversed. Table 5.2 (pages 90-91) reports the proportion of claims that receive indemnity benefits following an initial claim denial. Findings are discussed on pages 87-92. Initially denied claims that ultimately receive paid indemnity benefits are likely to have been reversed. However, more detailed questions related to the length of time between claim denials and reversals were not within the scope of the study, and we did not address these questions here.

Our study relied on secondary analysis of WCIS data as a readily available source of comparable data on employers and claims administrators across the state. While the WCIS, like all data sources, has limitations, we are not aware of any alternatives that would provide better coverage of public-sector employers—especially self-administered public-sector employers.

General Comment:

How is it that there could be a statutory requirement for a determination of compensability on or before 90 days, but no system of data captures the status of such a claim at 90 days?

Response to General Comment:

It may be possible to examine the timing of initial claim denials using WCIS data, but issues related to the timeliness of initial denials or other milestones in the claim process were not specified in the scope of this study and we were not able to pursue them in this study.

We agree that the incompleteness of data from some public agencies poses a barrier to policy analysis and research on how well the workers' compensation system is serving first responders. We note that other analysts, such as WCIRB and CWCI, conduct special surveys of their members (insurers and claims administrators) to gather data that is not routinely reported in transaction-based or unit statistical report data submissions. Similar surveys focusing on issues specific to public-sector employers could be conducted (either by those organizations, by DWC, or by other independent researchers). However, it is not clear that claims administrators that do not submit complete data to the WCIS would be able or willing to provide high-quality data in response to a survey. This might be particularly challenging for smaller self-administered agencies that may have limited resources.

Last Comment:

Lastly, to reflect on a helpful finding in the study. The study's conclusion regarding the lack of access to culturally competent providers is alarming, but important to know. This is a significant finding that requires an urgent response from policy makers and the administration.

Response to Last Comment:

We agree this is an important finding that warrants further attention from policymakers. Thank you for highlighting this.

Commissioner Nicholas Roxborough's Comments and RAND's Responses

Comment #1:

For a study to be of value there obviously must be a valid statistical basis for those who are interviewed. However, such appears to not be the case here where the 13 individuals were not randomly selected.

Response to Comment #1:

Qualitative interviews allow relevant respondents to share information in their own words about their views and experiences. Interviews are useful for gathering detailed information and understanding social processes such as claim filing for mental health conditions. The aim of qualitative research is to understand the social reality of individuals and cultures, gathering information about views and experiences from relevant stakeholders. In contrast to quantitative studies that prioritize representativeness and generalizability, qualitative methods draw upon small samples to understand complex phenomena, prioritizing the collection of rich descriptive data as a critical first step in addressing a problem.

We also note that all quantitative estimates in the report (as in Chapters 3, 4, 5, and 6) had either large probability samples (Chapter 3) or used administrative data designed to capture the entire population of claims (Chapters 4, 5, and 6), and thus should be viewed as providing valid estimates of quantities in the relevant populations of interest in those chapters.

In Chapter 3, the population of interest consists of first responders and other workers employed in California between 2013 and 2019. We used 7 years (2013-2019) of the CHIS, which uses random sampling to produce population-based estimates for California as a whole, for major geographic areas (most counties), and for racial and ethnic groups within California. All estimates reported in the study used sampling weights from the CHIS to produce representative estimates. As described in Table 3.1 (pages 40-41), we analyzed a sample of 73,969 workers in California, including 136 firefighter survey respondents and 343 peace officer survey respondents.

In subsequent chapters, we used administrative data from the WCIS, which is intended to capture all workers' compensation claims filed in the state. We acknowledge that the sample of usable data is limited by missing variables and by systematic reporting issues at a number of claims administrators. That said, the sample sizes available for our analysis are large enough that sampling error is small. As described in Table 4.3 (p. 63), we analyzed a sample of 2.9 million claims with dates of injury between 2008 and 2019, including 32,592 claims filed by firefighters and 82,966 claims filed by peace officers.

Comment #2:

Nor would 13 of 30,000 employees, even if randomly selected, be deemed sufficient upon which to present the kind of information that apparently was being requested. Such is probably only valuable from an anecdotal standpoint.

Response to Comment #2:

The inclusion of 13 responders was not intended to be a representative sample of a group of 30,000 employees. See the aim of the qualitative interviews in Response #1 above.

We also note that the study contains extensive quantitative analysis of survey and administrative datasets with samples larger than 13, as detailed in our response to Comment #1. As noted above, those estimates are representative of the relevant populations of interest.

Comment #3:

I would therefore recommend that if there is to be a useful study conducted that there first be a valid statistical sample created from which meaningful information can then be drawn and recommendations made.

Response to Comment #3:

As noted above, the quantitative analyses in the study either used random samples (in the CHIS and NHIS) or used administrative data on all claims reported to the WCIS, which is the most complete existing source of claims data.

For questions that cannot be addressed with existing secondary data sources, we agree that a constructive next step would be to develop a survey and construct a representative sample of first responders across California. We hope that both the quantitative and qualitative findings of our study can help to inform the design of such a survey in the future. See our Response to Comment #2 from Commissioner Kessler (above) for further discussion of how our results might support future survey research on first responders' experiences in the California workers' compensation system.