

DELVING INTO THE ROOT CAUSE OF THE WORKERS' COMPENSATION CLAIM



PARMA 2016

CHARACTERS



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THE ACTS

- ❖ Act One
 - ❖ Workers' Compensation Statistics
- ❖ Act Two
 - ❖ The Vision
 - ❖ Plan, Pilot and Implement
- ❖ Act Three
 - ❖ Data Analysis
 - ❖ Future Plans



CLAIM STATISTICS

- ❖ Since 2010, indemnity claim frequency in California has continued to increase.
 - ❖ AY2012 – 3.2% ↑
 - ❖ AY2013* – 3.9% ↑
 - ❖ AY2014* – 0.9% ↑
 - AY2013 and AY2014 totals are estimated
- ❖ Continued increase recognized to number of continuous trauma and multiple body part claims filed.
- ❖ 80% of continuous trauma claims involve attorneys.



CLAIM STATISTICS

- ❖ By 2006, medical costs were on the rise confirming the 2004 reform was short-lived.
- ❖ Average medical paid per indemnity claim, valued at 12 months.
 - ❖ AY2006 - \$5,282 (12.2% ↑)
 - ❖ AY2012 - \$7,353 (5.2% ↑)
 - ❖ AY2013 - \$7,631 (3.8% ↑)
- ❖ Greatest increase noted in pharmacy and durable medical equipment.
 - ❖ 232.6% ↑ between AY2005 to AY2013



CLAIM STATISTICS



- ❖ Indemnity costs demonstrated similar trends as medical costs
- ❖ Average indemnity paid per claim, valued at 12 months.
 - ❖ AY2006 - \$5,452 (13.8% ↑)
 - ❖ AY2012 - \$6,501 (7.6% ↑)
 - ❖ AY2013 - \$7,391 (13.7% ↑)

CLAIM STATISTICS



❖ Estimated Ultimate Total
Loss per Indemnity Claim

❖ 2006 - \$63,437

❖ 2012 - \$87,232



DATA ANALYSIS

10 Leading Causes of Workplace Injury in 2012

- ❖ Overexertion (25.3%)
- ❖ Falls on same level (15.4%)
- ❖ Struck by object or equipment (8.9%)
- ❖ Falls to lower level (8.6%)
- ❖ Other exertions or bodily reactions (7.2%)
- ❖ Roadway incidents (5.3%)
- ❖ Slip or trip without fall (3.6%)
- ❖ Caught in/compressed by equipment or objects (3.5%)
- ❖ Repetitive motions involving microtasks (3.1%)
- ❖ Struck against object or equipment (2.9%)

NEWS FLASH

The only good workers'
compensation injury is
the one that doesn't
occur.



THE VISION

❖ California JPIA implemented “Lessons Learned” in 2010 on the liability program.

❖ Intended to identify risk within policy and/or process; or items where immediate corrective action is required to avert future incident.

❖ Prepared analysis reviewed with member agency



THE VISION

- ❖ A Lessons Learned success story
 - ❖ Member agency with civil claim for use of excessive force by police officer.
 - ❖ Forensic review of case facts, policy and procedure was shared with entire police department.
 - ❖ Resulted in reduction of allegations and complaints.
- ❖ How can this success be replicated in the workers' compensation program?



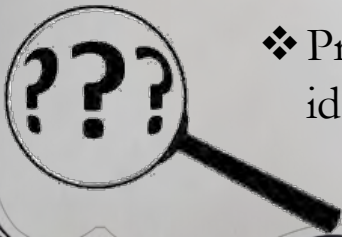
PLAN, PILOT AND IMPLEMENT

- ❖ What is the Root Cause?
 - ❖ Generally, there are three causes to every accident: the immediate cause, contributing or surface cause, and root cause.
 - ❖ Example: If an employee breaks their arm after slipping on a wet floor, the immediate cause of the injury is that the employee slipped in a puddle of water, the surface cause is that the floor was wet because the water had not been cleaned up, but the root cause of the puddle and subsequent injury is a leaking pipe.

PLAN, PILOT AND IMPLEMENT

❖ Benefits of a Root Cause Analysis

- ❖ Identify trends within departments where organizational lasting improvements can be made.
- ❖ Loss control measures can be implemented based on tangible evidence of cause and effect.
- ❖ Promotes safety and accountability by involving key stakeholders in analysis.
- ❖ Provides an avenue to help control future losses by identifying where the process or task failed.



PLAN, PILOT AND IMPLEMENT

❖ Factors to consider

- ❖ Workers' Compensation is a no-fault system
- ❖ Workers are unionized
- ❖ Process should be easily implemented into current process



PLAN, PILOT AND IMPLEMENT



- ❖ Program not centered on blame, but loss prevention and control.
- ❖ Develop effective safety culture that reduces workers' compensation claims.
- ❖ Root cause factors should be limited to be effective.
- ❖ Employee, supervisor and organization are responsible

PLAN, PILOT AND IMPLEMENT

❖ Employee Responsibilities

- ❖ Active participation in Illness and Injury Prevention Program
- ❖ Continuous practice of safety compliance
- ❖ Use only safe tools and equipment
- ❖ Wear required PPE - shoes, glasses, etc.
- ❖ Notify supervisor of accidents, near misses, spills, fires, hazards or damaged equipment
- ❖ Notify supervisor of any impairments



PLAN, PILOT AND IMPLEMENT

❖ Supervisor Responsibilities

- ❖ Leadership - good example; attitude
- ❖ Provide resources - equipment/guidance
- ❖ Safety in work plans/evaluations
- ❖ Feedback on safety & enforcement
- ❖ Ensure training is provided
- ❖ Respond immediately to safety issues



PLAN, PILOT AND IMPLEMENT

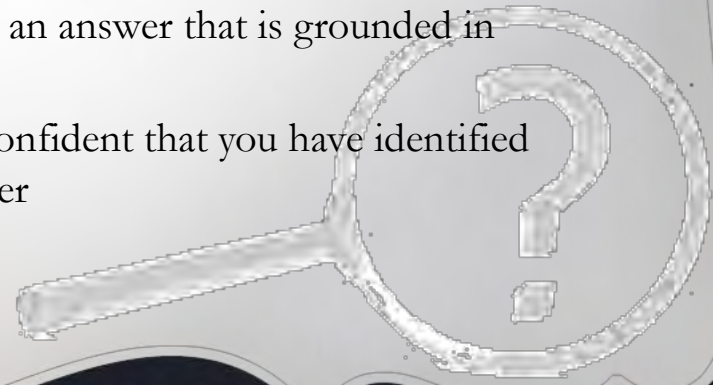


- ❖ Organizational Responsibilities
 - ❖ Management commitment is the key
 - ❖ Ultimate responsibility for safety
 - ❖ Legal obligation to provide safe workplace
 - ❖ Provide leadership & make safety a priority
 - ❖ Display proper attitudes; provide resources

PLAN, PILOT AND IMPLEMENT

❖ The 5 Why's Technique

- ❖ Developed in the 1930s by Sakichi Toyoda, founder of Toyota. Still used by Toyota today.
- ❖ Simplicity of this tool gives it great flexibility, and it combines well with other methods and techniques.
- ❖ Each time "why" is asked, look for an answer that is grounded in fact.
- ❖ Keep asking "why" until you feel confident that you have identified the root cause and can go no further



PLAN, PILOT AND IMPLEMENT



- ❖ Agencies in workers' compensation pool – 108
- ❖ Pilot initiated with 8 agencies
 - ❖ Included agencies with safety personnel
 - ❖ Different regions throughout California
- ❖ Supervisor report modified to include root causes
- ❖ Training with participating agencies and TPA
- ❖ Root cause identified on supervisor report and confirmed during 3-point contact process



PLAN, PILOT AND IMPLEMENT

EQUIPMENT

- Malfunction
- Safety guard(s) modified
- Safety guard(s) missing
- Improper use of tool or material
- Defective tool(s) used
- Improper protective equipment, clothing
- Defective protective equipment, clothing
- Inadequate protective equipment, clothing

WORK ENVIRONMENT

- Arrangement of equipment, work flow, tools
- Poor housekeeping – cleanliness and organization

POLICY/PROCEDURE

- Unsafe procedures or work practice
- Policy and/or procedures missing
- Policy and/or procedures inadequate

TRAINING

- Employee was not trained for this task or assignment

SUPERVISION

- Policy and/or procedures not enforced

WORKER

- Horseplay, unsafe behavior
- Short cuts, carelessness
- Distracted, inattentive
- Non-Preventable
- Presumption

PLAN, PILOT AND IMPLEMENT

❖ The Investigative Process

Injury
Reported by
Employee

Supervisor
Incident
Report

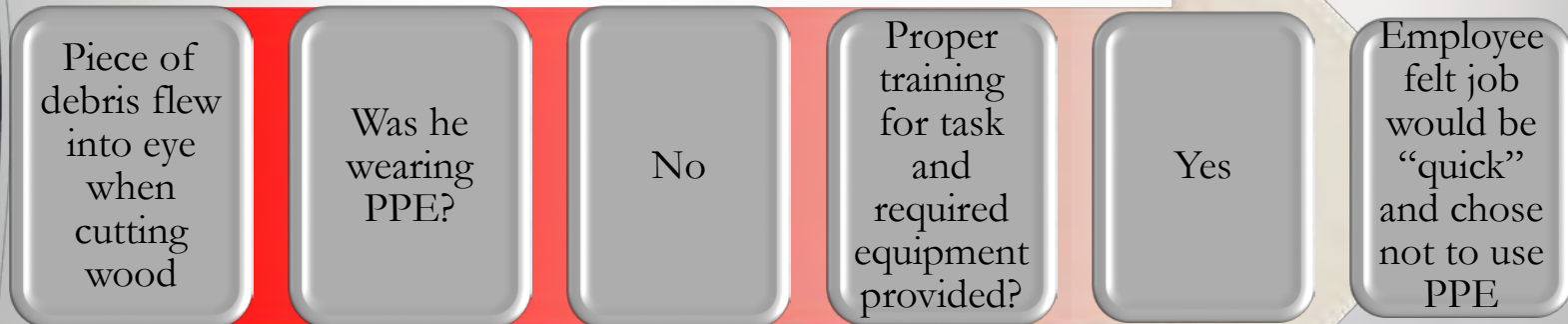
Claim
Reported to
York

Contact
with
Stakeholders

Root Cause
Identified

Data
Captured
for Analysis

PLAN, PILOT AND IMPLEMENT



Root Cause: Employee failed to follow policy or procedure

PLAN, PILOT AND IMPLEMENT

❖ Initial observations

- ❖ Training at locations may not have trickled down to frontline supervisors.
- ❖ Difficulty in understanding in concept of root cause in a no-fault system.
- ❖ Member agencies not consistent with use of supervisor's report
- ❖ Non-preventable root cause became catch-all



PLAN, PILOT AND IMPLEMENT

- ❖ Follow up training at member agencies
 - ❖ Frontline supervisors are key to effecting lasting change

- ❖ Investigation now fully conducted by TPA
 - ❖ No longer reliant on receipt of supervisor report

- ❖ Removal of non-preventable root cause

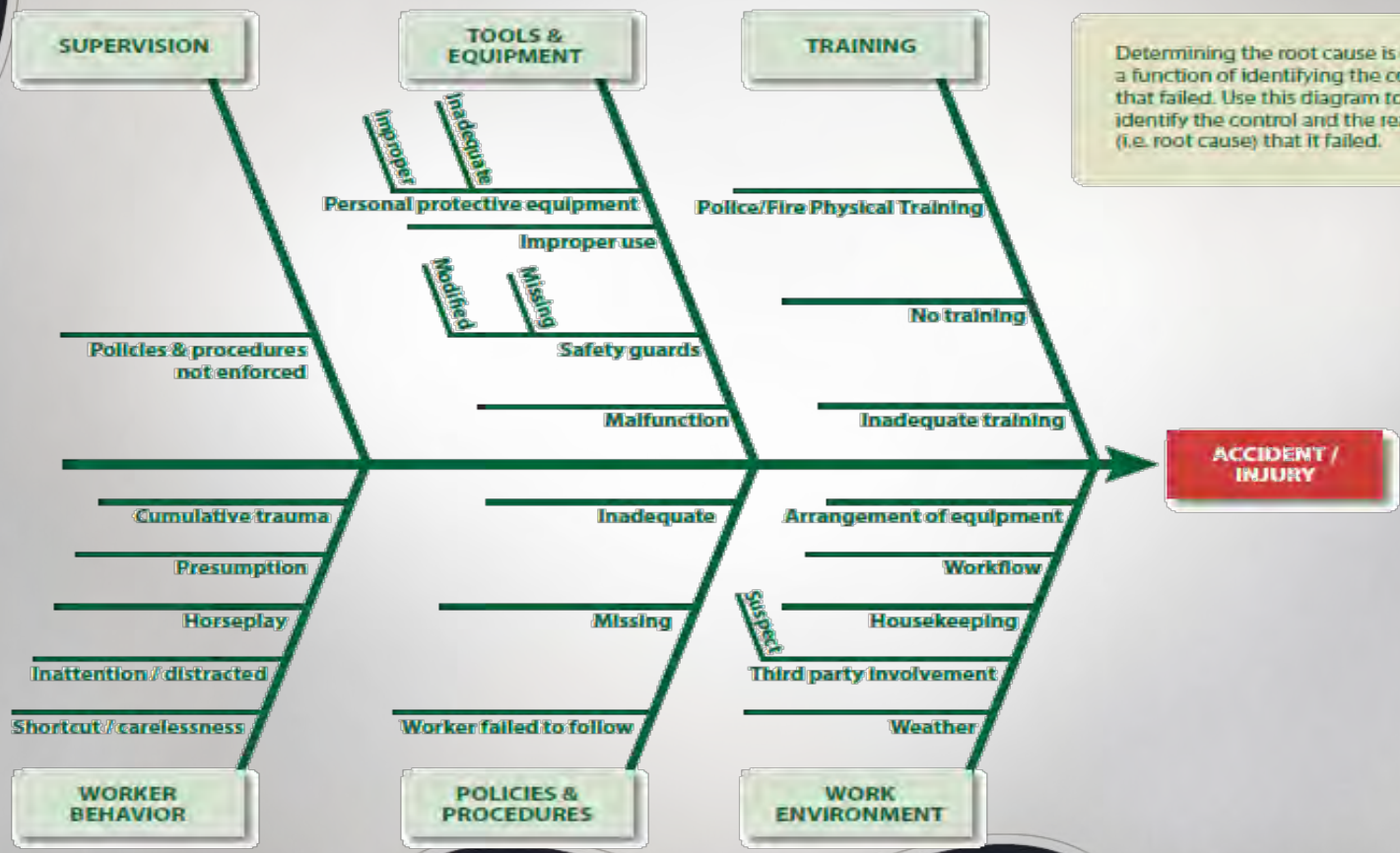
- ❖ Addition of four new root causes
 - ❖ Police/Fire Training
 - ❖ Weather
 - ❖ Continuous trauma/Repetitive Strain
 - ❖ Third Party - Suspect



Equipment	
Malfunction	Includes any power and non-power equipment that failed to operate properly, broke during use, or malfunctioned.
Safety guard(s) modified	Employee used a tool with proper safety guards in place, but modified to prevent proper operation.
Safety guard(s) missing	Employee utilized a tool without the proper safety features.
Improper use of equipment or material	Employee failed to use the equipment or material properly.
Defective tool(s) used	Employee utilized a tool/equipment that was defective.
Improper protective equipment or clothing	Employee utilized protective clothing or equipment not specific to the operation.
Defective protective equipment or clothing	Employee had proper protective clothing or equipment, but was defective.
Inadequate protective equipment or clothing	Employee lacked the proper protective clothing or equipment for the operation.
Work Environment	
Arrangement of equipment, work flow, tools	Area in which employee was operating was not orderly and contained noticeable hazards.
Poor housekeeping – cleanliness and organization	Walking surface, water on floor, loose electrical cords, rugs not tacked down, improper or poor lighting, improper or poor ventilation, and signage.
Third party causation	Injury caused by a third party. Employee followed all policies and procedures.
Third party causation – suspect	Injury caused by suspect. Employee followed all policies and procedures.
Weather related	Injury was a direct result of weather related conditions. Employee followed all policies and procedures.

Policy / Procedure	
Unsafe procedures or work practice	Employee failed to follow procedures or training.
Police/Fire Department Training	Employee was injured as a direct result of a training exercise.
Policy and/or procedures missing	Agency does not have policy or training in place to address action/mechanism performed when injury occurred.
Policy and/or procedures inadequate	Agency has inadequate policy or training to address action/mechanism performed when injury occurred.
Training	
Employee was not trained for this task or assignment	Employee has not or did not receive training for the use, operation, or safe work practices.
Supervision	
Policy and/or procedures not enforced	Employee failed to follow policy/procedure.
Worker	
Continuous Trauma/Repetitive Strain	Injury caused over period of time, no acute traumatic incident occurred.
Horseplay, unsafe behavior	Injury caused while engaging in horseplay or inappropriate behavior.
Short cuts, carelessness	Employee showed lack of concern about the consequences of the action.
Distracted, inattentive	Includes injuries caused by lack of attention to detail, surroundings, etc.
Presumption	Injuries or Illness specific to certain classes of employees presumed to be compensable under state law. Example – skin cancer for lifeguards.

INJURY AND ILLNESS CONTROL FAILURE AND ROOT CAUSE DIAGRAM



Determining the root cause is often a function of identifying the control that failed. Use this diagram to help identify the control and the reason (i.e. root cause) that it failed.

PLAN, PILOT AND IMPLEMENT

- ❖ Rollout to entire membership
 - ❖ Presentations to membership during pilot phase introduce concept
 - ❖ News article in monthly newsletter
 - ❖ Included link to the revised supervisor report
 - ❖ Regional Risk Managers discussed program with key stakeholders



DATA ANALYSIS

- ❖ Claims reported 08/2014 through 06/2015

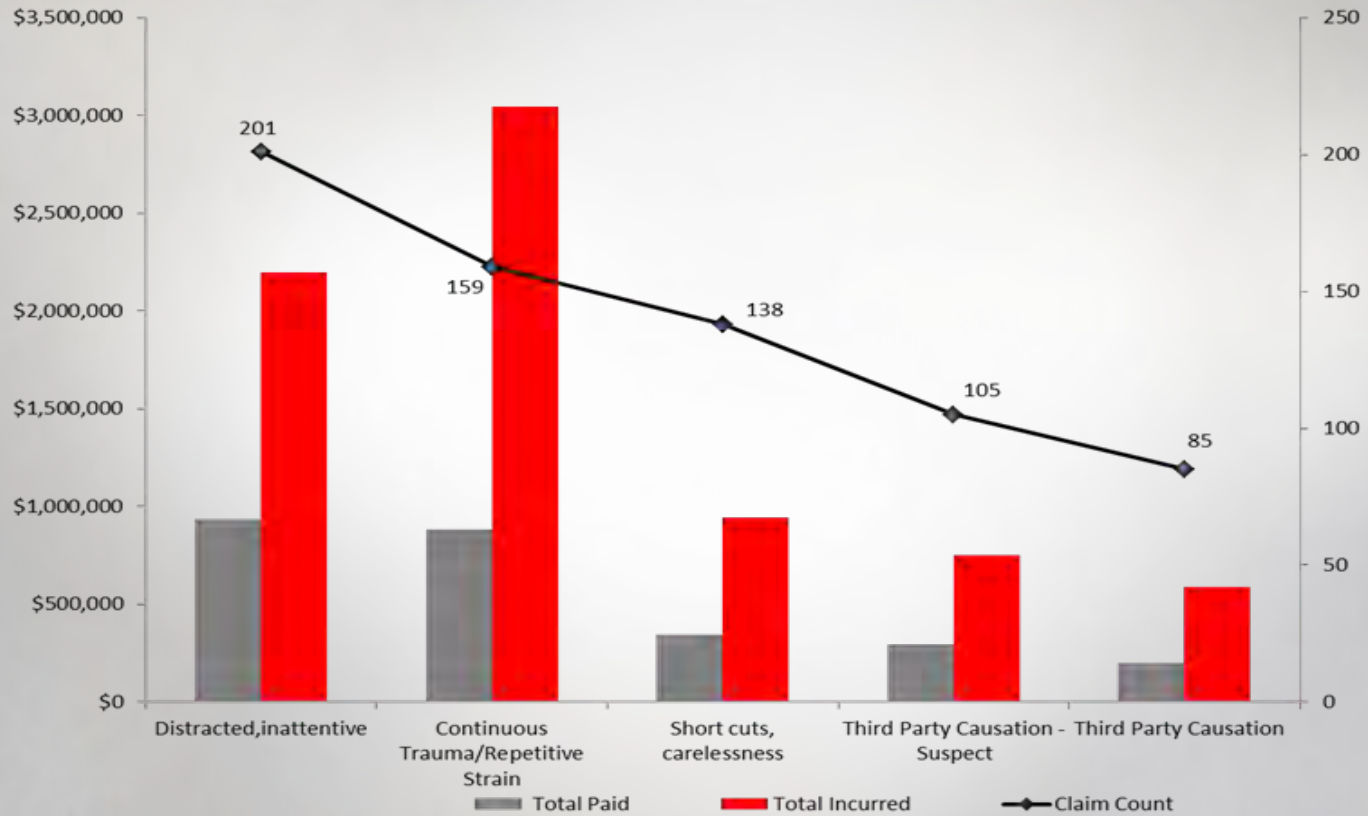
- ❖ 1,068 claims
- ❖ Total Paid \$4.0 million
- ❖ Total Incurred \$10.9 million

- ❖ Top Five (5) Root Causes of Injury

- ❖ Distracted/Inattentive
- ❖ Continuous Trauma/Repetitive Strain
- ❖ Short Cuts/Carelessness
- ❖ Third Party Causation- Suspect
- ❖ Third Party Causation

- ❖ Accounts for 64% of reported claims
- ❖ Accounts for 65% of total paid





DATA ANALYSIS

Distracted/Inattentive

❖ Medical Only (134 claims)

❖ \$120,000

❖ Indemnity (67 claims)

❖ \$2.1 million

Continuous Trauma/RSI

❖ Medical Only (39 claims)

❖ \$41,000

❖ Indemnity (120 claims)

❖ \$3.0 million

DATA ANALYSIS

Distracted/Inattentive

- ❖ Municipal-Manual Labor (86)
- ❖ Police (43)
- ❖ Fire (24)
- ❖ Municipal – Non Manual (23)

Continuous Trauma/RSI

- ❖ Municipal-Manual Labor (69)
- ❖ Police (35)
- ❖ Fire (17)
- ❖ Municipal – Non Manual (16)

DATA ANALYSIS

- ❖ Calculating a Return on Investment (ROI)

Cost of Problem X Likely Recurrence / Cost of Fix =

Return on Investment



DATA ANALYSIS

❖ ROI Example

- ❖ Maintenance Worker injured back when lifting box of supplies
- ❖ Root Cause: Not adequately trained
- ❖ Department Size: 20
- ❖ Claim Cost: \$2,500
- ❖ Training provided during tailgate safety meeting

$$\$2500 \times 10 / \$0 = \$25,000$$



FUTURE PLANS

- ❖ Immediate escalation of emergent trends or high-risk root cause identification, i.e., missing safety guards, lack of policy.
- ❖ Complete data analysis in order to identify pool-wide trends and patterns.
- ❖ Incorporate data into Loss Prevention program.



FUTURE PLANS



- ❖ Develop member specific training that assists member in establishing control needed to prevent claim from recurring.
- ❖ Deliver training through a variety of modes, including small group, webinar and train-the-trainer.
- ❖ Measure and monitor results for ROI

The
End.